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SOCIOCULTURAL INFLUENCES UPON PSYCHIATRIC DISEASES IN EGYPT: A STRESS MODEL

by

© MOHAMMED FAROUK MAHMOUD MAHMOUD EL SENDIONY

A THESIS

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "Socio-Cultural Influences Upon Psychiatric Disorders in Egypt: A Stress Model" submitted by M. Farouk El-Sendiony in partial fulfilment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

This dissertation describes a research effort focussed on the relation between culture and mental disorder in a non-Western society. The study concentrates on the patients admitted to a state psychiatric hospital and to a private hospital, both in the city of Cairo. Some statistics with regard to Ain Shams University Psychiatric Clinic in Cairo were also used.

The dissertation demonstrates how the use of life histories can help the fieldworker locate areas of stress in a society such as, in the Egyptian case, being low class, being a female, and being young. Since psychiatric theory assumes that stress is an important etiological factor in conditioning people to schizophrenia, it was hypothesized that the schizophrenic rate of hospitalized patients would be higher in areas of maximal stress than in areas of minimal stress. An examination of the schizophrenic rate revealed that it was significantly high in the lower class and among younger patients, but low among Egyptian women patients. The high schizophrenic rate in the lower class and among the young supports the stress model developed in the study, whereas the low rate among Egyptian women patients is not consistent with the hypothesis. Explanation of this might be found in the cultural barriers to the hospitalization of women patients in Egyptian society.

Despite this low schizophrenic rate among Egyptian women patients, a psychiatric epidemiological survey revealed that psychoneuroses occur more frequently in the female; that the suicide rate is higher in the female than in the male category; that extremely overt manifestations of psychopathology prevail more frequently among hospitalized women than

among men patients and, finally, that the death rate of women patients is significantly higher than that of men. This high rate of morbidity among Egyptian women may be a function of high sociocultural stress.

Another point of interest is whether the Egyptian culture presents cases which defy classification according to the standard nomenclature of Western psychiatry. The findings suggest the universality of psychiatric syndromes and that the same clinical clusters of behavioral traits that provide the basis for Western diagnostic classification can be found in Egyptian society.

However, significant differences frequently exist. Senile psychoses, as an illustration, are rare in Egypt. There are also few cases of alcoholic psychosis. The findings also reveal that the content of symptomatology of Egyptian mental patients is different from its Euro-American equivalent.

These differences in content and frequency of mental illness in Egypt appear to be a function of the difference in cultural milieu.

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Chapter I

INTRODUCTION

A. Research Problem

In the broadest sense this dissertation is concerned with the evaluation of cultural factors in the etiology, symptomatology, and frequency of mental disorders in Egypt. More particularly, special attention is directed to the formulation of a model which attempts to relate schizophrenia to the stressful conditions impinging upon the individual.

Of all the psychoses, the schizophrenic syndrome is probably the most common. It is the writer's opinion, based on psychiatric findings and his analysis of the life histories of patients, that the different degrees of stressful conditions associated with social class, sex, and age play havoc with the human organism and precipitate and maintain this disorder. The fact that stress and strain are distributed differentially by social class, sex, and age, thus leads to the conclusion that schizophrenic rate differentials are also associated with such social variables.

The author thus employs what might be called a "Stress Model of Schizophrenia" as a theoretical or inferential construct and maintains that, as such, it has heuristic and explanatory value. The explanatory value of the model itself consists largely of specifying differential rates of schizophrenia for the various parts of the Egyptian social structure.

In sum, the *independent* variables in the model are social class,

sex, and age, and the rate of schizophrenic reaction types is the *dependent* variable. The amount of stress experienced by the patient is an *intervening* variable.

The relationship among the various levels analyzed in the dissertation are diagrammed in Figure 1. Level 3 refers to the reality itself (in this case, schizophrenia) which causes the patient to involuntarily withdraw from society.[1] This level cannot be observed directly but, as in the case of disease generally, must be inferred from symptoms and from a knowledge of the etiology of the situation. On the symptomatic level, the examination of individual symptoms can be quite misleading. Thus it is only when a typical *syndrome* of symptoms is present that it becomes possible to postulate the presence of a particular disease. But the presence of such a syndrome can even be interpreted differently as in the common case of conflicting diagnoses on the part of psychiatric experts present at judicial trials.

For this reason, a knowledge of etiological factors assumes great importance. Being able to follow the course of the development of a disease is obviously more satisfactory than relying on the observation of symptoms alone. Since most mental disorders come to light after the fact — thereby ruling out a precise knowledge of etiology,[2] the second-best approach is to determine through various sorts of interviewing techniques whether certain factors associated statistically with the occurrence of a particular mental disorder (epidemiology) are present or not in the case of a particular subject.

The goal of psychiatric anthropology is to eventually be able to make valid cross-cultural generalizations concerning levels 2, 3, and 4.

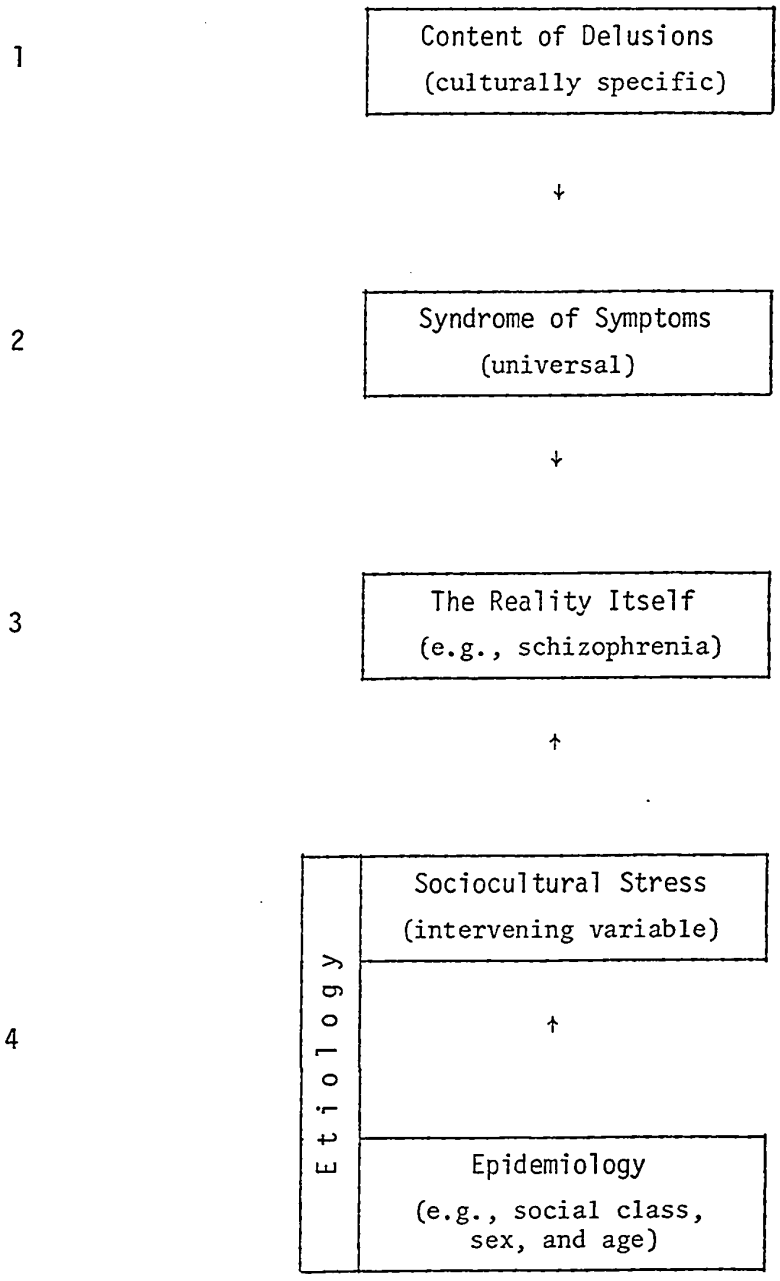

Figure 1. The four levels investigated in this dissertation.

Level 1, however, is culturally specific in that it deals with the cultural *content* of one element in the schizophrenic syndrome — namely delusion.

B. Organization of the Thesis

Chapter II opens with a brief sketch of the nature of Egyptian society and its traditional culture. This sketch does not purport to be a complete ethnography but is included to portray possible determinants of the psychopathology of Egyptian culture. In Chapter III the methodological procedures of the study are given.

Turning to the psychiatric data in Chapter IV, the most important chapter, a content analysis of dominant themes of stress in the life histories of the patients investigated is presented. The dominant themes are treated statistically (with due caution) in order to establish their significance. Their distribution is arranged according to social class, sex, and age. Levels of significance are derived from calculations of Chi square. The various areas of stress in the Egyptian social structure are located and rank ordered.

Chapter V is primarily devoted to rates of mental illness. The "Stress Model of Schizophrenia" is not only proposed; it is also tested. That is, different rates of schizophrenia are predicted for different social class, sex, and age groups before the actual rates are known. In addition, an epidemiological survey of the psychiatric morbidity in Egypt is made involving the distribution of various types of psychiatric problems according to social class, sex, and age, the overt manifestation of psychopathology, and the death rates of psychiatric patients.

Chapter VI is devoted to the cultural elements of symptoms. Although it was hypothesized that mental illnesses are basically the same in Egyptian and in Western cultures, it is to be expected that the symptoms would be coloured by Egyptian cultural patterns. Basically the question is *how* and to *what extent* Egyptian culture affects the content of delusions. In the present study, delusions and other symbolic patterns are correlated with each patient's social class and sex, and the content of delusions occurring in patients of different class background are compared. Change in the content of delusion over time is also considered.

C. Review of the Literature

The study of mental illness as seen in the broad framework of cultural differences and determinants is of increasing importance in anthropology, as the development of the field of "psychiatric anthropology" testifies. Such studies as those of Opler, Leighton, Murphy, and others on the social and cultural background of mental illness are indicative that the study of mental illness has become a legitimate area for anthropological investigation.

Within recent years a number of research projects have investigated various aspects of mental illness in its community and societal setting. These investigations have included epidemiological efforts to locate *actual* prevalence and incidence rates for community and county populations, as well as relational studies which have attempted to link *differential* rates and patterns of illness with sociocultural factors of possible etiological significance (Kennedy, 1970). To date, these

research efforts in the field of social psychiatry have included very few epidemiological studies in non-Western societies, and also very few comparative studies of patterns of psychiatric disorder.

As the interest of some researchers begins to turn to cross-cultural studies, it seems appropriate to explore the major dimensions of this problem area in some detail. The study this thesis describes is the first of its kind in the Middle East. Beside providing badly needed additional data on Egypt, and thus on contemporary Middle Eastern culture and mental illness, this study may provide data useful to the development of theory in psychological anthropology, psychiatry, and the dynamics of sociocultural change. The discovery of direct or even circumstantial evidence that some mental disorders are significantly related to specific culture patterns may be important not only in itself; as in any advancement in human knowledge it can lead to new ways of inquiry into the psychiatric problems that remain unanswered.

Concerning the question of relationship between sociocultural factors and mental disorders, no crucial scientific finding which could be viewed as a "major breakthrough" in showing the relevance of anthropological theory for explaining functional mental disorders has been discovered. However, there have been a number of published conferences, a few summary reviews attempting to assess the relationship between cultural differences and mental disorder, and a few empirical studies which have contributed to our information in this field. Even so, little has been added to our theoretical sophistication in this new area (Dunham, 1959).

In 1949, a conference sponsored by the Milbank Memorial Fund on

the epidemiology of mental disorders[3] attempted to review our social knowledge about mental disorders, including minor psychiatric disturbances, to examine the central methodological issues, and to stimulate the development of more interdisciplinary efforts in this area. While in the light of these goals the conference could be regarded as successful, it did not succeed in coming up with major suggestions or insights whereby the various epidemiological studies would make a more definitive contribution to our knowledge of etiology (Dunham, 1959).

Another conference was inaugurated by this Fund in 1952[4] to explore interrelationships between the sociocultural environment and mental disease. As in the first conference, the emphasis was interdisciplinary and there was a clear recognition of the necessity for investigators in any field to understand and incorporate in their theoretical framework the concepts and theories from the other fields (Dunham, 1959).

The conference consisted of five theoretical papers and the reports of nine on-going projects bearing on the epidemiology of mental illness. Again, while these papers and reports were informative — all trying to come to grips with the problem of clarifying in a more definitive fashion the relationships among social structure, culture, and mental illness — none of them succeeded in adding major new insights concerning the possible relationships.

From the viewpoint of theory we need, among other things, to understand how social events are experienced and interpreted by the person whose behavior we are investigating. To do this, we have to investigate possible functional linkages between sociocultural variables

and the development of "disturbed" behavior in the individual. Unfortunately, all too often in the literature, contradictory statements are made about the effects of social factors on psychiatric disorders. For example, Kubie (1957) pointed out in a paper that wealth is accused as the cause of mental disease as often as poverty, and license is blamed for maladjustment as much as stern discipline.[5]

The specialties of science are usually linked directly to various kinds of phenomena in the world or to various levels of conceptualization. In an age of specialization in science, psychiatry finds itself without an integrative frame of reference for dealing with a subject matter that straddles several levels of organization. The expert in neurophysiology can describe how certain processes of the central nervous system are linked to a limited range of mental disorders. The biochemist and pharmacologist can tell something about the types of chemical compounds which appear to affect the emotional states and behavior of certain classes of disturbed patients, as well as normal persons. The personality psychologist provides information on the psychic traumas of the patient's early life. The sociologist speaks in the context of community disorganization which surrounds the ill individual. And the anthropologist points to the factors of rapid acculturation which immerse certain individuals in conflicting cultural worlds (Kennedy, 1970).

All of these specialists have something to contribute to our understanding of mental illness and mental health, but they do not speak the same language, nor do they conceptualize the phenomena according to a common set of basic assumptions and primary units of analysis.

In 1959, a Ph.D. dissertation entitled "Cross-Cultural Study of

Mental Disorders," was submitted to Cornell University. Its author, D.A. Kennedy, reported on two pilot studies conducted among the Navaho Indians of the American Southwest in order to test out specific research problems and strategy under field conditions. However, his thesis did not present a major analytical framework for the conduct of cross-cultural studies in the field of mental illness. Analytical schemes are mentioned and suggestions are made, as to the direction in which theory construction might proceed but there was no attempt to provide a frame of reference or a theoretical model for the empirical research under discussion.

One of the major figures in the area of "psychiatric anthropology" is Alexander H. Leighton. He supervised the Stirling County Study (an on-going project, 1948 - 1959) conducted by Cornell University in collaboration with the Department of Public Health of the Province of Nova Scotia. This epidemiological survey is relevant to the desire to increase knowledge about the etiology of psychiatric disorder and to Leighton's belief that sociocultural factors are important and worthy of exploration. In his view, the advance on these large questions was small. However, the principal relevant findings of the Stirling County Studies can be summarized as follows: persons of low socioeconomic status are more likely to have psychoses and brain damage than persons of higher status; this is manifested in their behavior, such as failure to plan ahead, susceptibility to depression, lack of friendliness and personal trust, greater authoritarianism, acting out problems, and passive dependence (Torre, 1960). In general, this study revealed that in socially and culturally disintegrated communities, more people are found to have psychiatric symptoms than in integrated communities (Leighton & Lambo,

1963).

However, a question remained unanswered. This question can be put simply as follows: Are disintegrated communities producing a high frequency of psychiatric disorder in their members, or is it rather that social process tends to precipitate inadequate personalities together so that they form disintegrated communities? As part of the Stirling County Study an attempt was made to answer this question from historical and migration data. The indications were that sociocultural disintegration comes first, but the evidence was not conclusive.

The fact that the Stirling project developed criteria for identifying degrees of sociocultural disintegration and found marked differences in communities so distinguished, opened up a more promising approach. If one could replicate aspects of the Stirling Study in a wholly different cultural group organized on a tribal basis where downward drift of individuals in the social system does not occur, this would provide data with some further bearing on the hypothesis. That is to say, if integrated and disintegrated units could be found within the same tribe, where there is presumably over-all genetic homogeneity, and if the factors producing the disintegration were external to the units and not self-selected, this would provide a basis for more definitive investigation regarding the relationship of sociocultural environment to disorder. The reason for emphasizing that the change should not be self-selected is to avoid the possibility that in the population studied certain kinds of personalities with a tendency to disorder on a constitutional basis would, more than others, be the very ones who seek change.

When A. Leighton visited T. Adeoye Lambo, a Nigerian psychiatrist

from the Yoruba group in West Nigeria, he discovered by accident that they had a common epidemiological interest. This resulted in a replication of the Stirling Study in a Nigerian cultural setting. In this study[6] Leighton, Lambo, and others believed it important to give primary emphasis to the questions of method and background information, and to make sure that success with these questions was not jeopardized by overloading themselves in operations consequent upon more ambitious aims. Therefore, emphasis on the illumination of theory was postponed for later studies that might be carried out on the basis of the results obtained in this study.

In summary, a review of the literature indicates a lack of theory in the field of psychiatric anthropology. In view of this situation, this thesis is primarily an exploratory analysis of data gathered in Egypt during the summer of 1971. It is hoped that this exploration will contribute to the development of a more adequate theoretical framework for future research.

Chapter II

ETHNOGRAPHIC BACKGROUND

The purpose of this section is not to provide a complete ethnography of Egyptian culture but merely to introduce those aspects of Egyptian culture and society which are directly relevant to the empirical research presented later in the thesis. These aspects include the supernatural emphasis in Egyptian culture, native folk beliefs concerning mental illness, and sociocultural variables related to the etiology of mental illness such as social class, status of women, and position of young people. All this cultural information came from secondary sources but it is important for the problem.

Egypt was one of the first countries to be incorporated in the expanding Arab empire 1,300 years ago. An Islamic nation ever since, Egypt is commonly identified by its own people and others as an "Arab" country. There is justification for this claim in Egypt's centuries under Arab rule, in its Arabic speech and Moslem faith, and in its current effort to place itself at the head of a revived and united Arab world. There is, however, a specific quality about Egyptian life, a distinctiveness which has its roots in a pattern of existence in the Nile Valley long antedating the rise of Arab Islam. While Egypt shares much with its Middle Eastern neighbors, it remains unique.

A. The Supernatural Character of Egyptian Beliefs

The religious component in the culture of Egypt -- as in other

Muslim Middle Eastern countries — permeates the totality of life. A close connection exists between religion and other aspects of culture. Art in its entire scope is closely circumscribed by religion, and all the arts serve primarily religious purposes (Patai, 1962:288).

All public recitations of romances begin by praising the Prophet Mohammed. In the Holy Month of Ramadan all the public folk singers gather around the Shrine of Sayedena El Hussein, the grandson of the Prophet, in order to sing the religious songs. A lady named Khadrà el Sharifa is among the most famous of these singers. It is remarkable that thousands of Muslims from Egypt come to hear her and other folk singers. From the day E.W. Lane wrote his description (1860) up to the present, the content of these folk songs is mostly religious. As an example:

> As a pilgrim to Mekkeh he journey'd, and there,
> In my father's house, a guest he sate:
> . . . . To God I cried — O Compassionate!
> Thou living! Eternal! I pray, for the sake
> Of the Excellent Prophet, thy delegate
> Grant me a son like this noble bird, . . .[1]

The grand principles of the faith are expressed in two articles, the first of which is this: "There is no deity but God." His unity is thus declared in a short chapter of the Koran. The other grand article of the faith, which follows the first, is this: "Mohammed is God's Apostle."

Mohammed is believed, by his followers, to have been the last and greatest of the Prophets and Apostles. It is further necessary that the Muslim should believe in the existence of angels, the immortality of the soul, the general resurrection and judgement, and in future rewards and

punishments in Paradise and Hell (Lane, 1954).

The Egyptians are culturally inclined to emphasize the supernatural, the most prominent aspect of which is the belief in "Ginn," or "Genii" (in the singular, "Ginnee"). The Ginn are said to be of pre-adamite origin, and, in their general properties, an intermediate class of beings between angels and men, but inferior in dignity to both, created of fire and capable of assuming the forms and material fabric of men or monsters, and of becoming invisible at will (Lane, 1954:228).

In Egypt, demonology exhibits a complex system of spirits, demons, ghosts and fairies. It is important that their demands are satisfied and that they are not offended, otherwise misfortune would befall the transgressor. Popular belief in the power for good or evil was very much alive until quite recently. The appeasement function of the *Zar* Ceremony (to be discussed later) is one example of the survival of an age-old cutom in Egypt until the present day.

Magic

From the earliest times Egypt has been celebrated for its magicians, and accounts of their marvellous achievements have been preserved to us not only in ancient Egyptian records, but in the Bible, in the Koran[2] and in the works of several of the classical writers. Furthermore, many of the tales in the famous collection of stories known as *The Arabian Nights* show what wonder-working powers were attributed to magicians in medieval Egypt (Blackman, 1927:183). Rampant magic does tend to characterize modern Egypt and in almost every village

one or more magicians are to be found.

The modern Egyptian magician, who may be of either sex, is appealed to in all kinds of emergencies. Sometimes his fame has spread far beyond the confines of his own village, and an urgent call for help from distant parts of the country may cause him to travel far afield (Blackman, 1927:183). After having exhausted all Western medical resources, one of the author's relatives who was suffering from cancer, had to resort to a magician, known for curing such difficult cases. This magician was possessed by a certain *shaikh* (a member of one of the communities of supernatural beings who are supposed to live beneath the earth), who enabled him to cure the sick. The patient, however, died before the consultation took place.

The Evil Eye

Most of the ethnographic description given in the following lines concerning the belief in the evil eye and its institutionalized defenses is given by Winifred S. Blackman who spent several years in Egypt. Her book, *The Fellahin of Upper Egypt* (1927), represents a product of these years. A description of the life of the peasants of Upper Egypt during the first half of the twentieth century, this work is of utmost significance to the anthropologist.

Belief in the evil eye assumes a central position in Egyptian religious thinking. The most intense fears the Egyptians experience are generated in situations that are emotionally structured by this belief. For most Egyptians "the eye" is a real source of danger from infancy to old age. Any misfortune, accident, or malady is apt to be

attributed to the effects of the evil eye. The basic principle involved is that the malignant power of an envious glance destroys the thing which is coveted.

In a symposium held by the American Anthropological Association, Toronto, 29th November - 3rd December 1972, the evil eye and related beliefs were described and analyzed from the world regions where such beliefs are most prominent. In regards to the question of its function there is a host of hypotheses. Some have suggested that the spread of this belief in peasant societies is functional as it creates fears of sanctions which will be invoked against the progressive and ambitious individual by fellow villagers who see their universe as one in which economic resources are limited and one man's progress is at the expense of others.

There are some people who are supposed to possess very powerful evil eyes; still it is sinful to accuse an individual of having an evil eye. These people who have it may be recognized by their envious sighs or covetous glances. But at the same time it is interesting to note that there are usually traditional means available for the alleviation of these culturally constituted fears. The individual is not altogether left at loose ends; he may obtain some relief and reassurance through the utilization of institutionalized defenses such as extending the five fingers of the hand toward the eye of the envious person; putting a *Hegab*[3] around the neck of a child; breaking a piece of pottery or throwing dust behind the back of the suspected person; and not allowing a child to look too beautiful by permitting dirt to accumulate on him. If a mother suspects that one of her visitors has cast the evil eye on her child, she cuts out a human figure in paper and then takes a pin,

repeating the name of each of her visitors in turn, pricking the paper figure at the mention of each name and setting the figure on fire.

A belief in the evil eye as described by Blackman (above) is still entertained in Egyptian villages and urban slum areas. From extensive interviews with dozens of relatives of patients who claim to have experienced the bad effects of the evil eye, it is apparent that many people do not question whether the evil eye does or does not exist, but take it for granted. In the words of a high school student from Cairo:

At home my parents believed in envy or the evil eye. . . . My mother gave birth to many children before I was born. Many of them died in early infancy. The death of my brothers was interpreted by my mother as being an inevitable result of the evil eye as my deceased brothers looked beautiful. . . . In order to avert the evil influences of the evil eye my mother did not permit me to go out of our house and thus I was prevented from playing with other children.

A second example shows how the fear of the evil eye leads to social isolation. The fear of the evil eye and its institutionalized defenses are vivid in the following words of a 17-year-old student in a Cairo secondary school:

Because I was born with a twin my father, who was a mason, was very afraid lest we should be envied by other people. Therefore my father discouraged me to mix with other friends. He also was afraid of bad company as he believed that bad company led to failure.

. . . . . .

In the preparatory school certificate my name got the best mark among four children of my family. My family was very happy and they distributed some sweets. But although my parents were very happy that I succeeded and joined the secondary school, they became fearful of the evil eye which they believed might do me and my brothers great harm as my three brothers got their B.Sc. with honors. My parents were poor and this added to their fears.

. . . . . .

Once I was passing by my neighbor who was pushing her son to study his lessons diligently as my brothers did. She was saying to him,

"Look how the sons of our neighbor are very successful. I want you to follow their example." *My parents and my brothers and sisters used to hear this neighbor repeating these sentences. This was, for us, tangible empirical evidence of the evil eye and a major source of peril.*

. . . . . .

My mother used to believe firmly in the evil eye. Therefore she tried to isolate herself and her children from her neighbors in order to avoid the bad effects of the evil eye. Also in order to counteract the effects of the evil eye, she used to turn on the radio which read verses from the Koran. In addition to this, my mother became very angry with our neighbor (the envier) and did not talk with her for three years.

Veneration of Saints

Although it is unauthorized by the Kur-àn or any of the Traditions, deceased saints are venerated by all sects of Muslims (except the Wahhabees), and more particularly by the Muslims of Egypt. Over the graves of the more celebrated saints are erected large and handsome mosques; over that of a lesser saint a small building crowned with a cupola would be built (Lane, 1954:242).

The Egyptians occasionally visit such graves either with the view of paying honour to these venerated persons in the belief that they will call down a blessing, or for the purpose of urging some special petition such as the restoration of health, success in examinations, increasing wealth, or for the gift of offspring. This is done in the belief that the merits of the deceased will insure a favorable reception of the prayers which they offer up in such holy places (Lane, 1954:243). The majority of the lower class Muslims of Egypt regard their deceased saints as mediators with God, and make offerings to them. On arriving at the tomb of a Saint, one should greet him with the salutation of peace.

Religion is thus a psychological factor of major magnitude for the majority of the Egyptian people who live in villages and urban slum areas. Only in certain social classes of the larger towns, among whom

Westernization and modernization have made considerable headway, does the power of religion become weaker and the general orientation show a tendency toward secularism (Patai, 1962).

From the above it is clear that there exists in Egypt an elaborate system of folk custom and belief with its observances, prohibitions and rituals. It is not claimed that Egypt is unique in having such a vast folk system but it is apparent that nowhere has an ancient folk tradition continued to play such an important part in influencing everyday life up to the present day. The significance of the foregoing in the emergent pattern of psychological illness in Egypt will be discussed later. These customs and beliefs have been briefly enumerated here to assist understanding indigenous ideas about mental illness and its ceremonial treatment in Egypt. We now turn to a brief discussion of these ideas.

B. Indigenous Beliefs About Mental Illness

It is necessary to map Egyptian beliefs and practices toward individuals whom *they define* as mentally ill. What follows is not a comprehensive analysis of all the various ways one might approach the problem, nor is any claim made for having achieved generalizations about Egyptian traditional psychiatry as a whole.

Etiology

As was indicated before in the discussion of Egyptian folk customs and beliefs, there is a great emphasis upon the supernatural. This supernatural emphasis extends into the native theory of mental illness

in the sense that the cause of mental illness tends to be seen as supernatural in origin. An ordinary person can become mentally ill from accidental contact with a witch, or from witchcraft (*amal*) intentionally directed at him. Also, mental illness may result from spirit possession, the evil eye, and sadness.[4] Mental and emotional malfunctions, especially when preceded by a state of normalcy, are always attributed to possession by these spirits and in most cases are regarded as curable after the demands of the possessing spirit have been met or through appeals to other members of the spirit's community, particularly its superiors or adversaries (El-Shamy, 1972:20). Since the Egyptians are geared to a set of supernatural etiologies which are radically at variance with the natural-causative factors of Western psychiatry, it is hard to equate the two systems. There are thus marked differences between the Egyptian patient and the Egyptian psychiatrist who is trained in Western medicine; the latter's explanations in terms of physiology have no meaning for the patient because they have no link with other beliefs about causative forces of a supernatural type.

Treatment

Due to this emphasis upon the supernatural origin of mental illness, native treatment tends to be quite different from that of Western psychiatry. There is a rich body of ceremonial practice in Egyptian culture, most of which is directly concerned with curing mental illness and giving positive protection against misfortune. Some of these ceremonials have been described in the discussion of

magic, the evil eye, and the veneration of saints.

In the process of spirit possession, El Shamy (1972) could distinguish four consecutive stages requiring corresponding degrees of treatment from religious specialists (sheikhs) or shamans in hierarchial sequence. At first sign or symptom of a serious emotional or mental irregularity one of the following p rocedures is prescribed: 1) seeking the help of a religious specialist, i.e. a *sheikh*, 2) a recitation of verses from the *Quran*, 3) visits to saints in the local city or to supreme saints in the capital, 4) or the holding of a *zikr* (an evening activity in which large numbers of adult males gather in a private home or mosque for the exalting and enumerating of the names, characteristic traits and favors of God) associated with food gifts to the poor on behalf of the sick person (pp. 19-20).

If symptoms still persist, then the aid of a higher specialist is sought. At this stage the shaman seeks to establish communication with the possessing spirit with the purpose of reaching an agreement with it to leave the body of the possessed. If all these procedures fail to cure the sickness and the symptoms continue to persist, then a higher regional or national shaman is consulted, usually at the recommendation of the administering shaman (p. 21).

The *Zar* is usually the last stage in a multi-phase therapeutic treatment (p. 22). The *Zar* Ceremony is specifically directed at pacification of the demonic powers of evil which secretly enter the body of the victim and consequently cause psychopathological manifestations. The treatment associated with the *Zar* Ceremony will be described in detail in Appendix V.

Hallucinations

Among the Egyptian peasants, the presence of hallucinatory experience would be considered as an exceptional happening. The Egyptian village condones or even worships forms of "exceptional behavior" which would be classified as "deviance" in a Western cultural context. In a country which values "truth by revelation," an individual who has hallucinations may be placed in a position of power and influence by being made a saint.

For the traditional Muslim, Muhammed was sent as the Seal of Prophecy to bring the final revelation of God's word to mankind. At first Muhammed's revelations took the form of dreams, until finally revelation came to him while fully conscious, in the form of the angel Gabriel who appeared before him on Mt. Hira, and told him he had been sent by God.

An example of the sacredness of hallucinatory experiences in recent times is the phenomena of the apparition of Zeiton in which the Virgin Mary is alleged to have appeared on the dome of a Coptic Church. This religious experience which was studied by Cynthia Nelson and presented in a paper at the Third International Congress of Social Psychiatry in Zagreb in 1970, will be described here.

The Apparition of Zeiton: An Egyptian Experience

During the Six Day War of 1967 when Egypt suffered a cataclysmic defeat that left the country in despair, the Egyptian people experienced perhaps the severest crisis in their contemporary history. Here was a situation of a people humiliated by defeat in a war that lasted only

hours when all expected victory and believed in the prowess of their army (Nelson, 1970:3).

