WIAMH Newsletter

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WIAMH CONDEMNS LONDON AND SHARM EL SHEIKH BOMBINGS

World Islamic Association for Mental Health (WIAMH) condemns the atrocious Inhumanity of those who planted the bombs that shocked London on 7 and 21 July 2005 and killed approximately 54 victims and injured nearly 700 as well as the terrorist attacks on Sharm El Sheikh which killed nearly 70, and injured nearly 120. WIAMH also condemns the inhumanity of the killers of Ehab El Sherif, head of Egypt's diplomatic mission in Iraq. The crimes in those situations reflect humanity in short supply. The trouble is that these crimes are committed in the name of Islam. The following paper shows the position of Islam regards these heinous crimes.

CULTURE, RELIGION, AND PSYCHIATRY
THE ISLAMIC PERSPECTIVE OF KILLING INNOCENTS

M.F El Sendiony,
American University in Cairo

This congress will be held at a time when the Western and Muslim worlds are generally seen as pitted against each one other in an ugly conflict-though not perhaps one of their choosing.

This paper examines Islam references through what their might be in common between Islamic traditions and the Western Traditions. A new reading of those references is, therefore warranted in order to achieve a better understanding of these universal values.

While the author believes that in both Iraqi and the Palestinian cases the context should be taken into consideration, he does not think even that can justify certain sorts of behavior which are clearly not acceptable from the standpoint of Islam. "We should say that there are kinds of behavior that are condemned per se and there is no way to justify them. The context may explain but it does not justify. Whatever the context, **beheading people, taking innocents hostage, bombing underground and above ground transportation and killing innocents is not Islamic and should be condemned as such by all Muslims"**

A hundred years later the words of Suttner, author of: Lay Down your Arms, still inspire. Should not we echo her call to a crazy world from the rooftops, minarets and church steeples?

THE MUSLIM GHETTO

In the US, after the 11th of September 2001, no less than in Europe, Muslims are being pushed into isolation rather than integration. Thirty-two percent of Americans polled by the Pew Foundation in 2004 had an unfavorable view of Muslims, While 44 percent believed that Islam is more likely to encourage violence than other religions. And now the problem is getting worse. A poll released in December by Cornell University indicated that nearly half of all Americans believe the U S government should restrict the civil liberties of Muslim Americans. The failure of many Americans to distinguish terrorists from their law-abiding Muslim neighbors is driving some Muslims to adopt an unwholesome form of the identity politics that has already eroded the melting pot ideal of the post-war period.

Younger Muslims in particular are increasingly choosing not to assimilate into American Society. Young women are deciding to wear headscarves even if their mothers did not.

To counter their discomfort in public schools, Muslims in America and Europe are building Islamic Schools as an alternative.

In general WIAMH thinks that Muslims living in Western countries should participate as full as possible in the societies in which they find themselves, avoiding any temptation to retreat into narrowly defined politics of identity. We are not alone in this respect. Perhaps "European Islam", a school of thought adopted by prominent intellectual **Tarek Ramadan**, may provide guidelines towards integration. According to Ramadan one can be both a loyal Muslim and a full European citizen. "Loyalty to one's faith… requires firm and honest loyalty to one's country, (Islamic Law) requires honest citizenship, Ramadan States in his book "**To Be A European Muslim".** Such a blend can happen, he noted if Muslims neither lose their identity through assimilation nor reject European values and thus separate themselves from the societies in which they live.

Professor **Jocelyn Cesari**, research associate at the center for Middle Eastern studies, Harvard University, and coordinator of the European Commission's Network on comparative Research on Islam and Muslims in Europe holds similar view. He believes that integration is a two-way process that involves commitment on both sides. "Muslims have a duty to reveal the genuine tolerant face of Islam, to show its diversity and reveal to the world that an intellectual as Mohamed Abdou is the best example of a modern thinker". On the other hand, "now is the time to merge Islam into European culture, to insert its culture in Europe's educational curricula".

WIAMH SYMPOSIUM

Sponsor: WIAMH

World Islamic Association for Mental Health: WIAMH

Proposed symposium for XIIIth World Congress of Psychiatry, Cairo, September 2005

Proposal Type: Symposium

Title: Recent Developments in Culturally Appropriate Mental Health Care Among Muslims

Topic: 04 Social and Cultural Psychiatry

LANGUAGE OF THE PRESENTATION: ENGLISH

Presenters /Authors :

Abstract:

Psychiatry is a Western import to the Muslims, pioneer Muslim psychiatrists felt that for psychiatry to work more effectively in the Muslim World, all aspect of the psychiatric process, have to be adapted to the Islamic cultural context. The World Islamic Association for Mental Health (WIAMH) founded two decades ago to promote these efforts is sponsoring this symposium. In this workshop, a number of world renowned mental health workers will participate and present the progress they have developed utilizing the Islamic principles. Professor Dr. El-Sherbeeny will discuss "Overview of Psychiatry in Arab Culture". Dr Wahida Valiante will present a paper entitled "Towards Development of an Islamic Approach to Family Therapy". Dr El Rady and Dr Prof. Osama Tawakol will discuss: "The Influence of Culture and Religion on Mental Health Treatment: A Stigma Revisited". Dr Farouk El Sendiony will present a paper entitled: "The Cultural Differences in the Manifestation of Torture". Dr Elizabeth Coker will discuss: "Religion, Morality, and Psychiatric Stigma in Egypt: Implications for the development of culturally appropriate mental health care and education". The format of the workshop will encourage a discussion between the panel members and the audience and we hope to generate a number of valuable recommendations.

Additional Information

The ability to diagnose, and treat psychiatric disorders is enhanced when clinicians fully integrate an appreciation of the cultural context of patients. It's felt that this integration of the Muslim cultural context into the diagnostic and treatment plan will make modern psychiatry-which is a recent western import to the Muslim World-work more effectively.

Article:

Culture Emotions and PTSD, by Janice H Jenkins, in Cultural Aspects of PTSD, Issues, Research and Clinical Applications, Anthony J Marcella and Matthew Jay Friedman, Editors, American Psychological Association Washington DC, 1997.

"Cultural Aspects of Delusions: A Psychiatric study of Egypt", **Australian and New Zealand Journal of Psychiatry**, June 1976, Vol. 10, P.201. Farouk ElSendiony

These observations have led a number of mental health workers around the Muslim World to develop innovative methods for the promotion of mental health and the prevention of mental illness.

The Cultural Differences In The Manifestation Of Torture

DR. M FAROUK EL SENDIONY - THE AMERICAN UNIVERSITY IN CAIRO

The ability to treat trauma victims of torture is enhanced when the clinician fully integrates an appreciation of cultural differences. Cross cultural aspects of torture present many challenges. By understanding the cultural context of the tortured, the torturer may induce more psychological pressure on him or her.

