After 11 September Events. : Revival of the Need to Listen to each other

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Egypt. J. Psychiat. 25: 1&2 January & July 2002
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The relation of culture to psychiatry is not simply like the relation of culture to other branches of medicine. Psychiatry is a medical profession that deals with the structural basis of existence, the goal of life and the how of re-channeling suffering of handicapped individuals to live up to their potentialities and aspirations. Cultural studies in psychiatry should neither be restricted to comparing epidemiological figures of specific disorders in a particular territory nor to delineating some different delusional contents or particular outcome of certain syndromes. Such activities are simply describing superficial differences rather than making use of profound diversities.

To establish some genuine converging synthesis between cultures (transversely) and civilizations (longitudinally), what is needed is to uncover basic structural differences in the how of conceptualization along the way towards complementary synthetic integration between different groups of people sharing common human interest. This lies very deeply in the structural and biological make up of different cultures and individuals. Besides, this is basically bound to both language and religion as the most significant and available bio-existential structures of human beings. Language is the basic biological structural configuration that judges our perception to ourselves and the world in health and disease. Religious stands and attitudes are unconscious structures that could not be identified or managed simply through some declared beliefs influencing certain overt behaviour. 'Islam,' for instance, is not a system of beliefs with different unfamiliar rituals as a western man may perceive. **It represents another way of being in the world**. This could not be judged at a distance or properly evaluated through a casual accident, biased claims or emotional prejudice. This file has been opened lately and could have its negative influence on whatever discipline dealing with cultural differences. Psychiatric practice would come among the top ones.

Reading September 11th's (20010) incidence, in teleological language, could reveal indispensable cues to know better about the current status of human race. It could be perceived as some real, serious, **protest against dominant discipline**. Simultaneously, it could indicate a definite **threat to such dominant level of existence** (including dominant brain organization). On the other hand, the so called 'new world order' proved to be either: 'in the make' or but an 'illusion'. Human race is passing a critical evolutionary impasse. Power system is getting more and more blind, chaotic and deleterious. The recent technological devices proved to be at least double edged.

The ongoing consequences of September's events are proving to be more and more negative than positive. For instance, the international regulations and laws have been overlooked, put aside or neglected; the dominant partner is becoming much more dominant, hence more blind. More and more prejudice has been cultivated on both sides and the influence of secret authorities (Lobbies and Mafia) seems to be augmented.

On the other hand, the hopeful positive results depend on the how of management of such consequences. There is a real chance for revision of current human illusions including the mutilation and solidification of old religions, as well as the risky, false and new 'pseudo-religions'. The idealized pseudo-freedom called democracy as well as the literal human rights would be reevaluated. Creative search for better alternatives would be activated. The so-called 'quality of life', as well as the ill-defined common goal of human existence would be re-defined or at least re-considered. Promoting human growth at individual level and human evolution at race level **would find better systems apt to fulfill better achievements that are essential for promotion of human evolution**.

All such hazards, as well as hopes, have their direct or indirect influence on psychiatric practice. Perhaps globalization of psychiatry has preceded globalization at large. The world wide invasion by the vocabulary innovated by the DSM-IV, and to a less extent by the ICD -10, has been going on throughout the last three decades. The side-effects of such tendencies have resulted in nullifying cultural differences, leading to more and more hazardous effects that devaluate the claimed benefits of agreeing upon common diagnostic labels. Psychiatrists have succeeded to agree much upon what they do not really know.

Four terms may interfere with each other when dealing with the issue of globalization, they are not the least synonymous. These are: globalization. internationalism, totalitarianism and trans-nationalism (up to trans-continental).
'To Globalize' means to make worldwide, in scope or application. 'internationalism' refers to what is across nations (two or more). 'totalitarianism' relates to central control (extremely centralized authority),' trans-nationalism refers to extensions above or beyond nations and ' trans-continental' is what transcend even continents.

Perhaps it is necessary to identify two types of globalization: authoritarian globalization, (what mighty authorities are after, becoming a sort of totalitarianism) and humanistic globalization aiming at objective synthetic convergence of diversities. The latter is essentially related to the degree of orientation of cultural differences, hence working through them and converging towards new synthesis.

In spite of the many alternative meanings of the word 'culture' and the occasional equating it with 'civilization' as synonym, it is necessary to delineate one from the other. Culture is an unconscious network of a holistic mode of existence of a particular group of people at a particular moment of history. Civilization is not simply a relatively high level of cultural and technological development or refinement of thought, manner or taste. For instance, to consider a specific culture to be

considered as civilization, it should represent a specific different existential stand in life. Revelation of such stand in everyday life by most individuals related to this culture, a tendency to export (to market) it to others (all over the world) and efficient methods and tools to fulfill such goal should be considered in defining 'civilization'. Besides, test of efficacy and test of time would prove that such stand and tendency are promising something better to human beings which is apt to propagate worldwide.

Moslems, nowadays, do not fulfill such criteria to make their hundreds of sub-cultures a unified competitive civilization. Islamic civilization is both a historical fact and possible alternative potential. Genuine basic principles of Islam emphasize practicing monotheism in everyday life all the time as a tool for cultivating genuine creative personal freedom. Overvaluing self control and judgment, in spite of, and along with all written rights and disciplines, are essential to be a Moslem. The direct relation to nature and macrocosms in a biorhythmic open ended harmony is coloring most praying and religious practices.

As such, nobody, including psychiatrists, could claim that he is dealing with what he labels 'Islamic Civilization'. The above mentioned principles do not currently or predominantly exist. What is available or presenting all over the world are but sporadic different subcultures having the same label 'Al-Islam'. What is needed is to find out current real differences between cultures in order to get use of whatever positive aspect of each that may be useful for all others.

In psychiatry, for instance, through respect of other's cultures (and civilizations), methodologies, and clinical results, observations and special art of healing, some possible integration of knowledge and experiences could be achieved. In our practice, especially that of relatively senior psychiatrists, some possible hypotheses re-emerge once and again. They need verification by different methodologies. For example, controlled studies (including double blind techniques) could prove to be more illusive than narrating clinical results. Clinical experience does not go parallel with the results of the so called scientific research. Individual variations between psychiatrists are wide enough extending to their use of drugs. The so called algorithm is becoming more handicapping for creative management of individual patients. Diagnostic labels are more and more replacing unique individual identification of each patient. Most practitioners are coming back to emphasize that it is essential to know the state of the disorder than to label it by an agreed upon particular term (name or label). It is more important to know the how of the disorder than to know the why of it. It is more useful to know the pathology of the biorhythmic pulsations (periodical, intermittent, remittent) than to know the possible micorpathology of limited neurotransmitters. It is more important to follow-up by clinical monitoring denoting which brain organization is dominant than by the blood level.

It is more courageous to expect, assimilate and make use of the relapse rather than to follow a strict 'prevention program' with the possible deadening of affective resonance and creative potentialities.

We are in due need to listen to each other instead of claiming destructive conflicts between civilizations, while declaring pseudo-equality and unification.

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