In the months immediately following the war, and first on April 2nd 1968, in a district called Zeiton which is twenty miles northeast of Cairo, there occurred an event that has brought hundreds of thousands of persons flocking to the Coptic Church of St. Mary. It is here that the Virgin Mary was witnessed appearing on the top of the dome of the church (Nelson, 1970:4). The first apparition took place during the night of April 2-3rd when two Moslem mechanics, working at a garage facing the church, were the first to notice the Virgin Mary. Since the spring of 1968 until today, hundreds of these apparitions have been seen and hundreds of thousands of Egyptians of all ages and ranks have thronged to Zeiton. Patients with all kinds of illness have gone to Zeiton to pray to the Virgin for help. Several miracles are alleged to have happened. As an illustration, a malignant tumor discovered by a prominent Cairo surgeon in a patient disappeared after the man had gone to Zeiton and prayed to the Virgin for help.

Nelson interprets the phenomena of apparition as a personally meaningful and culturally acceptable means of protecting the self from ontological insecurity (Nelson, 1970:13). For the Egyptians the Virgin came to restore their faith in God and give hope and moral support to the defeated (Nelson, 1970:9).

The Magzoob

An interesting and important part of the Egyptian native theory about mental illness concerns their belief in the *Magzoob* (the lunatic),

and the relationship between the *Magzoob* and the Saint.

Some saints are descendants of the Prophet, like El Hussein, the grandson of the Prophet Muhammed, and Sayeda Zeinab, his grandaughter. But not all of them are descendants from this honorable tree. The Egyptians often pay a reverence to those who, from a Western cultural point of view, are justly the least entitled to such respect. An idiot or a fool is regarded by the villagers as a being whose mind is in heaven, while his grosser part mingles among ordinary mortals; consequently, he is considered a special favorite of God.

> Whatever enormities a reputed saint may commit (and there are many who are constantly infringing precepts of their religion), such acts do not affect his fame for sanctity: for they are considered the results of the abstraction of his mind from worldly things; his soul, or reasoning faculties, being wholly absorbed in devotion, so that his passions are left without control. Lunatics who are dangerous to society are kept in confinement; but those who are harmless are generally regarded as saints. Many of the reputed saints of Egypt are either lunatics, or idiots, or imposters.[5]

While working in a small rural town in Lower Egypt (1953-1958), this author often met in the streets a deformed woman with long hair and riding upon an ass led by another man. On these occasions, the man always stopped his donkey directly before him, recited the Fathah (or opening chapter of the Kur-àn), and then held out his hand for charity. The first time, the researcher endeavoured to avoid him but a person passing by remonstrated with him, observing that this idiot woman was Shaikha Zeinab, a saint, and that he ought to respect her and comply with her demand, lest some misfortune should befall him.

Among the people of Sherbine (a small rural town) the author has seen many peasants pass on their knees before Shaikha Zeinab to receive

from her the blessing of her touch. All the babies and old people come also of necessity to have illness removed from them. This mentally deficient psychotic patient was not segregated as a "source of danger," but court was paid to her as a direct source of supernatural blessing.

A third example is that of a man who hallucinated and was mildly insane and whom the peasants thought to be gifted with medical and spiritual healing powers. He was placed in a position of power in his village where the *fellahin* left their work in the field and came to sit beside him in order to obtain some *barakah* (blessing). They would not leave until he gave them permission to go. When he died they built a shrine over his grave. The villagers from all the surrounding villages came to pay honour to this venerated deceased saint, especially on his birthday festival. After his death the supernatural blessings were transmitted to his son who continued to assume a medical and psychotherapeutic power. When the son died, his son — who was a student of the author — inherited his office. Finally he, too, became mentally deranged and committed suicide.

A final example of a mentally sick person who was regarded as a saint or *shaikha* by the people of the village was the case of a woman who recurrently experienced being "crazy and out of mind" and who, by several accounts, exhibited psychotic behavior. She had begun to think that people were trying to poison her. Married to an Egyptian peasant, she suffered a good deal of misfortune in her marital life. She was accustomed to go out in the night during winter and strip off her clothes. Peasants would thus find her wandering in the fields. They

also attributed miracles to her. Some of them said, "At night there was always a light in the sky to show her where to go." The author asked whether the people would build a shrine over her grave after her death. The answer was that in case of her death, if her body flies she will be buried wherever she stops and a mosque built over her grave.

From the above examples it appears that Egyptian culture provides acceptable roles for certain psychotics (that is, psychotics in Western diagnostic terms). It is also obvious that the people themselves do not make distinctions between acceptable and unacceptable behavior by using Western type definitions of psychopathology. For instance, delusional speech, particularly of a religious nature, would not lead to a village definition of disordered behavior, whereas uncontrolled aggressive behavior would easily evoke the designation "*magnon*" (insane) and lead to commitment.

All the previous factors account for the very low hospitalization rate of mentally sick persons in Egypt. By taking into account those psychotic cases which find acceptable roles in Egyptian society (such as the *Magzoob*) and those which are not socially defined by the Egyptians as mentally sick (although they are so defined in Western diagnostic terms), the apparently low rate of mental illness in Egypt would be brought up to a more realistic rate. This might explain the great disparity between the number of hospitalized mental patients in Egypt and estimates by Western-trained observers of the total population of the insane. According to the 1969 statistics, there are about 5,000 beds in Egyptian state mental hospitals, not all of which are occupied. This figure represents a very small percentage of the entire population

of mentally sick patients in Egypt which is estimated by the Egyptian Mental Health Committee to be not less than 40,000. This number does not include the mentally deficient which were also estimated as not less than 40,000 (Tawedros, 1969).

C. Sociocultural Variables of Egyptian Society

Egyptian Family Structure

For the majority of the Egyptian population who live in crowded villages family organization has its nexus in the extended family. The family is the basic social unit around which the individual's life is centered. In general, it can be stated that the Egyptian family — like the Muslim Arab family in other Middle-Eastern countries — is characterized by six basic traits: 1) extended, 2) patrilineal, 3) patrilocal, 4) patriarchal, 5) endogamous, and 6) occasionally polygynous. Ideally, the minimum personnel of the family comprises parents, unmarried children, and married sons with their wives (Patai, 1962). There are, however, many other variations on this pattern. In the big city the tendency is toward the nuclear family. However, both for economic reasons and for reasons of preference, three generations under one roof are not uncommon.

The rural Egyptian family is more than a close circle within which people live their personal lives; it is the primary institution of economic cooperation, social control, and mutual protection. Thus, the individual's first obligation is to his family and loyalty to family transcends any other. In fact, the entire culture of the country is permeated with family loyalty and influence (Patai, 1962).

Social Class Differences

The present study starts from the fact that Egyptian society is socially stratified, a system which can be traced back to the British occupation. Many of the changes that took place under British rule were already clearly established before the British occupation but were given greater impetus by British policies (Tignor, 1966:385). The agricultural and administrative changes sponsored by the British tended to increase the economic power of the landed gentry and thus added to their already extensive holdings at the expense of the vast majority of peasants who were gradually being turned into a rural proletariat. The emergence of both urban and rural proletariats in Egypt indicated the fragmentation of communal and kinship Egypt into distinct social and economic classes (Tignor, 1966).

By the same token, the spread of Western education throughout Egypt was creating a new group of leaders with new knowledge, able to perform tasks not well developed in Egypt before the French Expedition (1798-1801): this was the dynamic element in Egypt. They had the most radical political and economic goals, as they felt the resistance of the alliance of British administration and landholding classes excluding them from the exercise of political power. The new Western-educated class was, then, to varying degrees, class conscious, anti-British, and interested in promoting changes in the allocation of political power and economic resources (Tignor, 1966:386).

In summary, the British Administrators were in favour of maintaining the *status quo*. They controlled and limited the type of education given

to the Egyptian population for fear that full-scale education for the masses might increase their wish to get rid of the foreigner. They did not favor the movement for women's education. Indeed, the British tended to suppress the forces and pressures of change in many crucial areas (Tignor, 1966:396).

With the emergence of the Egyptian Revolution of 23rd July 1952, a new order was established in Egypt which, although it derived from the circumstances and environment prevailing, nevertheless meant a complete change in the economic, political, and social lives of the people. Since its early days, it waged a merciless war against "feudalism" and the social injustices that a pernicious system of land tenure had left in Egypt. The passing of the Land Reform Act (October 1952) set a limit to agricultural holdings at a maximum of 200 *feddans*. A complementary Land Reform Act, passed in July 1961, set a limit to agricultural holdings at a maximum of 100 *feddans*. The final Agrarian Reform issued in 1969 limited land holdings to a maximum of 50 *feddans*. It is difficult to exaggerate the political significance of Land Reform when such reform has for its main objectives the shattering of the political and financial control of the wealthy land owners and the liberation of the individual peasant from the oppressing fetters of this so-called "landlord aristocracy." Thus the battle for the Agrarian Reform ended in less than a month with complete collapse of the feudalists (Lacouture & Lacouture, 1958:279).

The Egyptian Revolution of July 23, 1952, has relaxed the class structure to the extent that individuals from the lower class can now get ahead. One of the most important channels for upward social mobility

is education. Before the Revolution, the upper class had an advantage over the lower classes primarily because the people who belonged to this class could afford to pay tuition fees while those of the other could not. Education, under British rule, had become the privilege of an elite group to the extent that it had become, for the first time in Egyptian history, exclusively the privilege of the rich. After the Revolution the state made education free for all. Since then the educational revolution has continued to make further strides in the spread of education.

As many students from the lower class have entered schools, examinations and educational certificates have acquired an exaggerated value in Egypt. The lower class parents want their children to join the university, but Egyptian universities cannot afford places for all those who complete their studies in high school. For example, in the academic year 1971-1972, 160,000 pupils completed high school, but only about 50,000 will go to university. As a result competition among students and parental pressure are quite fierce.

But despite its apparent homogeneity, Egypt is still riven by a great gap which separates a small elite from the mass of the people. The elite comprises the educated, former "landed aristocracy" now shorn of wealth and political power, government officials and military officers. The mass includes the great peasant majority of the villages and a growing body of urban workers.

The villagers and the urban slum city dwellers are considered by other Egyptians to be "truly natives," that is, least affected by "westernization" and "modernization" and to have their "own mentality" which is quite distinct from the more sophisticated, westernized middle

and upper class who have developed those attributes usually associated with a "modern" urban way of life — a secular, mechanistic ordering of activities and with a more sophisticated knowledge of the outside world (Nelson, 1968).

Sex: The Position of Women in Egypt and the Middle East

Ethnographic material from different sources points to the low position assigned to women in Egypt as in any other Middle-Eastern country. Islam has, of course, been the most important single factor in determining the traditional position assigned to women all over the Middle East. As Patai (1962) says: "To this day the foremost manifestation of the inequality of the sexes can be seen in the different moral standards applied by Islam to men and women."[6] This has sanction in the Koran. Characteristic of this is the Koranic dictum: "Men are in charge of women because Allah hath made the one of them excel the other." Down the centuries, this Koranic dictum has shaped the lives of women throughout the Arab world. Many of the proverbs reflect this low position of women. The following is a quotation from one of these sayings: ". . . *have no confidence in women*; do not eat what disagrees with you; do not expect to keep your wealth; seek knowledge from the cradle to the grave." [Italics mine.]

It is common knowledge among the Arabs that the Prophet Mohammed said: "Women have deficiency in mind and religion."

From the moment she is born the girl finds herself neglected. The undesirability of the girl and the desirability of bearing a boy have been emphasized even by Christian Arabs. Speaking about the Christian

Lebanese, Patai (1962) says: "When the midwife announces a boy there is much joy, firing of rifles, dancing, arak drinking. But she does not move if it is a girl, and later receives a small remuneration; everyone goes quietly after his daily task."[7]

This lowly position of women in Egypt has changed over the last 70 years. One of the most significant developments in Egypt during the first half of the Twentieth Century was that access to Western culture was substantially increased. One of the most influential intellectuals of the pre-World War I era was Qasim Amin, whose controversial book, *al-Marah al-Jadidah (The New Woman)*, contained severe attacks on the backwardness of Egyptian mores and institutions, particularly traditional Egyptian attitudes toward women, in comparison with the more humanitarian and liberal attitudes of the Western world (Tignor, 1966:254-255). Consequently Qasim Amin has been conceived in Egypt as the liberator of the Egyptian woman. Robert Tignor says about his role in this liberation process:

> In his analysis of Islamic civilization, Qasim Amin pointed out that its foundations were laid in a pre-scientific era and therefore were encrusted with practices detrimental to the well-being of society. For him, and for those of like mind, Europe, far from being an enemy to be resisted, should be seen as a civilization that had developed a superior organization of society and had enhanced the general well-being of its individual members.[8]

Western education for Egytpian women had its beginnings before the British occupation, but for a long time it was confined to the royal household on a private tutor basis. Then, under Kedive Ismail, several European-operated schools were established for girls, the first of which was Sania Secondary School for Girls in the centre of Cairo (Artin, 1890).[9] By the turn of the century, women began to assume a larger role in Egypt's

social life. This movement towards women's emancipation was reflected in the 1919 Revolution as women were slowly drawn into the orbit of this nationalist movement. During this period, women led by Hud Sha'rawi, the wife of an important member of the WAFD (the most important political party at that time), entered into public life to an extent which astonished observers and showed the degree to which the old traditional society was breaking down. The women's demonstrations of 1919 and 1920, it must be remembered, should be taken as a hint of the size of the upheaval rather than as a victory of feminism. The abolition of the veil was for many traditionalists the most startling result of the national rising (Lacouture, 1958:90).[10]

In summary, the 1919 Revolution was directly responsible for heralding the first signs of the social emancipation of Egyptian women. For the first time in Egypt's history, women had taken an active part in a nationalist movement, and were no longer content with the subdued home-life which they had lived for centuries.

This change in the status of Egyptian women continued into the 1930's. As *The Times Book of Egypt* reported in 1937:

> Fifteen years ago tradition forbade that a woman of decent society should be seen driving in a carriage with a man. If the occasion was compelled by necessity the hood was always lowered. Tradition, however, knew nothing of the motor-car, and the women seized their chance. Similarly with the cinema. Of old no woman could witness a performance at the theatre except veiled and from a box. No one was bold enough to maintain that this rule should apply to the cinema. So the women now flock to them in droves, with or without their husbands, and no one raises an eyebrow.[11]

The change in the position of women and in relations between the sexes during the post-First World War period has been the most fundamental of all. Here the example of Turkey had been decisive. In the late 1930's

there were Egyptian families of the upper class in which the women met only a very limited circle of men, but they were becoming the exception. In the families of professional men and Government officials, of what might be called the middle class, the proportion was certainly larger, but on the other hand, the barriers were going down more quickly.[12] In some cases it was only shyness on the part of the lady which stood in the way of her freely entering mixed society in the late 1930's. She was afraid of being spoken of among her friends as too "forward." According to *The Times Book of Egypt*:

> An Egyptian, on being invited with his wife to a European house, will often ask whether other Egyptians are to be present, and decline if that is the case. Anything in the nature of a public appearance is still considered daring. It was a great advance when Mme. Nahas, the wife of the Prime Minister, went to Europe last summer (1936) with her husband and appeared with him at official banquets and receptions.[13]

In the late 1930's the young people were rapidly breaking down prejudices. General contact between the two sexes could not be long delayed when girl students went unattended to lectures with young men and were beginning to enter professions hitherto reserved to men — as doctors and lawyers. Egyptian women were using the veil less and less, and then only when they thought they might become an object of scrutiny by strangers, as, for instance, in a railway carriage or a doctor's waiting-room. Contrast this with popular opinion before the First World War, when orthodox Egyptian Moslems objected to having telephones in their houses for fear that it might cause their wives or daughters to have a conversation with a strange man. With this advance in the status of women, polygamy was becoming a thing of the past, though

divorce, it might be noted, was as common as ever. The proportion of divorces to marriages among Moslems, in this same period, was nearly 50 per cent.[14]

The government, in 1937, was trying to extend the range of professions which were considered suitable by offering training in the girls' secondary and technical schools in dressmaking, cooking, designing, and so forth. In this same period, secretarial and office work, and even telephone operating, did not yet attract Moslem girls. These professions continued to be staffed chiefly by Jewesses, Armenians, Syrians, and a few Copts.

Egypt after the Second World War was considerably influenced by a great deal of social change — an example of what El Good (1949) refers to as a society in transition, in his book, *A Brief History of Egypt From Ancient To Modern Times*. Customs hallowed by tradition were perishing: marriage between cousins for instance, was disappearing, and polygamy was going the same way. Educated Egyptians have long since frowned upon plurality of wives, and the poorer classes were beginning to regard it no less dubiously. Yet the right of a man to divorce a wife was still unchallenged. But, as El Good (1949) pointed out:

> . . . men who spoke lightly of Egypt as unchanging and unchangeable, deceived themselves; standards and conceptions, indeed, were altering rapidly. Tradition might still oblige the women of the village to wail and sob; but the tears had lost their poignancy, and the mourners were paying no more than a tribute to convention. Noticeable, also, was the restlessness of the younger upper class women. If they did not claim equality of man, they were moving towards the goal. They had substituted the hat for the veil, they visited and shopped unattended by escort. Their sisters of the middle class had even taken a step farther. Marriage in their eyes was not the only career opened to women, and certainly not with a man the choice of parents; they had forced their way into the University, they had discovered in art, law and medicine attractive alternatives to matrimony.[15]

Thus, according to El Good, the day of the harim, that ancient buttress of Eastern conservatism, was passing in Egypt during the late 1940's.

Lastly we follow the enhancement of the status of women during the Revolution of 1952. The status of women is nonetheless being closely examined, and the law is still being changed in their favour. Women now have a political vote which was granted under the 1956 Constitution, but under the later electoral law was limited to those women who formally apply for voting rights, and who are thus, presumably, educated (Lacouture, 1958:300). More and more young women revolt against being married off to old men they have never met, the revolt taking such forms as escape, suicide, or sometimes horrible murders, as in the case of a 15-year-old girl who drenched her octogenarian husband with petrol while he was asleep and burned him to death (Lacouture, 1958:301).

The President of the Republic of Egypt (then Nasser) gave women the right to vote, and his own wife has been seen with him in public. Although Nasser had until 1960 been opposed to the introduction of a new code of rights for women, believing that a woman's place was in the home and not in the polling-booth, Madame Tito talked him round by arguing that he could not claim to have achieved a complete revolution until he conceded equal rights for the women of Egypt (Nutting, 1972:301). In the words of the National Charter (May 1962):

> Woman must be regarded as equal to man and must, therefore, shed the remaining shackles that impede her free movement, so that she might take a constructive and profound part in shaping life . . . .[16]

Although educated women are introduced to their husband's closest friends, yet they have to watch their mode of dress. Recently, moreover, some young Egyptian women in big cities like Cairo and Alexandria have

begun to wear mini-skirts. This is disapproved by many sectors in Egyptian society. In their reactions to Euro-American fashion, some fathers and brothers expressed themselves with regard to these abbreviated skirts as follows: ". . . an impolite habit." ". . . borrowed from a false civilization." ". . . against the Islamic tradition."

To sum up: time has chipped at the old dogmas, and in recent years — to the dismay of sheiks and male chauvinists — more and more Arab women are shedding the veils for the enticements of the modern world. Some, like Leila Khaled, the Palestinian commando whose spectacular sky-jacking made world headlines, choose the path of revolutionary politics. Others would far prefer to emulate Lebanon's lovely Georgina Risk, recently crowned Miss Universe (1971-1972).

Of the more than 300,000 students enrolled in Arab universities this year, 25 per cent are women. In Cairo, one-fourth of all technical students, 40 per cent of all medical students, and more than half of all students in the philosophical faculties are women. At the American University of Beirut, the ratio of men to women was 10 : 1 a decade ago, today it is 3 : 1.

The quest for equality ranges across many fronts. Even in such centers of traditionalism as Saudi Arabia, the radio station in the Diplomatic capital of Jidda now employs a female announcer — a development that would have been unthinkable until recently. In westernized cities like Beirut or Cairo, women now drive cabs, work in factories and earn a middle-class living in the professions. Recently, moreover, Egypt's voters accepted a new constitution that gave women equal status with men in "the political, social, cultural, and economic spheres" —

a constitutional first in the Arab world (1971).

Despite such legal breakthroughs, however, the concept of female equality does not find ready acceptance among most Arab men. The Muslim Middle East has been a man's world and its society a man's society, and this it remains to a large extent to this very day (Patai, 1962).

Position of Young People

Subservience to family authority and reliance on the advice of elders remain characteristic traits of men in their thirties and forties. In traditional Middle-Eastern society the basic educational aim pursued by the family, whether consciously or not, is to mold the child into an obedient member of the family group, able to integrate into the working of his immediate social environment. Only very slowly and gradually, in most cases at a relatively advanced age, is he expected to act independently. The growing child, the adolescent boy, has to learn to subordinate his wishes to those of his father and possibly to those of his elder brothers (Patai, 1962:97).

When children begin to understand what is said to them, they learn how to behave by being told, scolded, and punished. Such training of small children and older girls is largely in the hands of their mothers. Detailed information on the mother's methods of punishment is lacking, but such methods are less severe than those administered by men to boys of six or more.

In Egypt just as in the neighboring Arab countries, beating is the preferred punishment for boys. The Egyptians operate on the principle that sons must be made to fear their fathers. Punishment is intermingled

with scolding, shouting, and threatening punishment. When these latter methods fail to change a child's behavior, his father becomes exasperated and punishes him again. But it might be said that the higher the social class and the more advanced its westernization, the less severe punishment becomes. The age at which parents decide to stop physical punishment of their children, although depending on their tolerance and their degree of sophistication, is usually thirteen. There is a proverb which says: "Whenever your son becomes grown up don't beat him, make him a friend of yours."

Life Cycle

In the next lines the common prevailing forces that leave their impact on the personality development of Egyptian village children are discussed. This brief outline is based on Dr. H. Ammar's book, *Growing Up in an Egyptian Village*. It must be mentioned at the outset that sweeping generalizations should not be made from this single study. Generalizations can be made only after conducting field research in other areas and provinces having different cultural and economic backgrounds.

Birth, Infancy and Early Training. Infancy is regarded by Dr. Ammar as the three or four years of the person's life at the end of which, whatever the family and individual variations may be, the infant is weaned, begins to talk, and responds to adult commands.

Babies are normally born in their father's homes if there are women or older children to do the cooking and washing during the mother's confinement. If such assistance is not available parturition takes

place in the home of the mother's parents. A midwife assists at birth.

There is a considerable difference between the early socialization of a boy and of a girl and in this difference can be found one of the basic factors that make for the Egyptian flavor of the relationship between man and woman in adulthood (Patai, 1962). This can be seen in the different child rearing practices applied to the boy and the girl. Newborn boys and girls are still swaddled in old washed clothes. But in the case of a boy, relatives sing a lot whereas for a girl they sing only one line (Ammar, 1966:91).

On the seventh day from his or her birth a special ceremony is held called "Sobou." On this occasion the name of the child is declared. The name is usually chosen by the parents if the paternal grandfather has not already done so. The best names are those which are similar to the Prophet's names (Ammar, 1966:92). However, there are also modern names, usually a reflection of political change. Some babies who were born after the Revolution of 1952 were named after the late president, Gamal Abdel Nasser.

On the Sobou, when the mother shows the baby to the guests, they are obliged to give their gifts. An old lady sings the following song with the help of a children's chorus:

> God, the Great Lord, may this
> baby be well grown up like us.

The songs also emphasize the gifts which the relatives feel obliged to give the baby and how the child is to be molded into an obedient member of the family group. The reading of the 'Fatiha' (the opening of the Koran) with prayers for the child's long and happy life ends the ceremony (Ammar, 1966:92).

The differential value of boys and girls is apparent in the difference of presents given to the midwife on the birth of a boy compared with those on the birth of a girl. When the midwife announces the birth of a boy to the father she asks him for a present and warmly congratulates him. If it is a girl, the father is usually teased by telling him: "May she never sneeze." There is a saying that 'a boy who dies is better than seven girls' (Ammar, 1966:95).

It is appropriate here to discuss some of the hypothesized factors in the differential value of boys and girls in the Egyptian village. The whole range of factors can be classified into two categories: 1) those which are related to the economic subsistence of the village, and 2) those which are related to its prestige structure.

With respect to the economic factors it may be mentioned that boys are an economic asset as they work in the fields and are consequently a major contribution to the family's means of subsistence. In addition they are obliged to help with the economic and social security of their old parents and widowed sisters. The daughters, on the other hand, are not expected to support their parents as they belong to their husbands.

Boys also enhance the position of their fathers in the prestige structure of the local community. Fathers who have seven sons or more are considered an ideal, and one of the most favourable prayers to any man is to wish him 'seven sons and to perform seven pilgrimages' (Ammar, 1966:95). Conversely, the daughter is considered a source of social stigma to her family, especially before her marriage.

Until the arrival of the next baby, close bodily proximity

establishes the first educational relationship for the child. Ammar notes that with respect to nursing, the child experiences no special frustration. Children are fed generously and frequently and are given the breast whenever they cry.

Speaking about the Middle Eastern child, Patai claims that a boy is breast fed for almost twice as long as a girl (1962:97). Ammar enquired whether the same was being practised in his village, but he was assured the opposite. It was recognized that a boy is usually nursed less than a girl.

Despite idiosyncratic variations, weaning occurs at an average age of between a year and a year and a half and is done gradually. The mother begins by weaning her child first from one breast, and later from the other. She stops milk from the breast by rubbing the nipple with a concoction of spices, ground sheep tripe, henna, cactus juice and salt stone (Ammar, 1966:103).

Patai (1962) believes that weaning in the life of the Middle Eastern child is something of a traumatic experience. However, Ammar (1966) believes that in psychoanalytical language, mothers in his village recognize weaning as a 'traumatic experience' for the child and do their best to absorb the child's attention in other directions, especially in play with other children or providing it with some delicacies of food.

Visitors try to win a smile from the baby by tickling or caressing it, or in the case of a boy, by massaging his genitals (Ammar, 1966:105). The amount of kissing the Egyptian child gets far exceeds its European equivalent. No efforts are made to teach the child to talk

or to walk during infancy.

Childhood. The period from the age of three or four to about the age of twelve or thirteen is considered by Ammar to be childhood. In the following lines the main characteristics and events of childhood affecting both the social and psychological aspects of the individual personality in Ammar's village are to be discussed.

Sibling rivalry is considered essential in the process of a child's growth. That is, the mother may deliberately stimulate jealousy in her baby by showing preference for some other child. In the case of the first child, the mother usually induces him to suckle by offering her breast to a strange child (Ammar, 1966:108). Although jealousy is considered a healthy drive for growth it must be kept within limits. There are necessarily cultural checks upon too excessive jealousy in children. Excessive jealousy was always dangerous and was conceived by the villagers to cause some physical symptoms such as diarrhoea, swellings, lack of appetite, temper tantrums, and sleeplessness.

The greatest experience that the child undergoes during childhood is circumcision which is accompanied by a ceremony. The ceremony emphasizes a social fact: the adult prerogatives of men are more far-reaching in that culture than women's, and consequently it is more common for the people in the village to take note of the boy's circumcision than the girl's. The boy's circumcision is accompanied by a public ceremony, whereas in the case of a girl's circumcision, the celebration is confined purely to women, and no man, not even the father, is expected to participate or to show an interest in it (Ammar, 1966:116).

The boy wears a female cloth in order to avert the evil eye.

He is not expected to cry or show any signs of pain, otherwise he would be accused of girlishness while the girls, in contrast, are expected and allowed to cry. In general the girl's operation is more painful than that of the boy (Ammar, 1966:122).

Children are often frightened by their elders. Constant threats are made to recircumcise them even if they are already circumcised. The adult is playful in his intentions, but some children are seriously frightened by this form of teasing.

The process of growing up is envisaged as a way of disciplining the child to conform to the adult's standards, and to comply with what their elders expect them to do, thus acquiring the qualities of being polite — 'muaddab' (Ammar, 1966:126). Parents ask God in their prayers not to make their children disobedient. The keynote to the educational process is the eagerness of the adults to emphasize subservience and filial piety.

Physical punishment is not uncommon either by beating, striking, whipping, or slapping. But the important point is to maintain a balance and to avoid excess. Childhood is considered the most appropriate period for punishing and disciplining the child (Ammar, 1966:139). Adolescents, on the other hand, are rarely physically punished.

Another characteristic of the period of childhood is the decreasing amount of care and attention given to the child by its mother (Ammar, 1966:111). The girl finds herself neglected and cries without being listened to. In our consideration of the process of 'growing up' of girls, there is hardly need to stress the fact that this negligence is intensified in later life. Through the process of

socialization she learns that she is a rather unimportant member of the family and that her function is to serve her brothers, her elder sisters, her mother and father. When she is four or five, she assists her mother in tending her smaller siblings. At about this time the mother very consciously begins to inculcate the norms that transform the child into an adult. She begins to prepare her daughter for her marriage, explaining to her whenever occasion arises that sooner or later she will marry and move into the house of her husband's parents where her function will be to serve not only her husband but, primarily, her husband's mother (Patai, 1962:98).

To return now to the first years of a boy child's life. He is integrated with the play group and age mates. When the boy grows older his attachment to his mother is expected to be over and his socialization is shifted from the hands of his mother to the hands of his father (Patai, 1962:100). He is progressively introduced to the economic pursuits of adults, taken by his father to the fields and allowed to help with the agricultural work. While working with his father the boy notices that his mother and sisters are subservient creatures. The fact that they serve him in more or less the same manner in which they serve his father reinforces in his mind the subordinate role of the female. In this way the boy is conditioned for the male role of leadership in the family and society at large. Naturally, this role means that upon his marriage his wife will be not so much his equal companion as a subservient fulfiller of his needs (Patai, 1962:100).

It is appropriate here to evaluate the period of childhood, in comparison with the period of infancy. Ammar (1966) feels that infant

disciplines are weak, permissive, and protective, while the child-rearing practices are prompt, strict, and on the whole severe (p. 139). Childhood in his village is the period through which a boy or girl experiences a great number of the pressures of socialization.

Adolescence. The period from the age of thirteen or fourteen to marriage is considered by Ammar to be the adolescent period. In his home village adolescence is culturally passed over without ceremonial. In the villager's view, adolescent boys are sometimes referred to as unmarried men and the period is inextricably connected to marriage (Ammar, 1966:183).

Among the dominant norms that loom larger in this stage is the emphasis on industry and responsibility of the maturing boys and girls. The boys and girls stop going to school Now the child is changed from an economically passive burden into a producer, thus becoming a decided economic asset.

With this increase in participation in adult responsibilities and work, boys enjoy more freedom as compared with their period of childhood. They are no longer physically punished (with few exceptions) and are more entitled to freedom of movement. But this does not apply to girls who find their freedom more restricted and who become more confined to the house and the neighbourhood (Ammar, 1966:184). Nevertheless, this does not mean that the boy's freedom is considerably increased. Both still have to observe the central theme of subordination which governs the pattern of relationship between old and young. However, sometimes exceptional cases do occur in which boys, on disagreement with their parents, desert them for some relatives in another village or go to

town to work. Needless to say, such a desertion can never be entertained by girls (Ammar, 1966:190).