We have seen that psychological pressure-based on understanding of the culture of the tortured, in certain instances can be even harder on the tortured than physical pressure. This had been demonstrated by jails which happened to be administered by governments which belong to Western Cultures. The overwhelming majority of inmates are mostly Arabs and Muslims. In some of these jails prisoners were never beaten, but they were on the verge of a nervous breakdown. They take advantage of the fact that Arabs and Muslims are culturally conservative. Based on this inherent cultural conservatism, the torturer induces more psychological pressure on the tortured.

Using this cultural mechanism, the torturer specializes in creating a psycho-cultural nightmare for the tortured. The nightmare for the Arab inmate is the total disrespect for and total disregard of Arab and Muslim cultural conservatism.

Nudity and Humiliation tactic. Are naked and photographing them repeatedly. Others were made to engage in humiliating sexual practices while alliance soldiers – man and women- watched them and took pictures.

The United Nations has made the 26th of June torture day around the World, calling for the strengthening of the fight against torture. This should include both physical torture and culturally based culture.

Additional information:

There is a compelling and imperative need for crossing the culture gulf in extending meaningful and appropriate interventions in the sites of traumatic stress around the world. The major question is: what is the weight of cultural factors on the manifestation of torture and on the techniques for its remediation. There currently is no basis for the definitive resolution of this problem. But the author will seek a provisional and partial clarification of this objective.

Book

Ethno-cultural Aspects of Post Traumatic Stress Disorder, Issues, Research, and Clinical Applications. Anthony J. Marsella, American Psychological Association, 1997.

Towards the Development of an Islamic Approach to Family Therapy

Wahida C. Valiante, B.S.W. M.S.W. OASW

In theory, the contemporary view of family therapy may be applied within an Islamic context to treat families that have experienced traumatic events or conflict, or are suffering from clinically diagnosed Post Traumatic Stress Disorder. In practice, however, such an application is problematic, due to ideological and philosophical differences in prevailing therapeutic theory and Islamic social constructs.

Most modern treatment theories presented in standard family therapy textbooks or professional articles and studies, continue to be based on western theory of the person, whose perspective emphasizes the concept of abnormality (i.e., "original" or "generational" sin) as a starting point, and whose treatments focuses upon the individual (defined as an self-determining and self-contained unit), whose ultimate goal is to “do his/her own thing.” Under this definition, the locus of control for the individual is "ipse dixit" (I say so), with individual decision-making based on his/her emotions and desires, which are by definition ephemeral. Accordingly treatment proceeds within the context of self and self alone, while sacrificing all other aspects of that individual’s social structure, including their family.

Islam, however, starts by defining human nature as having been created “in the best of mould” and provides a supra-system in which the individual is regarded in a unique way. The individual is responsible for his/her own actions, while being simultaneously linked in relationships of kinship to the masakin (needy), orphans, wayfarers, strangers, society at large, and ultimately with the total world community. In Islam not only self-consciousness but God-consciousness must be balanced within the individual, the locus of normative behavior is with Allah (God), with the individual held accountable for his or her actions and the ultimate impact of their actions on their family and society as whole. All deviations or variations in this relational system are overseen by the supra-system of Islam.

The Islamic philosophical position is holistic, more humane and is primarily focused upon an individual's strengths, critical thinking, intellect, resilience, knowledge, abilities, and his/her potential for change within this extended network of kinship, societal, and divine relationship. Consequently, the individual is neither an isolated individualistic entity, stuck in the past or the present, but as an integral component of society who can also look forward to the future with hope.

The foregoing describes the basis on which this paper will propose a distinctively Islamic approach to family therapy.

Overview of Psychiatry in Arab Culture

LOTFY A.M. AL-SHERBINY , PSYCHIATRIST .

INTRODUCTION

CULTURE AND MENTAL ILLNESS:

Mental Illness is a universal human phenomenon. It is an experience which is recognizable in any culture in which it has been sought (Bebbington 1993, Leff 1981;1988).The influence of culture on the frequency and presentation of mental illness in general has been of persistent interest . The major psychiatric conditions are recognizable across cultures, but there are important variations in the form in which such disorders present, which may well stem from cultural influences (Harding et al 1980).

There are certain psychiatric features which are characteristic of Arabs and can be attributed to the influence of cultural background of Arabs on the mental illness (El-Islam1982).The model characteristics of Arabs vary from one community to another, but there are certain widely shared features of general relevance to psychiatry which can be recognized (Racy 1970). The influence of Arab cultural background on mental illness in the Arab cultures has been reviewed by some authors (El Mahi 1960, Hottinger 1963, El-Islam 1982), and will be reviewed and discussed in some detail in the following chapters of this study.

ARAB CULTURE:

The Arab World extends over two continents (Asia and Africa) and includes 21 nations (As shown in the map). The term “Arab “, as it is used in this research, refers to people who live in the World Countries. The most important unifying factors for the Arab World are the Arabic language , history , religion (mainly Islam followed by Christianity),and a common cultural heritage that form unifying bonds for a population approaching about 200 millions .

There are considerable variations in details of characteristics of Arab peoples from one local community to another, however generalization can be valid in most occasions based on the existence of a unitary national character. To understand the nature of Arab stereotypes, an Arab is defined as one whose native language is Arabic and thus feels as an Arab (Patai 1973). In an article relevant to the Arab character, Marrace (1983) stated that defining Arabs is a complicated task as there are three terms which are used interchangeably; Arab, Middle East and Islam. The Term Arab is closely associated with Bedouin Customs and Culture, and important traditions of desert life which constitute the core custom of Arabism. On the other hand, the term Middle East is a Western one of a geopolitical consideration.

Arabs and their culture are the focus of this research. There is lack of research addressing significantly psychiatry in Arab Culture. Before discussing the Arabic cultural psychiatry and investigating the cultural background to the mental health of Arabs, it is believed to be necessary to describe the Arab Cultural background. Awareness of cultural context of Arabs; their customs, relationship patterns and ways of verbal and non-verbal communication help the understanding of psychiatric conditions and the normal and deviant behavior (Abusah 1993, El-Islam 1982, Baashar 1963)

The relationship between Arabic language and the patterns of presentation and expression of mental illness in Arab culture is emphasized (German 1979, Shouby 1951). The importance of non-linguistic communication system used in Arab culture is mentioned in relation to the way of presentation of complaints among patients who tend to exaggerate their reports of distress.

The Arabic language tends to be overemphatic, and exaggeration of the verbal communication is expected from Arabs to impress others and let them know that the speaker means what he says. The Arab language is described as expressing emotively at the expense of rationality, and the medical practitioners and psychiatrists in this culture are familiar with the cultural correlates of the language
(El-Islam, 1982).

Cultural change is a major experience which has taken place in the Arab culture and the process of change is reflected on psychiatric disorders. In comparison with developed countries, the rate of change in Arab Societies, like other economically under developed countries, is fast up to the extent that developments which took 200 years in the west are being telescoped into50 or even 20 years in some Arab countries.

