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Preliminary Psychiatric Observations in Egypt

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In the following paper a short clinical, descriptive account is given of the first 1,000 patients attending Ain Shams University Psychiatric Clinic from the beginning of 1966. Although the clinic is in the centre of Cairo, its catchment area extends all over Egypt. Patients are referred through three channels; either general practitioners send them for a psychiatric opinion or they come from other medical outpatient clinics at the University. The third group represents those who come independently and ask for psychiatric examination. Usually these are patients from the countryside who have tried lay therapy in their villages but without improvement. This group represents a deficit in the organization of referral, as many of them, having been examined at the psychiatric clinic may have to be referred to another medical outpatient clinic because of a non-psychiatric organic pathology.

The age of the majority of our patients ranged from 20 to 30 years. Married patients were the most frequent, representing 53·5 per cent. Males were commoner (57·4 per cent.) than females (42·6 per cent.). Almost all social classes were represented, except the upper classes which form a minority during our socialist reform. It is shown in Table IV that most of our patients belonged to the skilled group, followed by housewives and then students.

Schizophrenia

Schizophrenia is the commonest chronic variety of psychosis in Egypt and represents the major bulk of in-patients in our Mental Hospitals. Our figure of 15·3 per cent. of the total of newly examined cases at our University Hospital represents a different sample from those of Mental Hospitals as they show the percentage among psychiatric patients seen naturally in the community without the necessity of their admission to Mental Hospitals. We accept Lambo's denial (1960) of Carothers's statement that "paranoia, paraphrenia and even paranoid schizophrenia are relatively rare among Africans". As seen in Table VI, paranoid schizophrenia comes next to the hebephrenic type in frequency. Persecutory delusions with ideas of reference are the rule, delusions of grandeur are not common. The delusional content differs greatly in relation to the cultural background. What strikes one first and foremost in schizophrenia occurring among natives of the countryside is the naive belief in the intervention of supernatural beings, occult forces or magic. Systematized delusions are not common except in the educated group. Lambo (1960) did not accept the popular belief that catatonic schizophrenia is very common among the Negro populations of Africa. We found in our observations that catatonic forms were relatively common compared to other varieties. The main symptoms were retardation, withdrawal, mutism and stupor. This may be interrupted by outbursts of excitement. A large group of patients presented with an undifferentiated type of schizophrenia exhibiting a wide variety of symptoms such as confusion of thinking and turmoil of emotion manifested by perplexity, ideas of reference, fear, dream states and dissociative phenomena.

Schizophrenic defect state was commoner in patients belonging to the higher social classes. Patients coming from the countryside used to have an acute onset, better response to treatment and did not become chronic, most probably because of the protective nature of the family surroundings and the cohesion of the community among such classes. Our figures for the incidence and presentation of schizophrenia are fairly similar to those for the Continent except that we may have a commoner incidence of the catatonic and undifferentiated forms.

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TABLE I
Marital State

Single	424
Married	535
Widowed	18
Divorced	19
Engaged	4
	1,000

TABLE II
Age

0–9	14
10–19	176
20–29	307
30–39	294
40–49	141
50–59	47
60–69	18
70–79	3
	1,000

TABLE III
Sex

Male	574
Female	426
	1,000

TABLE IV
Job

Unskilled	134
Skilled	298
Professional	43
Student	171
Housewives	252
No Job	102
	1,000

TABLE V
Diagnosis

	Number of Patients
Anxiety	226
Hysteria	112
Obsessive Compulsive	26
Reactive Depression	107
Manic Depressive Psychosis	86
Involutional Melancholy	52
Schizophrenia	153
Schizo-affective	26
Hypochondriasis	45
Personality Disorder and Addiction	30
Adolescent Crisis	5
Anorexia Nervosa	1
Behaviour Disorder	24
Stammering	5
Nocturnal Enuresis	19
Mental Deficiency	25
Epilepsy	40
Dementia	12
Organic Reaction Type	6
	1,000

TABLE VI
Types of Schizophrenia

Simple	23
Hebephrenic	38
Catatonic	22
Paranoid	29
Acute Undifferentiated	19
Chronic Undifferentiated	11
Grafted	4
Schizophrenic Defect State	7
	153

Affective Disorders

The distinction between affective disorders and anxiety neurosis is well embedded in European psychiatry; in Britain it is a rather controversial subject and has valuable implications for responsibility in patients and for their disposal. Its value for African psychiatry is far more questionable.

It is usually asserted that in Africa the majority of manic-depressive illnesses are manic in form. We could not confirm this observation in our study, as less than one in five of our manic-depressives presented with a manic picture.