Boys and girls have to adhere strictly to the traditional Middle Eastern sexual code. Sexual disciplines are strict and there is a puritanical attitude toward the free discussion of sexual topics. They are given no parental instruction in these matters.

During adolescence girls are tattooed — a sort of indication of adult status. Boys form the so-called 'circle of romance boys', in which they sing the songs of love (Ammar, 1966:186). At this stage of adolescence, boys show an interest in religious matters. They go to Friday prayers and some of them join mystic orders.

The basic personality configuration which is shared by adolescents in this village is characterized by timidity, apprehension, and dependency. The most insightful material to emerge from Ammar's study is the tremendous adolescent concern about dependency, that is, seeking his elders for help, expecting to receive support, and reaching success through dependence on others. In attempting to account for such general characteristics, Ammar uses Kardiner's (1939) approach in terms of the early experiences which these villagers have in common. He attributes their striking appearance to the cumulative effect of the severe social disciplines, and especially those connected with sex (Ammar, 1966:190). It seems, for him, that this excessive prohibition on sexuality at the stage of adolescence is a social discipline imposed to create and perpetuate the attitude of timidity and dependence of the growing individuals on their seniors (Ammar, 1966:191).

Adulthood. The adolescent stage is certainly the prologue to

the full status of adulthood which is eventually attained by marriage (Ammar, 1966:192). Marriage marks the beginning of the fourth stage of growing up in Ammar's village.

Marriages are arranged by the parents of the young people. In this village, when marriage actually occurs, the bridegroom first establishes himself in a matrilocal residence. The young couple move to the patrilocal residence after the wife brings forth a child. Having been installed in the home that her husband shares with his parents and siblings, the bride will perform a subservient role. This motivates her to have as many children as possible and the sooner the better, as her prestige is enhanced with the birth of each child and especially with the birth of male children. When her sons grow up and marry she reaches a stage of life in which her burden of everyday work is lightened by her daughters-in-law (Patai, 1962:99).

Similarly the boy, now a young husband, remains in an inferior position vis-à-vis his own father. His prestige is similarly increased when he becomes a father. With the birth of many children he is regarded as more of an authority in his own house (Patai, 1962:100).

Summary

Egypt as a society in transition is very heterogenous, comprising distinct social class categories. These range from a small elite at the top — including former landed gentry, military officers, and technocrats — to the vast majority of peasants and an ever-growing "rurban" proletariat at the bottom. The peasants and the rurban proletariat are the least affected by "westernization." Their mentality has been

influenced greatly by an ancient folk tradition in which religion and the supernatural continue to play an important part in everyday life. The urban bourgeoisie, on the other hand, have developed those attributes usually associated with a "modern" urban way of life — that is, a secular, mechanistic ordering of activities and more knowledge of the outside world.

In Egypt there prevails a pattern of women's status typical of countries with a history of Islamic civilization. Despite the enhancement of her status vis-à-vis men, Egypt is still considered a man's world and its society a man's society.

For Ammar, the arc of growing up in his home village seems to be similar to that in Japan, represented as a curve with maximum freedom and indulgence allowed to babies and to the very old. Social disciplines are imposed after infancy, reaching the lowest point in the curve of freedom just before marriage, whereupon it gradually ascends (1966:184). Other things being equal, the degree of ascendency of the curve of freedom varies directly in relation to sex, reaching its lowest point in the case of the female and ascending in case of the male.

Chapter III

METHODOLOGICAL PROCEDURES

A. Sampling Procedures

Because of the time limits imposed on the study, rather than taking a community approach, the researcher decided that it would be better to study Egyptian psychiatric problems by concentrating on a study of the patients admitted to two psychiatric hospitals in Cairo: a State psychiatric hospital (to be referred to as "X Hospital") and a private hospital (to be referred to as "Z Hospital").[1]

This choice turned out to be a happy one for the following reasons. First, the number of mental hospitals in Egypt at the present time is four (X Hospital, Z Hospital, the State hospital in Alexandria, and Khanka Mental Hospital), and the two hospitals chosen for the study actually accommodate more than 50 per cent of the hospitalized population. Second, X Hospital is the only hospital in Egypt which hospitalizes patients of both sexes, and its population is drawn from a wider geographical area than that of the State mental hospital in Alexandria.[2] Third, the class affiliation range of the patients in X Hospital is much wider than in Khanka Mental Hospital where the patients come mostly from the lower class as they are treated on a charity basis. Fourth, Z Hospital caters to an upper class population which thus enlarges the range of the class backgrounds of the sample and at the same time enriches its degree of representativeness.

Once X and Z hospitals were designated as a sampling frame, a decision was made as to how many cases were to be used in the sample. Resident in Z Hospital during the survey period were 120 Egyptian patients.[3] The decision was made to use half of these cases. A list of the patients, excluding all foreigners, was compiled from which every second patient was selected. With respect to X Hospital the population was over 2,000 from both sexes. Since this hospital includes different grades and is thus stratified in respect to some of the variables included in this study, it was decided to use stratified sampling as follows: X Hospital is divided into four grades varying in the kind of food provided for the patients. These grades are the following arranged according to superiority: 1) the economic, 2) the first, 3) the second, and 4) the third grade. In the economic grade the patient pays £ 2 per day as expenses for his treatment. It caters to a few patients from the upper class. In the first grade the patient pays £ 12 per month, in the second grade £ 6 per month, and in the third grade he is treated on a charity basis.

In this study it was ensured that sufficient patients were drawn from every grade (stratum) and from both sexes. As one example, imagine a sample of patients drawn from X Hospital. It is known in advance that the top economic grade consists of only a few patients, the first grade is also relatively small in size, but the second and third grades are relatively populous. A sample drawn at random from X Hospital as a whole might happen to include nobody at all from the top (economic) grade since there are altogether so few in this stratum. Yet, for proper representation, patients from the highest level should be

included. Because of their small number (50), all the patients in the economic grade were chosen. For the remaining grades, a representative sample of 347 patients was drawn by selecting the first and every sixth person thereafter for each grade.

Both hospitals include a full range of psychiatric disorders from brain syndromes and functional psychoses to psychoneuroses and behavior disturbances. However, the two hospitals differ in the socio-cultural background of the patients. X Hospital is one of three State mental hospitals in Egypt. It accommodates patients from both sexes with different class backgrounds and with various degrees of exposure to Western culture. Almost all social classes are represented, but the overwhelming majority of its population is comprised of patients from the lower class. About 80 per cent of the patients originated in rural and urban slum areas. Approximately 85 per cent of the hospital patients are of the lower class and 15 per cent are of the middle and upper classes.

In Z Hospital, by contrast, the majority of patients came from a highly westernized urban bourgeoisie. This aristocratic hospital, which accommodates the mentally sick of the elite of Egypt and the Arab World, requires a minimum patient fee of £2 per day as expenses.

Approximately 450 patients with different diagnostic categories were studied by scrutiny of their hospital records, by collecting life histories, by individual interviews with psychiatrists, hospital staff, patients, and relatives,[4] and by participant observation in the hospital life-space. In addition, use was made of available data like official statistics, and psychiatric reports submitted to the 1st Arab Congress

on Mental Illness held in Cairo in December, 1970.

To sum up, the main methods used in this study were those of participant observation, interviews, use of archival material (hospital records and life history material and papers submitted to the 1st Arab Congress on Mental Health), statistical methods and ethnographic material.

B. Degree of Representativeness

It is appropriate here to discuss the degree of representativeness of the sample drawn from X and Z hospitals. In consideration of the sampling procedures previously discussed, there is hardly need to stress the fact that the sample used in this study does not match the total population picture of mentally sick patients in Egypt in 1971.

There are a set or organized systems for dealing with cases of mental illness among the Egyptians. They fall into two types: Egyptian and Western. The type of system used in treatment varies as a function of the patient's social status. For lower classes, treatment at a mental hospital is the second stage. The lower class patient goes to the traditional healer first. And when he finally decides to use Western psychiatric treatment, he will receive, in general, an inferior quality of treatment.

The fact that upper and middle class patients tend to enter treatment earlier and are more likely to be treated effectively and permanently discharged from hospital, while the lower class patient is likely to become a permanent resident of the hospital, will tend to have a cumulative effect upon statistics of class-specific prevalences based upon institutionalized populations. The frequency with which lower

class patients initially become ill (*incidence* rather than *prevalence*), however, may be the same as that of higher status patients. Such a factor might serve to seriously distort observed prevalences relative to their actual or "true" rates.

Another factor of sampling bias relates to unreliability of diagnostic procedures. The diagnosis depends not only on the symptoms and manifestations of the patient, but also on the psychiatrist's familiarity with the patient and his culture. Culturally appropriate behavior may be misunderstood by the psychiatrist because the psychiatrist is from a different social stratum. One explanation which has been offered to account for this distortion is the lack of convergence between patient and psychiatrist values and communication systems. This may result in mentally sane patients being mistakenly diagnosed and consequently committed to mental hospitals.

Because of these limitations in representing the total universe no claim is made for having achieved generalizations about Egyptian mental patients as a whole. Generalizations are made only for the populations of X and Z hospitals.

C. Methodological Problems in the Field Study of Culture and Mental Disorders

A central problem in the field study of culture and mental disorders is methodology; how can outsiders, i.e., persons from outside the hospital, look inside the minds of mentally sick patients and comprehend their views of the universe that surrounds them? Further,

a mental hospital is an institution for the purposes of treatment. An outsider would disrupt and interfere with this purpose. The outside observer must develop some mental as well as behavioral techniques to deal with the inevitable disturbance introduced by his presence.

It was necessary to accustom oneself to the unabashed curiosity of the mental patients. The author's presence often provoked direct questions which could be used to establish contact and gain information. The most frequently posed questions were: what was he doing? how old was he? was he married? and how much did he earn in Canada? It was important to devise means of moving from these conversation dead-ends to topics more useful to the study undertaken.

The impact of his disturbing presence often was reflected during the conferences which were held weekly in both hospitals. Sometimes he felt tension in what was going on around him. Feeling this, he would move from one hospital to the other.

A second problem stems from the nature of the symptoms of mental illness. Such patients are restless, suspicious, and not willing to cooperate. Giving them cigarettes or small pieces of money made them more cooperative. But in spite of this, the nature of the symptoms of some types of schizophrenia makes it impossible for patients to cooperate. For example, a schizophrenic patient in catatonic stupor does not speak and appears entirely oblivious to his surroundings and to his own bodily needs. In a state of catatonic excitement, on the other hand, there is impulsive and jarring overactivity, but the patient seems to be reacting to his hallucinatory experiences and delusional ideas rather than to anything that is happening around him.

Given the fact that catatonic persons did not respond to questions, the author sometimes talked with relatives about the onset of their illnesses and their past histories. Interviewing relatives gave him the chance to compare the complaints of patients with the complaints offered by those perhaps more directly responsible for the consultation, or of otherwise interested persons. The greatest divergences were possible here. For example, it was common to meet a patient who accused his wife of plotting with other people. Interviewing the wife might reveal that the patient was highly deluded. Sometimes you could not tell whether the patient or his wife was in the right. As an example, the author met a patient who accused his wife of being a prostitute. Because he objected to her immoral attitude, she contrived, through the help of some of her upper class clients, to get rid of him by committing him to the mental hospital. To the wife, the patient was a highly deluded homicidal person. However, the author became suspicious after seeing that her clothes and the way she squandered money did not correspond with her social class. Perhaps she really was a prostitute.

Sometimes the responses of the patients did not reveal whether they were joking or whether they were serious. For example, in response to the question, "You know where you are, don't you?", a patient in X Hospital replied, "The house of the antiquities."

Another problem stems from the fact that during the course of their illnesses, some patients are homicidal. Once during field research the nurse asked the author not to go into one of the wards. Looking around he found a mental patient on the roof of the hospital engaged in throwing different kinds of big stones at the patients. This developed into a good fight as the other patients reciprocated.

Finally, the special rapport the author seemed to be able to establish rested upon the confidence inspired by ordinary human kindliness and sympathetic understanding on his part and a willingness to spend whatever time and energy were necessary to do justice to the problem. Very often his task was to school himself to listen and learn.

D. Problems of Definition

The analysis should begin with some working definitions. By *symptom*, the author means subjective evidence of disease or physical disturbance on the part of the patient (hallucination is a symptom of some mental sicknesses).

By *content*, is meant the subject matter of the symptom. The content of a symptom such as delusion might be religious (if the patient expresses in his delusion any supernatural belief), or scientific (if the patient expresses, for example, that his thoughts or actions are under scientific force [influence] or control), and so on.

By *etiology*, is meant causation in mental disease. More specifically, this refers to factors (cultural, social, biological, or psychological) which play important roles in the production of mental disorders, that is, the locus of the distortion where psychopathology originates (Wallace, 1969:172).

When such a term as *social class* is used, one must clarify exactly what the concept means in the particular instance. In determining a patient's class affiliation at the time of field research, three coordinates were used: education, occupation, and the grade in which he is treated in the hospital. Each of these attributes was divided into five

parts, with corresponding scores ranging from 1 to 5. The maximum possible score in each case was therefore 15. The combined scores with respect to education, occupation, and grade in the hospital were used to determine each patient's class affiliation. A total score up to 6 placed him in the lower class, a score of 7 - 10 in the middle, and 11 - 15 in the upper class (see Appendix 3 for index of social position).

Perhaps the most significant item of definition, and the item around which much debate still centres, is the discussion as to what should constitute a "case" for research purposes. For the purpose of this study, a *case* is defined as any person under treatment — from a person certified by a psychiatrist to have a mental disorder to a person who arrives at a self-judgement that he is in need of treatment.

Chapter IV

Part I

THE STRESS MODEL OF SCHIZOPHRENIA

This chapter consists of two main parts. In the first, an outline is given of a model which attempts to relate schizophrenic rate differentials to the stressful conditions impinging upon the individual. The most important issue is the content analysis of themes of stress in the life histories of patients. The second part focuses on specific case histories as a means of illustrating areas of stress in Egyptian society.

A study of the literature reveals that no generally accepted theory encompassing the biological, psychological, social, and cultural aspects of "normal" and "abnormal" behavior pertinent to the interest of this study is available for test or verification. This statement is made in full cognizance of the attempts of anthropologists and sociologists to formulate unitary theories of behavior which bridge the gap between the individual as an organism and the sociocultural matrix that surrounds him. It is made in the light, also, of the contributions of Freud and his disciples to our knowledge of the psychopathology and psychology of the individual.

A. Frame of Reference

This section is concerned with a frame of reference in which the mental illness rate differentials in various communities can be

conceptually organized for study. Some theoretical expectations are outlined regarding the associations between sociocultural environment and psychiatric disorder.

Taking for a point of departure a recognition of the importance of stress in conditioning people to mental disorders, it is proposed in this chapter that sociocultural stress is causally related to high proportions of psychiatric disorder, whereas low amount of stress is associated with comparatively low proportions of psychiatric disorder. This expectation arises not only from the empirical results of psychiatry but also from theories of personality formation, of the character and effects of stresses that may influence adult personalities, and of conditions conducive to the maintenance rather than alleviation of symptoms.

Because schizophrenia is the number-one mental health problem and because it is often associated in the psychiatric literature with sociocultural stress, this study will concentrate on the etiology of schizophrenia.

The most tenable hypothesis as to the etiology of schizophrenia at this time is that various combinations of hereditary vulnerability and environmental stress (either in early childhood or in later life) may lead to overt manifestation of the disorder (Clausen, 1961:165). More recently Wilson and Lantz (1957:28) concluded that the stress and strain of life produce schizophrenia, senile, and arteriosclerotic psychoses among the Negroes. A similar view is held by psychiatrist David Rothchild (1956). This view is illustrated by diagrammatic representation in Figure 2 (adapted from Strecker & Ebaugh, 1945).

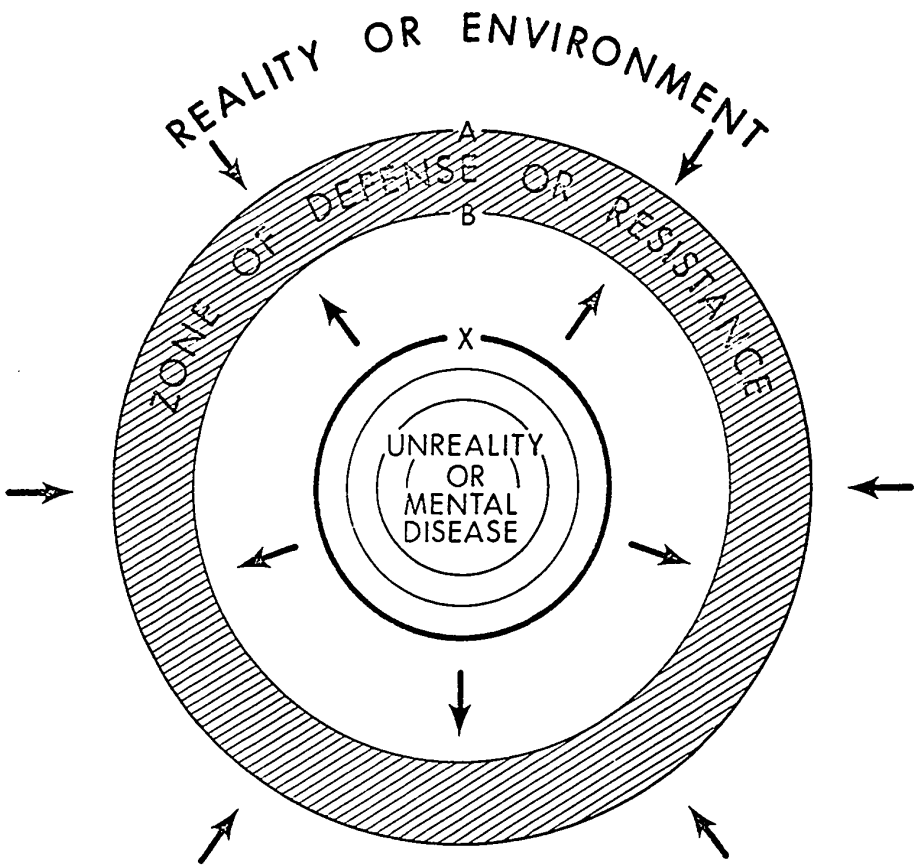

Fig. 2. The Zone of Defense which the individual is able to interpose against the development of a psychosis.

The individual is symbolized by a circle (A) and normality or sanity is equivalent to perfect contact with reality or environment at every point. On the other hand, mental disease is synonymous with unreality (X) of which there are naturally many grades of severity pictured by the smaller circles included within the circle (X). The Zone of Defense (AB) is the amount of resistance which a given individual is able to create to insure against the development of schizophrenia (Strecker & Ebaugh, 1945). It is obvious that the extent of the defense zone or, diagrammatically, its thickness, is dependent not only upon inherited, intrinsic, and constitutional deviations and weaknesses, but also upon acquired, extraneous, and environmental handicaps and liabilities among which must be included every possible type and degree of sociocultural stress (Strecker & Ebaugh, 1945). Thus, the development of schizophrenia usually may be interpreted not as an acute process but as a gradual impairment of resistance, either because the latter is intrinsically insufficient to meet ordinary demands, or because the sociocultural stresses become too frequent and too severe, or, commonly, because both conditions exist. Once the resistance has become seriously diminished and impaired even an insignificant thrust from the environment may be sufficient to break through and then, for reality or sanity, there is substituted unreality or mental disease (see Figure 3, adapted from Strecker & Ebaugh, 1945). It cannot be emphasized too strongly that the painstaking and laborious method of evaluating all the factors which deminish the zone of resistance is the only sure way to understand the true state of affairs (Strecker & Ebaugh, 1945).

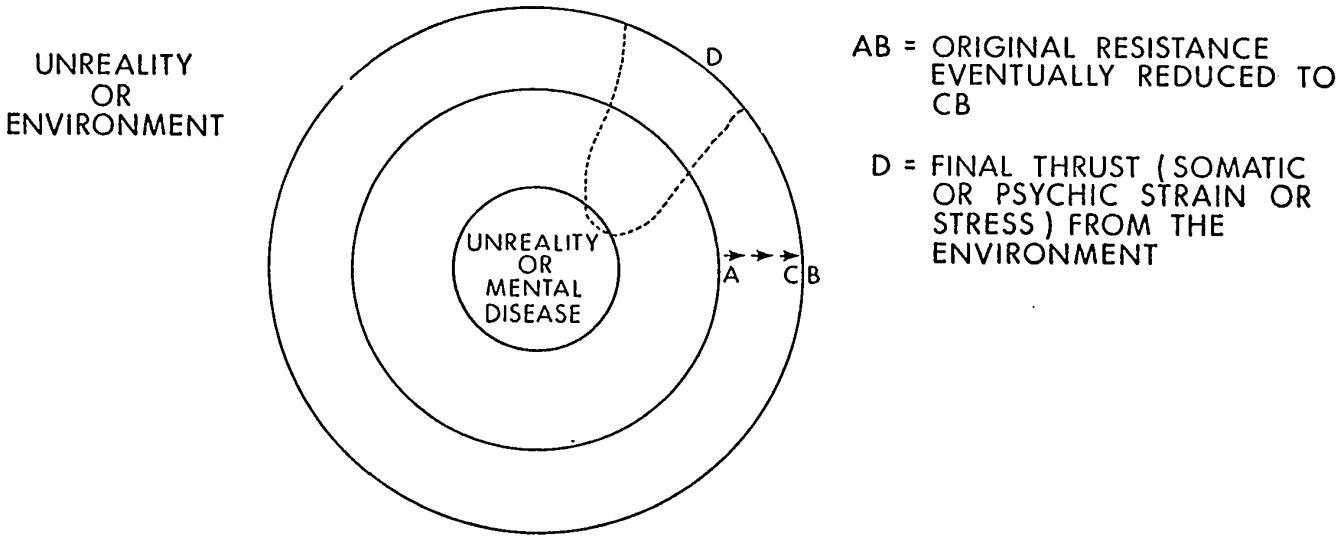

Fig. 3. Decrease in the thickness of the Zone of Defense

The methodological procedure used in this study to analyze the relationship of sociocultural stress to schizophrenic rate differential is to locate the areas of conflict, stress, and tension in Egyptian society. After delimiting such areas within the social structure, the analysis then proceeds to examine the schizophrenic rate. If the rate is significantly higher in areas of higher sociocultural stress than in those of low sociocultural stress, the stress model of schizophrenia suggested above will receive support.

B. Clinical Method

Of the approaches useful to cultural st. dy, the clinical approach is the oldest, perhaps because it lies closest to a common sense level. For it is the person with variant behavior and distorted mentality who is most easily observed, and such observation points immediately to the need for some kind of systematic examination (Dunham, 1959).

The concern of this investigator with the clinical approach is primarily in terms of its research value, although in psychiatry, as in other branches of medicine, its use is intimately tied up with the pressing need for therapy of any pathology which is demonstrated or inferred. The clinical method is naturally preferred in medicine because it brings the physician into first-hand contact with the patient who requires treatment (Dunham, 1959).

The development of the clinical method in psychiatry has been both descriptive and analytical. It has been descriptive in the sense that careful case examinations have been used to build up various schemes

of classifications on the basis of symptoms which could be observed and at least partially objectified. It has been analytical in the sense that various investigators have attempted to make the data secured from these sources support or fit into some etiological theory (Dunham, 1959).

The clinical approach is also found in cultural anthropology but from quite an altered perspective concerning the nature of man and his relationship to society. Here, the clinical approach is best seen in the use made of the life history document. The life history method has two major functions. It is a technique for studying the process involved in the internalization of experience with its meaning to the person in terms of his self conception and his orientation to the world. Again, it can be and has been used as a means of gaining insight into the organization and functioning of certain aspects of a given culture, as viewed through one human experience (Dunham, 1959).

As long ago as 1935, when Dollard stated his criteria for judging the adequacy of the life history document, he emphasized as one of these that "the person should be considered a specimen in a cultural series."[1] This point of view can show how the rough but powerful outline of the new individual life is forecast by the traditional life of the group itself. Dollard (1935:16) stressed at this point the fact that the scientific student of a human life must adequately acknowledge the enormous background mass of the culture; and not as a mere mass either, but rather as a configurated whole. Before any individual appears, his society has had a specific social life organized and systematized, and the existence of this life will exercise a tyrannical compulsion on him. To state the point in an extreme manner, we can think of the organic man as the mere

toy of culture (Dollard, 1935).

If the life historian is not equipped with the above criterion he will certainly fall into error by referring to accident, whims of individuals, much that is properly seen only as a part of the society into which the individual comes. One of the marks of an effective grasping of this point is the stated or implied "in our culture" whenever one makes any point in connection with individual behavior; it is a good thing to get into the habit, for example, of saying "men are more able than women to exhibit aggressive behavior in our culture" (Dollard, 1935). One might venture that to the psychiatric anthropologist the three most indispensable letters in the alphabet are "I.O.C." (in our culture). This implies that the life history worker must have a good conscious as well as unconscious control of the culture in which he takes life histories (Dollard, 1935).

C. Central Themes of Stress

Specifically in this section the researcher is concerned with the central themes of stress in the life histories of the patients and in the ways in which these themes can be confirmed by ethnographic and other material. For the purpose of exploring the stressful situations in the lives of patients, an adequate sampling of sex, age, and status differentiations has been obtained as expressed in Tables 1 and 2. Table 1 summarizes the age and sex of the patients on the basis of their life histories. The class affiliation of the patients is expressed in Table 2.

Basic to this section is the attempt to show how the use of life

Table 1. *Distribution of Patients in the Sample by Age and Sex*

Age	Male	Female	Total
14 - 19	45	60	105
20 - 29	105	120	225
30 - 39	27	40	67
40 - 49	12	18	30
50 - 59	8	12	20
60 -	3	7	10
Total	200	257	457

Table 2. *Distribution of Patients in the Sample by Sex and Class Affiliation*

Total	Male	Female	Total
Upper	43	67	110
Middle	35	45	80
Lower	122	145	267
Total	200	257	457

histories in the field of psychiatric anthropology (in addition to the use of hospital records, available statistical data, ethnographic material, and observation in the hospitals utilized for the purpose of research) sharpens the field worker's insights and leads to a more logical and coherent interpretation of the data. Moreover, the use of life histories has definite research value in that the frequency of certain themes leads the field worker to watch for overt manifestations of these in everyday life, the significance of which might not be fully appreciated without cues given by the life histories. For example, life histories of young patients emphasize the theme of physical punishment by a parent, particularly the father, as a means to enforce achievement of educational goals. This emphasis, noted in the life histories, can lead to a much fuller comprehension of the dynamics of sociocultural change than would probably have resulted had these cues not been forthcoming.

A Definition of Sociocultural Stress

Perhaps the investigator might commence with a working definition. By *stress* is meant any painful or distasteful experience, social or domestic difficulties, emotional states damaging to the personality, and any other conscious causes of unhappiness or worry. A patient often has more than one theme of stress involved in his life history; in such a case he is scored for more than one stressful situation. The sum total of the themes of stress expressed in his life history represents the position of the patient on the stress scale. In analyzing the life history documents the researcher looked for what the patient chose to tell about

himself and what painful or distasteful experience he had passed through.

On the whole, the patients' life histories were clear and spontaneous. As a picture of Egyptian patients' discoveries of the world about them, they are likely to be unforgettable. The patients' descriptions of their feelings about their kinsfolk and friends and their behavior are particularly revealing.

The crucial methodological problem in the research design was to avoid contamination between the recorded life histories and the analyses of the dominant themes of stress which cut through them. This was complicated by the fact that the same person collected and analyzed the life histories. This problem could be solved if the life histories could be analyzed "blind" without the contaminating knowledge of the research objectives. Unfortunately, lacking a staff, the researcher was obliged both to administer the life history documents and score the themes of stress. However, he did not consult data from any other source while scoring any particular life history; any information about education, occupation, and the grade in which the individual was being treated in the hospital was not taken into account.

Some Indices of Sociocultural Stress

The attempt in the preceding section to give a description of what is meant in this thesis by sociocultural stress leaves a number of questions unanswered and many points still in need of clarification. One way to approach a further development of the concept is to operationalize it for research purposes. Inasmuch as sociocultural stress in a society cannot be directly apprehended, application of the concept means

the selection of indicators, and this act constitutes a further definition.

Such a relationship between indicator and definition of referent is common in social science. Typically, the investigators have a general something in mind, but, as they work at choosing ways and means for indicating the presence of that something and recording variations in its characteristics, the decisions become part of the concept. This sort of procedure is perhaps best seen in the development of intelligence tests. It has been said that "intelligence is what the intelligence tests measure." Although this is facetious, to an important extent it is true. The tests have become a part of what we mean by intelligence (Leighton, 1959).

In other fields of knowledge indicators are not so closely tied to the definition of their referents. When litmus paper is employed to indicate degree of acidity, the red color of the paper is not part of the definition of acid (Leighton, 1959). This indicator does not define the phenomena to which it refers and its validity can only be assessed by independent means.

The case is different with most sociocultural indicators. For example, if one were trying to distinguish a "lower class" individual, he might choose such indicators as occupation, education, and area of residence. But each one of these is not only an indicator but part of the descriptive definition of social class.

These points have been made for two reasons. One is to make evident the kind of indicators that will be used in connection with

sociocultural stress and to point out that they constitute a further working out of the definition. The second is to avoid confusion between the nature of these kinds of indicators and those of the physical sciences. There is danger in doing this, since both are called indicators or indices, and it is very easy to transfer the meaning of a name in one context to another context in which the meaning does not apply (Leighton, 1959).

Returning to the central topic, the steps through which the analyses of life histories took place are the following:

1. In the first reading, all stressful and painful experiences were isolated.
2. In the second reading the manifest content of the life histories was scored. Every stressful theme was put in a category.
3. The third step consisted of combination of similar categories and revised frequency.
4. Finally, the last step in the thematic analysis consisted of deciding which categories to use for further analysis. The data showed central tendencies that constituted modal themes for our patients. There were other themes which were not as frequent as the modal themes, and therefore these were not considered (see Appendix 1).

The modal themes are: 1) hatred of one's spouse, 2) fear of being killed, 3) jealousy, 4) loneliness, 5) persecution by a step-parent (impaired relationship), 6) physical beating, and 7) sexual guilt. When one looks at this set of themes the question naturally arises: Why these, rather than some others?

It is difficult to give a complete answer and it is certainly not possible to maintain that they are necessarily the best choices. They are the product of a preliminary look at what seems to be the manifestation of stress — according to the investigator's definition — in the patients' life histories.

When it comes to the use of these indicators, it is at once evident that they cannot be applied in any simple manner. Thus a system of categories for scoring the manifest content of the life histories was worked out. In this way the indicators seem to be operable in the sense that they promise to distinguish the areas of maximal and minimal stress.

Although the life histories were suggestive of a variety of dominant themes, the author is not concerned in his research objective with the world view of these mentally sick patients. What is of great importance to him is the strain of life and the stressful conditions of existence which have affected the patients.

Thus, the investigator is not interested in all the recurring concerns that cut across all the life histories and which appear to dominate the outlook of most patients in the two hospitals. Instead, attention has been concentrated on the themes relevant to the immediate research — the stressful themes — to the exclusion of those themes which are outside the present concern. These modal themes shall now be defined in theoretical terms.

Fear is defined as a perceived threat to the self. For example: "fear of being killed as a result of illegitimate pregnancy."