This makes the cultural environment unreliable and unpredictable, and this in turn seems likely to have a major effect on the frequency of psychiatric problems in these countries. As stated by Bebbington (1993) these changes affecting the third world can be described in terms of the process of urbanization, modernization, acculturation, social change, and more wide-reaching cultural change.

A community psychiatric survey conducted in an Arab oil-rich state which has seen rapid spectacular changes in life-styles showed high rates of psychiatric morbidity in people living in areas characterized by the most Western life-styles, and the greater frequency of disorder was in women whose behavior seemed more modern than their attitudes (Ghubash et al 1993). This finding is interesting as it points to the position of conflict in a local Arab culture associated with the rapidity of change. Although changes in Arab people lives and in the culture abounded, many facets of life and beliefs endured (Krieger 1989).

CONCEPTS AND BELIEFS IN ARAB CULTURE:

In the Arab culture, there are some concepts and beliefs which are widely accepted by local populations. Among the most prevalent beliefs among Arab is that the causes of being upset are almost thought to be beyond one's control and out of his personal responsibility (Low 1985). The beliefs in supernatural powers which cause illness such as jinn (ginn or genies), devil, sorcery, and the evil eye have been termed ` delusional cultural beliefs` (Murphy 1967, El-Islam 1982). The presence of these supernatural forces is culturally recognized and seems to be deeply imprinted to be erased by education. (El-Islam and Abu Dagga 1992).

Culturally-shared beliefs about devil assume the ability of the malevolent jinn (genies) to possess the person with weak religious faith and to exert an adverse upsets on him. Physical and mental conditions or emotional disturbances may be culturally attributed to the devil or possession by spirits (jinn). Possession by jinn is expected to unreasonable and unpredictable behavior for which the affected person claims unawareness and others do not hold him responsible for this behavior (El-Islam 1982).

Sorcery is similar in some aspects to the effect of jinn and means a way in which ill-wishing people can use the witchcraft to summon devils to attack someone. Using sorcery by persons for revenge is recognized by people in Arab culture and defence againts its harmful effect involves rituals by healers or religious persons (Racy 1970, El-Islam and Abu Dagga 1992).

Envoy or evil eye involves the wish or power directed to the prosperity, health, property or beauty which can induce harmful effect through gaze or even by a glance. Unpleasant personal changes, especially when sudden and out of keeping with a person's usual self, are attributed to the envy of others` evil eye. In Arab culture, the society is non-competitive and low achievers use envy to make better achievers lose their precedence and come down to their level (El-Islam 1982).

The belief in God's will as a fatalistic determinant of events is quite common among Muslim Arabs. Symptoms, like any other event, may be part of this attribution which leads individuals no further in attempts to formulate any knowledge about their illnesses. Part of this fatalistic belief may be that whatever appeared through God's will such as symptoms may also disappear by God's will and prayers to `Allah` may help the affected individual (El-Islam and Abu Dagga 1992).

The belief that somatic symptoms are more serious health hazards than emotional symptoms is generally adopted by people in Arab culture. Arab patients believe that doctors treat only physical disorders and expect to listen to objective physical complaints. This seems to be the explanation of preponderance of somatic presentation in Arab patients (Gawad and Arfa 1980).

PUBLIC ATTITUDES TO MENTAL ILLNESS:

Comparatively little work in this area has been carried out in Arab Culture. In the existing literature, there seem to be three views of thought concerning the public's attitude toward mental illness in general (Person and Yil Yiu 1993). The first view is holding a negative attitude in which the general public are found to perceive psychiatry with fear and distrust (Brockman et al 1979). The second claims that the public hold a more positive view and are sympathetic towards psychiatric patients (Bentz and Edgerton 1970, Crocetti el al 1971). The third view suggests that the public's attitudes and views are more ambivalent (Smith and Hanham 1981, Nieradzik and Cochrane 1985).

Intensely negative attitudes about mental illness and the mentally ill may be part of a larger cluster of beliefs and values characterized by absence of sympathy for people who need help, and a rigid outlook in the culture on what is right and wrong (Bhugra 1989). Dislike and fear have been remained high among the surveyed attitudes towards mental illness and the mentally ill, together with lack of sympathy and rejection, and people with this orientation can not easily be swayed by rational arguments to change their views (Murphy et al 1993). Fortunately most people have much less intense negative feelings that can be modified on the basis of experience and as they become knowledgeable, learn to make finer distinctions about kinds of mental illness and treatment (Jones et al 1984, Al Sherbiny 1994).

Survey data suggest that attitudes of community members can be influenced by several variables such as demographic characteristics, socio-economic statues education level and contact with the mentally ill (Person and Yin Yiu 1993). There are several determinants at the contextual, situation and also individual levels, in addition to cultural and religious factors, contributing to public negative or favorable attitudes toward and beliefs about psychiatry (Bhugra 1989). Negative attitudes are correlated with lower educational level, older age, lower socio- economic class, but people who report high knowledge about mental illness are less fearful and more sympathetic with the mentally ill (Murphy et al 1993).

In the eyes of the general public in Arab Communities, a person takes the label of mentally ill when he or she enters a psychiatric hospital, and this label tends to stick. There is stigma attached to mental illness in Arab Culture. Stigma despite being a general phenomenon in many other cultures is more pronounced in Arab communities because of the importance of the individual reputation (Neff and Husaini 1985).

Reputation in Arab local societies means the concept of an individual held by people who know or have heard of him, and who can consign him or her to the appropriate sicial category e.g.good or bad person. Females in the local Arab Cultures are especially vulnerable to attacks on their reputation (Krieger 1989). Stigmatization of the mentally ill is a widespread phenomenon, and thus, to have mental illness is a tangible stigmata of the Arab family great potential influence on public attitude (Jones et al 1984, Harrison 1985). The image of mentally ill people in the Arabic cinema, press and T.V., when portrayed as dangerous, funny and unpredictable convey a negative message to the general public. The estimation of the stigma of mental illness in Arabs, and in any society, is bound to be largely impressionistic. (Al Sherbiny 1996 a, Al Sherbiny 1996)

IMPLICATIONS OF FAMILY AND GENDER ROLES:

The extended family pattern is available in many Arab communities together with the unclear families. The members of extended families are usually emotionally committed to one another and that is why they continue to live in the extended family rather than separating into nuclear families (El-Islam 1982). The supportive security-providing role of extended family during childhood extends to adolescence and adulthood and help cope with emotional upheavals (Kline 1963). Sometimes nuclear families, though living separately, maintain a mutually supportive network within the frame of the extended family or even the tribe (Hamdy 1960).

Intergenerational conflicts take place and are described in many Arab communities as a result of adoption by younger generation of values , attitudes , and behavior which are in opposition to the traditions represented by the older generation (El-Islam 1982) . The intergenerational conflict may have adverse effects in the Arab community as the young try to deal with a double set of values (Hottenger 1963) .

