

The sociocultural boundaries of mental health: experience in two Arabian Gulf countries

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Abstract *Mental health includes adjustment to human environments (positive component) and excludes psychological suffering (negative component). In Arabian Gulf communities in two countries little emphasis is placed on achievement motivation and work productivity among indigenous citizens. Therefore work adjustment has a minor role in defining ill health and recovery. Rapid socioeconomic change led to a lot of intergenerational conflict in the community and among psychiatric patients. An apparent rise in mental ill health rates associated with increased education that unmasked the less endowed and changed the attribution of disturbed behaviour from the supernatural to the psychological. Social problems e.g. deviance or misconduct have been psychologized.*

Collaboration with families provided an alternative to mental health legislation in these communities. Families are the only support of the mentally ill and their involvement in the patient-doctor relationship, aftercare and rehabilitation is the rule. Liaison with religious healers is minimal in the area of mental ill health. Auto-religious healing is encouraged instead of resort to religious healers.

Key words: mental health, positive mental health, culture, social change, achievement, mental ill health rates, supernatural attributions, family contributions

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INTRODUCTION The definition of Mental Health (Sells, 1969) securely affirmed its positive conception as the well being of adjustment and adaptation in the human environment, in addition to the absence of suffering during the performance of psychological functions, i.e. the absence of mental illness. Positive mental health satisfies the socially acquired motive of security and status among fellow human beings by employing psychological capabilities in order to fulfill the requirements of the family, work and other social environments. Adapting the environmental requirements to suit individual capabilities, leads to environment mastery. Adapting individual capabilities to suit the environmental requirements, leads to conformity. The negative component of mental health, i.e. the absence of mental suffering, refers not only to the absence of psychological symptoms in an individual, but also implies that others are not made to suffer by the individual's symptoms.

Twenty five years (1971-1996) of clinical and academic psychiatric practice in Kuwait and Qatar (El-Islam, 2000), which came after 6 years of practice in U.K., highlighted the role of culture in beliefs, attitudes and behaviour relevant to mental health. In these two oil-exporting Arabian Gulf countries the transgenerationally transmitted culture has been recently challenged by socioeconomic changes, which transformed the region from eighteenth century nomadic life to twentieth century civil life over two decades. New educational, occupational and informational

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opportunities have had a significant impact on traditional conceptions of mental health and mental illness.

The positive component of mental health

Culture in Kuwait and Qatar does not promote achievement motivation as defined by McClelland et al. (1953). For indigenous citizens, many jobs are created or overstuffed by individuals who are not motivated to carry out, or excel at, work. They receive wages for the post they are assigned, without much input on their part. Adaptation to the work environment does not contribute to positive mental health, because of the poor accountability of indigenous citizens. Most jobs are really the responsibility of expatriates. In a study of life events precipitating depressive illness, El-Islam et al. (1983) found that work-related events played a minor role in cases of depressed Kuwaitis and Qataris, compared to depressed expatriates.

Adjustment to the family environment, on the other hand, played a major role in mental health of Kuwaitis and Qataris. Mutual support and interdependence of family members play a major role in positive mental health and early detection of signs of mental ill health and their management. Patients living in traditional extended families presented earlier and fared better than those living in Westernized nuclear families (El-Islam, 1982). On the other hand, women's traditional monorole of marriage and mothering, which associated with mental ill-health in women failing to satisfy this role, has recently given way to multirole models. This associated with virtual elimination of the culture-bound monorole stress among women. Outdoor socialization is a traditionally male role prerogative and hence the high prevalence of social phobias in men and the rarity of agoraphobias in women who are nearly always escorted outdoors by family members (El-Islam, 1994).

Among indigenous citizens, exemption from law enforcement or even law breaking is a symbol of status and not a dissocial trait. Their ambivalent attitudes to expatriates are quite overt. Expatriate technicians and professionals outnumber indigenous citizens. They are indispensable for the everyday running of affairs in these countries, but have no political rights or rights to own land, business or homes. Mutual mistrust does not suggest any pathological suspiciousness between the indigenous and the expatriate in Kuwait and Qatar.

The negative component of mental health

The absence of suffering during the performance of psychological functions, which is the second pillar of mental health, is also subject to cultural considerations. Disturbed behaviour may not be considered a sign of mental ill health. The affected individuals are traditionally held to be the victim of supernatural agents and therefore they have no shame or guilt about their aggressive and/or socially embarrassing behaviour. Beliefs about temptation to wrong doing by the devil are not Schneiderian delusions of influence (Al-Ansari et al., 1989). Obsessional ruminations are generally attributed to the devil. Worries and morbid fears are regarded as signs of weakness of faith rather than signs of mental ill health. They therefore call for faith reinforcement rituals by traditional healers (allo-religious healing) or by the affected individuals themselves (auto-religious healing). No symptoms call for ostracizing an individual from supportive integration into the family. Religious cognitive schemas confer after-life rewards on those who patiently endure mental or physical suffering and it is only the blasphemous who give up the hope of relief by God. Hence, the rarity of suicide.

Intergenerational conflict and mental health

Rapid socioeconomic changes associated with the acquisition of oil wealth led to departure of the younger generation from traditions of their parents and grandparents. The young prefer equity in relationships of various family members, emancipation of women and love marriages to the traditional male authority in the family, the monorole of marriage and mothering for women and the arrangement of marriages by the family elders respectively. Intergenerational conflict undermines family support for its members and may precipitate professional help seeking for problems which are normally manageable within the family (El-Islam et al., 1986).

An apparent rise in mental ill health rates

The enforcement of basic school education for all citizens in Kuwait and Qatar unmasked the proportion of the learning-disabled who would otherwise have gone undetected in simple traditional nomadic life. Special mental health care programmes had to be provided for these individuals. Education provided alternatives to supernatural attributions of disturbed thoughts, moods and behaviour, the management of which shifted from the domain of traditional healers to the domain of mental health professionals when mental health services became available. Socially deviant or disapproved behaviour has been psychologized into mental health problems because the former brings shame on the family, whereas the latter call for support and sympathy by the family. Family violence has been psychologized in order to be decriminalized. Failure to observe religious rituals has also been reformulated as a mental problem, e.g. breach of the fast in public during the fasting month or the consumption of alcohol by Moslems. Similarly females with unconventional sexual behaviour may be referred to the psychiatric clinic for help.

A family alternative to mental health legislation

Families run the affairs of normal people in Arabian Gulf countries e.g. the management of property or business, nepotistic interventions, arrangement of marriages, decisions on professional help seeking, etc. Families are therefore expectedly involved in compulsory admission of psychiatric patients who do not agree with professional medical advice to be admitted voluntarily. The verbal agreement of a first-degree family member with a consultant is sufficient to secure an involuntary admission without the stigma of formal or written certification. Though patients were informed about their right to appeal, none did so. Families are the only welfare “officers” in these countries and family involvement is the rule in the patient-doctor relationship, community care, aftercare and rehabilitation for both the mentally ill and the physically ill in Qatar and Kuwait.

CONCLUSION The sociocultural heritage of beliefs, attitudes and traditions is involved in the recognition, pattern, management and outcome of mental ill health problems in Kuwait and Qatar. The generally agreed boundaries between mental health and ill-health, according to international definitions, should take into account local cultural considerations in specific communities in order to have practical applicability in clinical practice.

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