The life history is scored as "anxious" if any kind of fear is expressed. The life histories revealed a variety of fears ranging from

fear of being killed, fear of death of the parent(s), to fear of failure in study.

Jealousy is defined as a disposition or state of mind which results from hostile rivalry, as among co-wives or siblings.

Hatred is defined as a feeling of intense dislike towards another person, revealed in the wording of a life history.

Loneliness is defined as a feeling of disappointment, depression, sorrow, grief, unhappiness, melancholy, despair as a result of separation from love objects (parents or parent-substitutes) due to death, divorce, etc. For example, ". . . the patient seeks comfort by turning to some person for help but he does not find any." "Loss of love object due to death."

As to *persecution* (impairment of relationship), a life history was scored as such if the patient was made to suffer (insult, defeat, rejection, scorn, repulsion, or refusal of help).

Sexual guilt in a life history was scored as such if the patient expressed self blame because of sexual wrongdoing.

For purposes of our discussion, a life history was scored as expressing *physical beating* if the patient stated that he was thrashed anywhere on the body.

D. Distribution of the Seven Dominant Themes of Stress

These stressful themes, which were the most frequent in the distribution, are the "dominant" themes. These recurring concerns that

permeate many of the life histories and which appear to dominate the stressful outlook of most patients are summarized in Table 3, which expresses distribution of patients by themes of stress and sex. This table indicates that there is a higher concentration of the first three themes in the female category than would be expected on the basis of chance distribution between the two sexes. The distribution of the remaining themes does not differ significantly for the two sexes.

Distribution of patients by themes, and social class, which is expressed in Table 4, indicates that there is a higher concentration of all themes in the lowest class than would be expected on the basis of chance distribution.[2]

Turning to the distribution of themes by age, two categories were defined: young and old. The patient was considered young if he was not more than 29 years old, and he was considered old if he was more than 29.[3] Table 5, which presents the distribution of themes and patients by age, indicates that there is a higher concentration of two themes, Nos. 6 and 7, in the young category than would be expected on the basis of chance. The pattern of distribution of the rest of the themes is almost identical with the distribution of age populations.

The interaction between the three variables of social class, sex, and age is shown in Tables 6, 7, and 8.[4]

To summarize the argument thus far, it was discovered that the situations which were defined by the patients as "stressful" were unevenly distributed by social class, sex, and age. These findings support the view that who suffers stressful experiences depends in large part upon where one is in the class structure, and in a smaller part

Table 3. *Distribution of Patients by Themes of Stress and Sex*

Dominant Themes of Stress	*Male* - 200 No. of Themes	*Male* - 200 % to Total of Life Histories	*Female* - 257 No. of Themes	*Female* - 257 % to Total of Life Histories	Difference Between Males and Females χ^{2*}	df	Level of Significance
1) Hatred	31	15.5	179	69.65	68.6	1	P = .001
2) Fear	41	20.5	96	37.3	9.3	1	P = .01
3) Jealousy	49	24.5	155	60.3	30.4	1	P - .001
4) Loneliness	148	74	171	66.5	.80	1	P = .50
5) Persecution	99	48	132	51	.50	1	P = .50
6) Beating	125	62.5	130	50.5	2.40	1	P = .20
7) Sexual guilt	126	63	143	55.6	.95	1	P = .50

*Based on equal number of males and females = 200.

Table 4. *Distribution of Themes and Patients by Social Class*

Dominant themes of Stress	*Lower Class - 267*		*Middle Class - 80*		*Upper Class - 110*		χ^{2}*	df	Level of Significance
	No. of themes	% to Total of Life Histories	No. of themes	% to Total of Life Histories	No. of themes	% to Total of Life Histories			
1) Hatred	167	62.5	24	30	19	17	19	2	P = .001
2) Fear	113	42.3	13	16	11	10	18	2	P = .001
3) Jealousy	163	61	25	31	16	14.5	24.5	2	P = .001
4) Loneliness	254	95	40	50	25	22.7	38	2	P = .001
5) Persecution	198	74	21	26.4	12	10.9	45.4	2	P = .001
6) Beating	202	75.6	27	33.7	26	23.6	27	2	P = .001
7) Sexual guilt	219	82	30	37	20	18	36.95	2	P = .001

*Based on equal number of lower, middle, and upper class = 80.

Table 5. *Distribution of Themes and Patients by Age*

Young - 330 *Old* - 127

Dominant Themes of Stress	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	χ^{2*}	df	Level of Significance
1) Hatred	147	45.4	63	49.6	1.1	1	P = .50
2) Fear	99	30	38	29.9	.00	1	P = .00
3) Jealousy	146	45	58	45.6	.02	1	P = .90
4) Loneliness	228	69.6	91	71.6	.05	1	P = .90
5) Persecution	167	51.5	64	50.7	.00	1	P = .00
6) Beating	231	76.6	24	18.8	.37	1	P = .001
7) Sexual guilt	238	79.9	31	24.4	29.4	1	P = .001

*Based on equal number of young and old = 127.

Table 6. *Distribution of Themes and Patients by Sex and Age in the Lower Class Social Category*

(Total number of patients - 267)

Dominant Themes of Stress	Male - 122				Female - 145				Total No. of Themes
	Young - 97		Old - 25		Young - 100		Old - 45		
	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	
1) Hatred	20	20.6	5	20	98	98	44	97.7	167
2) Fear	26	27	6	24	56	56	25	55.5	113
3) Jealousy	30	31	8	32	88	88	37	82	163
4) Loneliness	95	98	23	92	92	92	44	97.7	254
5) Persecution	70	72	17	68	75	75	36	79.9	198
6) Beating	97	100	5	20	90	90	10	22	202
7) Sexual guilt	96	99	8	32	100	100	15	33	219
Total	435	447.6	72	288	599	599	211	467.8	1316

Table 7. *Distribution of Themes and Patients by Sex and Age in the Middle Class Social Category*

(Total number of patients - 80)

Dominant Themes of Stress	Male - 35				Female - 45				Total No. of Themes
	Young - 20		Old - 15		Young - 25		Old - 20		
	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	
1) Hatred	2	10	2	13	11	44	9	45	24
2) Fear	3	15	2	13	5	20	3	15	13
3) Jealousy	5	25	3	20	10	40	7	35	25
4) Loneliness	11	55	8	53	11	44	10	50	40
5) Persecution	5	25	3	20	7	28	6	30	21
6) Beating	11	55	3	20	10	40	3	15	27
7) Sexual guilt	10	50	4	26.6	13	52	3	15	30
Total	47	235	25	165.6	67	268	41	205	180

Table 8. *Distribution of Themes and Patients by Sex and Age in the Upper Class Social Category*

(Total number of patients - 110)

Dominant Themes of Stress	Male - 43				Female - 67				Total No. of Themes
	Young - 33		Old - 10		Young - 55		Old - 12		
	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	No. of Themes	% to Total of Life Histories	
1) Hatred	2	6	0	0	14	25	3	25	19
2) Fear	3	9	1	10	6	10.9	1	8.3	11
3) Jealousy	2	6	1	19	11	20	2	16.6	16
4) Loneliness	8	24	3	30	11	20	3	25	25
5) Persecution	3	9	1	10	7	10.9	1	9.3	12
6) Beating	8	24	1	10	15	27	2	16.6	26
7) Sexual guilt	8	24	0	0	11	20	1	8	20
Total	34	102	7	70	69	133.6	13	107.8	129

upon one's own sex and age. The analysis shows that stressful situations are extremely common in the lower class, that they occur more frequently in the Egyptian female and, finally, that young Egyptians are more exposed to stress than old Egyptians. Thus the three major determinants of stress according to importance can be diagrammed as illustrated in Figure 4.

The patients can then be divided into 12 categories by class, sex, and age with these three variables weighted in that order. Thus social class takes precedence over sex which in turn takes precedence over age as illustrated in Figure 5. This rank ordering produces the 12 categories listed in Table 9. If the variables have been weighted properly one would expect that the first category, lower class young women, would experience the *greatest* amount of stress (as experienced in the content analysis), that the last category, upper class old men, would experience the *least* amount of stress, and that the intermediate categories would show a *decreasing* amount of stress.

The actual results are depicted in Table 10. By looking at this table it can be seen that there is almost a perfect correlation. The only discrepancy is that the middle class young men category has been interchanged with the middle class old women category.

Each of the twelve categories of patients lives in a different type of stressful condition and probably needs to be handled differently. Type 1 — lower class young women — may be considered living under the most complicated and stressful conditions in their culture, for their human relations in their society are, for them, relatively unhappy. The situation is the opposite in Type 12 — upper class old men — for whom the

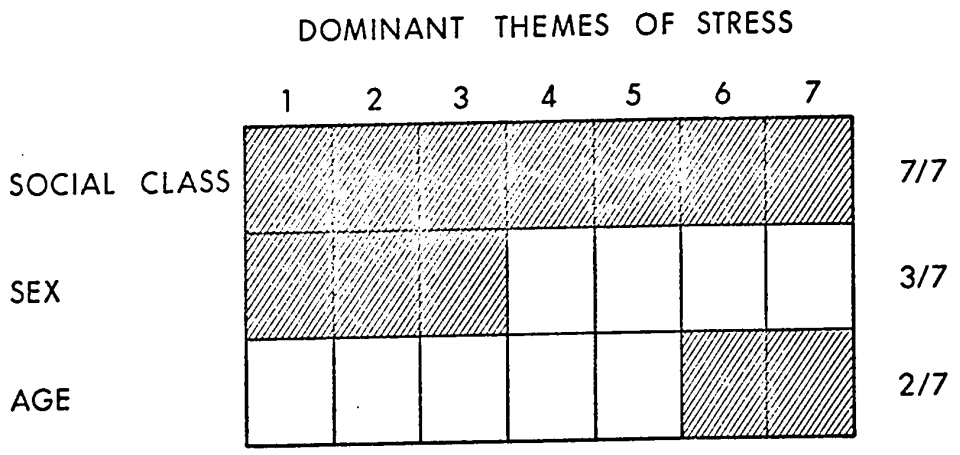

Fig. 4. Major areas of maximal stress in Egyptian society.

RANK ORDERING OF VARIABLES ASSOCIATED WITH STRESS

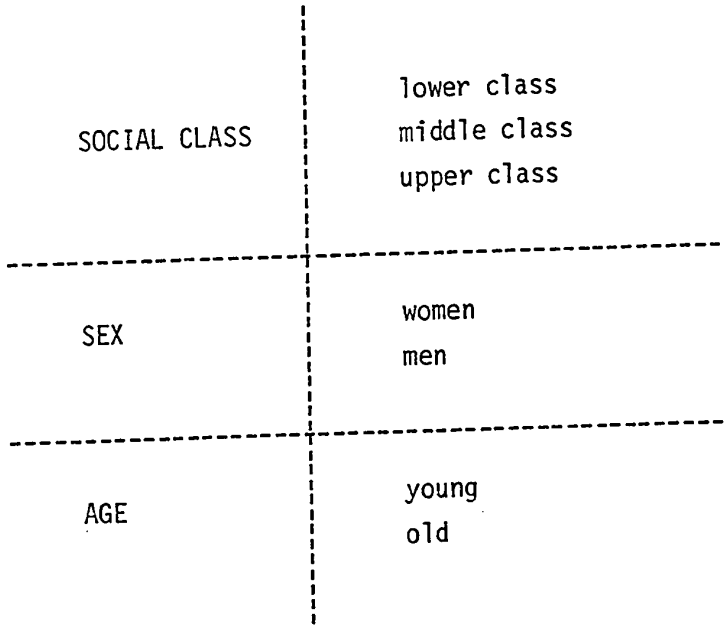

Fig. 5. Rank ordering of variables associated with stress.

Table 9. *Division of Patients into 12 Categories by Class, Sex, and Age (if these three variables weighted in that order)*

1. Lower Class young women
2. Lower class old women.
3. Lower class young men.
4. Lower class old men.

5. Middle class young women.
6. Middle class old women.
7. Middle class young men.
8. Middle class old men.

9. Upper class young women.
10. Upper class old women.
11. Upper class young men.
12. Upper class old men.

Table 10. *Comparison of Expected and Actual Ranking*

Expected Ranking	Actual Ranking	Average Number of Themes of Stress per Patient According to Class, Age, and Sex
1. Lower class young women	Lower class young women	5.99
2. Lower class old women	Lower class old women	4.68
3. Lower class young men	Lower class young men	4.48
4. Lower class old men	Lower class old men	2.88
5. Middle class young women	Middle class young women	2.68
6. Middle class old women	Middle class young men	2.35
7. Middle class young men	Middle class old women	2.05
8. Middle Class old men	Middle class old men	1.66
9. Upper class young women	Upper class young women	1.34
10. Upper class old women	Upper class old women	1.08
11. Upper class young men	Upper class young men	1.02
12. Upper class old men	Upper class old men	.70

condition is relatively happy.

Such results indicate clearly that social class is the first major factor in the determination of stress in the Egyptian culture, followed by the two factors of sex and age.

These findings could have a direct bearing upon the distribution of mental sickness for there would seem to be no question now that stress and strain are distributed differentially in the various parts of the Egyptian social structure. Having delimited such areas the investigator can proceed in the next chapter to hypothesize the schizophrenic rate differentials. It will be hypothesized that the schizophrenic rate differentials follow the rank order of the stress areas mentioned in Table 10, more specifically that the schizophrenic population should fall low on the social scale, that Egyptian women should be more afflicted by schizophrenia than men, and, finally, that the largest percentage of schizophrenic patients should occur in the young age category. Before proceeding with this analysis, however, some examples of dominant themes will be considered.

Part II

EXAMPLES OF THE DOMINANT THEMES

To exemplify the above points it will be helpful to borrow from the life histories of the patients some instances of three types of themes.

1. Themes Which Correlate Only with Social Class

First, the themes which correlate positively with lower social class, but not with sex or age. These are theme No. 4 (loneliness) and theme No. 5 (persecution).

(Theme 4) Loneliness. Referring to Tables 3, 4, and 5, it is clear that this theme is the most prevalent among the seven dominant themes. There were 319 life histories in which there was some explicit reference to loneliness. In nearly all the cases the reference was to separation from father, mother, or both, because of death, hospitalization, institutionalization, desertion, and so on.

These elements are unevenly operating in the social hierarchy: in the lower classes the feeling of loneliness is a more significant source of damage. This is obvious from the figures 95 per cent, 50 per cent, and 22.7 per cent for the lower class, middle class, and upper class, respectively. If we turn our attention to the patients exhibiting schizophrenic behavior (next chapter), one of the most interesting findings is that, in 95 of 154 randomly selected cases of schizophrenia in persons under 35 years of age, one or both parents were dead by the time the patient first entered the hospital at an average age of 20 years. Again, it would appear that only community studies directed to case-finding could determine whether in this society there is a positive correlation between schizophrenic incidence and disrupted homes. Moreover, in the Egyptian village family structure — with usually at least the father's near kin residing in the same house or nearby — because of the possibility of substitute mothering and of the presence of several parental figures, parental loss would have a different meaning than it does in the relatively

isolated conjugal American family.

Characteristic of this kind of theme:

1) A 21-year-old student suffering from an obsessive compulsive neurosis expressed his feeling of loneliness because of the total separation from both parents. His life history shows that as a child he was brought up away from home. He was raised in his mother's brother's home. The reason for this is that he was born a year after his older brother, and his mother could not take care of both children. Consequently he was sent to his grandmother (on his mother's side) who lived with her son (his mother's brother) to take care of him. "My mother gave me to her mother to take care of me and forgot that she had a son. Sometimes I used to say to myself that she might not be my mother."

2) Another patient who was also a student and a son of a separated couple from the upper class remembered that he languished about the house for several days when his mother left him and then wrote her a letter imploring her to return home, emphasizing that he had been bedridden since she left . . .

(Theme 5) Persecution. The second theme in the lower class themes is that of persecution. This theme is an important and logical corollary to the loneliness theme. Turning to Table 4, it is clear that persecution of the patient is also expressed in the life histories. There were 231 histories in which there was explicit spontaneous reference to persecution. In nearly all cases the reference was to persecution by a step-mother, particularly after the real mother was divorced.

A typical theme is expressed by a 20-year-old schizophrenic patient:

My mother died and my father married another woman. This woman was jealous of me because I got better academic results than her son. Once when my father was absent from home she put a piece of iron in the fire, then she put it in my hand. I cried and complained to my father. On seeing the signs of burning in my hand [there was a scar in his hand] *my father became furious and gave her a good beating. Consequently she wanted to get rid of me. Thus my father brought me here.* "But I am a brave man. Whenever I see anything wrong I would have the courage to declare my opinion. This made them angry."

Ethnographic and Other Material Supporting the Themes

Data in the following part of the present section, based on ethnographic material and available statistical and historical data, is used to explore the overt manifestations of the themes discussed above. Specifically, ethnographic descriptions of the Middle East and other material are introduced to verify and substantiate the dominant themes in the patients' life histories.

The value of the ethnographic material is not that it proves anything but that it can balance or supplement a rigorous, structured, methodological procedure — such as content analysis of life histories — with the addition of qualitative data which may aid in explaining quantitative results.

Having just indicated the two "lower class themes," it remains to account for their development. Having made a brief survey of the literature of the Egyptian culture, one could distinguish for Egyptian society its distinctive cultural contributions and background, its particular pace of cultural change, and its typical or special patterns of stress in family conflicts. The crucial point for any cultural group is that it is the normative or "normal" standards of conduct of each group which help define the kinds of conflict or repression, the types of emotional expression, the system of values, or the functioning of the family for each individual. Consequently, we have to view each stressful theme in its meaningful cultural setting.

These themes are consistent with what we know about traditional Middle Eastern societies. In Egypt, as in many other Arab countries, there is a high divorce rate. Divorce in a Muslim society is extremely

simple. The husband can divorce his wife at will by pronouncing the traditional formula, "I divorce you," in the presence of two witnesses (Goode, 1961:390-406).

A glance at the frequency of divorce is also instructive. This can be measured by the number of annual divorces per 1,000 married couples, which in the United States was 165.3 in 1939-41 and 231.7 in 1949-51, the highest rates in the Western world. In the Middle East, however, these rates per 1,000 marriages are higher still. In Egypt, they were 269 in 1930 and 273 in 1950. In Table 11, various divorce rates are presented for comparison.[5]

As yet there is no adequate analysis of contemporary Arab families so that a precise statement of the reason for the extremely high divorce rates cannot be made. But it can be stated that, though the second union would not be so advantageous a match, the repudiated wife would usually be able to remarry. There is no great excess of females, and since each man typically has only one wife, the high divorce rate simply means a high rate of marital turnover.

In the more educated Arab strata, however, Western ideas about the rights of women have penetrated, so that divorce is less frequent and the age at marriage is higher. A study of the relation between class affiliation and divorce in the author's small town shows that divorce was concentrated highly in the lower class. Extremely high divorce rates generally prevail in low income-low prestige occupations (personal observation). Within this context we can explain why the themes of loneliness and persecution are predominant in the life histories of the patients. When the woman is divorced she returns to her own

Table 11. *Divorces per I,000 Marriages in Selected Countries, I890 - I959**

Country	1890	1897	1900	1910	1920	1930	1935	1940	1946	1950	1955	1956	1959
Algeria		370	352	288	396	286		292			161		
Australia			13.6	12.4	20.4	41.2		41.6	90.0	97.3		85.5	
Egypt						269	273			273		288	
England & Wales					9.0	11.1		16.5		86.1		74.5	
France	24.3		26.1	46.3	49.4	68.6		80.3		106.9		100.5	
Germany			17.6	29.9	40.7	72.4		125.7		145.8			89.2
Iran								194		211		185	
Japan	33.5		184	131	100	98		76		100			
Sweden			12.9	18.4	30.5	50.6		65.1		147.7		175.4	
U.S.A.	55.6		75.3	87.4	133.3	173.9		165.3		231.7		259	

*All figures calculated from governmental sources and adapted from Merton (1960:406).

family. According to Muslim law, all the children of divorced parents belong to the father and the mother must deliver them up to him, usually at the age of seven (Patai, 1962:106). It is no exaggeration to say that leaving his mother for the step-mother is something of a traumatic experience for the Middle Eastern child.

2. The Female Themes

(Theme 1) Hatred. When one looks at the female themes as reflected in Table 3, it is clear that hatred of spouse as a result of a woman being married against her own will is clearly expressed in the life histories. There were 210 histories in which there was some explicit spontaneous reference to hatred. In nearly all cases the reference was to marriage against one's own will as a result of submission to a higher authority — particularly a parent — with females showing a significantly higher frequency than males.

The life histories show the relevance of cultural factors by illustrating how the hatred of spouse may play a role in conditioning Egyptian women to mental disorder. First, the researcher borrows from the hospital records of patients and psychiatrist' narrations a few instances of *psychoneuroses.*

A typical theme is expressed of a 35-year-old female patient:

1) The patient came for medical consultation. She was suffering from anxiety neurosis. Her symptoms first manifested themselves about eight months before she came for treatment. There was a more diffuse torment. She developed all sorts of fears. Such fears were often associated with attacks of panic, with heart palpitation, sweating, weakness so that there was a terrible sensation of dread. Investigation of her life history reveals that the patient was raised in an Egyptian rural atmosphere with a brutal father and that she didn't leave her home before her marriage except to the house of her husband. She didn't like her

husband who, like her father, treated her unkindly and refused to give her permission to go out except to the home of her parents on festival days and a few other special occasions. Once while she was visiting her father's family she was invited by some relatives to go to the cinema. While she was enjoying the movie she saw her husband come in. All of a sudden she felt a terrible feeling of impending doom and disaster and her heart began to palpitate. When the husband reached them he didn't speak to her. However, he spoke with her relatives expressing his displeasure at her going out with them without his permission. As a punishment he didn't allow her to return to his house. She spent one month in her parents' house. Although she expressed to her brother repeatedly that she didn't love her husband and that she didn't like to go back to his home, her relatives forced her to return to his home. Immediately after returning her symptoms began . . .

The following example was related by an Egyptian psychiatrist:

2) A 22-year-old married woman complained of a violent cough which attacked her at midnight for the last two months. A complete physical and laboratory examination revealed that there was no evidence of organic disease (actual physical disease of any of the organs of the body). This led to an examination of her life history. A detailed analysis of her life history indicated that though her father came from an upper class background he was rigid. He denied the patient actual necessities and there was a spirit of that type of stern, unbending religion which reveres ugliness as a virtue. She was denied her right to mix with girlfriends and she used to go to school and return home in a special car. When she reached the age of 14 her father ordered her to sit at home. As soon as she reached the age of 20 her father arranged for her marriage with a young man without consulting her. Reared in such an atmosphere, it was not unnatural that before the marriage ceremony she only saw her husband twice. In these two instances her father was present. After marriage her husband was cruel to her. Consequently she didn't feel love towards him. But she didn't dare to express her real feelings to her own family. Since her marriage she suffered from convulsions in utero *accompanied with* vaginismus. *She was treated by many physicians without any recovery . . .*

This life history indicates the price the Egyptian woman must pay for the cultural interference in her search for love. This cultural suppression causes bottled-up unhappiness which finally expresses itself in the form of symptoms. This *vaginismus* or uterine symptom was a body language expressing her protest against the culturally imposed marriage. This is why so many female Egyptian patients suffer from nausea, especially vomiting, during the sexual act. This symptom is more prevalent among

women than men (Okasha, 1969). It is also more expressed by married women and might be a symbol expressing their disgust of their spouses. This was found to be the case with a 25-year-old woman. Her life history is summarized as follows:

3) Her nausea and vomiting became so persistent that her husband joyfully took her to a gynecologist, sure that she was pregnant. She was not pregnant, nor was there any other physical basis for her morning symptoms. Only to the psychiatrist did she finally confess, in a flood of tears, that she had married her husband against her own will. Although her father told her that she was going to love him after marriage she failed to develop any such feeling toward him. Her husband disgusted her. She could not say anything to her parents, but this so nauseated her that throughout the day her mere presence in her husband's home was enough to start her vomiting. Strangely enough, when she left her husband's house to go to her father's house her vomiting came to an end. Here the body language expressed her revulsion at her husband's very presence in her life. She wanted to leave him but did not dare to cast him out. Symbolically, every time she vomited, she did cast out her husband, but her husband did not know it, and only she was the sufferer.

Such cultural pressures might cause a wide variety of symptoms which may be physical or mental. Sometimes these pressures result in ambivalence. Here the sufferer developed two different types of personality. Characteristics of this kind of theme are expressed in the following life history narrated by a psychiatrist:

4) I have treated a very miserable lady who was 35 years old and was raised under severe parental pressures. She was married against her own will in spite of the fact that she said to her parents that she didn't like her husband. Her husband, feeling that she hated him, mistreated her. After several years she began to suffer from multiple personality. Sometimes she identified herself with a 16-year-old girl. During this attack she would say and do whatever she felt, singing, dancing, and going out with very young men. She would alternate between this type of personality and its reverse. During the second attack she would exhibit symptoms almost in antithesis to the first type. Thus she was inert. She could not think, scarcely ate or slept, had ideas of dying, and really had to be watched by her relatives so that she would not commit suicide.

This ambivalent conduct resulted from the conflict between the desire to do as she pleased and the fear of doing what she wanted. Although the patient was 35 years old yet she was still carrying on a struggle with her

parents, especially with her father, a struggle within herself which she had felt in adolescence when he forced her to marry her husband.

The theme of hatred of one's spouse is not completely confined to the women's life histories. Sometimes it happens, though rarely, among men. This is exemplified by the following case:

5) A middle-aged man from upper Egypt developed an anxiety neurosis. He came to the psychiatrist convinced that he had heart disease and would soon die, because periodically he was overcome by such weakness, with cold sweats and terrific pounding of the heart, that he would not catch his breath and amost fainted. He was sent to a heart specialist for an electrocardiogram. The report came back: entirely negative. When this report was given to the patient he exclaimed, "I can't believe it. There must be some mistake, I wish it were true!" *The analysis of his life history revealed that he married (at the age of twenty) one of his relatives according to the traditional middle eastern pattern. He had a feeling of hatred for his wife from the beginning of his marriage. In spite of this fact he had to submit to these traditions and kept his secret within his own heart. His marital life lasted for fifteen years during which he felt his hatred for his wife increasing gradually. His wife also began to feel his dislike. In one particular night when he tried to stand up to her he could not. He was afraid to subject himself to the test. His wife began to take advantage of him and he could not avoid her jeers. He was surprised about his sexual inability and began to think about this matter. Suddenly he felt weakness, a clammy perspiration, painful pounding of his heart and inability to catch his breath.*

Secondly, we borrow some instances of the histories of *psychotic* cases:

1) The patient was a 19-year-old woman, suffering from schizophrenia of the paranoid type. Her symptoms first manifested themselves seven months before she was admitted to the hospital. It is noteworthy that this case was precipitated by a marriage against her own will. Although she declared to her family that her husband was an ill omen, as she associated her engagement to him with the death of her sister, she was forced to complete the marriage. After marriage she asked her husband to divorce her but he refused. He said to her, "If your eyes went out of their place, I would divorce you." *She often pleaded with him, asking him to let her free as she didn't like him. But all these requests were rejected by her husband.*

2) The patient was a 27-year-old female, suffering from schizophrenia of the hypephrenic type. She was disturbed for a long time following a marriage against her own will. On the day of her marriage she took eighty pills of aspro in an attempt to commit suicide. Her

father threatened to kill her if she didn't marry the proposed bridegroom. She began to feel that the best of her life was gone. She developed delusions, hallucinations, and ideas of influence immediately after marriage.

The most insightful material to emerge from the thematic analysis of the female patients' life histories is the tremendous concern about hatred of spouse. There is an expression of an internalized feeling of agony. As one of the young female patients who married a man as old as her father expressed it: "What can you do? I am waiting in the hope that my husband might die or I might die." No feeling of agony could be better described.

In summary, the clinical analyses of the life histories of Egyptian psychotic and neurotic cases provide support for the theory that cultural and social characteristics are important factors in their etiology. There is a basis for presuming that Middle Eastern culture has a bearing on what types of conflicts show up in psychoneurotic and psychotic patients, the defense mechanisms which are chosen, and the ways in which individuals react to anxiety.

Ethnographic and Other Material Supporting the Theme of Hatred

Anthropologists working in Egypt and Middle Eastern societies have frequently noted the compulsory nature of marriage. Dr. Patai (1962) noted that, under traditional circumstances which prevail among practically all the nomads and villagers of the Middle East and many of the townspeople, marriages are arranged by the parents of the young people. A son or daughter is expected to carry out the decision of his or her parents in this, just as in other matters of greater or lesser importance. These restrictions prevail everywhere in the Middle East in one form or

another, and they apply usually with much greater strictness to women than to men (Patai, 1962:100).

The compulsory nature of marriage with respect to Middle Eastern sons and daughters, and especially daughters, has been well documented by many observers. Referring to the lower class Cairenes women, yet confident that her remarks are applicable to many of Middle Eastern women, Dr. Cynthia Nelson says that marriage in *baladi* (native) Cairo are arranged marriages between families, not personal choices based on "romantic love." As she puts it: ". . . in fact the woman is not even present during the signing of her marriage contract, this being carried out by her father, the father-in-law, and the bridegroom."[6]

Further evidence in favor of this can be adduced from still other sources. These are: 1) novels, 2) Egyptian movies, and 3) newspapers. Expressed in many Egyptian novels are the grievances which result from enforced marriage. An ingenious expression, consistent with the theme of hatred of one's spouse, is illustrated by the late Dr. Heikal in his popular novel, *Zeinab*. Although Zeinab harbored tender feelings toward Hassan, the son of a neighboring family, her parents told her that she was designed to marry her cousin. The news had come as a terrible blow to her. Her only chance — and it was a very, very slender one -- was to run away with her lover, but then she would have to flee far from her home and people and abandon all hope of ever seeing them again. Consequently, on meeting her lover she rejected his proposal to run away with him fearing that this would bring shame and disgrace to her whole family. "How would my parents feel." Zeinab, thus, sacrificed her love to save the face of her family. However, she never forgot her lover and passed

her long life in misery and despondency.

A second source which supports the same cultural characteristic is the Egyptian film. Cairo is most important as an educational, cultural, and industrial center. Its influence in other parts of the Arab world is enhanced by exports of Arabic films, production of which centers in a Cairo suburb. One of the most successful films is "Ana Bint Nas" (I am a daughter of a good family). This film contains all the elements of the theme of hatred of one's spouse. However, this particular movie is credited with initiating a revolutionary act against Middle Eastern traditional marriages. Thus Faten, the hero of the film, was more fortunate than Zeinab, the central character in Dr. Heikal's novel. Faten was a very pretty girl whose father died when she was young. Her older brother wanted to marry her to a very wealthy and ugly tradesman. Faten was very brave. She left her town, Tanta, and fled to Cairo. In Cairo she worked hard until she found a young man whom she loved greatly. Almighty God had given this boy perfect health and appearance. Many girls liked to go out with him but he rejected them. He was captivated by Faten who was graceful and who attracted him with her beauty. What could he do to Faten who was extremely provocative and how could he withstand her beauty? They always met to enjoy their very deep love. Then they married and lived happily ever after. They had a good future awaiting them. Even their sons shall love in a manner after their parents.

It seems that this movie wants to provide institutionally-sanctioned outlets for the reduction or the resolution of stresses in the larger Egyptian social system of which these women are participants. It attempts

to shed the veils for the enticements of the modern world. However, women like Faten, of course, remain a small minority in the Arab world. But their number is growing apace, even in the more benighted parts of the Arabian peninsula and North Africa.