Arranged marriage is favored by traditions in the Arab culture, and cousin marriage is recently challenged by the younger generation polygamy is still manifest in parts of the Arab World, mostly in Arabian peninsula and Gulf countries (El-Kholi 1971).

The older members of the family are still accord great respect in spite of the rebellion of younger generation against their authority (Okasha and Lotaif 1979). The relatively good mental health of the old for psychiatric care where the extended families are common. In some Arab communities, the urbanization and lack of care of the old by the extended families which are replaced by nuclear families resulted in the trend to care for elderly in institutions (El-Islam 1982).

The status and sex roles of women in Arabic Societies are in a state of flux. Many factors have contributed to the changing role of Arabic women, including socio-economic changes in Arab countries, increased educational and occupational opportunities for women, and the influence of Western culture. Nevertheless, stereotypic sex roles continue to be assigned through socialization process. Arabic women are expected to be dedicated wives, self-sacrificing mothers, and obedient daughters, faithful to their husbands, pure and chaste. Women are expected to be passive, submissive, and underachieving. Arab men, however, are allowed great latitude in their roles as fathers, sons, and husbands (AbdAlla and Gibson 1984 , Adams et al 1984 , Sawaie 1983) .

From the psychological point of view , women in Arab Culture are not expected to control the expression of their " upsets " in physical symptoms , but they can , however , control how they use the emotional and physical manifestations of being upset to get what they desire in social sphere (Krieger 1989) . Women publicize their emotionally caused illnesses in order to put social pressure on the individual causing their upset and physical ill health or to gain emotional support if they have undergone a difficult life experience. The social use of emotional upset and the physical symptoms it causes is but one tool with which women manipulate the social realm (Nelson 1974, Racy 1980).

Massive literature has mentioned that females are more likely to consult doctors (Briscoe 1987, Verbrugge and Ascione 1987, Waldron 1983). In Arab Culture, some investigators observe the increased likelihood of women to ignore symptoms (El-Islam and Abu Dagga 1990). This can be due to the fact that women are less likely to think of serious causes of their illness as they tend to attribute illness to emotional rather than reasons (Brown and Harris 1978).

PSYCHOPATHOLOGY AND PRESENTATION :

Here are preliminary observations from psychiatric practice in Arab culture including description of illness behavior in Arab patients, variations in the presenting symptoms and particular features of mental disorders.

The way various people recognize that they are ill , in addition to what they do about that is the meaning of the term illness behavior . The illness behavior in Arab culture which is directly related to the meaning of symptoms of mental illness and health attitudes is deeply embedded in cultural assumptions (Harrison 1985) . The demographic variables such as age , sex , education and occupation are associated with certain forms of illness behavior in local Arab Cultures . Non consultation illness behavior such as ignoring brooding or self help has been found to be more likely in Arabs than consultation behavior (El-Islam and Abu Dagga 1990 , Wahid 1988).

In Arab culture, it has been observed that somatic symptoms, mainly pain , may be the only indication of illness , but emotional and social problems are not recognized or directly expressed . People in Arab culture, including patients and medical practitioners , are semantically oriented , and only somatic complaints call for medical help (Racy 1980 , Briscoe 1987) . The somatic symptoms of psychic origin are usually beyond the imagination of many patients and beyond the knowledge of many doctors . Out of all psychological symptoms , insomnia is considered a common complaint associated with high consultation rate in Arabs (El-Islam and Abu Dagga 1990) .

Tension is often described by Arab patients as aches referred to bones , as pain is the only symptom which many people are able to describe in expression of their complaints (Okasha 1977) . The physical bodily symptoms are used by Arab patients as a method of communication and expression of distress to doctors. The preponderance of somatic symptoms in the presentation of psychiatric disorders among Arabs is well documented (Okasha et al 1968 , Racy 1980 , El-Islam 1982) .

Symptoms of conversation hysteria have been described to be of higher rates in Arab Communities (Leff 1988 , Hafeiz 1980, Okasha 1968) . Common conversion symptoms include aphonia , breathlessness , vomiting , paresis , fits and blindness . Obsessions in the form of ruminations and rituals (mainly washing and cleanliness) occur usually in relation to cultural and religious background (El-Islam 1982). Obsessive rituals (Wiswas) related to ablution before prayer, and to prayer performance are frequently seen in psychiatric practice among Arab Muslim adults. Sexual dysfunction is a relatively frequent presenting complaint in men, but sexual disorders on females are very rarely seen in psychiatric practice in Arab culture (Okasha and Demerdash 1975).

Affective disorders in Arabs have been reported to show characteristic presentation especially in cases of depression. Guilt feelings are not frequently encountered presentations of depressive illness. Depression may be regarded as punishment of God , but guilt feelings are hidden in the back growing behind projection of responsibility for illness onto others in the environment (El-Islam 1982) . Though suicide is strongly condemned by Islamic religion, high rate of parasuicide cases continue their religious practices. Generally suicide rate in all Arab communities is much less than that in the Western societies (Okasha et al 1968) .

Schizophrenia in Arab patients needs to be diagnosed carefully in consideration of the normal culturally-shared beliefs. Delusions which usually have a cultural coloring should be distinguished from the socially shared beliefs e.g.delusions involving devil or jinn when their content is not culture-alien (El-Islam 1982) . When the delusional content ideas about evil eye or sorcery it is also culture-accepted (El-Sendimy et al 1976).

Arabic words for expression of symptoms and emotions can be described as culturally-molded to describe the feelings and state of the individual . The terms used differ from one local Arab Community to the other i.e.Arabs in Egypt use some terms to express certain psychological symptoms which differ from those used by Arabs in the Gulf region. The doctors practicing in the Arab world have to know these variations. There are some terms denoting feelings and states which are frequently used ; these are ;

- **Narfuza** : An irritable , nervous kind of upset (in Egypt) .
- **Dega** : Irritability with chest oppression (in Gulf)
- **Katma** : Feeling of irritability , tightness and breathlessness
- **Zaal or Hozn** : Feeling of sadness and sorrow (in Egypt)
- **Hashrah** : Same as the previous with tight chest (in Gulf)
- **Ikteaab** : Expression of depression generally in Arabic
- **Magnoun** : Pan-Arabic colloquial term for mad person in general
- **Alaa** : Arabic expression of anxiety (Arabic letter " Qaf " is pronounced as a glottal stop in Egyptian colloquial dialect , transliterated as)
- **Khouf** : Fear of something (generally used by all Arabs)
- **Khada** : Sudden feeling of fear in response to surprising event (in Egypt)
- **Kharaa** : Same as the previous expression (in the Gulf)
- **Wiswas** : Obsession , sometimes used by Arabs to describe ruminations or the devil
- **Aasab** : A word for psychosis used in colloquial Arabic of Egyptians .
- **Metlawaz** : Similar expression of psychotic disturbance in the Gulf
- **Weshra** : A word implies possession by jinn in Bedouin Culture .
- **Tanseem** : An expression used in local cultures in Gulf (Saudi Arabia) to describe the belief that menta illness is caused by assumed opening in the head which is to be closed by cautery .

