

Summary Article

The Eclipse of a Culture Bound Syndrome

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INTRODUCTION Psychiatric services were introduced in Qatar for the first time in 1972. The country had more than a hundred thousand inhabitants according to the official census of the population in 1971, and the capital, Doha, had 72% of the population (Qatar Ministry of Economy and Commerce, 1973). Qatar is an oil-and-gas-exporting country, which lies about the middle of the Western coast of the Gulf that separates Arabia from Persia. Of the working population 2% were females, and two thirds were expatriates according to the economic report (1973). The health system was free of charge for the indigenous and expatriate populations alike.

Patients recognized that they had a medical illness only when they developed somatic symptoms. They then sought the help of doctors and welcomed physical investigation of their bodily ailments. The majority were self-referred. Somatic symptoms were regarded as legitimate reasons for waiving various obligations as they were not the individual's responsibility. On the other hand, emotional symptoms (e.g. worries, low spirits or fears) were attributed to weakness of faith for which the individual was held responsible. Behavioural symptoms (e.g. aggressive or socially embarrassing behaviour) were invariably attributed to possession by bad spirits (*jinn*), who acted on their own initiative after the individual transgressed culturally-shared sanctions, or were maliciously employed by human beings who did not wish the victim well through sorcery (El-Islam, 1978).

The early 1970s

Under the title of culture bound neurosis, 60 females with longstanding (>4 years) multiple recalcitrant somatic symptoms were compared to 40 other neurotic females presenting to the newly established and only psychiatric clinic during 1972-1973 (El-Islam 1975).

The physical symptoms, for which no adequate physical explanation was found, qualified these women for diagnoses of neurasthenic and hypochondriacal neurosis (300.5 and 300.7) according to the WHO ICD-8 (1968). Their commonest symptoms were giddiness or feeling faint (*dora*), which was attributed to the head, nausea (*chabid*), which was attributed to the liver, heartache and palpitations (*gulb*) and general fatigue (*ta'ban*), which was attributed to the limbs. Multiple consultations and negative physical investigations gave patients an implicit message that the doctors were looking for something they could not find. Many patients wondered whether they had serious or mysterious disease, which were incurable or unknown to doctors. They never

complied with prescribed medication which did not make them better, or made them worse through side effects.

When compared to controls, these women who somatised had significantly more number of the illiterate, the unmarried, the infertile, the marriages with primary or secondary infertility, threats of breakup of marriage and persistent gynaecological disorder. The findings were explained in terms of the then-prevalent indigenous and medical cultures. The former assigned to women the role of marriage and mothering. The number of children symbolized status and affluence. Women who did not fulfill this role were regarded as social failures. The medical culture was mostly made of doctors, who had no undergraduate training in psychiatry. They, therefore, colluded with the patients' somatic orientation and indulged in physical investigation and physical treatments. The syndrome was bound to, and conditioned by culturally shared social expectations. It was not geographically bounded or restricted to the culture in Qatar. The somatic symptoms of these patients elicited a lot of care from relatives (secondary gain), who reversed the causal sequence of events by attributing the women's failure to get married or to have children to their physical ailments.

The early 1990s

During the period 1990-1996, the culture bound syndrome was monitored by the author in the second stint of his work in the governmental psychiatric service, which he established in 1972. Only three cases were encountered, two of which belonged to the old series reported in 1975. Over a period of twenty years, education developed in massive strides and Qatar prospered economically with a gross domestic product that was one of the highest in the world. Females had equal access to educational opportunities and they excelled at all levels of education. Female school drop-outs before standard 9 were fewer than male drop-outs. The country became less dependent on expatriates. Women had multiple roles in society, and those who never married or had children were no longer regarded as social failures. In the affluent Qatari society many women became economically independent. The extended family, which broke into several nuclear households, maintained a functional integrity and interdependence of members through frequent visits and communications within the extended family framework. The group ego of the 1970s was still there in the 1990s and the family continued to manage the affairs of its healthy and unhealthy members alike.

DISCUSSION AND CONCLUSION The introduction of psychiatric services paved the way to early detection of psychogenesis of many somatic symptoms in neurotic patients. Primary care doctors had in-service training in Psychiatry. They could diagnose common psychiatric disorders and participate in their patients' aftercare. Consultation-liaison psychiatry with non-psychiatric specialists helped to orient them to the possibilities of psychiatric disorder in somatising patients. Their "suspicion index" of underlying psychiatric disorder had definitely improved. An Arab board graduate programme in psychiatry had been adopted and some Qatari doctors specialized in psychiatry.

Therefore, it was not surprising that the neurotic syndrome, which invalidated some women in the 1970s, had gone into eclipse over two decades. The culturally conditioned disorder changed its prevalence as the culture progressed from the adoption of dual roles (as wife and mother), to the adoption of multiple roles for women and as the medical culture became more conscious of the psychogenesis of somatic symptoms in Qatari patients.

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