Despite the popularity of this movie, the concepts it wants to introduce do not find ready acceptance among many Egyptian men. In the remote villages men still pick their wives like livestock. Egyptian women still have a long way to go before they marry on the basis of personal choice.

The third source which supports the same idea is the Egyptian newspaper. In women's pages you may find many instances of women's arranged marriages and their implications. The fact that Egypt is an overpopulated country surrounded by very rich oil-producing Arab countries adds to the complexity of the problem. One can imagine the shock given to Egyptian society by the presence of such a horde of young men from neighboring Arab countries (on leave and thirsting for women), even from such bastions of traditionally directed societies as Saudi Arabia and Libia. Their gold suddenly flooded and enriched an irresponsible class whose members would provide them with prostitutes.

However, many people from the neighboring, rich oil producing countries like to marry Egyptian girls. In this setting go-between marriage arrangements are institutionalized to cope with the multitude of bridegrooms seeking marriage. Typical of this pattern is the following incident from an Egyptian newspaper: "A 17-Year-Old Girl Discovers That Her Bridegroom Is Old Enough to be Her Great-Grandfather."

Under this headline a real story is told about a young girl from

a lower class family who was married against her own will. A matchmaker was sent by an old wealthy man from a neighboring Arab country to make economic and other arrangements with the parents of a pretty girl. The matchmaker was clever enough to convince them of the great profit they would gain from this marriage. The bridegroom would give them a new car as a bridewealth. And of course they had never owned a car. But when the bride reached the home of her bridegroom she discovered that he was seventy-five years old and that she had to share him with three other co-wives. This was traumatic for the girl. When she expressed her annoyance the co-wives gave her a good beating. Thus the girl fled to the Egyptian embassy. But the husband was able to obtain her return by using his religious and legal rights.[7]

Although the newspaper was telling the story in a satirical way, it had some roots in reality. During his last visit to Egypt the author read several stories in the newspaper which represent a pattern of repetition of the above story. Also, he heard of similar incidents from others.

(Theme 2) Fear. The second theme in the complex of female themes is fear of being killed. Examination of Table 3 shows that this theme is expressed in the life histories of the female patients with great frequency. There were 137 life histories in which there was some explicit spontaneous reference to fear. In nearly all cases the reference was to fear of being killed by a father or older brother as a result of illicit sex relations or loss of one's virginity. The woman is afraid that if she is not a virgin when she comes to the marriage bed she might be killed. Characteristic of this kind of theme are the following life histories:

A young man related this story during visiting hours about a 21-year-old female schizophrenic patient.

1) This patient is from a province in Upper Egypt. She is from a very good family. However, she committed a very bad mistake; she had an illegitimate pregnancy. Before her pregnancy was discovered by her menfolk, she ran away to Cairo. She gave birth to a baby and the man who was the father of this baby denied any relation whatsoever with her. In Cairo she worked as a servant without any salary, just for her food, despite the fact that she herself had two servants in her father's home. My mother found her in a friend's place. She sympathized with her and brought her to our place. A few weeks before she was admitted to the mental hospital she became preoccupied by the idea that if her family found her, they would kill her. Immediately after, she developed symptoms. She returned home one evening expressing great anxiety, stating that her father and brothers had followed her and were going to kill her. At 10 p.m. she became actively hallucinated, stated that she could see her father and brothers climbing the telephone pole on the outside; thought that she could see them looking at her from the walls of her room, and that she could see birds and geese. The patient had almost complete insomnia and all measure to reassure her were unsuccessful. She became entirely uncommunicative and had to be carried to bed . . .

Or this life history from a 20-year-old peasant girl:

2) Born in a village in Lower Egypt. Fourth in a family of eleven. Onset of menstruation. Came home from the field crying. Thought she was bleeding to death. Mother teased her and said she would be ashamed. Sat next to girls at work (in her father's field) who practiced mutual masturbation. Was told vile stories of several girls who became illegitimately pregnant and whose bodies were found in the River Nile a few miles away from the village. Loved a boy, son of her father's friend. They used to meet in the dark on the roof of her house where she was accustomed to feed the chickens. On one particular occasion they were on the roof indulging in an intimate discussion. As it progressed it got out of hand and emotions rose. In a fit of passion he sexually assaulted her. He left her in a state of partial shock and humiliation. Disturbed for a long time following this. Felt it was her responsibility to save her family's honor. Later she began to hear voices. She felt that people on the street were talking about her, claiming that she was a bad girl. At one time she felt that she was facing death but stated that she was willing to die. Voices asked her if she had intercourse with men and referred to other sex topics . . .

The life histories of the above two cases show that they were faced with a high degree of cultural psychological bombardment which aroused the most intense fears and precipitated the onset of their mental illness.

In both cases the fear of being killed because of failing to preserve their virginity became an obsession.

Ethnographic and Other Material Supporting the Theme of Fear

In Egypt, as in many other Arab countries, men still claim the ancient right to kill their daughters and sisters (but not their wives) if caught in illicit sex relations (Patai, 1962:21). A man who does not behave in this manner is considered to be unmanly. Sometimes he becomes mentally sick. For example, the researcher saw a case of a man who developed schizophrenic symptoms immediately after discovering that his wife was unfaithful. Because the patient had a son from his marriage whom he loved greatly he was torn by conflicts: between the desire to kill his wife and his deep love for his son. When the researcher saw him he was hallucinating and saying, "My son . . . is going to be an orphan." In a conversation with his relatives during the visiting hours one of them commented that if the patient had killed his wife he would not have developed mental sickness.

Anthropologists working in Egypt in particular, and Middle Eastern societies in general, have frequently noted that the relationship between the sexes is governed by rigid sex mores that place special emphasis on female purity and chastity, both premarital and marital. In fact, the entire culture of the Middle East is permeated with great emphasis on premarital virginity and female purity (Patai, 1969:37).

Thus virginity (with certain exceptions, discussed later) is as highly prized among Arabian nomads as it is among the villagers and townsfolk. Nelson (1968) describes a marriage among lower class Cairenes:

> During a baladi (a typical Egyptian) marriage the most crucial event is the moment when the groom deflowers his bride. As this is a public ritual in which the entire community is witness to the success or failure of the young man to emerge from his bride's room with the telltale bloodstained handkerchief, the honor or shame of the girl and her entire family is at stake.[8]

All ethnographic material emphasizes that the standard for Egypt and the Middle East is to regard premarital and extramarital sex relations of women with the utmost severity. Woe betide the bride if she is not a virgin when she comes to the marriage bed. Philby (1939) and Musil (1928) relate that an unmarried pregnant girl must either try abortion, in which her female relatives help her, or persuade her lover to marry her at once, or run away from her family, or commit suicide. Should she be found out by her menfolk, they will be honor-bound to kill her.[9] Thus, when one of the investigator's students sexually assaulted his servant and abused her virginity she could find no solution other than suicide. Usually, when a girl commits suicide her relatives do not inform any authority. They would say that their daughter died as a result of a sudden illness. And this is one of the things which surprised the author when he was in Egypt: so many young girls died as a result of sudden "heart attack." But sometimes one hears rumors that when the girl found herself about to be discovered by her menfolk she burned herself to death.

In the following we shall give two examples as empirical evidence of the rigid sex mores in the Middle East and the theme of killing a girl who violates the sexual code.

> 1) Fulanian (1928) tells the tragic story of a shaykh of the noble Bani Sabah tribe of the Quraysh who, after having sojourned for twenty years as a fugitive among the Marsh Arabs of Lower Iraq, noticed that his only daughter was harboring tender feelings

towards one of the youths of a marsh tribe. And although the two young people never met face to face, and the youth asked for the girl's hand in marriage, the old shaykh preferred to kill his only daughter rather than let her marry into a low-status tribe.[10]

2) Dickson (1956) found further evidence of this rigid sexual code. Referring to the bedouin of Irak, yet confident that his remarks are applicable to much of the Middle East, he told the following real story:

The heroine is Benniyah, a 16-year-old girl of the al-Gharri Tribe, headed by Shaykh Manshad al-Habayib. Her people lived at Batha, a village on the Euphrates, some twenty miles from Nasirayah, and she lived happily with her father and mother in their black tent until a short time previously, when they told her that she was to marry her ibn 'am (first cousin) and that the wedding was to be solemnized on the new moon. She loved another boy of the tribe and he loved her, and had told her of his love for her. In great distress she had told him that her father proposed giving her to her cousin on the new moon, and begged his advice and help. She would die, she had told him, rather than be the wife of anyone but him. The youth had received this calmly, but had been deeply angered, with murder in his heart. He had told Binniyah that he must have time to think out a plan, and would return on the third day and tell her what this was. They had arranged to meet on the river bank where she was accustomed to fetch water at midday, and he would find an opportunity of talking to her. Binniyah had passed three long days in misery. She knew that if, in spite of everyone, she married someone other than her cousin, her life would be forfeited — her cousin would kill her. Tribal law never forgave in such matters. Three days later she had been at the rendezvous by the riverside. Other women had been drawing water also, but her lover had managed private words with her as they walked part of the way home. He had only one plan to offer: to run away, and on that very night. He would appear behind her tent at midnight with a fast mare and, on his giving the cry of a jackal three times, she was to slip out from under the tent curtain, join him at the back, and together they would fly away to Suq ash Shuyukh and take refuge with the Mujarrah tribes. There they would get married, and if they could not find safety they would flee further to distant Basra . . .

Midnight had arrived, and Binniyah had crept out quietly to the rear of the tent on hearing the jackal cry. Silently they had got through the sleeping camp unnoticed and then, mounting one behind the other, had sped away to open country, their objective the palm belt opposite Nasiriyah town. Alas, someone or some dog must have given the alarm. Binniyah could not tell how it had happened. Suffice to say, when dawn had broken the fleeing pair had seen in the distance behind them a party of horsemen, obviously following hard on their trail . . . .

They had thrown off their pursuers for a moment, and Binniyah had been almost happy. Then what disillusionment: The young man had apparently decided that, handicapped by Binniyah, he would never escape, but that he might get away alone. He had suddenly told her he was leaving her. It was useless, he had said, for them both to get killed, when he could escape to Suq and Basra by way of the Hamar Lake. He had just disappeared into the darkness. Life was sweet so why throw it away on a bint?

Thereupon Binniyah fled into Dickson's house. Somewhat later Shaykh Manshad too arrived and demanded that Dickson hand the girl over to him. But Binniyah pleaded for her life: "He is only concerned with getting me out of your hands and the hakuma's protection. Afterwards he will hand me over to my ibn'em and the tribal justice."

Turning to Manshad she said: "I cannot, I dare not go back with you, Ya Manshad," and sobbed in a way that touched the heart. "You know the tribal law; it is utterly unforgiving in the case of erring girls like me, and you know full well that you must hand me over to my father and brethren, since they will demand me of you. I am afraid to die, for I am young."

So Binniyah remained for a while with the Dicksons. "In my predicament as to what to do with her, I sought the help and guidance of Dhari Beg al Fahad Al Sa'dun. I told him the whole story and he advised me that the only hope for the girl was to have her married to some worthy citizen of Nasiriyah town. According to Dhari, if she were once properly married and settled down in the town, her tribe would no longer attempt to molest her, and in due course her ibn'am and parents might forgive her, especially if her husband were to pay over a sum of money by way of compensation to the ibn'am who fancied himself injured. Binniyah herself approved this step, so I acted on Dhari's advice and after some days, found a very respectable man who ran a coffee shop a few doors away from my house and he agreed to marry Binniyah. The wedding was a quiet one and turned out very happily. As my contribution to the happy event I gave the bridegroom six hundred rupees to be paid over to Binniyah's cousin.[11]

No information as to the actual administration of such extreme punishment in the villages is available, but the severity of the attitude toward female sexual laxity persists in them (Patai, 1962:125). Urban society is in a state of transition in this respect as in many other aspects of social intercourse. Due to lack of information all that Patai

can give is a rough generalization to the effect that the higher the social class and the more advanced its Westernization, the less the attention paid by it to the traditional sexual code.

Thus in a study which the researcher made on the influence of education on the rigidity of the traditional sexual code, it was found that the higher the education the greater the personal flexibility in the observance of this traditional sexual code or, inversely, the lower the education the more rigidity. Table 12 gives a comparison of response of illiterate fathers and their high school sons to the question: "What would you do if you discovered a dishonourable relationship between your sister or your daughter and a young man?" The fathers were equally willing to jump to the conclusion of adultery and to react violently to it. The response was usually immediate, clipped, and emotional: "Kill her!"

On the other hand, their sons are significantly less violent. Illustrative of the response pattern of students are the following examples: "If I discover such a dishonourable relation I'll force him to marry my sister whatever the results are, because a girl without honour is like a tree without fruit." "I"ll raise a complaint against him in the court." "First of all, I'll tell my mother and if she fails in solving the problem I'll tell my father." "I'll behave like an educated man." And, finally, "I'll give the young man a good beating and then take him to the *Mazoon* [the man who makes the marriage contract]."

The Concept of Virginity and the Theme of Being Killed in Egyptian Folklore

Further evidence in favor of the theme of killing the female if

Table 12. *Responses of Male High School Students and Their Less Educated Fathers to Adultery of Sisters or Daughters*

Reaction to Adultery	Number of Cases		Percentage of Group	
	Fathers	Sons	Fathers	Sons
Kill	88	42	90	28
Other Responses	10	107	10	72

she fails to observe the sexual code can be adduced from still another aspect of Middle Eastern culture. Among the infinite phenomena to be observed in any society, one is extraordinarily important and interesting: as Simmel so brilliantly argued, they "play society" (Wolff, 1950). They play society by creating and acting within certain social forms or "models," which in addition to reflecting their perception of social reality, often assume through time the character of moral and explanatory principles. No society can do without these.

Many of the proverbs, songs, and tales known to the peasants of Egypt seem to correspond to the rigid sexual code of the Middle East. An intensive analysis of a few such cultural items indicates that this theme plays a significant role in their folklore.

In the remainder of this section, one example of that folklore shall be presented. You will recognize in it ample evidence of this theme. This song is called "Shafika and Metwally." A folk artist sings it in the villages but in the Holy Month of Ramadan he sings it in the center of Cairo near the shrine of El Hussain, the grandson of the Prophet Mohammed.

"Shafika and Metwally"

> Once upon a time, a young man from Upper Egypt by the name of Metwally was drafted into the Army. He left a sister called Shafika under the care of his old father in his small village. Because Metwally was brave, smart and intelligent he was promoted very quickly. Under his leadership there was a soldier who was spoiled and a trouble maker. Metwally was deeply angered by him and hit him in the face. This soldier said to him, "You beat me, you coward; your sister's photo is in my pocket." This statement came as a catastrophe to Metwally who was deeply humiliated. He asked his chief officer for a vacation which was granted to him. On his arrival at his village he asked his father: "Where is Shafika?" His father said, "Shafika died."

> "Well, Father," Metwally said, "come and show me her grave." The father then told Metwally the truth. He said to him that he had become an old man and his eyesight was becoming weaker and weaker. As a result of this he could not guard and chaperone his daughter. Shafika thus was able to do as she wanted after Metwally left for the Army. A young boy was able to abuse her virginity. Afraid of being killed she escaped to a big city. Metwally pursued her until he found her in a house of prostitutes. He went to meet her. Perhaps it is here that Metwally touches the listeners. She asked him for forgiveness and promised to atone. But he then got his knife. Shafika put her head back offering her neck and Metwally made one quick violent blow with the knife. Shafika then fell to the ground and quickly expired. After that he went and informed the police. The judge was a good man. His name was Hasan (meaning good) and he was a man of great virtues. He asked Metwally about the reason for killing his sister. Metwally said, "My dear Sir, if you have a tree in which there is a bad branch, wouldn't it be better to cut it off?" The judge agreed with Metwally that it would be better to cut the bad branch off and he sentenced him to only three months in prison saying to him, "You, Metwally, have made a minor offense. You have not been found to be guilty." The public who used to listen to the folk singer would cheer at this point and say in chorus, "Long live the Judge Hasan."

All this emphasizes the rigidity of sex mores in the Middle East in general and Egypt in particular. But are there no institutionally sanctioned outlets for an unmarried pregnant girl? I would say that in the past there was no outlet, but recently with the advancement of medicine an outlet has been found. Some surgeons now are capable, through surgery, of returning the girl's appearance of virginity and they have made good money out of it, especially in rural areas. Usually her female relatives will go with her and this operation is done in secrecy, without letting the males in the family know anything about it.

(Theme 3) Jealousy. The last theme in the complex of female themes to be discussed is that of jealousy. Turning to the dominant

themes as reflected in Table 3, it is clear that the theme of jealousy was expressed frequently in the life histories of the patients. There were 204 life histories in which there was some explicit spontaneous reference to jealousy. Sixty per cent of the life histories of the females expressed this theme as compared to twenty and a half per cent among the males. In some cases the reference was to a polygynous situation, particularly a co-wife. But the majority of cases refer to the husband's sexual laxity.

A typical theme is expressed by a 25-year-old schizophrenic female. This patient related to the psychiatrist her own domestic plight in which her husband had taken a second wife:

1) The patient had been sleeping very poorly, frequently going several nights without any sleep at all. The patient refused to eat and it was only with great difficulty that her family were able to force her to take a little liquid. She quarreled with other members of the family, especially the co-wife, and on several occasions threatened to kill her. During this period the patient showed extreme overactivity, shrieked, cried, prayed, and sang alternately. Her husband was interviewed after his wife's admission to the hospital. What had happened prior to her admission? When had he first felt that something might be wrong? The husband was not a highly verbal person. His education went only to the third grade in a village school. His answers were brief, direct, concrete and, the interviewer felt, sincere. His wife had become violently distrustful of him, especially in the past two months, but the first indication had come nearly 10 months ago prior when he married another wife. He recalled, "It was when the second wife came. My wife was jealous if I talked with her. She resented it." *From this time, the husband thought of his wife as having a* "nasty streak in her that made her act jealous" . . .

2) A 22-year-old patient came to the psychiatrist because of complete deafness. She came convinced that she had ear disease. A physical examination revealed no evidence of ear disease. It developed that preceding the deafness the patient had suffered some exasperation in her family life, because of her husband. The husband was frequently smoking hashish, sexually demanding, and running around with other women. On questioning, she acknowledged that prior to the attack she heard him phoning other ladies and expressing his love to them. Her hysterical deafness was a transformation, or conversion of the patient's basic unhappiness into a physical symptom.

Ethnographic Material Supporting the Theme of Jealousy

This is consistent with what anthropologists working in Egyptian and Middle Eastern societies have frequently noted. Referring to the lower class Cairenes women, Nelson (1968) says: "Where a woman must be monogamous, men may, and among the *baladi* (typical Egyptian) people men often [take] more than one wife."[12]

The most famous ethnographer of the Middle East, R. Patai, has frequently emphasized the men's laxity. He says that one of the characteristic features of traditional Middle Eastern culture is that "strongly marked double standards of sexual morality prevail, with great emphasis on premarital virginity and female purity."[13] Speaking about the position of women and sex mores in the Middle East he points out that official Islam countenances a considerable sexual laxity in men while imposing a rigid code of sex mores on women (Patai, 1962).

In the Arab Women's Congress in Cairo in 1944 an unqualified condemnation of polygyny was never issued since allowance for it was made in cases of sterility and incurable sickness, a fact that demonstrates how far tradition still influences the Muslim women even of the educated class (Patai, 1962:107).

Further evidence of the men's laxity is to be found in Egyptian novels. A recurring theme that cuts across Nageeb Mahfoz's novels is that where as a husband is supposed to be free to do as he pleases, a wife is not. In his most famous novel, *Been el Kasreen (Between the Two Palaces)* one finds endless repetition of this theme. Thus, when Amina (the central character) heard about the sexual laxity of her husband and wanted to protest in a polite manner, her husband caught her ear and shouted in a firm way, "I am the man, I am the boss. I have the right

to command. I don't accept any criticism of my behavior from you. You have nothing but to obey me. Be careful lest I should give you a good beating." From that time on Amina obeyed her husband unconditionally.

3. The Young-Age Themes

Finally, we discuss the young-age themes. They are theme No. 6 (beating) and theme No. 7 (sexual guilt).

(Theme 6) Beating. Turning to the dominant themes as reflected in Table 5, it is clear that the beating of children, seen in everyday life, is expressed in the life histories of the patients. There were 255 life histories in which there was some explicit spontaneous reference to beating, particularly by a father, with male victims showing a slightly higher frequency than females.

A typical theme is expressed in the life history of a 14-year-old female:

1) The girl fell on the ground while beating the ground with her hands and legs. She also murmured some vague words. The psychiatrist concluded from the way the girl fell onto the ground that she was exhibiting a hysterical fit rather than an epileptic one. Investigation of her life history revealed that the parents were insisting that the girl go to school and saw this as an important goal. Sometime they beat her for this. The patient expressed in an indirect way that she did not like to go to school. But she didn't dare express her desire to them. This is the problem which she solved unconsciously.

2) A 25-year-old schizophrenic male patient remembered that when he was young his parents prevented him from sitting with the female family guests: "Once I went to see a movie with some of my school friends. Immediately after returning from the cinema I heard my father saying that bad company leads to deviant behavior. I was tied to the bed pole and I was beaten severely for coming late and fooling in the streets which was not the pattern of behavior characteristic of the family. In my family everyone must always be at home before dark and is never allowed to go home alone at night. I never went to the cinema after this bad experience except in my late university years. . . ."

3) Another 21-year-old male schizophrenic patient recalled that when he was 12 years old his father punished him severely for disobeying him. "He beat me with his hand so that I was about to faint as his hand was so big. I ran in the streets. My father asked the people to seize me." *The patient also remembers when his teacher beat him.* "I laughed in the class at one of my friend's jokes. My teacher saw me and asked me to come to where he was sitting. He told me that I was an impolite student. He began to beat me on my face but I didn't weep. Then he kicked with his foot and I didn't weep. Finally he kicked me to the extent that I fell to the ground. I fell on my face and I began to cry. He continued to kick me while I was weeping. He ordered me to stand up beside the wall. I stood up till the end of the class period . . ."

Most of these beatings were a kind of parental pressure to achieve educational goals. The majority of the patients so treated belong to the lower class.

Explanation of the high concentration of this theme in the young age category (76.6%) as compared to the old age (18.8%) is consistent with the enhanced educational facilities and the high demand of intellectual performance made on children. Since the Revolutionary regime has implemented education for the masses and opened up class structures, individuals from the lower classes, if talented, may gain positions of power or prestige.

Motivated by its conviction that every citizen has the right to receive education, the State has decided to provide free education in all stages for all citizens. The young have an advantage over the old because they can go to schools and universities without paying tuition fees. But in so doing they suffer a new stress, particularly parental pressure through beating. Parents subject themselves to agonies to assure their children an easier future, particularly by helping them to achieve a station in life of greater prestige than that to which they once belonged. Their attempts to push the children up the social ladder are often brutal.

Relatively speaking, the older and less educated patients are more free from this kind of stress.

(Theme 7) Sexual Guilt. The second theme in the young-age themes is that of sexual guilt. There were 269 life histories in which there was some explicit spontaneous reference to sexual guilt. In nearly all cases the reference was to masturbation, with males showing a slightly higher frequency (63%) than females (55%) (Table 5).

Explanation of the high concentration of this theme in the young age category lies in the fact that the age of marriage for the young patients is higher. In our sample it was found that for the young male patients three per cent had married at the age of fifteen years or under; 12 per cent between the ages of sixteen and twenty years; and 17 per cent between the ages of twenty-one and twenty-five years — or a total of 32 per cent had married up to the age of twenty-five years. Among the old male patients, the corresponding figures were as follows: married at the age of fifteen years and under, 10 per cent; sixteen to twenty years, 27 per cent; twenty-one to twenty-five years, 20 per cent — or a total of 57 per cent married up to the age of twenty-five years. In other words, within the last years the percentage of male patients married up to the age of twenty-five years decreased from 57 per cent to 32 per cent, and the percentage of male patients married up to the age of twenty years decreased from 37 per cent to 15 per cent.

Among the female patients there was a very considerable decrease within the last years in marriages at the age of twenty years and under (see Table 13).

A typical theme of sexual guilt is expressed by a 17-year-old male patient suffering from hysteria:

Table 13. *Percentage of Age at Marriage in Young and Old Male and Female Patients*

Males	Young		Old	
15 and under	3.0		10.0	
16 - 20	12.0		27.0	
21 - 25	17.0		20.0	
25 and under		32.0		57.0
Over 25		68.0		43.0
	Total	100.0	Total	100.0
Females	Young		Old	
15 and under	16.0		25.0	
16 - 20	25.0		40.0	
21 - 25	22.0		15.0	
25 and under		63.0		80.0
Over 25		37.0		20.0
	Total	100.0	Total	100.0

1) He could not sleep; was plagued by vague fears and nervousness that interfered with his studies and felt generally unhappy and utterly worthless. He was in despair because he was going to be flunked. How would his parents feel? He was deeply religious, as were his parents. He had been taught that to touch oneself "there" was sinful, harmful, would lead to insanity and other diseases, and yet he could not stop however much he tried. Then suddenly one morning he awoke with a loss of sensation in his right arm. His right arm, the offending arm with which he masturbated, was paralyzed. This was his apology, his admission of guilt, and his self-punishment. . .

Or this theme from a 22-year-old female schizophrenic patient:

2) When the patient was a 16-year-old she attended a lecture in school by a teacher of religion on "Self Abuse Causes Insanity." She was disturbed for a long time following this. Later she began hearing voices which made her confess onanism, which had been a source of worry to her for a long time. She felt that she was under the influence of sorcery which caused her to masturbate shamelessly during the day as well as at night. . .

Typical is the following life history by a 22-year-old male schizophrenic patient:

3) The patient had always been self-conscious about his short fat body, because even as a child schoolmates had called him "Butterball"; this had resulted in his being shy and a poor mixer. One of his friends advised him to masturbate so as to reduce his weight and avoid the mocking laughter of the other boys. He described his tremendous efforts to reduce his weight by saying, "The Holy Month of Ramadan was coming. Do I have to stop masturbation and thus become a target for the other boys' jokes, or do I have to exploit the opportunity of fasting in addition to the effort spent in masturbation to reduce my weight? It was a terrible conflict especially that many religious sermons are given in Ramadan. Finally I found myself driven by masturbation and consequently I used to spend the rest of the day in an extreme distress. Sometimes I wept by myself in the fields. In addition to that, my family were watching me carefully to see that I was praying punctually. How could I miss the communal prayings on Friday? For if I missed this praying my family would know that I was ritually polluted because I masturbated. How can I stand in front of God while I was *Gonob* (in a state of ritual pollution). Am I mad? Finally I found the solution by standing among the people while praying, doing their movements but not saying the words. But I returned after that in the utmost state of mental exhaustion. I imagined myself as Satan wearing the clothes of a monk. I used to speak to myself, 'you pervert,' . . . 'you deviant.'" *This patient felt that he had injured himself by masturbating, that his parents would not go to heaven because of his sins, and that dire things would happen to him. In the nightmare which had heralded his illness, God had spoken to him, and his feeling had been one of terror. . .*

It is striking to note how often religiosity is conjoined in these cases with depreciative attitudes toward sex. It is clear from the last case that these patients live in a real nightmare. For, as Erich Fromm (1953) states, "There is nothing more effective in breaking any person than to give him the conviction of wickedness."[14]

In many case histories we find expressions that the physical effort spent in masturbation is equal to the effort in working in a field for full seven days, one masturbation makes one lose what is equal to one cupful of blood and, finally, that the effort spent in masturbation is equal to the effort spent in copulating one hundred women. Another problem which faced the patients through their life histories is that they have to take a bath after masturbation in order to achieve ritual purification, and continue their prayings. But since their families watched them carefully they were compelled to go and take a bath of cold water in the Mosque, even in winter time when it was very cold.

Summary and Conclusions

To summarize the argument and findings thus far, a statistical thematic analysis of the life histories of a sample of hospitalized patients shows that stress is differentially distributed by social class, sex, and age. Lower class patients experience the greatest amount of stress (as experienced in the content analysis). This finding corresponds with other studies done by the Egyptian social research center. Although not primarily concerned with stress, these studies reveal that the lower class population suffer more from broken homes, economic deprivation, ill health, and so on. The psychic distress associated with

the lower class reported in this chapter may be interpreted as evidence of socially disorganized lives.

The female themes and the young age themes can be related, in part, to differences in the socialization of males and females and to differences in age during the life cycle. There is a considerable difference between the early socialization of a boy and of a girl in Egyptian society. The higher concentration of the two themes of *jealousy* and *hatred* in the female category corresponds to the fact that the girl learns through the process of socialization that she is a rather unimportant member of the family and that upon her marriage she will be not so much the equal companion of her husband as a subservient fulfiller of his needs. The third female theme — the *fear of being killed* — is mainly connected with the sense of 'shame' which a girl might bring to her family. "Girls at a very early stage, on seeing a moth hovering round the fire, are taught to repeat 'Fire is preferable to shame'" (Ammar, 1966:95).

Similarly the young age themes can be related to differences in age during the life cycle. Ammar (1966) has pointed out that the life cycle in his village can be represented as a curve with maximum stress experienced by the young. Social disciplines reach their climax just before marriage, whereupon they gradually descend. This may shed some factual light on the young age themes: the two themes of *beating* and *sexual guilt*. The keynote to the socialization process is the eagerness of the adults to create a docile attitude in their children (Ammar, 1966: 127). If the child shows reluctance to comply with, or to conform to, its elders' commands, he is physically punished. 'The stick is for the

disobedient' (Ammar, 1966:139). Childhood and early adolescence are the most appropriate periods for physical punishment and discipline.

In attempting to account for the theme of *sexual guilt*, the writer attributes its striking appearance in the young age category to the cumulative effect of the severe social disciplines, and especially those connected with sex. It seems that this excessive prohibition on sexuality at the stage of adolescence plays an important role in conditioning adolescents to suffer from sexual guilt.

Chapter V

THE CULTURAL PREVALENCE OF MENTAL ILLNESS

Having proposed the "stress model" of schizophrenia, the author now turns to the process of testing it. Drawing on the analysis of themes of stress presented in the foregoing chapter, the various distribution patterns of psychiatric disorders are examined in relation to the three areas of maximal stress in Egyptian society: being low class; being a female; being young. From these findings conclusions are reached and some generalizations are made bearing on the relation between sociocultural stress and frequency of mental illness. There is, in short, a reassessment of frame of reference and of theory bearing on etiology.

In this chapter the investigator will deal with the following questions: 1) How much psychiatric disorder is there? 2) What are the proportions of different varieties and kinds? 3) How are these distributed in relation to sociocultural factors?

This approach to the study of diseases (comparing their frequency, pattern, and distribution in different populations) is technically referred to as epidemiological. It assumes that each group can be viewed as a natural laboratory in which factors of illness and health maintain a balance. If the balance in one group seems to differ significantly from that in another, this difference is a clue that can lead scientists to the detection of factors promoting or inhibiting the disorder. Goldberger's (1952) dramatic use of epidemiological clues to explain, control, and prevent pellagra is perhaps the best known psychiatric

example. There can be no guarantee that the same approach will also be effective with mental disorders, but there is reason for optimism. Mental disorders are definitely not distributed at random throughout the human race. If more can be learned about the precise nature of these population differences, plausible and experimentally testable hypotheses are likely to emerge which can put scientists on the trail of new knowledge in a field now enveloped in mystery and obscurity.