The Arab words for description of symptoms and feelings are nouns or verbs denoting states of the individual. There are some other terms widely used in Arab culture in relation to treatment methods which will be mentioned elsewhere.

The responses of Arab patients to psychological testing and to the diagnostic instruments which are almost developed in the West and translated into Arabic language show some peculiar characteristics. Some of the tests are not feasible when used as diagnostic tools in different cultures, and psychiatric research should not depend up assumption of universality by directly translating into other languages to determine the mentally ill in other society (Klienman and Good1985). Nabolsi (1989) in his translation and presentation of the psychological testing after the works of Moussong noted that Arab cases differ in their responses from cases in the West.

Arabs tend to respond to the graphic expression of the concept of time(L`expression graphique de concept du temps) by starting to put the past on the right side followed by the present in the middle and the future to the left,while Western people start from left to right(Nabolsi 1989, Moussong 1989).Comparison between Arabic and Western samples has been shown points of agreement and others of difference when a translated scale is used for assessment of certain dimensions(Eysenck and Abdl-Khalek1992).

TREATMENT IN ARAB CULTURE:

There are some preliminary observations about therapy of mental disorders in Arab culture which worth mentioning before psychiatric therapeutic practices are discussed. The importance of awareness of the cultural context of Arab patients, their way of verbal and non-verbal communication, customs, family relationship patterns has been emphasized. It is essential for understanding the management of psychiatric disorders in Arab communities to be able to judge the extent to which behavior is deviant or culture-alien. The Western methods of treatment have to be adapted to the local Arab culture before they can be therapeutically employed.

The therapeutic modalities of mental disorders in Arab culture depend mainly upon the prevailing explanations of and beliefs about mental illness. Arab subjects` responses to their symptoms are recorded by El-Islam (1990) under four headings:

A. Those who would do nothing in relation to the symptom i.e. they ignored the symptom. Their reasons for this decision were sought; eg. the symptom was found to be mild, self limiting, too common among others or not curable. Individuals who did not ignore the symptom proceed to B,C and /or D as follows:

b. Those who would brood (i.e. let their mind dwell) on the symptom out of concern. The intellectual introspective exercise aimed at making sense of symptoms by they proceed to C and/or D.

C. Those who would resort to self-help; methods of self-help included:

- Modification of activities at work or at home.
- Resort to destructive or pleasant activities e.g. sports, reading, watching T.V., visiting friends, etc.
- Meditation, i.e. resort to religious activities such as playing, reading the holy `Quraan`, or forcing oneself to be patient.
- Traditional easing activities e.g. deep breathing, smoking, food and drink.

D. Those who consult others whether these were members of their social network (relatives and friends) or professional helpers (doctors, psychiatrists, psychologists, pharmacists, religious men or traditional healers).

Based on the attribution of mental illness in local Arab Cultures to supernatural influences, patients and their families resort usually at first to lay methods conforming with their concepts and beliefs. Among the common ritual healing practices are the use of fumigation with incense, amulets which take different shapes and sometimes include verses of holy Quraan, or other rituals involving drinking or washing in water washed off Quraan verses written on paper or a plate (Sanua 1977, Baashar 1982).

Visiting the Shrines or tombs of dead Sheiks is practice for healing and blessing in some Arab Communities which involves submission to the Sheik and asking for help (El-Islam 1982). Assuming that envoy, sorcery or devil are the causes of mental ill health, Arab patients resort to consultation of religious men who use verses of the holy Quraan or Hadith (the teaching go prophet). These methods which are widely used serve undisputed psychotherapeutic functions in Arab culture, and are useful to people who believe in it and faithfully seek their aid (El-Islam 1990, Berkanovic and Telesky 1982). Among the religious practices which have influence on mental health is pilgrimage i.e. `Haj` and `Omra` (El Sendioni 1981, Morris 1982). Traditional healers may be the first referral agency for mental patients in Arab culture and their practices are widely accepted as the traditional views about mental illness flourish. An example of the traditional healing practices is ` El-Zar`; an account about it is given here.

Modern psychiatric treatment is provided in all Arab countries, and there are some observations about the interaction of the public with modern psychiatry. Arab patients have a dependent attitude towards doctors and are not keen on active participation in own treatment e.eg. They are reluctant to follow treatment regulations (El-Islam 1979). Arab patients expect and may insist on somatic treatment in the form of bills and injections. They may not accept psychotherapy (only talking) as a treatment that replaces prescription of medicines (Racy 1970, West 1987). Patients and their relatives keep changing the treating doctor hoping to find the one who is clever enough to effect a complete cure (El-Islam 1982). The relationship between psychiatrists in Arab cultures and traditional healers has been the subject of interest as attempts to integrate traditional and modern views in theory and practice have been made to achieve the goal of co-operation and understanding. The situation at present is that Arab patients seek traditional treatment and psychiatric help alternatively and they resort to psychiatrists when traditional healers fail to trea them and vice versa (Al-Issa and Al-Issa 1970, El -Islam 1982).

EL-ZAR:

One of the most popular traditional healing cult is“El-Zar”which is an expression of healing ceremonies hold mainly in Egypt.Following the public beliefs which represent shared notions by the healer and his audience about the illness , the curing effect of “El-Zar” is directed to ward the causative factor rather than the symptoms . The central idea of “El-Zar”is to placate the spirits (called also jinn , or asyad) which are supposed to have entered into the body of the victim and caused him to suffer (Okasha 1966).

“ El-Zar “ ceremonies vary in certain details according to whether they are private or public but in all cases the major elements include the possessed persons , the leader who is usually a women and her assistants mainly those drumming , dancing or chanting (El Sendiony 1974) . The leader and audience usually seat cross-legged on the ground. The possessed are dressed in white garments. The music and drums start and become faster until primitive ecstasy dominates the gathering, and as the trance state is approached the leader can hear to the spirits demands. The wishes of the spirits e.g. birds, lamps or gold must be answered to persuade them to leave the possessed body or at least to placate them (El-Islam 1982 , Okasha 1966).

“El-Zar “has lost much of its popularity. Some patients who used to visit “El-Zar” ceremonies are no more recourse to this practice for relief of their emotional problems. This change may be a result of transmission of Islamic teaching through the media that “ El-Zar “ does not really help people , and is not part of Islam (Krieger 1989).People who believe that “ El-Zar “ will help their relief of symptoms can benefit of it .

There are certain terms describing some cultural and religious therapeutic issues in different local Arab communities. Here are the meanings of some commonly used Arabic expressions.