Some workers have denied the existence in depressed Africans of self-reproach and self-depreciation, but our experience denotes that these feelings are present but not a common feature of the illness. Physiological changes in the form of insomnia, anorexia and loss of libido are common presentations of the illness. The

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insomnia is not characteristically described as associated with early morning waking. Patients tended to be wakeful throughout the whole night. The patients lost interest in most things except religious duties in which they became deeply involved and absorbed. Agitation was commoner than retardation in all affective disorders in our cases. Neurasthenic symptoms and hypochondriasis mainly directed towards abdominal organs and skeleton, e.g. dyspepsia, distension, epigastric discomfort, vomiting, nihilistic ideas, pains all over the body, aches in the bones and joints, were common. These symptoms are very characteristic of the depressed Egyptian. The positive diurnal rhythm of the European depression has been encountered among our cases, but not highly represented. A neurotic overlay may colour the picture, especially in that many cases do not show the sadness of mood so characteristic of depression in Europeans. This pseudoneurotic picture may make the diagnosis rather difficult. Tendency towards chronicity is very rare in affective disorders in Egypt. The majority respond to M.A.O.I., e.g. nialimide, isocarboxazid, and to tricyclic compounds, e.g. imipramine and amitriptyline, or a combination of both in difficult cases. The response to electroplexy is dramatic, but patients are not very willing to accept such a line of therapy. It is a popular belief that electrical treatment is only given to mad people and so it may disturb the patient's reputation especially if she is a single girl awaiting marriage. Another false belief is that a patient who has received E.C.T. will need it all his life, will not respond to another line of therapy and will acquire a sort of dependency. Many of the psychiatric centres in Egypt still give straight E.C.T.s, but in our clinic we started two years ago to give modified E.C.T. under anaesthesia and muscle relaxants. This may gradually change the popular opinion about E.C.T. after a period of time. The majority of our patients respond to anti-depressants with smaller doses than those recommended for the European patient.

Information regarding the incidence of suicide in Egypt is scanty. It lies under a religious taboo, and usually the relatives do not inform any authority. From our clinical observations, we may say that suicide as a whole is not common and that it is not encountered frequently even among depressives, probably because of the Moslem religious background.

Anxiety Neurosis

Anxiety neurosis represents one of the major parts of psychiatric practice in Egypt. It was manifest in 22·6 per cent. of all our attendances and in our study was the commonest psychiatric presentation. It is usually secondary to a conflict situation or external events, being commoner in single and unhappily married women. Patients usually came complaining of palpitations, left mammary pain, choking sensation in the throat, shortness of breath, insomnia and unpleasant dreams. These symptoms are described in a particular pattern according to the individual's culture. Tension headache may be the sole presentation of anxiety, mainly described as heat and pressure on the top of the head radiating occipitally and bitemporally. These tension headaches are represented in our series as 1·6 per cent. of all our attendances. The same holds true of psychogenic impotence, 2·9 per cent. of all our cases. Males present this symptom with the guise of backache, pain in the thighs or knees or generalized asthenia.

Malignant anxiety states described by Lambo and other different acute native anxiety states were not observed among our patients. Most cases of anxiety neurosis responded adequately to supportive psychotherapy, M.A.O.I. and minor tranquillizers. There is an intractable group of chronic anxiety states with neurasthenic symptoms secondary to marital disharmony which does not respond to any line of therapy and represents a challenge to physicians.

Hysteria

Hysterical symptoms are perhaps the commonest neurotic manifestations in Egypt. No fewer than 11·2 per cent. of all our cases were suffering from an hysterical illness. Although many European and British psychiatrists (Slater, 1961) may deny the existence of hysteria as a primary entity and claim that it is secondary either to organic reactions or other psychiatric syndromes, yet many clinicians, especially in Africa, are aware that it can occur as a primary

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psychogenic disturbance. Hysteria manifests itself in fashions. Previous authors in Africa have surveyed hysterical illnesses in their countries, e.g. Lambo (1955, 1956). In 1960 Lambo stressed that periodic somatic disabilities and the massive hysterical ones of fluctuating intensity were characteristic of the primitive African in contrast to the monosymptomatic type of hysterical reaction of the westernized African.

Okasha (1967) surveyed the presentation of hysteria in Egypt among 100 females and 50 males. The majority of patients were between 20 and 40 years. It was commoner in married women and in single men. In his series, 12 per cent. were university graduates, which is contrary to the popular belief that hysteria occurs mainly in the uneducated classes.

Presenting symptoms in our present study were multiple rather than monosymptomatic. Motor disturbances in the form of paralysis were commoner in males (18 per cent.) as compared with females (8 per cent.). Hysterical fits, on the other hand, were more frequent in females (28 per cent.) than in males (4 per cent.). Other motor manifestations were not uncommon, e.g. spasms, tremors, aphonia and bizarre gait and globus hystericus.