For the purpose of this section the author will depend on official rates of mental disorder which are generally based on the number of inmates in X State and Z private mental hospitals and in Ain Shams University Psychiatric Clinic. Hospital records, statistics, and papers submitted to the 1st Arab Congress on Mental Illness contributed data to most of the findings reported here.

Before proceeding to test the stress model it might be relevant to briefly review. The thematic analysis revealed that stress and strain are distributed differentially in various parts of the Egyptian social structure. The areas of maximal social stress are to be found in the lower class, the Egyptian female, and, finally, the young Egyptians. On the basis of this uneven distribution of stress it is predicted that the rate of mental illness generally, and schizophrenia in particular, would be higher in these areas than in areas where social stress is at a minimum.

A. Social Class and Mental Illness

Occupation and Mental Illness

Some social scientists are developing a substitute for the concept

of "class" that is psychologically meaningful to persons. For example, the variable of "occupations" alone, to them, represents a psychologically meaningful classification of people that correlates with mental health. Social scientists now are developing less encompassing and less ambiguous terms, such as "occupational *situs*" (Langer, 1960).

In demonstrating the relation between occupation and mental illness the data from X state mental hospital and Ain Shams Psychiatric Clinic (Tables 14 and 15) show that a high percentage of the mentally ill are found in the categories of skilled and unskilled laborers, housewives, and students — that is, occupations with low income and prestige. The Egyptian mentally ill population, thus, falls low on the status scale. Low psychosis rates are associated with high occupational prestige and income, and high rates with low occupational prestige and income.

Why is the percentage so low for those with no job? It should be noted that some people with no job are wealthy landowners. Members of this class boast about the fact that they have no job because this means that they are rich and do not need to go to work.

Social Class and Diagnosis

A book edited by the staff of X state mental hospital in 1969 indicates that schizophrenia represents the major problem in Egyptian State Mental Hospitals. Only three years ago, 60 per cent of the population of these hospitals were schizophrenic. During the summer of 1971, the prevalence of hospitalized schizophrenic patients surpassed this percentage.

Table 14. *Distribution by Job in Ain Shams University Psychiatric Clinic*

Job	Percentage of Patients
Unskilled	13.4
Skilled	29.8
Professional	4.3
Student	17.1
Housewives	25.2
No Job	10.2
Total	100

Table 15. *Distribution by Job in X State Mental Hospital*

Job	Percentage of Patients
Unskilled	23
Skilled	20
Professional	5
Student	21
Housewives	25
No Job	6
Total	100

The percentage of schizophrenic patients in X state mental hospital at the time of the field work was 66 per cent (Table 16).

It would be interesting to investigate the relation of diagnosis of mental illness to the patient's class. With respect to Z private mental hospital the author has data about education and occupation of every inmate. The population of the hospital consists of former big landowner gentry, professionals, western-style businessmen and members of aristocratic families. The majority of these were university graduates and many of them were educated in European schools from their early childhood. In sum, they are members of the elite group. This information made it easy to determine the class affiliation of the population. Using the social class affiliation index the author found that the total scores of the patients ranged from 11 to 15, which he took to indicate membership in the upper class (see Appendix 3 for Class Affiliation Index).

The fact that every patient in this hospital has to pay £ 2 per day, at least, as a fee for his expenses represents a check on the validity of the conclusion. Concerning X state mental hospital, the researcher does not have specific detailed data about every patient. But the fact that 85 per cent of the population in this institution are treated on a charity basis and that only five per cent are professionals may be an indication that the majority of the patients came from the lowest social stratum. Furthermore, the patients treated on charity are of low socio-economic background, have relatively meager education, and by occupation are mostly unskilled workers and landless peasants.

Considering the fact that these two hospitals cater to patients completely different in social class and background, a comparative study

Table 16. *Distribution by Diagnosis in X State Mental Hospital*

Diagnosis	Percentage of Patients
Schizophrenia	66
Manic Depressive	17.5
Epilepsy	4.5
Senile Psychosis	1
Organic Reaction	3
Involutional Melancholia	8
Total	100

Table 17. *Distribution by Diagnosis in Z Private Mental Hospital*

Diagnosis	Percentage of Patients
Schizophrenia	5
Depressive Reaction Types	40
Arteriosclerosis	30
Other Types	25
Total	100

of diagnostic categories in these hospitals may show whether the diagnosis of mental illness is related to the patient's class. Examination of Tables 16 and 17 will show that class differences and diagnosis of mental illness follow the rule that the higher the class the more depressive disorders and the less schizophrenic reaction types or, inversely, the lower the class the more schizophrenic reaction types and the less depressive disorders. Thus, in Z private mental hospital, which hospitalizes only the upper class, depressive psychoses were the leading diagnostic category representing 40 per cent of the population, and schizophrenia was the least common, representing five per cent only of the population. On the contrary, in X state mental hospital which hospitalizes a majority of lower class patients, the distribution by diagnosis is in direct antithesis to Z private mental hospital, with a high percentage of schizophrenia (66%) and a relatively low percentage of depressive disorders (17%).

Interpretation of this high prevalence of schizophrenia among the lower class can be handled by the stress model. As mentioned above, schizophrenia is most highly correlated in the psychiatric literature with cultural stress. Certainly the most tenable hypothesis as to the etiology of schizophrenia at this time is that various combinations of hereditary vulnerability and environmental stress (either in early childhood or in later life) may lead to overt manifestation of the disorder (Clausen, 1961).

To date, ecological studies of mental illness have been concerned primarily with the relation of social conditions to the incidence of schizophrenia. Despite the lack of total agreement about the meaning of

the findings, higher rates of schizophrenia have been found in lower socioeconomic nieghborhoods and in the central high mobility areas of cities. Many of these studies have failed to associate depressive disorders with the same social factors as schizophrenia.

On the other hand, depression is not correlated in the psychiatric literature with cultural stress. C. Savage, A. Leighton, and D. Leighton state that in manic depressive reaction types grief may appear where there is no external cause, or where the cause is insufficient (*in* Murphy and A. Leighton, 1965:49). Strecker and Ebaugh (1945), noting the absence of stressful conditions in the precipitating depressive psychoses, offer the explanation that these psychoses spring from a constitutional basis which has its roots in inheritance and that these psychoses appear in certain predispositions which have been fairly well delineated (p. 305).

More recently, Hare (1956) obtained similar findings in England. Commenting on this, Arieti suggests that manic-depressive psychosis is connected with "a structured well organized . . . milieu, removed from the disorganization or relative looseness of organization that we find . . . in low economic or socially instable elements of the population."[1]

The results of this section may, then, be summarized as follows: It seems reasonably well established that the prevalence of psychosis in the Egyptian population is greater among the lower as compared with upper classes. This conclusion seems especially true of schizophrenia. This might be a function of the amount of stress since it has been demonstrated by thematic analysis of the patients' life histories that the lower class is an area of maximal stress in the Egyptian social

structure. However, it remains possible that the results of the present study may be attenuated by some flaws in the diagnostic procedures. It may be that whether a given patient is classified as, say, schizophrenic when diagnosis is uncertain, will be in some measure a function of his social status. The psychological distance between Egyptian psychiatrist and patient, based on the social class and hospital role difference, was striking. If this is true the results reviewed above would, in part at least, refer to status factors in the diagnosis of mental disorder.

Low class patients, particularly, generally took a passive and submissive attitude toward the psychiatrist because of their reverence for doctors, but their case records tended to interpret this response as "excessive humility, feelings of indignity and guilt." One must be aware, however, that the hospital diagnostic procedures were based on records of a rather minimal communication between doctor and patient.

It was also noticed as a result of interviewing young and old psychiatrists that young psychiatrists, unlike the old, did not take cultural factors into account in their evaluation of mentally sick patients, and consequently made regrettable errors. They were applying automatically what they had learned from Western psychiatry in order to put patients in various diagnostic categories.

On the other hand, there were a few experienced Egyptian psychiatrists who were anthropologically oriented. This was evidenced in an interview between an old and very experienced psychiatrist (the chairman of X mental hospital) and a young peasant from Upper Egypt. The peasant was claiming that at night he saw the Prophet Muhammad in a semi-dream. This patient, who was thought to be suffering from private

delusions by a young psychiatrist, was discharged from the hospital at once by the chairman who recognized the pattern as a common one among peasants of that region.

Social Class and Drug Addiction

Alcoholism is rare in Egypt as alcohol is prohibited by the Moslem religion. The most common type of addiction Egypt faces is opium. The latest report of the outpatient clinic for the treatment of drug addiction in X state mental hospital states that the greatest majority of the addicts were opium-addicted. Among 1,447 cases treated in this clinic, 1,187 cases were addicted to opium, 29 cases to hashish, and 25 were alcoholics.[2] This is probably no accident. The social and cultural milieu of these people functions to reduce their exposure to alcoholism.

It would be interesting to investigate the relationship between social class and the kind of addiction. Fortunately the author has data about the social class background of the 25 alcoholic addicts. However, he does not have specific details about the class affiliation of the opium and hashish addicts who represent the majority of the addict population who were treated in this clinic, although he does know some general characteristics of their social background.

A comparative study of alcoholics and of opium addicts shows that alcoholics are usually found among the middle and upper classes, whereas opium addicts are usually found at the bottom of the social scale. It would appear that type of addiction is clearly a function of class position.

Hashish represents a major problem in Egypt. It has been known

in the Middle East for 500 years, and probably much longer, that the flowering tops of *Cannabis indice* have a pleasant intoxicating effect. It is used chiefly because it has been held — very debatably — that it acts as a sexual stimulant and prolongs the sexual act. It is unlikely that there is any specific effect, but it may serve as an aphrodisiac by inhibiting higher moral control and releasing instinctive desires (Okasha, Kamel & Hassan, 1968:954). It is rare to find a hashish smoker presenting himself at the drug addiction clinic as the above mentioned report indicates. In spite of the fact that it is a common habit, most people do not consider it an addictive drug.

In view of the widespread use of hashish, there have been many social and clinical studies of its problems in Egypt (Soueif, 1967). It has been shown that hashish takers in Cairo took the drug five times or more per month while the majority of those coming from semi-urban and rural areas consumed it three times or more. It seems difficult to draw a conclusion as to whether hashish is used more in big cities or in the villages. The fact that the amount of hashish seized in the cities usually outweighs the quantity seized in rural areas may simply be a function of police control. The methods of consumption are given in order of frequency: 1) the *"josah"* (this does not differ much from the *"nargileh"* of Lebanon); 2) smoking in cigarette form; 3) boiling with water almost the same way as Turkish coffee is made; 4) swallowing in the form of pills and, 5) mixing the drug with some kind of food (Okasha, Kamel & Hassan, 1968).

The majority of hashish takers started using it before the age of 20 years. Their conscious motives in taking hashish for the first

time were in the following order: 1) conformity to a group of personal friends, 2) seeking euphoria; 3) curiosity; 4) trying to appear like "real men," and 5) the desire for sexual excitation. Positive family history of hashish dependence was marked (Okasha, Kamel & Hassan, 1968: 954). Soueif (1967) found that hashish takers suffer from some manifestations of anxiety as defined by a few items selected from the Taylor Anxiety Scale.

It seems fairly clear that the Egyptians are in a general sense freer in their use of hashish than many national groups. In a book devoted to the problem of drugs in Egypt[3] (1970) some investigators report the prevalence of hashish to be an inverse function of social class position, prevalence increasing with descent down the status scale. There seems little doubt that smoking or drinking hashish plays a large part in dealing with many deeper frustrations and conflicts and, as many authorities have said — from the psychodynamic standpoint it is remarkable that the Egyptian can find an outlet for so many diverse forms of psychic conflict in this single means of escape. But hashish has, in some degree, the effect of inducing and enhancing the fantasy life which is so inherently a part of Middle Eastern cultural heritage. As R. Patai (1962) says: "In the Arab culture there is a great preoccupation with folklore -- poetry, song, tales, and music."

B. Sex and Mental Illness

Sex and Schizophrenia

Contrary to expectations, data from different sources reveal that

the number of hospitalized schizophrenic female patients is significantly less than the male patients. In X state mental hospital there were 1300 female patients as compared to 800 male patients who were diagnosed as schizophrenic. But if the number of hospitalized schizophrenics in all state mental hospitals is counted, the number of male schizophrenics surpasses the number of their female counterparts. According to Dr. Abou El Azaim, head of Abbassiya state mental hospital, and Dr. Ghaly, head of Al Khanka state mental hospital, there are about 3,000 male hospitalized schizophrenic patients *vs.* 1,300 female.[4] Out of the 3,000 male schizophrenics 800 are legal offenders.

The Prevalence of Psychoneuroses

Egyptian psychiatrists seem to be agreed that the prevalence of psychoneuroses in Egyptian patients is surprisingly large in relation to other national groups.

Watts (1952), whose research covered all persons under psychiatric care, whether in hospital or not, on a specific date in a given area of urban Britain, found that 12 per cent suffered from psychoneuroses and ten per cent from psychosomatic diseases. However, Okasha (1969) claims that psychoneuroses in Egypt, either in its totality, or more frequently as additions to organic morbidity, constitute 60 to 70 per cent of Egyptian medical practice and that psychoneuroses are more prevalent among women. A large number of statistical studies would seem to indicate that psychoneuroses occur more frequently in the female, with the female rate exceeding the male rate by some 60 per cent; that it is extremely common in lower class women; that the peak of its prevalence is attained by

women during their second and third decades.

Okasha (1969) surveyed the presentation of hysteria in Egypt among 100 females and 50 males. The majority of patients were between 20 and 30 years of age. Speaking about the hysterical personality, he states that it is probable that ten per cent of the Egyptian population is characterized by this personality. But he reiterated that this personality syndrome is more prevalent among Egyptian women where it reaches from 20 to 25 per cent of the whole female population.

The Prevalence of Suicide

Information regarding the incidence of suicide in Egypt is scanty. It lies under a religious taboo, and usually the relatives do not inform any authority. From clinical observations of interviewed psychiatrists, it may be said that suicide as a whole is not encountered frequently even among depressives, probably because of the Moslem religious background. With reference to depressive reactions, it is incidentally interesting to note that no instance of suicide had occurred inside X state mental hospital for the past several years. Suicide is negatively sanctioned by the Koran. Egypt has had one of the lowest suicide rates in the world (see Table 18, derived from the *United Nations Demographic Yearbook* of 1957) for as long as comparison has been possible. However doubt was expressed recently as to whether the Egyptian suicide rate was really as low as the figures in the official tables indicate and whether, for religious reasons, great pains are taken to represent suicide, when it occurs, as death from other causes. While the true suicide rate is probably higher than official figures would suggest, it seems likely

Table 18. *Suicide Rates for 37 Countries, per 100,000 Population,* circa *1955*

Country	Rate	Year	Country	Rate	Year
Australia	10.3	1955	Italy	6.1	1954
Austria	22.8	1956	Japan	25.3	1955
Belgium	13.6	1955	Mexico	1.3	1955
Bulgaria	5.2	1956	Netherlands	6.0	1955
Canada	7.6	1956	New Zealand†	9.0	1955
Ceylon	7.8	1956	Norway	7.4	1955
Chile	4.4	1954	Panama	2.9	1952
Colombia	0.9	1956	Peru	0.6	1953
Costa Rica	2.6	1956	Poland	5.7	1955
Denmark	22.5	1956	Portugal	10.0	1956
Dominican Republic	3.1	1955	Spain	5.9	1953
Egypt*	0.1	1954	Sweden	17.8	1955
England & Wales	10.8	1953	Switzerland	21.6	1955
Finland	22.4	1956	Taiwan	3.0	1956
France	15.9	1955	Union of South Africa	11.1	1954
Guatemala	3.5	1956	United States of America	10.2	1955
Hungary	17.8	1954	Uruguay	11.4	1955
Iceland	11.8	1956	West Germany	19.3	1955
Ireland	2.3	1955			

*Population within Health Bureau Localities
†European population

that it is still one of the lowest in the whole world.

As to variation within the nation, evidence indicates that suicide rates in Egypt do vary according to sex and age. The latest official report on suicide, published on June 12th 1971,[5] shows that female suicide rate exceeds the male rate (even when adjusted for population distribution of both sexes). It is also disclosed in the same report that married women are more prone to suicide than the widowed, single, or divorced female.

Worldwide, fewer women commit suicide than men. According to United Nations, World Health Organization (1956),[6] the male suicide rate exceeds the female rate in 24 nations. The extreme cases are Norway and Japan, with the male rate exceeding the female rate some 350 per cent and 60 per cent, respectively. That Egyptian women are more prone to commit suicide than men presents an exception. The ratio of female to male suicides in Egypt is exceptionally high and is a clue that may lead us to the detection of cultural factors promoting suicide among women and inhibiting it among men.

The Degree of Manifestation of Psychopathology

Another finding revealed by this investigation is the severe and extreme overt manifestation of psychopathology among women as compared to men.

Let us commence with a working definition of the term. Following the clinical approach as used in psychiatry, the author defines a patient as presenting severe overt manifestations of *psychopathology* when he is dangerous to himself (suicidal) or to others (homicidal).

Thus, the index of overt manifestation of psychopathology for each of the two sexes is measured in terms of the sum of patients defined by the staff members of the mental hospital as dangerous to themselves or to others relative to the whole number of patients of each sex.

Expressed in Table 19 are the differences by sex in the percentage of patients who are defined by the staff members of X state mental hospital as dangerous to themselves or to others. A glance at this table shows a steady decline in percentages of these dangerous patients over a ten year period. This fact is related to the general decline in the frequency of manifestations of extreme psychopathology which is assumed to be the result of more effective drug therapy (the drug revolution), more favorable hospital conditions, improved physician-patient relationships, and the fact that nowadays patients suffering from mild schizophrenia are more willing to seek admission to mental hospitals than they were earlier. Still, the percentage of female patients who are defined by the hospital as dangerous to themselves or others is much greater than for the male patients.

There was one check on the validity of the index on extreme overt manifestation of psychopathology by patients in men's and women's sections of the mental hospital as computed. This has been provided by the death rate of patients per 1,000 population. Although there has been a decline in death rate in both women's and men's sections, as was the case in the overt manifestation of psychopathology, yet the death rate of women patients is much greater than that of men patients. This can be seen in Table 20.

Considering the fact that the median age of women has been slightly

Table 19. *Percentage of Patients in X State Mental Hospital Who Are Defined as Dangerous to Themselves or Others, According to Sex, for the years 1960 - 1969**

Women's Sections	Men's Sections	Year
97.6	78.4	1960
78.2	72.9	1961
95.5	74.4	1962
95.9	73.9	1963
95.3	78.9	1964
88.6	79.9	1965
91.9	74.8	1966
42.3	28.5	1967
7.9	7.2	1968
7.1	1.7	1969

*According to a book edited by the staff members of X State Mental Hospital.

Table 20. *Male and Female Death Rates per I,000 Population in X State Mental Hospital**

Year	Rate		Ratio of Female to Male Rate	Excess of Female Rate
	Male	Female		
1960	3.3	13	4.3	9.7
1961	3.3	12	3.7	8.7
1962	2.2	13.5	6.1	11.3
1963	3.3	11.4	3.5	8.1
1964	4.4	9.9	2.2	5.5
1965	2.2	10	4.6	7.8
1966	2.1	9.9	4.7	7.8
1967	2	4.9	2.4	2.9
1968	2	5	2.5	3
1969	2.2	4.9	2.4	2.7

*According to a book edited by the staff members of X State Mental Hospital.

lower than the same for men during this period, we can rule out the possibility that the large number of deaths of women as compared to men is related to the youthful character of the population of men. This large death rate in the women's section is consistent with their extreme manifestation of psychopathology.

Drug Addiction and Sex

Another aspect which emerges is that the problem of addiction is a male phenomena. Among the 1447 addicts only four were females and these came to the clinic because they were addicted to sleeping drugs.

This is consistent with what anthropologists working among Middle Eastern societies have noted about sex mores. Whereas it is culturally sanctioned for a man to smoke cigarettes and sometimes hashish or opium, it is deviant for a female, especially if she is lower class, to behave in this manner.

C. Age and Mental Illness

Age and Prevalence

As to distribution by age, the majority of the patients in all three hospitals ranged from 18 to 29 years. Egyptians fall victim to mental illness soon after adolescence or in the first flush of manhood or womanhood. This suggests that age is in some way linked to the prevalence of mental illness, but beyond this little can be said (see Table 21).

As to the relation of age to the schizophrenic rate differentials,

Table 21. *Percentage Distribution of Patients by Age in X State Mental Hospital, Z Private Mental Hospital, and Ain Shams University Psychiatric Clinic*

Age	Percentage at "X"	Percentage at "Z"	Percentage at Ain Shams
0 - 9	0	0	1.4
10 - 19	17	21	17.6
20 - 29	44	35	30.7
30 - 39	26	21	29.4
40 - 49	5.5	12.5	14.1
50 - 59	3.5	8.5	4.7
60 - 69	2.5	2	1.8
70 - 79	1.5	0	.3
Total	100	100	100

a book edited by the staff members of X state mental hospital[7] suggests that the most frequent age at onset for Egyptian schizophrenics lies within the range of 16 and 30 years. The majority of Egyptian schizophrenics have their onset of schizophrenic reaction in their early twenties and especially between 18 and 20 years. Around this age the student shows a marked apathy, and inability to concentrate on his studies.

Age and Suicide

As to variation by age, suicide rates in Egypt vary consistently under this category. Suicide is more prevalent among the younger age groups, the rate increasing rapidly up to age 25, then plunging to a low with advancing age. However, among the younger people who commit suicide, students represent the leading group.

Mental Disorder of Old Age

Schizophrenic and manic-depressive reaction types account for the majority of hospitalized cases in X state and Z private mental hospitals. Eighty-four per cent in X state mental hospital belong to these diagnostic categories compared to 45 per cent in Z private mental hospital (Tables 16 and 17).

The proportion of organic mental disorders in the population of X state mental hospital is exceedingly small — three per cent X state mental hospital and six per 1000 in Ain Shams University Psychiatric Clinic. In contrast, approximately half of the patients admitted for the first time to American state hospitals for mental disease in 1948 or

1949 were definitely diagnosed as suffering from mental disorders due to organic conditions.[8] The latest epidemiological statistics on the frequency of senile brain disease in the U.S.A. indicate that one of every four first admissions to public mental hospitals is a patient 65 years of age or over. Of these elderly first admissions, 80 per cent or more are diagnosed as having senile brain disease (Busse, 1968). Although there are serious problems regarding the validity of such comparisons, it has nevertheless seemed apparent that there are several points of contrast worthy of attention.

This low proportion of organic psychotic conditions may be related, in part, to the extremely youthful character of the Egyptian population; many organic psychoses are conditions of middle and old age. Thus, the high mortality of the general Egyptian population must be considered. But, even so, other determinants must also account for such a low proportion of senile psychoses in the hospital population. The fact that Egyptians are protected, by their way of life, from exposure to alcohol and syphilis is another factor in the relative rareness of organic psychoses. The high prestige older people enjoy and the communal support they receive may be of prophylactic significance in inhibiting symptoms of extreme social deterioration that sometimes accompany old age. These might be factors in reducing the prevalence of severely disturbed behavior among older persons which, in the general American population, often leads to institutionalization.

The communal support old people receive in Egypt is validated by the sacred literature. It would be superfluous to cite examples from the Koran which reinforce kindness on the part of the children towards

their aging parents. In all Koranic references one finds endless repetition that kindness ought to be shown toward parents. Also one notices that whenever God is mentioned in the Koran, prescribed kindness toward parents is mentioned immediately after. Worshipping God will not be accepted without kindness to the parents.[9]

Psychiatric Disorders in Children

Psychiatric disorders among children are not encountered frequently by Egyptian psychiatrists. One obvious reason is lack of awareness among the general public that these problems come within the province of psychiatrists. Behavior disorders in children represented 2.4 per cent of the Egyptian epidemiological survey (Table 22). They were mainly in the form of hyperactivity, aggression, stealing and wandering around. This was more common in patients from cities than from villages (Okasha, Kamel & Hassan, 1968:953).

In a short clinical descriptive account of the first 1,000 patients attending Ain Shams University Psychiatric Clinic from the beginning of 1966, Drs. Okasha, Kamel and Hassan state that in the Egyptian village the conditions are present to develop happy and s ocially secure children. Such children learn crafts and appropriate conduct from their parents and elders by imitation rather than precept and are gradually initiated into the fuller social responsibilities of the extended family community. If such people move to the cities, their work becomes mechanized, mothers as well as fathers work away from their homes, they pass on to their children little knowledge and fewer skills which could earn for them the children's respect. In such circumstances, it is difficult to train

their children in social responsibilities; hence delinquency and behavior disorders tend to develop. Since schooling has become compulsory, there is a tendency to see more cases of educational problems (Okasha, Kamel & Hassan, 1968).

Nocturnal enuresis was represented in 1.9 per cent of the cases in the above mentioned psychiatric report. Bedwetting is tolerated in a child up to 5 or 6 years. The age at which parents decide to do something about it depends on their tolerance and their degree of sophistication — usually the child is between 7 and 10 years of age.

Stammering occurred in 0.5 per cent of cases. It was clearly secondary to anxiety neurosis, mainly manifest at the age of entry to school and at puberty. It was restricted to children living in big cities. Egyptian psychiatrists have not seen any case among those coming from the village. This confirms previous suggestions that stammering is very rare or never occurs in primitive people (Okasha, Kamel & Hassan, 1968:953).

Mental deficiency was not a great problem in the past, owing to the high infant mortality rate which accounted for the death of those with a low degree of viability, and certainly because of the lack of any big demand for intellectual performance made on children in the past (Okasha, Kamel & Hassan, 1968:953). But now, with a decreasing infant mortality rate and increasing intellectual demands on children, psychiatrists are beginning to see more cases of mental deficiency, represented as 2.5 per cent of all cases attending Ain Shams University Psychiatric Clinic. Again, mental deficiency was restricted to children living in big cities. However, there are a number of factors which make this supposed lesser frequency more apparent than real. First, there is much

Table 22.* *Distribution by Diagnosis in Ain Shams University Psychiatric Clinic*

Diagnosis	Percentage	Number of Patients
Anxiety	22.6	226
Hysteria	11.2	112
Obsessive Compulsive	2.6	26
Reactive Depression	10.7	107
Manic Depressi Psychosis	8.6	86
Involutional Melancholy	5.2	52
Schizophrenia	15.3	153
Schizo-affective	2.6	26
Hypochondriasis	4.5	45
Personality Disorder and Addiction	3.0	30
Behavior Disorder	3.0	30
Stammering	.5	5
Nocturnal Enuresis	1.9	19
Mental Deficiency	2.5	25
Dementia	1.2	12
Organic Reaction Type	.6	6
Epilepsy	4.0	40
	100	1000

*According to Okasha, Kamel & Hassan, 1968.

much greater tolerance of mental deficiency in the village setting. Secondly, in rural areas certain mentally deficient persons can be admired and approved; for example, they are called Saints and honored as such.

(For bedwetting, stammering, and mental deficiency figures, see Table 22.)

Problem of Interpretation

The first finding revealed in this chapter is that, in Egypt, the prevalence of treated mental disorders by type and by total is related to social class. The results showed: the lower the class, the greater the proportion of patients in the population. The data also suggest a greater prevalence of schizophrenia among the lower class. These findings are consistent with the hypothesis that in areas of maximal social stress the prevalence of psychosis, and especially schizophrenia, would be higher than in areas where social stress is at a minimum. However, another explanation may account for the findings. This was revealed to the investigator by one of the remarks of the dean of Egyptian psychiatrists in which he said that 50 per cent of the lower class patients who were admitted to X state mental hospital on the basis of schizophrenic morbidity have been mistakenly hospitalized by upper class psychiatrists.

The unresolved questions which could differentiate between the two explanations are: Is sociocultural stress causally related to high proportions of schizophrenia? Or is it, rather, that a high prevalence of treated schizophrenic patients in the lower class is due to status

factors in the diagnosis of mental disorder? The present study was not set up to differentiate between these hypotheses. However, one procedure to help in the solution of the problem is to perfect clinically the diagnosis of schizophrenia. If, in the future, ways can be found for breaking up the current schizophrenic grouping and for determining a more objective diagnosis of schizophrenia, psychiatric medicine will have taken a giant step forward.

A second major finding of this study is that in Egyptian culture women have more psychiatric disturbances than men. Statistical studies seem to indicate that psychoneuroses occur more frequently in the female, with the female rate exceeding the male rate by some 60 per cent; that the suicide rate is five times as high in the female category as in the male category; that extremely overt manifestations of psychopathology, as measured by a psychopathological index, prevail more frequently among women patients than among men patients and, finally, that the death rate of women patients is significantly higher than that of men patients. However, the findings of the study reveal that the number of female schizophrenic patients is significantly less than the male equivalent.

It seems to the author most reasonable to assume that this high rate of psychiatric morbidity among Egyptian women is a function of sociocultural stress. It has been demonstrated by the thematic analysis of the life histories of the patients that one effect of the low socio-economic position of the woman in Egyptian society is greater stress on the psychic and mental life. Three combinations of vulnerability have led to her overt manifestation of mental disorder. The two vulnerabilities of age and social class which she shares with the man are combined with

the vulnerability due to her sexual role. As for the conditions of conflict resolution, the Egyptian culture does not provide instruments by which the culturally-created stresses and strains of the women may be solved. For example: According to the traditional ideals of the Muslim religion, women occupy an inferior status to men which is clearly expressed in the differential legal rights accorded to men and women in the society (Nelson, 1968). In matters of divorce, it is only the man who has the right and power to divorce his wife, not vice versa. Thus, when a woman does not like her husband, she has no institutionally sanctioned outlet to rid herself of him. Faced with such a blind alley she might resort to mental illness as a means of airing her grievances obliquely in a stressful marital relationship. On the other hand, Egyptian culture provides a man with institutionally sanctioned outlets. If he is forced to marry against his own will and finds that he hates his wife, he may resolve his stress by divorcing her.

The low rate of schizophrenic hospitalized female patients as compared to the male equivalents is, however, not in line with the author's hypothesis. Explanation of this may be related to the fact that there is a culture barrier against the hospitalization of female patients. Interviewed psychiatrists seem to agree that in Egyptian culture people are not very willing to send female patients to state mental hospitals as this may affect their chances of being married. The fear of committing a female to a psychiatric hospital may be connected with the sense of 'shame' which a girl might bring to her family, especially before her marriage. If any disgraceful rumour about a girl or a woman spreads, the father as well her brothers bear the social stigma. The fact that

the age of onset in schizophrenic reaction types is in the early teens (which is the suitable age of marriage for females) may shed some light on the strong resistance of the Egyptian father to the hospitalization of his schizophrenic daughter. Treatment of females in a mental institution is viewed in extremely negative terms.

Why does this cultural barrier not affect *other* areas discussed above, such as psychoneuroses? The psychoneurotic is not considered as *magnon* (insane). The stigma attached to schizophrenia and the sense of shame which stand in the way of the schizophrenic female going to the hospital do not exist in the case of psychoneuroses.