- **Tamima** **:** An Arabic term for the amulets of different types.
- **Taawiza** **:** These are amulets containing almost verses of holy Quraan.
- **Hegab** **:** A similar Egyptian description of this type of amulets.
- **El-Zar** **:** Healing ceremonies attended mostly by women for placating the spirits.
- **Hadra** **:** A term used for “El-Zar “ceremony in Egyptian colloquial dialect.
- **Rukaia** **:** Arabic expression of a religious treatment of envoy by verses of Quraan .
- **Hassad** **:** The term widely used, especially in Egypt, for envoy or evil eye.
- **Nafs** **:** Similar expression of ` hassad` used in the Gulf with implied supernatural influence.
- **Ein** **:** Literally means eye, this is an expression of envoy or evil eye.
- **Sehr** **:** Pan-Arabic expression of sorcery and influence of devils.
- **Amal** **:** A similar expression of sorcery used widely in Egypt.
- **Asyad** **:** Egyptian colloquial term for devil or jinn controlling a patient by entering into his body.
- **Afreet** **:** A term for bad genies which cause harm.
- **Sheikh** **:** The religious man who may use his influence in therapy.

- **Moutawa** **:** Similar expression for religious man in the Gulf.

- **Mulla** **:** The same description of religious people in local Gulf societies.

- **Maalesh** **:** A word widely used in Arab Culture, mainly in Egypt, which means ` never mind` , and used also for reassurance in hard time.

- **Baraka** **:** This term means blessing which is always related to religious practices by Sheiks or to visiting the Shrines.

- **Haj and Omra:** Pilgrimage and visiting holy places in Mecca for Muslims.

Conclusion & Recommendations:

In this work the influence of Arab Culture on Psychiatry was studied through reviewing the relevant literature and field study of the case of first wife in polygamy as an example of a cultural-specific condition. The influence of culture on mental illness was discussed together with the theoretical background of concepts of culture and fields of cross-cultural psychiatry.

Arab culture characteristics in relation to psychiatry were reviewed in the available literature. Concepts and beliefs in Arab cultures that thought to be related to explanation and causation of mental illness were discussed together with attitudes towards psychiatry and stigma of mental illness. The implications of family and gender roles in Arab culture were reviewed as to show the status of Arabic women in relation to mental health in Arab Culture. Psychopathology and special patterns of presentation of mental disorders in mental disorders in Arab Culture were reviewed with concentration on certain widely used practices e.g. El-Zar.

There are several phenomena in Arab Culture which also need to opened for cultural and interpretative analysis. Further psychiatric studies of cultural issues have a variety of direct applications and offer important directions for research in this field.

Building on the finding of this study in Arab Culture, we put forward the following recommendations:

- There is a need for further studies in the field of relationship between Arab culture and psychiatric disorders for better understanding of different problems and phenomena.

- Clinical and descriptive research is required to serve evaluating and resolving psychiatric problems in the local Arab cultures to help the purpose of adjustment and adaptation.

- Systemic psychiatric study and cross cultural comparison of similarities and differences with other cultural models can offer important opportunity for acquiring shared useful experience.

- Efforts should continue to find out the most suitable methods and instruments for research across cultural boundaries for valid measurement of cultural specific psychiatric conditions.

- Explanation of culture-bound psychiatric conditions (such as that described in this study) should be encouraged to be done by individuals familiar with the local cultures and languages .

- An agenda for future directions should be put to reflect the growing awareness of areas in mental health related to cultural issues for organization of support and services.

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تتضمن هذه الدراسة عرضاً للطب النفسي في الثقافة العربية ، وتبدأ بمقدمة عن تأثير الثقافة بصفة عامة والثقافة العربية خاصة علي الأمراض النفسية ، ثم المفاهيم والمعتقدات التي تتعلق بالمرض النفسي في الثقافة العربية ، ورصد للإتجاهات العامة نحو المرض النفسي والطب النفسي في العالم العربي ، وتحديد لأهمية دور الأسرة والجنس وجوانبها النفسية لدى العرب ، ثم عرض للأعراض والمظاهر المرضية للإضطرابات النفسية وما تتميز به في الثقافة العربية باختلاف مع النموذج الغربي ، وطرق العلاج التي يتم ممارستها في الثقافة العربية بصفة خاصة وتلقي قبولاً واسعاً بما يلقي الضوء علي موضوع هذه الدراسة عن الطب النفسي في الثقافة العربية .

Religion, morality and psychiatric stigma in Egypt

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Title of paper: Religion, morality and psychiatric stigma in Egypt

Religion and religious beliefs are inseparable from mental illness and its treatment in many societies, including Egypt, and religious beliefs therefore have important implications for psychiatric help-seeking in these societies. Studies have shown that among Muslims in particular, prayer is seen as having both a curative and protective influence on mental illnesses (Hatfield, et. Al, 1996). In Egypt, religious beliefs play an important role in definitions of health and illness as well as stigma production and management. For example, religious healers are commonly consulted prior to, in conjunction with, or after seeking psychiatric or medical care for mental health problems. Religious healing has a long history in the Arab/Muslim world, and, in societies where such studies have been conducted, may be viewed as complementary to, but not replaced by, modern medicine (for example, Al-Krenawi, et al, 2001; Al-Subaie & Ahlhamad, 2000; El-Islam, 2000). Related to this, views of the "healthy self" in Egypt are informed by religious notions of morality and spiritual strength, directly contradicting alternative explanations that may locate behavioral disorders in the mental or physical realm.

In Egypt as elsewhere, one of the most commonly cited reasons for the under-use of available psychiatric services by the lay-public is the notion of stigma. 'Stigma' is frequently blamed for the cultural incompatibility of western-based mental health programs in certain contexts, for the continued reliance on traditional healers and the failure of certain non-western countries (and immigrants from the same) to fall in step with the dominant psychiatric paradigm (Al-Krenawi, et al, 2000; James, et al., 2002; Raguram, et al., 1996). The concept of stigma, however, is too often poorly defined and may be uncritically employed as a catch-phrase in support of imported mental health promotion programs. This paper is based on the results of a large-scale qualitative study aimed at identifying and understanding the cultural meanings associated with the unique forms that psychiatric stigma takes in Egypt. The present focus is on treatment-related stigma as it impacts the acceptance of psychiatric services, in the context of religious/cultural beliefs that may locate many mental health problems in the spiritual and social, not medical realm. In this case, "stigma-management" techniques that assume a natural linear progression from "traditional" to "modern" and that rely on educational programs to accomplish this may be doomed to fall far short of their goals.

The data for the present study consisted of in-depth interviews with 209 lay persons, 106 psychiatric patients and their families, and 26 psychiatric nurses and social workers in order to determine local knowledge, beliefs and attitudes towards mental illness and mental illness treatment in Egypt, and the relationship of these to actual practices of treatment-seeking for mental health-related problems. The lay-person interviews were based upon clinical vignettes of hypothetical persons (either male or female) suffering from depression, psychosis, alcohol abuse, or a classic "possession" syndrome as it is culturally understood. Stigma was measured by judgments of social distance, i.e, whether or not the respondent would accept the person in question as a neighbor, friend, teacher, or as a spouse to a member of the family.

The results suggested that Egyptians have a very high tolerance for mental disorders, provided that they are able to interpret these disorders in a culturally-acceptable manner. Illnesses are generally viewed in terms of causal factors rather than disease processes, and appropriate treatments involve directly addressing these causes. For example, if someone exhibits extremely bizarre behavior due to a stressful marital situation, then the "problem" is the marriage and the "solution" is the resolution thereof. In this case, the bizarre behavior is expected to resolve when the problem is solved, and no stigma is attached to the behavior itself.

Psychiatric hospitals, as part of the medical establishment that treats "physical" disorders, are seen as treating only permanent, organic mental diseases. A behavior that would not be stigmatized were it seen as due to a "marital problem", is highly stigmatized when the cause is redefined as "organic disease process". Thus, the stigma associated with psychiatric hospitals is partly due to the nature of psychiatric theories of disorder that locate a given problem inside the individual (and due to biological causes), rather than in the realm of social interaction.

Negative views of typical psychiatric definitions of disturbed behavior and preferences for socially-contextualized causal explanations were relatively independent of educational and social background, meaning that psychiatric disorders (defined as such) and psychiatric hospitalization were stigmatized by people from all socio-economic classes. However, the results also indicated a certain willingness on the part of the respondents to accept that psychiatrists (but not psychiatric hospitals) can be useful in the treatment of mental disorders as long as they serve the purpose of solving "social and emotional" problems rather than "organic diseases".

The results of this study highlight the need to look beyond static categories of person toward a more nuanced understanding of cultural meanings in order to unravel the complexities of psychiatric stigma in Egypt. The following discussion emphasizes findings from the qualitative data analysis that specifically address attitudes towards psychiatrists and psychiatric hospitals within the context of cultural beliefs about mental and behavioral disturbances that are often at odds with those of mainstream medicine.

Psychiatrists were often mentioned by the lay respondents as a first resort for treatment. The responses indicated that Egyptians have a good deal of respect for the expertise of doctors in general and their ability to treat illnesses of all types. However, the responses indicated an equally strong tendency to place limits on the abilities of doctors, and particularly psychiatrists, to solve certain problems. In fact, several people spoke as if seeing the psychiatrist was a mere formality before moving on to the "real" treatment. The following excerpt is from a man who was presented with the vignette portraying psychosis. He made the following commentary on the efficacy of doctors, only to be negated at the end in favor of religious treatment:

"If she (person in vignette) went to a psychiatrist he would analyze her and tell her her problem. She needs a psychiatrist or a Qur'anic healer. The Prophet said 'take from the Qur'an what you want for what you want.' And she should go to the psychiatrist". (Interviewer: How are the two related?) "She would go first to the psychiatrist and she would not get treated so she would go to Qur'anic healing"

The above excerpt indicates (among other things) that because of the respect shown to doctors, people would often agree that the person might see a doctor, along with other types of treatment, because after all, it couldn't hurt. However, most of the time 'psychological' problems were viewed as either social or spiritual in nature, thus rendering a psychiatrist unnecessary. Psychiatrists, like all medical doctors, were seen as necessary mainly for organic/biological problems, which were only believed to be related to psychological disturbances in certain cases. For example, a middle-aged man said, when asked what could help the man in the depressed vignette:

"It [the illness in question] begins with a serious breakdown followed by a psychological disturbance and a mental disorder. If not treated medically in two weeks time, this man will get epileptic and be insane or paralyzed. (Interviewer: do you think he should seek a religious sheikh for treatment?) "No because his problem now is biological and not spiritual. The only recovery for this man is through medical treatment and nothing else. Spiritual illness can only be treated by means of refining the spirit and by regular use of the Qur'an and the religious rituals. As for the psychological illness it is a biological disease that could only be treated by medical doctors".

This man was able to suggest a doctor after recasting the problem at hand as a "biological" illness, as opposed to a spiritual one. As mentioned, psychological disturbances are often seen as more akin to spiritual than biological illness, hence no need for a physician. However, in this case the man has defined psychological illnesses as biological in nature, probably through the association with "*sara3*", or epilepsy, itself a disorder with ambiguous physical/spiritual roots. As one man eloquently put it: "He (the doctor) is responsible for the body, and on the other hand the Holy people are responsible for the soul".

Simultaneous or hierarchical treatment resort has been often noted by psychiatrists and social scientists, and indeed the vignette responses indicated this as well. It was common to mention both sheikhs and psychiatrists as paths of first resort, and the general idea was that if one didn't work, the other would. In the following excerpt, this theme is demonstrated, as well as the ongoing idea that doctors might be consulted "just in case" even if it is not believed that they will be of any help:

(Interviewer: Should this man seek treatment? And whom should he seek?) "Of course he should seek treatment and if didn't ask for that with his own tongue then his family must treat him or take him to a psychiatrist if he were not possessed by the Jinn, but I am sure that he is possessed by the Jinn".

It is very important to keep in mind that religious healers are much more likely than psychiatrists to see a person early on in the illness process (particularly in the rural areas). Medical or primary care doctors might see the patient first if the presenting symptoms are primarily somatic, however, the evidence here indicates that religious healers are routinely sought, often in great numbers, in the early stages of disorders that eventually lead to psychiatric hospitalization. Many patients and their families reported having been referred to a psychiatrist by a religious healer after he had "ruled out" a spiritual influence. As this suggests, confirmation that an illness is medical in nature and not spiritual does not seem to impact belief in the possibility of spiritual illnesses in the slightest, it merely confirms one of several possible cultural explanations for behavioral disorders. Therefore, it is unrealistic to presume that as psychiatric treatment gains acceptance in the society that there will be a corresponding decrease in resort to spiritual healers, as the two systems coexist side by side in Egypt, as they do in many societies.

However, the acceptance of religion and medicine as non-competitive healing resources is not shared by medical personnel, and this has the potential to seriously impact patient/physician communication and patient satisfaction. Over and over again, patients and families claimed that they were afraid to discuss their resort to religious healers or their spiritual beliefs with their doctors or nurses, saying that the doctors "would laugh at them" or "know nothing about possession". This can create a communication breakdown that could impact satisfaction with treatment, and therefore compliance and adherence, as well as prevent the patient from fully incorporating the idea of psychiatric treatment into his/her belief system.

From the responses collected here, it would appear that people are well aware of the role of psychiatrists in treating mental disorders that are defined as such (i.e., as biological rather than spiritual). However, mental illnesses defined as requiring the services of a psychiatrist, or worse, a psychiatric hospital were by definition no longer social or spiritual in nature, and therefore much more likely to be stigmatized. The word "magnuun" or crazy, was used by the respondents only when discussing a person who might require a psychiatric hospital rather than a religious or social cure. Give this, it becomes easier to interpret the way in which psychiatric hospitalization is often associated

with "giving up" on the part of the patients' families, and why, once the decision is made to hospitalize, families often more or less abandon their family member to his/her fate. Clearly, psychiatric hospitals are not seen as places of cure, but rather as homes for the hopeless.