The third major finding is that the peak of the prevalence of mental illness is attained in the second and third decades of the patient's life. Egyptians fall victim to mental illness soon after adolescence or in the first years of manhood or womanhood. An important and logical corollary to this last finding stands out in the fact that the prevalence of senile psychosis is low, and surprisingly so in relation to other diagnostic categories.

Chapter VI

THE PROBLEM OF CULTURAL ELEMENTS OF SYMPTOMS

In previous chapters the relation of cultural variables to mental disorders was studied by epidemiological and comparative methods. The author investigated the relation of *social class*, *sex*, and *age* to the *frequency* of mental disorders. In this chapter the emphasis will be on locating more specific cultural traits and social relationships that may be significantly related to specific symptoms of disorder. It must be noted that the author is still dealing with the variables of *social class* and *sex* as independent variables, but this time he is taking the *symptomatic* picture and the *content* of symptom, rather than degree of stress or rate of schizophrenia, as the dependent variables.

The author tries to answer the following questions:

1. How far can Western psychiatric classifications be applied to another culture?
2. To what extent does the content of mental illness vary with the variables of sex and social class?

Research attempts have shown that the reliability of Western psychiatric classifications in Western society is far from being satisfactory. The diagnosis can be difficult and uncertain in cases where impairment is slight and in situations in which special features conspire to obscure the picture. When one turns to the application of Western psychiatric classifications to another culture, the problem becomes more

intricate. Greater difficulties and risks of error are bound to occur.

The author thus admits the weakness inherent in Western psychiatric classifications. The problem then is: If he starts with the traditional Western definitions of disorder and the criteria by which psychiatrists trained in Western medicine recognize them, is it possible to take these into another culture with some hope of being able to identify comparable phenomena?

A. Psychosis

Schizophrenia

This is the most common diagnosis of cases in American mental hospitals, but as Otto Fenichel (1945:415) points out, "The diversity of schizophrenic phenomena makes a comprehensive orientation more difficult than in any other class of mental disorders."[1] There are four predominating types of schizophrenia. The *simple* type of schizophrenia is characterized by dullness, apathy, with a tendency gradually to withdraw more and more from reality into a world of fantasy and daydreams. The *paranoid* type of schizophrenic patient manifests extreme suspiciousness, has a tendency to misinterpret trivial events so that they fit in with his ideas of being persecuted, and also shows fairly active hallucinations. The *hebephrenic* type of schizophrenia presents a picture of silliness, inappropriate giggling, smiling, and mischievous behavior. The *catatonic* type is divided into two forms: catatonic

stupor and catatonic excitement. The word stupor as applied here does not have the usual medical connotation of unconsciousness, but merely signifies such an extreme withdrawal from the world of reality that the patient appears entirely oblivious to his surroundings and to his own bodily needs. The schizophrenic patient in a catatonic stupor does not seem to feel even a pinprick; he does not speak, will not eat, and has to be washed, fed, and given the toilet care of a baby. In catatonic excitement, on the contrary, there is impulsive and jarring overactivity, but the patient seems to be reacting to his hallucinatory experiences and delusional ideas rather than to anything that is happening around him (Strecker, 1945).

In the application of this diagnostic term to Egyptian patients, the author was guided by the definition of the diagnostic and statistical manual of the American Psychiatric Association[2] which equates schizophrenic reaction with split personality (Polatin, 1949). This is a better designation than *dementia praecox*, formerly in wide use, since it names the fundamental splitting of the personality.

Schizophrenia is the commonest chronic variety of psychosis in Egypt. Analysis of the clinical notes of the sample inclined the author to accept Lambo's (1960) and Okasha's (1968) denials of Carother's (1951) statement that "paranoia, and even paranoid schizophrenia are relatively rare among Africans."[3] Paranoid schizophrenia represents 25 per cent of the author's sample. In a short clinical descriptive account of the first 1,000 patients attending Ain Shams University Psychiatric Outpatient

Clinic from the beginning of 1966, Drs. Okasha, Kamel and Hassan (1968) found that 29 per cent of their schizophrenic patients were paranoid.

Social Class and Delusions

The author tried to investigate the relationship between social class and delusional content. For the purposes of discussion, *delusion* is defined as a false belief which cannot be changed by any appeal to reason. The belief that is held must be false in fact, completely unshakeable and impervious to argument, and one not accepted by persons of the same cultural and social background.

The recurring concerns that cut across all the delusions and which appear to dominate the outlooks of most deluded patients are summarized in Table 23.

An attempt was made to establish a system of categories for scoring the manifest content of delusions. The content of delusion is scored as physical, chemical, or technical when the patient expresses in his delusion that he is under the influence of electricity, the radio, the computers or any other physical technical force; as religious, if it is colored by religious dogma, if the patient expresses any of the supernatural beliefs whether central or peripheral to the religious dogma (the latter includes *jin*, sorcery, and the evil eye), or if he has the grandiose idea that he is a prophet or any other religious character; political, if the person claims that he is an important political character or if he is concerned with wielding power; persecution, if the

Table 23. *Percentage of Delusions According to Sex*

Dominant Delusional Themes	Male - 56		Female - 54		Total No. of Patients
	No. of Patients	% to Total No. of Delusions	No. of Patients	% to Total No. of Delusions	
Physical, chemical or technical	8	14	6	11	14
Religious	20	36	24	44	44
Political	10	18	8	15	18
Persecution by the father	14	25	11	20	25
Food poisoned	4	7	5	10	9
Total	56	100	54	100	110

patient expresses his concern that some individual (usually the father) is torturing him or wants to kill him, etc., and finally, food poisoning, if the patient conceptualizes his interpersonal relationships by saying that someone is poisoning his food.

Turning to the dominant delusional themes as reflected in Tables 23 and 24, it is clear that religious ideology is the major dominant theme expressed in the patients' delusions. There were 44 delusions in which there was some explicit spontaneous reference to religion. In nearly all cases the reference was to a supernatural authority, particularly sorcery, evil eye, and *shaikhs*, with females showing a slightly higher frequency than males.

Despite its apparent homogeneity as a Moslem-Arab-Socialist-Nationalist country, Egypt is a very heterogeneous society comprised of distinct social classes. There are the urban bourgeoisie, including former landed gentry now shorn of wealth and political power, middle class government officials and civil servants, and the vast majority of peasants and "rurban proletariat," including migrants from the rural hinterland and the native-born city dwellers. The latter groups have not developed those attributes usually associated with a "modern" urban way of life. These people are considered by other Egyptians to be "truly natives," that is, little affected by "westernization" and "modernization" and with "their own mentality" which is quite distinct from that of the more sophisticated, westernized middle and upper class Cairenes who also have a "world" of their own (Nelson, 1968).

Table 24. *Percentage of Delusions by Class Affiliation*

Dominant Delusional Themes	Lower Class		Middle Class		Upper Class		Total No. of Patients
	Percentage of Themes	No. of Patients	Percentage of Themes	No. of Patients	Percentage of Themes	No. of Patients	
Physical, chemical or technical	5	3	20	6	26	5	14
Religious	54	33	27	8	16	3	44
Political	10	6	20	6	32	6	18
Persecution by the father	23	14	23	7	21	4	25
Food poisoned	8	5	10	3	5	1	9
Total	100	61	100	30	100	19	110

It follows that individuals in different social strata, by virtue of diverse styles of life, should show corresponding differences in both the nature and content of delusion. To test this statement an instrument to measure the socioeconomic status of the patients was constructed: it divided the sample into three social classes (see Appendix 3 for social class index). As seen in Table 24, the delusional content differs greatly in relation to the patient's class affiliation.

What strikes one first and foremost in schizophrenic delusions occurring among natives in the lowest social stratum is the belief in the intervention of supernatural beings, occult forces, or magic. There appear to be interesting differences in the percentages of religious delusions associated with such social differences. This is indicated by the figures of 16 per cent, 27 per cent, and 54 per cent for upper, middle, and lower class, respectively.

Religious Delusions

We borrow from the clinical notes of the patients some instances of religious delusions:

1) A 51-year-old lower class male who is an unskilled worker states that he is a Prophet sent by God. To quote his own words: "Dear Sir: the person who is in front of you is not myself, he is a substitute for myself, he is a Saint, ask the people and they will tell you that Mr. . . . is a Saint."

2) Another megalomaniac from the same class: "I am the Saint of the Saints. El Sayed El Badawy takes orders from me."

3) An 18-year-old girl who is the daughter of a truck driver claims that she is "God the Highest potent," *and whenever she makes any statement she will follow it by saying,* "I am the Truthful Lord."

4) A 16-year-old lower class peasant states that a Shaikh *has controlled him through sorcery and consequently has made him unable to eat or drink.* "One of my enemies hired this *Shaikh* and got a meter of red cloth and a meter of another color and put them under my sleeping mat. I found the cloth but my enemy denied any knowledge of them. This magic compels me to count my fingers repeatedly."

Religious dissimilarities within any culture often become as significantly different from each other as are the dissimilarities between different cultures. This is exemplified by the two following delusions derived from the notes of two patients with different religious backgrounds.

5) A 42-year-old Christian Minister from the middle class says: "People should not smoke, use neither money nor metals. The kingdom of God will unite Jerusalem in 3-5-1950." *In addition, he claims that he is the Holy Christ. He wants to go to Jerusalem to carry on with his functions.*

6) A 30-year-old Moslem teacher of religion was severely deluded. He stated that whenever he moved the Angels surrounded him. He gives false interpretation to the Koran. In addition, while he was moving through the streets of Cairo he imagined that he was making a pilgrimage to Mecca and thus he wore the special clothes for pilgrimage.

Scientific Delusions

Turning to delusions of a physical, chemical, or technical content as reflected in Table 24, it is clear that they are related to social class as indicated by the figures 5 per cent, 20 per cent and 26 per cent for the lower, middle, and upper class, respectively.

Characteristic of this kind of theme are the following delusions:

1) A full professor in the Faculty of Medicine who is apparently a member of the upper class frequently remarked that he was under the influence of the computers which kept "boosting" *him up and down. He thought at times his body was full of X-rays.*

2) A 21-year-old middle class girl, a student in the Faculty of Medicine, felt that she was under the influence of electricity including

X-rays; "electricity goes through my body." *She complained that various people in the Intelligence Bureau were persecuting her, putting a tape recorder in her room to spy on her and were watching her continuously. She added that they were putting her under the influence of a poisonous gas which she defined as D.F.B.B.*

Such instances enable the author to measure the influence of westernization upon the content of delusional ideas. The content of these patients' delusions can be evaluated through an accurate knowledge of their respective ways of life. Thus, the majority of the patients' delusions in the lower class is colored by religion. On the other hand, the delusions of the upper and middle class patients, the highly westernized ones, are not very different from similar delusions observed in European or American patients.

Psychiatrists with long experience in treating Egyptian psychotic cases have confirmed this finding in a series of interviews. The Chairman of X state mental hospital, for example, remarked that in rural areas where the belief in ghosts is rife a schizophrenic patient will often claim that ghosts come out of the walls to speak with him. These peasants believe that there are "powers" from the "underworld," that there are "shadows in the darkness," or that they "see and hear demons" which "climb the roof at night." On the other hand, educated urban Egyptians express in their delusions the notion that they are influenced by spheric waves and that other people communicate with them through wireless.

The Chairman of Z private hospital asserts that with respect to delusions, 1) highly intellectual patients feel that they are under the influence of electronic machines and X-rays, 2) for middle-educated it

is the radio, and finally, 3) for the illiterates (in most cases) it is sorcery and the sorcerers.

Cultural Change and Religious and Scientific Delusions

What is the influence of culture change on the content of delusions? Altnough the present project was not designed to investigate this problem, a discovery of the patients' book for the year 1907, when X state mental hospital was administered by British psychiatrists, made this feasible to the author. Religious delusions, and particularly delusions associated with bewitching and being in the power of the devil, have become more infrequent in 1971 just as are delusions based on the more primitive forms of magical thinking in general. This is obvious from the figures 75 per cent at the turn of the century (derived from the aforementioned patients' book) and 44 per cent for 1971 as illustrated in Tables 23 and 24. This reduced incidence might be correlated with the change in the position of religion in Egyptian life and thought. On the other hand, physical, chemical, or technical delusions have become more frequent along with the increasingly crucial role that technics play in present day Egypt and the modern conception of the world. This is indicated by the figures four per cent for 1907 (patients' book) and 14 per cent for 1971 (Tables 23 and 24). The delusions of the insane are merely the reflex or shadow of the prevailing beliefs of the age in which they live. In this comparative study of the delusions of the 1907 patients with those in 1971, the author is able to observe how the content of delusions presented by the psychotic of today is changing, obviously paralleled by changes in society and morality. Cultural patterns and prevailing conditions mold the symptoms, and cultural changes cause

changes in the content of the symptom; nevertheless, cultural patterns are not capable of affecting the structure of the psychosis itself.

Political Delusions

As regards political or authoritarian delusions, Table 24 makes a good case for the view that the expression of political authority in the content of delusion is significantly correlated with position in the class structure. This is indicated by the figures ten per cent, 20 per cent, and 32 per cent for the lower, middle, and upper class, respectively. Characteristic of this kind of delusion are the following:

1) A 35-year-old male who is an engineer and a member of a highly westernized family declares: "I was sitting in the White House (Washington) during the 1967 six-day-war and I used the hot line in talking with Mr. Kosygin. I predicted our defeat in this war before Mr. Hykal, the editor of Alahram newspaper, did."

2) A 23-year-old male and a graduate from the Faculty of Arts believes that he is a member of the Egyptian Detective Bureau. He used to go to big firms and ask the President to fire all young men who defected from the army in the 1967 war. Thus he would investigate the files of the employees and if he found any of these men he would give orders for the manager to fire them within two days. Following his orders the manager would fire them. He repeated this behaviour in ten big companies but was finally arrested.

3) A 33-year-old male and an associate professor in the Faculty of Law had prominent paranoid delusions which were directed against the university police authorities. He declares: "When I was coming from France one thousand Libyan military officers were waiting for me in the airport in order to ask about my opinion concerning the Libyan Revolution."

4) A 60-year-old male and a member of an aristovratic family (his uncle's cousin was a Vice President of one of the Prime Ministers) states: "I have been interested in politics since the 1919 Revolution. I found that the old politicians were corrupted and held false beliefs. In 1945 I established a political party, the Progressive party or the Anti-Corrupted and Faithful Group. [He was sentenced for three months in prison for this.] When the Revolution of 1952 first emerged I thought that the Leaders were sent by God to save the Egyptian people. But after a short period I realized that they turned to be new exploiters and new elites. For example, the late President Nasser aimed to establish an Arabic Empire. In 1967 he made a military demonstration. He never thought

that it would turn into disaster. As for President Sadat, he followed in letter and spirit the policy of Nasser. I would hold that direct negotiations with Israel would be more productive than indirect negotiations through U.N. mediator Gunar Yareng." *He sent letters to all the people who held the highest political offices criticizing them. All his money was spent on writing and printing political posters in which he criticized the government severely. When he was finally arrested the police found his pocket full of political posters. He said at this particular moment:* "I have achieved my mission."

By looking at the four previous delusions it is quite evident that political delusions involve a great deal of material of current interest. The recurring concern that pervades most political delusions was the 1967 war.

Delusions of authority have followed the changed political conditions to a surprisingly small extent; statesmen and politicians played scarcely any part in these delusions, whereas royal personages were encountered much more often. Thus there was only one case in which the patient declared that he was the president of the republic (Nasser). But there were several cases in which patients declared that they were members of the ex-royal family. This was a status problem. The king, though deposed, still enjoys a higher status than Nasser whose own humble origin is well known. Thus to identify with the royal family leads to a higher self esteem than identification with Nasser, the son of the postman.

The following delusions are examples of this:

1) A 25-year-old female patient claimed that she was the daughter of King Farouk. She gave orders to every other patient. She imagined herself sitting in the Royal Palace.

2) A 45-year-old male patient hears voices of Sultan Fouad telling him that he is Afandina "the heir of the throne" *while he hears women saying that he is to be killed. Sultan Fouad discusses with him his rights.*

Persecutory Delusions

The last point to be discussed with respect to the content of

delusions is the theme of persecution. There were 25 patients who expressed this theme in their delusions, with males showing a slightly higher frequency than females; the frequency among the three different social classes was constant.

Diagnostic Difficulties in Intercultural Situations

The problem of diagnosis is crucial to nearly any phase of the cross-cultural study of mental disorders. Research attempts to find "psychiatric cases" among the general population are intricate enough in Western society; they become challenging indeed when transposed to a culture radically different from the West. The language barrier, the different set of beliefs about etiology, and the variant expectations as to how a "deviant" person behaves — all of these things combine to present a serious challenge to field research in this area.

Psychiatrists working in a non-Western cultural context have to devote the greatest attention to cultural factors, otherwise they risk making regrettable errors. Wherever Western-trained psychiatrists have treated members of exotic cultures, they have often confused cultural practices with serious psychopathologic deviations. Many times only a close knowledge of the cultural conditions will enable the psychiatrist to ascertain whether an individual is normal or mentally sick and, if he is sick, to what extent. As an example of this consider the delusion of the 16-year-old lower class peasant (case No. 4 under *Religious Delusions*). It is obvious that the same clinical importance cannot be ascribed to his declarations as for a patient in the upper or middle class. A highly westernized upper class person who expressed belief in

sorcery of that kind would no doubt be considered a "serious case," whereas for a peasant it means he is entertaining a peripheral religious belief of which his ideology is characteristic. In a culture where everyone from time immemorial has ascribed disease to the influence of evil spirits and witchcraft, one must be very cautious before assuming that complaints of that order are delusions.

Such clinical manifestations must be looked upon as within the range of normal behavior. In this case the evidence of mental illness rests perhaps less on the patient's fear of sorcery than on his uninhibited way of expressing them in the presence of an upper class doctor. The author has attempted to indicate that the manifest behavior of this patient suggests that the causes of his anxieties are not of a different order than the culturally constituted fears of the general population. Thus the decision as to whether a patient is suffering from a delusion often hinges upon knowledge of the belief system of the group from which he comes.

With regard to case No. 4 (under *Political Delusions*) it is obvious that cultural divergence might enter into the evaluation of his mental illness. Suppose that a patient in a Western culture should bring identical complaints. Few psychiatrists would call them "delusions." But in an Egyptian, especially if he is highly intellectual and a member of an aristocratic family, things are not so easy to define. Nasser was the only leader the Arabs knew for many years, even though his authority was severely criticized — especially by the educated class — since the 1967 Six-Days-War. Thus, one must be cautious before assuming that complaints of that order are delusions. Perhaps the patient was really

afflicted with severe mental illness. Perhaps he was only a type of political innovator who was ahead of the historical age in which he lived.

In clinical practice, cases have turned up more than once that necessitated an evaluation of cultural factors in the formation of delusions. Some years ago a professor in Cairo University and a graduate from Cambridge, committed to X state mental hospital and thought to be suffering from private delusions, was discovered by a psychiatrist to be a progressive social reformer.

Cultural Interpretation of Delusions

With a skeletonized set of dominant themes in the content of delusions as indicated in Tables 23 and 24, it remains to account for the development of each kind. This can be put within Dunham's (1959:45) assumption that symbolic communication which has revelance in accounting for normal mentality and behavior, must also have some relevance in accounting for abnormal mentality and behavior. The detailed studies of brain-injured individuals have clearly documented the general thesis that, under the stress of illness, patients are concerned with their immediate life problems and that this concern is communicated in symbols (verbal, gestural, and acted out) that are part of early learned, preferred systems of intimate human communication (Weinstein, 1962). Thus, when a patient conceptualized his interpersonal relationships by saying that someone was killing him through sorcery, he usually came from a socio-cultural group where the belief in magic and witchcraft was an important vehicle for relatedness and communication.

The religious component in the culture of Egypt permeates the totality of life; it holds supreme sway over performance, thinking, and feeling. Religion is for the majority of the population the fundamental motivating force in most phases and aspects of culture, and it is in evidence in practically every act and moment of existence (Patai, 1962).

Religion, moreover, is an asset whose emotional value cannot be overestimated. It is a psychological factor of first magnitude, lending unfailing spiritual sustenance to all true believers. This holds good for all the religious denominations represented in Egypt inasmuch as they still live in small tradition-directed societies. Only in certain social classes of the larger towns, among whom Westernization and modernization have made considerable headway, does the hold of religion become weaker and the general orientation show a tendency toward secularism (Patai, 1962). This explains why religious delusions among the upper class are infrequent.

The prominence of the delusion of persecution by the father (23 per cent of the total delusions) can be interpreted along the same lines. The cultural values set great store on male parental or eldest sibling dominance. In Egypt, for instance, it was observed that "the undisputed head of the individual family is the father. He is treated with respect and deference, and even grown-up and married sons submit to his authority. Sons, daughters and wives kiss the hand of their father and husband" (Patai, 1962:89). The cultural values of the Egyptians thus were leading to the high frequency of this delusion of persecution, especially by the father.

Manic-Depressive Reactions

It is usually asserted that in Africa neither manic nor depressive psychoses are common and, when they do occur, manic states greatly outnumber depressives (Carother, 1953). In preliminary psychiatric observations in Egypt, Drs. Okasha, Kamel and Hassan could not confirm the above mentioned observations, as less than one in five of their manic depressives presented a manic picture. Some workers have denied the existence (in depressed Africans) of self-reproach and self-depreciation, but the experience of the above mentioned three psychiatrists indicates that these feelings are present but not a common feature of the illness. Neurasthenic symptoms and *hypochondriasis*, mainly directed towards abdominal organs and the skeleton, e.g., dyspepsia, distension, gastric discomfort, vomiting, nihilistic ideas, pains all over the body, and aches in the bones, were common. These symptoms are very characteristic of the depressed Egyptian. The positive diurnal rhythm of European depression has been encountered by Egyptian psychiatrists among their cases, but not highly represented. A neurotic overlay may color the picture, especially in that many cases do not show the sadness of mood so characteristic of depression in Europeans (Okasha, Kamel & Hassan, 1968).

The content of the delusions and the verbal expression of the Egyptian depressives seem to be greatly colored by their notion that the disorder is a spiritual or religious trial by God. Again, as in the case of schizophrenia, the symptoms are patterned according to the individual's social class. For example, an Egyptian female peasant said during the course of her depression: *"Ana Ashem Rehet El-Zaha,"* meaning she could

feel 'the smell of boringness.' This statement is closely intertwined with the belief in sorcery. If anybody attempts witchcraft against another person he will pour water on the ground around his house. In this case the mixture of the water with the dust would result in a particular smell which is called "*Rehet El-Zaha*" (the smell of boringness) in these rural areas.

Another example might show, as in the previous case, that the depression of the lower class patient is intrinsically interwoven with religion. The patient was a 30-year-old male who went to the minister of WAKF and said to him that Egyptian society was becoming corrupt and therefore he wanted to remedy the morals of the people. The minister pretended that he agreed with him but he informed the police. Shortly after, he was arrested while he was preaching in a crowd calling people to return to the original life of Islam.

Middle and upper class manic-depressive men and women, however, verbalize their symptoms in terms of economic and class conceptions of power. Thus, a 26-year-old upper middle class male who was passing through a manic phase squandered £ 400 freely on his pleasures because he managed to kill one of the politicians whom he hated.

B. Psychoneurosis

Analysis of the symptomatology of neurosis in Egypt should be a rewarding task as it seems likely on general principles that this should be somewhat different from that of neurosis in more industrial and urbanised societies. For example, phobic and depersonalized symptoms,

common in industrial societies, might be expected to be less common in rural Egypt. On the other hand, less sophisticated means of dealing with anxiety, such as conversion, might be expected.

Anxiety Neurosis

Anxiety neurosis represents one of the major components of psychiatric morbidity in Egypt. It is usually secondary to a conflict situation or to external events, being more common in single and unhappily married women. Patients usually come complaining of palpitations, choking sensation in the throat, shortness of breath, insomnia, and unpleasant dreams. These symptoms are patterned according to the individual's culture (Okasha, Kamel & Hassan, 1968). Patients from the village, for example, describe their psychogenic impotence within the framework of the condition of *Rabt* (see Appendix 5).

Hysteria

Hysterical symptoms are perhaps the most common neurotic manifestations in Egypt. Previous authors in Africa have surveyed hysterical illnesses in their countries, e.g. Lambo (1955, 1956). In 1960, Lambo stressed that periodic somatic disabilities and the massive hysterical disabilities of fluctuating intensity were characteristic of the primitive African in contrast to the monosymptomatic type of hysterical reaction of the westernized African.[4]

(Okasha (1967), presenting symptoms in a study of hysteria in Egypt among 100 females and 50 males, demonstrated that these were multiple rather than monosymptomatic. Motor disturbances in the form

of paralysis was more common in males (18%) as compared with females (8%). Hysterical fits, on the other hand, were more frequent in females (28%) than in males (4%). Other motor manifestations were not uncommon, e.g. spasms, tremors, aphonia, bizarre gait, and *globus hystericus* (Okasha, Kamel & Hassan, 1968).

Vomiting was more frequent among females during the sexual act with their husbands, especially among wives who marry against their own will.

Dollard and Miller (1950) have pointed out that psychoneuroses involve learned behaviors, which are reinforced by environmental influences. The Egyptian data fit this theory well. Adult patients in this country have chiefly those neurotic symptoms which were socially acceptable in their culture. If this sociocultural learning theory is applicable to psychoneuroses, it can explain why hysterical delirium is more frequent in females (20%) than in males (5%). The Egyptian culture generally sanctions the freer expression of emotions and sadness during funerals by women than by men. Thus an Egyptian woman, especially if she encounters a traumatic situation like the death of father or son, will wail, tear clothes, shriek wildly, or beat her face in lament. It is customary for women to wail during the mourning period prescribed by their culture (every Thursday). If they do otherwise they would be accused of being cold and having no sensitivity. (See Appendix 4).

The dynamic picture of hysterical delirium will be illustrated by a case summary. Names and other identifying information are fictitious. The following case is presented as it was told by an Egyptian psychiatrist:

Housewife, Age 40 *Diagnosis: Hysterical delirium*

I was asked to go to help a woman in her house. Her relatives complained that following the death of a male relative the patient was very sad and refused to take any food. She used to spend her time alone in her room. When she was beginning to recover she suddenly felt pressure and pain in her head. This was followed by a fit of great excitement in which she indulged in frantic movements and worked into a state of frenzy, crying and beating her face. This lasted for nearly ten minutes, and was followed by a deep sleep. This hysterical delirium continued to attack her every day at 7 o'clock in the evening. When I asked her about her complaint she said that she knew nothing about these fits of excitement. The patient was given a physical examination which showed that her body was functioning in a normal way. Thus I concluded that her symptoms represented hysterical delirium.

In this case, the wailing, crying, and self-beating were the most common symptoms. The culture of Egyptian women is conducive to such displays of sentiment. From early infancy these patients are apt to have seen women flying into a frenzy, throwing themselves onto the ground, and beating their faces with their arms in reaction to the death of relatives.

Hysterical illness in Egyptian culture, especially among the majority of lower classes and some of the middle classes, is attributed to spirits, witchcraft, and the evil eye. These patients are looked after by native healers and through certain traditional cults such as the *Zar* Cult described in Appendix 5 (Okasha, Kamel & Hassan, 1968).

Obsessive Compulsive Neurosis

Obsessive rituals related to cleaning are the most frequent form of compulsion. This may be attributed to the fact that cleaning plays an important role in Moslem religious rituals. Underlying many facets of Arab culture, there is concern with cleanliness. The rules of cleanliness by water, associated with the five daily prayers, are exacting. After every urination, defecation, menstruation, and sanctioned sexual practice the Moslem has to achieve ritual purification through the use of water.

Examples of this cultural symptomatic picture have been related by some psychiatrists:

1) A housewife used to put her children in the bathroom for cleaning throughout the whole day. This affected their physical health. Her compulsion was extended to washing every item in the house, like the telephone, radio, T.V. Her husband screamed in front of me that she ruined his life. She had destroyed the furniture through washing.

In general, the obsessive compulsive neurotic cases were colored by cultural factors. Thus, in a case which the author studied:

2) A clever and successful young man, an honor student in the Faculty of Engineering, suffered from a severe obsessive neurosis. For two years he had been haunted by the idea of the evil eye. He was afraid lest other people should envy him.

This clinical picture from a married woman is related by one psychiatrist:

3) A 35-year-old housewife was obsessed by the idea of the high probability that her husband was her brother by nursing. Her husband tried to convince her to get rid of this absurd idea. She herself realized that her fears were probably ridiculous. Still, she could not shake them off.

Again, we must not underestimate the importance of cultural factors in the coloring of this clinical picture. In the culture of the Middle East it is strictly taboo for a girl to marry a brother by nursing,[5] as it is prohibited by Moslem religion.

C. Summary

To summarize, it seems that although cultural difference adds to rather than subtracts from an already complex set of problems, it does not appear to present insuperable difficulties. It looks as though the Western psychiatric classifications can delineate Egyptian psychiatric cases. Although the content of symptomatology may be different from that

of European and other American psychiatric illnesses, most of the illnesses can be grouped under the same psychiatric nomenclature.

By and large, the similarities in psychiatric disorders in Egyptian and Western societies are much more impressive than the differences. In view of the contrast between the cultures and life situations, this is truly remarkable. The similarity applies to pattern quality (anxiety, depression, hysteria, etc.). The author draws attention to the similarities for two reasons. The first is that many people have emphasized strongly that cultural differences must mean major differences in psychiatric disorders — an expectation that is doubtless due in part to theories of personality and culture. The second is that the literature on psychiatric disorder in Africa, based on hospital statistics, gives much emphasis to differences (Carothers, 1953).

While the present study does not demand a swing from one extreme to the other or eliminate the view that culture is important in the origin, course, and outcome of psychiatric disorder, it raises some question as to whether the emphasis on cultural difference has been overdone. Perhaps a more balanced approach is appropriate, and the "why" of similarities now emerging is just as interesting as the "why" of difference.

The analysis also shows that the content of the symptomatic picture varies directly in relation to social class. There appears to be an interesting difference in the content of the delusions associated with such social differences. In most cases the delusions of middle and upper class patients — the highly westernized — are not very different from similar delusions observed in European or American patients. On

the other hand, the delusions of the lower class — the least westernized — are derived from traditional cultural ideologies. This difference in content is probably a function of the difference in cultural milieu.

In discussing this relationship between environment and mental illness, authors like Stanton and Schwartz (1954), or Fromm-Reichman (1960), have discussed patients' reactions to ways of handling them, to interaction processes on the ward or to different psychotherapeutic approaches. These authors concede a general validity to the idea that no patients, not even schizophrenics, live in a cultural vacuum.[6] But the related thought that the course of illness and the very structuring of personality bear a cultural imprint is neglected in the literature (Opler, 1967:302). Three cultural aspects of the delusions (Table 24) discussed so far show inner consistency and integration which constitute two different colors of the schizophrenic clinical picture for the lower and the upper classes. Psychiatrists, in treating each type, can be more effective if they understand these functional linkages between socio-cultural variables and personality. Important in the psychotherapy which accompanies and vitalizes such methods will be the joint contribution, no doubt, of psychiatry and anthropology. The former is expert in the guidance of the individual case, and the latter is helpful in indicating the types of family organization and social experience which influence all behavior, normative or pathological (Opler, 1959:440). Future research in psychiatric anthropology is now required on various mental disorders, and it is hoped that further explorations of this type will be carried out elsewhere.