This needs to be interpreted in terms of the notions of health and illness revealed in the various responses. A healthy, normal person has a family that supports him/her and is morally and personally strong. Ideally, the concept of the healthy person is also highly religious – he or she prays and fasts and follows the tenets of his or her religion. Behavioral, social and moral disruptions are seen as failures in the social/moral realm, not in the physical realm. Physical illnesses either get better or a person dies, but if one is physically ill he can still be a father, brother, good Muslim, etc. Not so if one is psychiatrically ill. If this is the case he is literally destroyed as person, he/she cannot pray, and cannot be a father or a brother or a mother. As long as the illness is simply a problem, then this is understandable and the cure is simple: strengthen the social, moral and religious fabric. However, if this can't be done, then the person no longer has a place, he is abnormal and cannot function as "person" among people in society.

On the other hand, there is hope for this from the responses. There is evidence from the present study that people are beginning to be more aware of the role that psychiatrists can play in solving "ordinary" problems rather than just the highly stigmatized biologically-based mental illnesses. In other words, perhaps through the influence of the media, many people said that psychiatrists could help people through talk, and those that had this view tended to express more positive feelings towards them than did those who saw the role of psychiatrists as prescribing medications only.

However, the average Egyptian will not likely embrace a treatment that involves redefining moral and social problems into "organic problems" (a shift which is definitive of the psychiatric patient experience, clearly), nor are they likely to accept a treatment that involves lengthy hospitalization away from the family. Again, this is the definition of a psychiatric patient and a fate that all want to avoid. Unlike the West, with its traditions of retreats and sleep cures and high-class asylums and such, Egyptian culture is simply not conducive to this form of treatment, which is, furthermore, directly imported from the West.

Creating more culturally acceptable mental health care

It would be a mistake to assume that simple public education in the biomedical paradigm of mental health would serve to reduce the stigma associated with psychiatric treatment. There are several related reasons for this. First of all, there is no evidence that acceptance of a "biomedical" explanation of mental illness is the basis of reduced stigma in any society (Fryer & Cohen, 1988; Read & Law, 1999). In fact, attempts to equate mental illness with physical illness have sometimes backfired in western societies, and resulted in an increase, not a decrease in stigma. Mental illnesses are not experientially or morally equivalent to physical illnesses in most, if not all cultures, and an unexamined reduction of one to the other will not change this. On the other hand, social and spiritual explanations for mental illnesses, such as those overwhelming found in the present study, have been found to serve a decidedly protective function against stigma (Hill & Fraser, 1995; Read & Law, 1999). Secondly, educating people about the biological bases of mental illnesses and the resultant need for chemical treatments by a trained professional is unlikely to be convincing in a population where such concepts are so very different from everyday conceptions of mental disturbances as being behavioral, social, and moral in nature.

The danger of assuming that a biomedical explanation will serve to reduce stigma against mental illness in Egypt is further underlined by our findings regarding the causal explanations of disorders seen as being appropriate for "psychiatric hospitalization", a highly stigmatized treatment. Psychiatric hospitalization was significantly associated with illnesses perceived to involve permanent, unalterable states of "craziness" and the like, in other words, to be for illnesses that are biological in nature. On the other hand, as long as the illness was categorized as an ordinary social or emotional problem, then there was no stigma and a hospital was not required. These findings can be interpreted as reflecting the notion that biological disorders are inherently incurable and thus highly stigmatized treatable only through social isolation, itself a highly stigmatized state.

In Egypt, one is part and parcel of the social environment until such time as that contract is breached through extreme antisocial behavior. Because of this, there are strong protective factors against psychiatric stigma, notably in the existence of normalizing discourses and moral and religious imperatives to help the sick and infirm. These stigma-alleviating tactics serve to contextualize the illness in a framework that maintains the sufferer within the realm of meaningful social interaction. From within that realm, the psychic is secondary to the social, and stigma aimed solely at an individual apart from his or her social environment does not make good sense. Behavioral, social and moral disruptions are seen as failures in the social/moral/religious realm, not in the physical or psychic realm. As long as the problem can be understood in terms of its social and moral implications, then it is understandable and the cure is simple: strengthen the social, moral and religious fabric.

It should not be assumed from the results of the present study that traditional/religious beliefs will necessarily lead Egyptians to prefer religious healers over psychiatrists in all cases. While it is true that religious healing carried little or no stigma regardless of the nature of the disorder, consulting a religious healer per se was actually mentioned less often than a psychiatrist. What was common was to situate the illness in the spiritual realm and suggest religious practice as a way of strengthening the spirit in order to resist the illness, and to place psychiatrists outside of the realm of ordinary social and religious treatments. What can be concluded is that social and religious explanations for mental illnesses are consistent, durable, and

unlikely to be "educated out" of the population by the current modernizing agenda. It is important that psychiatry adapt itself to cultural beliefs and norms of treatment that are stigma-protective, rather than expect society at large to adjust to cultural beliefs and norms of treatment imported from elsewhere.

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The Influence Of Culture And Religion On Mental Health Treatment: A Stigma Revisited.

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Culture and religion influence both patients and clinicians. For patients, culture and religion influence several aspects of mental illness, including how the patients manifest their disorders, their coping style, their motivation to seek treatment and the available support systems. Religion promotes healthy cognitions thru belief and represents a strong predictor of life satisfaction. Similarly, the clinician's culture and religion influence diagnosis, treatment and service delivery.

The western culture of medicine which stresses "the primacy of human body in disease" has strongly influenced the mental health practices worldwide since the 19th century. Therefore, it is believed that most mental health professionals share a worldwide culture which at times could be biased towards their patients. The striking disparities in cultural and religious beliefs between patients and clinicians may lead to mistrust. Mistrust of mental health services is a major factor preventing patients from seeking treatment. These concerns about clinicians' bias and stereotyping of patients can contribute to the stigma.

Stigma was described by the U.S. Surgeon General as "the most formidable obstacle to future progress in the arena of mental illness and health". This contributes to the array of negative attitudes and beliefs which motivate the public to fear, reject, avoid and discriminate against people with mental illness.

In response to societal stigma, people with mental problems internalize negative public attitudes and become so embarrassed or ashamed that they often hide symptoms and fail to seek treatment. Stigma also diminishes their opportunities in life which leads to demoralization, and greater sense of isolation and pessimism. Stigma against family members frequently, fragments family relations and diminishes marriage and economic opportunities for other family members.

The speaker will discuss strategies to minimize mistrust by patients of mental health professionals and will suggest methods to lower societal stigma against people with mental illness. This is discussed in light of the Mental Health Report of the U.S. Surgeon General on culture, race and ethnicity.