FOOTNOTES

In Chapter I

[1]As opposed to voluntary dropouts or the shaman who plays a behaviorally deviant *role*.

[2]Except in the case of an organic psychosis which leaves some kind of neurological trace, this dissertation, however, is concerned with mental disorders of the functional variety.

[3]*Epidemiology of Mental Disorder*, New York: Milbank Memorial Fund, 1950.

[4]*Interrelation Between the Social Environment and Psychiatric Disorders*, New York: Milbank Memorial Fund, 1953.

[5]Kubie, L.S. Quoted in *Social Class and Mental Illness*, Hollingshead and Redlich (eds.), New York: John Wiley & Sons, Inc., 1958, p.10.

[6]Leighton, Lambo and others, *Psychiatric Disorder Among the Yoruba*. Ithaca, N.Y.: Cornell University Press, 1963.

In Chapter II

[1]E.W. Lane, *Manners and Customs of the Modern Egyptian*. London: The Adline Press, 1954, p. 304.

[2]Magic and wonder-working powers of magicians have been mentioned and emphasized in the Koran (Pickthall, 1930 CXIII:5). See Appendix 4.

[3]An amulet written as a protective measure against the evil eye. The most esteemed of all *"hegabs"* (or charms) is a *"mushaf"* (or copy of the Kur-ân).

[4]Some Egyptian mental patients in X state mental hospital believe that sadness is the cause of their mental illness. Typical of their statements is the following said by one patient: "Damn the sadness which brought us here."

[5]E.W. Lane, *op. cit.*, p. 234.

[6]R. Patai, *Golden River to Golden Road*, Philadelphia: U. of Pennsylvania Press, 1962.

[7]Patai, *op. cit.*, p. 99.

[8]Robert Tignor, *Modernization And British Colonial Rule In Egypt, 1882-1914*. Princeton, N.J.: Princeton U. Press, 1966, pp. 254-255.

[9]Quoted in Tignor, 1966.

(Chapter II, cont'd)

[10]On March 31, 1969, the Egyptian government made a festival to celebrate the 50th anniversary of the participation of the Egyptian woman in public life. According to Hidiya Barakat, who was one of the first pioneers who participated in this revolution and who died suddenly on the day of the ceremony, "The Egyptian women participated in demonstrations during the 1919 revolution. However, tradition did not permit them to shout. They only raised posters in which they expressed their indignation. In their demonstrations they were wearing the veil. Sàd Zaghlul (the leader of 1919 revolution) was the first to unveil the face of an Egyptian woman during a political meeting in 1919. He said to the Egyptian women who attended this meeting: 'It is irrelevant for educated ladies like you to wear the veil.'"

[11]*The Times Book of Egypt*, Special Number published by the *Times* of London, 1937.

[12]*Op. Cit.*

[13]*Op. Cit.*

[14]*Ibid.*

[15]P.G. El Good, *A Brief History of Egypt From Ancient To Modern Times.* Cairo: Dar El Nahda, 1949.

[16]National Charter, Ministry of National Guidance, State Information Service, May 21, Cairo, U.A.R.

In Chapter III

[1]The main reason for the selection of this topic is that the author spent his army service as an observer in the Egyptian General Military Hospital where his function was to write up records about mentally disturbed soldiers. Thus, he already had some familiarity with the symptomatology and etiology which might prove to be helpful in this systematic analysis.

[2]"X Hospital" population is drawn from Cairo and Upper and Lower Egypt, whereas the population of Alexandria State Mental Hospital is drawn from Alexandria and its immediate surroundings.

[3]"Z Hospital" treats patients from the whole area of the Middle East.

[4]On visiting days, anthropological field surveys were used including discussion with the patients' relatives about their beliefs in sorcery, *rabt*,

(Chapter III, cont'd)

evil eye, spirits, ghosts, and particularly traditional theories of the causes of mental disease. These surveys were aimed at providing a sketch of Egytpian beliefs about illness in general and mental illness in particular.

In Chapter IV

[1]J. Dollard, 1935, p.8.

[2]According to the author's system of categories for scoring the manifest content of the life histories, it was hard for him to find many stressful situations in the upper middle and the upper classes. As an example of this is the professor in the Faculty of Medicine who was a member of an aristocratic family and whose father pushed him during his adolescent period to become a medical student. This patient did not see this parental pressure as a kind of stress.

[3]In deciding on the age of 29 for distinguishing between young and old, the author was greatly influenced by the way official statistics divide the population of institutionalized patients. According to these statistics, the age groups of treated patients are as follows: 0-9, 10-19, 20-29, 30-39, 40-49, 50-59, 60-69, and 70-79.

[4]Tables 6, 7, and 8 permit a closer inspection of the amount of stress which the average member of the above mentioned twelve categories bears. At the bottom of each N. column are shown the sum total of themes of stress expressed in the life histories of each of these categories. Not only do the columns show the number of themes of stress expressed by the members of each of these categories, but, what is more important, the average number of themes of stress per patient is also shown. The total percentage at the bottom of the % columns is the same as the average number of themes of stress per patient if you divide it by 100. These averages range from a high of 5.99 in the case of the young lower class women to a low of .7 in the case of old upper class men. Here it may be seen that the highest amount of stress expressed in the life histories of patients occurs in the lower class young women and the lowest in the upper class old men.

[5]A study done by the author in the small town of Sherbine in 1958 shows that there were 290 divorces per 1,000 marriages.

[6]Cynthia Nelson, 1968.

(Chapter IV, cont'd)

[7]The desire of non-Egyptian Arabs to marry Egyptian girls increased tremendously since June, 1972. This is expressed in the Egyptian notary department. Until the 16th July, 1972, 1850 cases of marriage were registered for 1972. The average number of marriages for each month is 300. The difference in age between married partners ranges from 24 to 55 years. Typical of such marriages is a bridegroom from Kuwait, born in 1898 (the Nineteenth Century, his age was 74 years at the time of his marriage) and married to an Egyptian girl born in 1953 (19 years old). Another example is a bridegroom from Abou Zaby born in 1910 (62 years old) who was married to a girl born in 1946 (26 years old). *Alachbar Newspaper*, July 16th 1972.

[8]Nelson (1968), p. 23.

[9]Quoted in R. Patai (1962:121).

[10]Fulanian (1928) , pp. 251-273.

[11]Dickson (in Patai, 1962:162-164).

[12]Nelson (1968), p. 21.

[13]Patai, 1962.

[14]Erich Fromm, in A. Lynch (1958:302).

In Chapter V

[1]Silvano Arieti makes this reference in his paper "Manic-Depressive Psychosis" which appeared in Vol. 1 of *American Handbook of Psychiatry*, New York: Basic Books, Inc., of which he was editor.

[2]The First Clinic of Drug Addiction presents its report by Dr. Adel Zaky and Dr. Gamal Maady Abou el Azaim, in a paper submitted to the 1st Arab Congress on Mental Health, Cairo, 28-30 December, 1970.

[3]M.I. Soueif, *Bulletin on Narcotics* XIV(2).

[4]Personal communication with Dr. Gamal Maady Abou el Azaim and Dr. Helmy Ghaly.

[5]El Achbar Newspaper.

[6]United Nations, World Health Organization, Epidemiological and Vital Statistics Report, Vol. 9, No. 4 (1956).

(Chapter V, cont'd)

[7][Men Al Abwab Al Mochlaka Ela Al Bab El Maftoh.] *Abbassiya State Mental Hospital From the Closed to the Open System.* Cairo. 1969.

[8]Federal SEcurity Agency, Public Health Service, *Patients in Mental Institutions.* (Washington, D.C.: U.S. Government Printing Office), Public Health Service Publication No. 89, Table 8, p. 38; and No. 233, 1952, Table 8, p. 39.

[9]The high prestige Egyptian old people enjoy and the communal support they receive are validated by the sacred literature. In many Koranic references there is a sense of duty to the family. The following are some Koranic references.

> And we have enjoined upon man concerning his parents — His mother beareth him in weakness upon weakness, and his weaning is in two years — Give thanks unto Me and unto thy parents.

Or this statement from another chapter in the Koran:

> Say: Come, I will recite unto you that which your Lord hath made a sacred duty for you: That ye ascribe no thing as partner unto Him and that ye do good to parents.

The most prophylactic measure against senile psychosis is given in the following statement from the Moslem Holy Book and in another section:

> The Lord hath decreed, that ye worship none save Him, and (that ye show) kindness to parents. If one of them or both of them attain old age with thee, say not "Fie" unto them nor repulse them, but speak unto them a gracious word. And lower unto them the wing of submission through mercy, and say: My Lord: Have mercy on them both as they did care for me when I was little (*The Glorious Koran*, translated by Pickthall:1930).

In Chapter VI

[1]Otto Fenichel, *The Psychoanalytic Theory of Neurosis.* New York: W.W. Norton & Co., 1945, p. 415.

[2]*Mental Disorders, Diagnostic and Statistical Manual* (Washington, D.C.: American Psychiatric Association, Mental Hospital Service, 1952), p. 26.

[3]The African Mind in Health and Disease, *World Health Organ. Monogr. 17,* Geneva, 1953, p. 220.

(Chapter VI, cont'd)

[4]T.A. Lambo (1960). *British Med. J.*, ii, p. 1966.

[5]A brother or sister by nursing is a child, not related, who is nursed by a mother along with one of her own children.

[6]See Opler, M.K. 1967, pp. 282-303.

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APPENDICES

APPENDIX 1

Theme	Frequency
1. *Fear*	
a) of being killed	97
b) other	40
Total	137
2. *Jealousy*	
a) in a marital situation	169
b) other	35
Total	204
3. *Hatred*	
a) of one's spouse	180
b) other	30
Total	210
4. *Loneliness* (Patient referred to one of the following situations in which he was deprived of a love object and thus he felt lonely.)	
a) Death of parent(s), or wife	150
b) Separation, desertion, divorce, hospitalization, institutionalization of parent(s)	123
c) The rearing of the patient away from the parental home	46
Total	319
5. *Persecution*	
a) by a step-parent	197
b) other	34
Total	231
6. *Physical Beating*	
a) by a parent	180
b) other	75
Total	255

Appendix 1 (Cont'd)

Theme	
7. *Sexual Guilt*	
a) masturbation	201
b) other	68
Total	269
Government confiscated his (or her) money	5
Son does not want to marry for the sake of his mother and feels sexually frustrated	9
Unhappy because of use of birth control	10
Mother unhappy because of her daughter-in-law	12

APPENDIX 2

A) According to E. Lane's book, which was edited first in 1908, the expression of sadness for women takes extreme form. The author believes that this picture is still applicable among Egyptian women of the lower order.

> Even before a person dies the women of the family, at the same time, raise the cries of lamentation called "welweleh" or "wilwal" uttering the most piercing shrieks, and calling upon the name of the deceased. The most common cries that are heard on the death of the master of a family, from the lips of his wife, or wives, and children, are "O my master!" (Ya seedee) "O camel of the house!" (Ya gemel el-beyt) (that is, "O thou who broughtest my provisions, and has carried my burdens") "O my lion!" "O my glory!" "O my resource!" "O my father!" "O my misfortune!" . . . The women continue their lamentations; and many of the females of the neighbourhood, hearing the conclamation, come to unite with them in this melancholy task. Generally, also, sometimes the family of the deceased send for two or more "neddabehs" (or public wailing-women). Each neddabeh brings with her a "tar" (or tambourine), which is without the tinkling plates of metal which are attached to the hoop of the common tar. The neddabehs, beating their tar, exclaim several times, "Alas for him!" — and praise "his turban, his handsome person," etc., and the female relations, domestics, and friends of the deceased (with their tresses dishevelled, and sometimes with rent clothes), beating their own faces, cry in like manner, "Alas for him." (1954 edition, pp. 517-518).

B) According to H. Ammar, whose book *Growing Up In An Egyptian Village* was published in 1966, the Egyptian woman is expected to express her sadness in an extreme way. As he puts it:

> The difference of 'ethos' between the two sexes reflects itself in their public attitudes towards a person's death. While the men solemnly gather in the guest house for the obsequies, and public demonstration of weeping is only expected from them on their return journey to the guest house, after the burial, the women express their grief in almost hysterical weeping, wailing and dirging (p. 122).

APPENDIX 3

Socio-Economic Index*

Patients are placed in classes by the author's Socio-Economic Index. This index is premised upon three assumptions: 1) that social stratification exists in the Egyptian society, 2) that status positions are determined mainly by a few commonly accepted cultural characteristics, and 3) that items symbolic of status may be combined by the use of statistical procedures so that a researcher can quickly, reliably, and meaningfully stratify the patients.

In determining a patient class affiliation at the time of field research, three coordinates were used: his education, his occupation, and whether he is resident in the private or the state mental hospital (and, if he is in X state mental hospital, what grade he is in). Each of these attributes was divided into five parts, with corresponding scores ranging from 1 to 5. Below are the details of the procedure.

Education	Score
Illiterate	1
Completed primary school	2
Completed preparatory school	3
Completed secondary school	4
College completed	5

*The author's index of socio-economic status is a modified version of Hollingshead's Index of Social Position. Hollingshead *utilizes ecological area of residence, occupation, and education* to determine an individual's class status. The author did not use the ecological area as he found it extremely difficult and inapplicable in the Egyptian case. Also, he found the grade in which the patient is treated more meaningful and practical as a means of determining social position.

Appendix 3 (Cont'd)

Occupation*	Score
Unskilled labor, landless farmer	1
Skilled manual labor, small owner farmer (owning 5 to 10 acres)	2
Clerical (low), farmer (owning 11 to 20 acres)	3
Low managers and officials, professionals (employed), officers of middle rank	4
High income businessmen, managers, self-employed professionals, officers of high rank	5

*In case the patient is a student, the author considered the occupation of the head of his family.

Class in Hospital	Score
Third class in X state mental hospital	1
Second class in X state mental hospital	2
First class in X state mental hospital	3
Economic class in X state mental hospital	4
Private mental hospital	5

The combined scores with respect to education, occupation, and grade in the hospital were used to determine each patient's class affiliation. A total score up to 6 placed him in the lower class, a score of 7 - 10 in the middle, and 11 - 15 in the upper class.

Explanation as to why the author did not use education, occupation, and rate paid at the hospital as independent variables rather than the composite of these, is that in most cases these three variables were co-related. A highly educated person, for example, usually ranks high on

Appendix 3 (Cont'd)

the occupational scale and pays a high rate in the mental hospital, and the reverse is true for an illiterate person. Another reason is that there have been several researches which demonstrate the relation between social class and mental illness in Western society (see Hollingshead and Redlich, 1958). So the question will be: does the apparent influence of social class hold up cross-culturally?

APPENDIX 4

Surah CXIII from the Koran:

Revealed at Mecca sanctions the belief in the evil eye.

In the name of Allah, the Beneficent, the Merciful:

Say: I seek refuge in the Lord of the Daybreak.

. . . From the evil of malignant witchcraft,

and from the evil of the *envier* when he envieth

(The Glorious Koran: Pickthall 1930:677).

APPENDIX 5

Egyptian Systems of Treatment

There are a set of organized systems for dealing with cases of mental sickness among the Egyptians. They fall into two types: Egyptian and Western. Some of these systems are formalized to the point of specialized personnel, facilities, and organizations in a legal sense; others are less obvious to the observer and tend to operate on an informal, face-to-face basis.

So far the author has discussed the Western type of treatment and sanction system. The system with a much longer tradition is the Egyptian ceremonial. There is a rich body of ceremonial in Egyptian culture, and most of it is directly concerned with curing mental illness and giving positive protection against misfortune. In the following lines the author describes two ceremonial treatments: the *Zar* cult concerned primarily with healing women, and the ceremonial treatment of the condition of *Rabt*, a disease which afflicts Egyptian men.

The Egyptian Women's Ceremonial

The ethnographic description of the *Zar* cult which follows is based on a field research made on the Egyptian woman by C. Nelson. The results of this study were summed up in a paper entitled "Self, Spirit Possession and World View: An Illustration From Egypt," presented at the Burg Wartenstein Symposium, summer season, 1968. In this paper, Nelson as a cultural anthropologist explains the *Zar* cult in terms of its regular social function and sees in the *Zar* ceremonial a legitimate and recognized outlet for airing the grievances of the Egyptian woman who — in Egyptian

society — is placed at the bottom of the scale.

In addition to Nelson the author also relies on another research conducted by Dr. A. Okasha: "A Cultural Psychiatric Study of El-Zar Cult in U.A.R.," published in the *British Journal of Psychiatry* in 1966. The latter report is a descriptive psychiatric evaluation of the *Zar* ceremonial as seen through the eyes of a psychiatrist trained in a Western medical context.

According to Nelson, the central idea underlying the *Zar* phenomena is the common belief that there exist a certain number of spirits that roam around on the surface of the earth. These spirits have the power of causing disease or unhappiness among human beings and are variously called *shaytan*, *afreet*, *jinn*, *asiyad*, and *zar* (Nelson, 1968). Belief in such spirits has sanction in the Koran which actually mentions the *jinn* in certain *surahs* (Dawood, 1959, in Nelson, 1968). As one informant said, "Surely these spirits belong to God and it is therefore not a sin to believe in them" (Nelson, 1968).

In the *Zar* Ceremony particularly, these demonic powers of evil, when they enter into the body of a person, especially women, are referred to as *asiyad* (masters), not as *jinns*. These spirits secretly enter the body of the victim for reasons that are not always clearly understood by the person, but usually the explanation is given that the subject has in some way annoyed the spirits who are constantly in the vicinity of human beings. They are considered harmful to persons they possess until their desires are fulfilled. Therefore, the person must always take good care not to "make the spirits angry." Once these spirits enter the body they cannot be gotten rid of but can only be pacified by the performance of a

Zar Ceremony which has as its avowed purpose soothing the spirits and persuading them not to do any harm to the possessed person. The spirit may enter and leave the body at will but the essential belief is not one of exorcism but of pacification (Nelson, 1968).

Following Egyptian belief, the curing ceremonial of the *Zar* is directed toward the etiological factors held responsible for the patient's condition, rather than toward the physiological or psychological symptoms of the disease itself.

Consequently it has been noticed that when some patients become ill and cannot find a cause for their illness, they attribute it to the *jinn*. So they seek treatment from the *Zar* healers, who are usually well known among the people, and a simple form of psychotherapy is conducted. The healer may tell the "client" to perform a one-day, three-day or seven-day treatment which might be held in a private home or at the house of the *kodia*. (A traditional healer who performs the *Zar* ceremony in hope of persuading the spirits not to do any harm to the possessed. In most cases the *kodia* is a woman [Okasha, 1966].)

Description of Zar Ceremony

Zar ceremonies vary in certain detail according to whether they are private or public, but in all cases the major elements include: the possessed person(s); the *kudiya* or *shaikha* (usually a woman but sometimes a man, who by knowledge and ability is able to designate the spirit or spirits who entered the patient's body); the *Zar* conductor and his assistants — tambourine players and dancers; and the spirits who, although they lack a physical aspect, can be identified according to their names (Nelson, 1968).

There are certain devices which usually accompany this kind of performance. These are contrived and prepared by the *kodia* herself. They consist of providing the necessary items for the meeting, namely: a large brass tray bordered by seven candles on which are presented all kinds of sweetmeats including dates and oranges, beverages of all kinds to refresh the guests, and one or two sheep or turkeys which are brought alive and slain near the end of the performance (Okasha, 1966).

The *kodia* and the spectators usually seat themselves cross-legged on the ground. The conductor of the *Zar* intones the wearisome, monotonous traditional songs, while the dancers revolve around urging those present to follow their example. The "possessed," dressed in long snowy white garments, takes hold of the sheep and leads it several times around the brass tray (Okasha, 1966:1217). The music becomes faster, the drums louder and the flutes higher until a primitive ecstasy dominates the gathering. The woman is believed to enter a trance at this point. When a woman goes into a trance it is described as "lending her body to the master" (Nelson, 1968). When all have fallen, the music comes to a stop. The *kodia* approaches each one in turn, takes hold of her wrist and enjoins the devil present in her body to state his origin and his demands (Okasha, 1966:1217).

The *kodia* alone can hear the devil's answer, and according to her, he may be either a Christian or a Mohammedan. Consequently, either a cross or a crescent is drawn on the gown of the possessed with the blood of the slain sheep. A silver coin is dipped in that same blood and later given to the possessed, who will have it bound in a leather case and wear it always as a charm (Okasha, 1966:1218). Finally, the *kodia* bids the

devil leave his victim in peace, promising to comply with his wishes. A pottery jar is put in the centre of the room and the devil is supposed to make his exit through the jar, thus breaking it. When the possessed is rid of her devil, she is awakened (Okasha, 1966).

This ceremony is also performed as a means of delivering more than one person "possessed" at the same time, and often includes the guests in its cleansing ritual.

The Influence of Culture on the Zar Ceremonial

In regard to the "cult of *El-Zar*," the influence of culture is manifested in a twofold way: a) by the ceremonialization, i.e., the sociopsychological and cultural pattern given to the abnormal manifestation (as though it were a dramatic plot already written, where the chief actor has learned his role well, or a ceremony whose details are ruled by tradition), and b) by the element of permissiveness conferred upon the manifestation by the given culture. It is significant that the *Zar* is now disappearing, just after the government policy began to suppress its very occurrence.

The Egyptian Social Structure and the Zar Cult

Nelson pointed out clearly that through the *Zar* Ceremony, the woman can express herself in ways that are not open to her or even acceptable in the larger social structure. Coming from one who is socially placed at the bottom of the scale, legally and religiously equal to only 'half a man,' and ritually the source of contamination by only the touch of her finger, such a cult is a means of both curing her grievances obliquely and gaining some personal satisfaction in an otherwise

insecure marital relationship. The category of persons most often found at *zars* are married women who express that they are neglected and abused by their husbands. The *Zar* cult makes it possible for persons suffering from status deprivation and generally females (who are normally received with much less enthusiasm at birth than are males) to experience the highly desired honors accorded a bride. The *Zar* cult originated, thus, as an exclusively female activity and is exoterically referred to as such by the male segment of society (El-Shamy, 1972:22-23).

An Evaluation of the Zar Cult by a Modern Psychiatrist

An evaluation of the *Zar* cult has been made by Dr. Okasha (1966) who is himself a psychiatrist trained in a Western medical context ("A Cultural Psychiatric Study of El-Zar Cult in the U.A.R.," *British Journal of Psychiatry*, 112, 1966). He conducted a study of 100 Egyptian women attending *El-Zar*. Their ages, marital status, levels of education, and diagnostic entities were evaluated. A full psychiatric history was taken and an examination carried out on every patient, and the results were evaluated. The study reveals that most of these patients were psychoneurotic. The majority (40%) had hysterical reaction, 16 per cent had organ neurosis mainly manifest in the gastro-intestinal tract. Bizarre symptoms of endogenous depression and involutional melancholia or menopaysal syndromes were attributed to parapsychological phenomena and patients used to attend *El-Zar* to be relieved of their symptoms. Dr. Okasha could find no abnormal psychological symptoms in eight per cent of his series; these ladies used to accompany their friends and relations as a prophylaxis against future illness. Table 25 expresses the diagnostic pattern of these patients.

Table 25. *Diagnosis of Patients Attending* El-Zar *Cult in Egypt**

Diagnosis	Percentage
Anxiety State	8
Hysteria	40
Involutional Melancholy	6
Endogenous Depression	6
Schizophrenia	5
Menopausal Syndrome	6
Obsessive Compulsion	4
Organ Neurosis	16
Gilles de la Tourette Syndrome	1
Normal	8
Total	100

*Source: Okasha, 1966.

The Healing Effects of the Zar Cult

A final word deals with the healing effects of the *Zar* cult. Despite the complications of the *Zar* ceremonial practice and the problem of comparisons with the nosology and approach of Western psychiatry, the fact remains that *Zar* ceremonials are used in cases of mental illness and misfortune to bring about a return to equilibrium and stability in the situation. Leighton and Leighton (1941) have commented on the psychotherapeutic features of such religious practices no matter what the specific disease syndrome may be; and Reichard (1950) (in Okasha, 1966) has stated her belief that the psychological effects are the only real therapy involved. There are many factors which accumulate to give the *Zar* cult its healing properties for those who have faith in such forms of therapy.

Pavlov's observations of the effect on his dogs of accidental occurrences, as during the Leningrad flood in 1924, gave him the clue to how the brain might be wiped almost clear, at least temporarily, of all conditioned behavior patterns recently implanted. Application of these findings to the mechanics of many types of religious and political conversions in human beings suggests that, for conversion to be effective, the subject may first need to have his emotions worked upon until he reaches an abnormal state of anger, fear, or exaltation during which he becomes suggestible (Sargant, 1957, in Okasha, 1966). Or a sudden complete inhibitory collapse may bring about a suppression of previously held beliefs. The same phenomena will be noted in many of the more successful modern psychiatric treatments. All the different phases of brain activity, from an increased excitement to emotional exhaustion and collapse in a

stupor, can be induced either by psychological means or by drugs, electric shock treatment, or insulin coma. The best results occur from inducing states of protective inhibition by continuing artificially-imposed stresses on the brain until a collapse or stupor is reached, after which it seems that some of the abnormal patterns may disperse and healthier ones may return (Okasha, 1966).

This is usually what happens in *El-Zar*, according to Dr. Okasha. The drums and dancing induce a state of nervous excitement and the patients are worked into frenzy, exhaustion, and finally collapse, followed by the paradoxical inhibition, after which they lose many of their abnormal patterns and gain the return of their healthier ones. Apart from this physiological explanation, Okasha found that individuals attending *El-Zar* go into different phases which help in the final ceremony and their symptomatic relief. These steps were summarized by Basheer (1966) (in Okasha, 1966):

1. Good initial preparation by the usual cultural traditions, and conviction that this is the only means of abolishing their symptoms.
2. Full confidence and faith in this line of treatment.
3. The experience of the native healer in dealing with such "clients."
4. The continuous group involved and the use of this group in establishing mass excitement and suggestion.
5. Full use of musical and sensory stimulation which excites the C.N.S. [central nervous system].
6. Identification with saints and other historical and religious personalities.
7. Dramatization.
8. Meaningful utterances and suggestions during their dissociative phases after collapse.

Although this line of therapy is based on no modern scientific grounds, yet it exploits the general psychotherapeutic principles of reassurance, persuasion, suggestion, abreaction, acting out, dream interpretation, individual and group therapies. Thus it reduces emotional tension, relieving certain symptoms and producing social training and hopeful outlets (Basheer, 1966, in Okasha, 1966).

The Egyptian Men's Ceremonial

A brief description of the condition of *Rabt* is presented in the following lines. This is followed by a description of the traditional ways of its treatment. This disease is prevalent in rural and urban slum areas. Among these natives we often hear about what they call "*Rabt*," that is, if someone should take some hair or other material from the body of the victim and put it in a grave while reading some verses of the Koran, the victim would lose his sexual potency. Or someone might hire witch doctors to write an amulet to make his enemies sexually impotent. For example, if an Egyptian peasant married his cousin who was engaged to another person before him, he would from the very beginning of his marriage feel afraid lest the other person should retaliate through the process of *Rabt* and consequently would deprive him of his sexual capacity. This feeling would increase if the young man might have heard too much about many such incidents during his childhood and adolescence. Furthermore, the Egyptians themselves are able to point out plenty of tangible empirical evidence that supports the interpretation of the realities that their culture imposes upon their minds.

In addition, a friend might tell him that other people were speaking about him. In this cultural setting the fear of *Rabt* (losing erection)

would be prevalent. This culturally conditioned attitude towards sexuality is a disruptive force leading to the sexual dysfunctioning of the individual.

There are other etiological factors at work, paramount among which is the way the marriage is ceremonialized in Egypt. At this public ritual, in which the entire community is witness, the young man has sometimes to copulate with his bride in the presence of some other women (usually the relatives of the bride). In the meantime the public outside the room would knock at the door and shout in order to make the bridegroom hurry. This situation might also make the young man fail in performing the sexual act.

Traditional Psychotherapeutic Ways of Treating the Rabt

There are different traditional psychotherapeutic ways of treating the *Rabt*. The patient asks the help of a traditional healer who would bring a specialized person to discover the hidden material. It is believed that once these materials are discovered the victim can regain his normal sexual functioning. A conjurer may be hired to discover the person responsible and measures taken to counteract the evil influence.

Or the traditional healer measures the handkerchief of the patient. He says to the patient that the amulet was written on a piece of bread swallowed by the whale of the sea. "We cannot destroy this amulet unless we bring the same whale," which the healer describes in great detail. He charges him a certain amount of money as his fee for seizing this whale. After a period of time this specialist brings a fish with a piece of bread bearing some writings. He visits the patient offering this fish. When the patient opens the mouth he finds the piece of bread.

Seeing the piece of bread the patient believes the traditional healer's statement. As a result of such belief the patient starts to get better.

Another way of traditional healing is to write some verses from the Koran on a cup which the patient uses in drinking. Also, the psychotherapist can half-boil an egg and write on it this statement: "There is no God but Allah and Mohammed is his prophet." The patient has to swallow the egg so that it might reach his stomach intact.

It is interesting to note that there are usually traditional means for the alleviation of culturally constituted fears. The individual is not altogether left at loose ends; he may obtain some relief and reassurance through the utilization of institutionalized defenses.

The condition of *Rabt* is illustrated by the following case history:

The case of X, a married middle-aged Omda *(village chief) suffering from a* Rabt *condition, clearly illustrates how cultural factors are of importance in the colouring of the clinical picture. Although he was successfully married, he was extremely happy when he saw a 16-year-old girl who was very pretty. He could not withstand her beauty and managed to marry her. Her father, who was a landless tenant, agreed with great enthusiasm. After all, the* Omda *would be of great help for, as he said to his daughter,* "happiness has been your fate."

On the very day of his marriage he tried to perform the sexual act with his bride. The girl, like other country girls, was shy. She said to him that she was previously engaged to her cousin. Thus he failed to achieve the sexual act. He tried several times but he failed. So he was sure that he was Etrabat; *that is, he had lost his ability to function sexually due to an amulet done by one of the witch doctors hired by the bride's cousin. Consequently he left his bride's place and went to his first wife who welcomed him with a smile. Surprisingly enough he was able to perform the sexual act with her in a normal manner. However, after this when he tried for the second time with his bride, he failed.*

This made him very sure that there was something wrong and he came to consult a modern psychiatrist (graduated from London) to direct him to a traditional healer who could restore his ability to function sexually; that is, a specialist who could find the buried hidden material and untie him.

Thus the psychiatrist began to untie him through the ways of Western psychiatry. He pointed to him that there was a big difference in age between him and his bride. He had to shave in order to be more attractive,

bring her some gifts, and tell her stories about sex. The important point was that he must not approach her unless she was ready to reciprocate.

The patient went and he was very successful. As an indication of his success he came the following day with a dozen sweet bottles as a gift for the psychiatrist.

Conclusion

Egypt has two types of psychiatric treatment: Egyptian and Western. The first system has a much longer tradition than the second. There is a rich body of ceremonial practice in Egyptian culture, and most of it is directly concerned with curing mental illness. These patterns of folkloric behavior, therapeutic as they are, are gradually disappearing as tradionary institutions and are being transformed by transplanted (though hybridized) Western institutions — among which Psychiatry and mental hospitals are not the least (El-Shamy, 1972).

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