Hysterical sensory disorders were more frequent in females, e.g. blindness, deafness, paraesthesia, anaesthesia. The description of their symptoms took a bizarre form, e.g. "sandpaper rubbing my skin", "ropes of fire encircling my neck", "worms tickling my skin". Those who were more educated used to bring maps of their bodies showing the non-anatomical distribution of their disturbed sensations. Dissociative phenomena, e.g. amnesia, fugues, twilight states and pseudo-dementia were far more common in males, usually secondary to marital or work dissatisfaction. None of them were aggressive or abusive during these episodes.

Visceral and somatic symptoms, e.g. headache, vomiting, anorexia, hiccough and pains, were more frequent in the middle classes. Hysterical illnesses in our culture, especially among the majority of lower classes and some of the middle classes, are attributed to spirits, witchcraft and the evil eye. These patients are looked after by native healers and through certain traditional cults. In a recent study (Okasha, 1966) it was found that 41 per cent. of all attendances of the traditional Zar cult in Egypt suffer from hysterical symptoms. The symptoms differed according to the level of education and social class. While visceral and somatic disorders predominated in the upper educated classes, motor, sensory and dissociative disorders were commoner in lower middle classes.

Obsessive Compulsive Neurosis

This illness was relatively common (2·6 per cent.). Obsessive rituals related to cleaning were the most frequent presentation. This may be attributed to the fact that cleaning plays an important role in Moslem religious rituals. Compulsive phobias were met with less frequently than in Europe, but ruminations and depersonalization were seen in many patients. Treatment was difficult, and the illness tended to take a chronic course and even those who improved were left with residual symptoms.

Hypochondriasis

Endemic helminthic and protozoal diseases are not uncommon in Egypt, especially bilharziasis, ankylostomiasis and amoebic dysentery. The majority of hypochondriacs focus their symptoms on the gastro-intestinal tract. It was rather common to find some active helminthic disease among many of our hypochondriacs, nearly one-third of our cases, but these endemic illnesses could not account for all their symptoms. Lambo (1960) found that ankylostomiasis and other nematodal infections were responsible for 32 per cent. of cases of hypochondriasis referred to their clinics in Nigeria.

We are not including here hypochondriasis secondary to schizophrenia, affective, obsessional, hysterical or anxiety disorders. Every psychiatrist has met patients in whom hypochondriacal symptoms fill the entire foreground of the picture and in whom there is little else to observe. This type of hypochondriasis represented 4·5 per cent. of all our attendances. Gillespie (1929) believed that hypochondriasis might occur as a separate entity characterized by a very chronic course, inaccessibility to therapy and not involving any deterioration of

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the personality. He considered it as one of the most intractable of psychiatric symptoms. Indeed, this was the picture we observed in our hypochondriacs. They were chronic attenders in all our out-patient clinics and were really a challenge for the psychiatrist. Symptoms were of a bizarre description, multiple and rarely monosymptomatic. They were commoner in females and more frequent in married women. In spite of their persistent hypochondriasis, they were able to keep their jobs and function satisfactorily in the society, a factor indicating the absence of gross personality disorder.

Psychiatric Disorders in Children

These disorders were not met with frequently. One obvious reason is a lack of awareness in the general public that these problems come within the province of psychiatrists. Behaviour disorders in children represented 2·4 per cent. of all our cases. They were mainly in the form of hyperactivity, aggression, stealing and wandering around. This was commoner in patients from cities than from villages. In the Egyptian village, the conditions are present to develop happy and socially secure children. Such children learn crafts and appropriate conduct from their parents and elders by imitation rather than precept and are gradually initiated into the fuller social responsibilities of the extended family community. If such people move to the cities, their work becomes mechanized, mothers as well as fathers work away from their homes, they pass on to their children little knowledge and fewer skills which could earn them the children's respect. In such circumstances, it is difficult to train their children in the social responsibilities, hence delinquency and behaviour disorders tend to develop. Since schooling became compulsory, there is a tendency to see more cases of educational problems.

Nocturnal enuresis was represented in 1·9 per cent. of our cases. Bedwetting is tolerated in a child up to 5 to 6 years. The age at which parents decide to do something about it depends on their tolerance and their degree of sophistication and usually it is between 7 and 10 years.

Stammering occurred in 0·5 per cent. of cases. It was clearly secondary to anxiety neurosis, mainly manifest at the age of entry to school and at puberty. It was restricted to children living in big cities. We have not seen any cases among those coming from the villages. This confirms previous suggestions that stammering is very rare or never occurs in primitive peoples. Encouraging results were obtained when stammerers were treated psychotherapeutically under the influence of LSD (Okasha and Hassan, 1967).

Mental deficiency was not a great problem in the past, owing to the high infant mortality rate which accounted for the death of those with a low degree of viability, and certainly because of the lack of any high demand of intellectual performance made on children in the past. But, now, with a decreasing infant mortality rate and increasing intellectual demands on children, we are beginning to see more cases of mental deficiency. It was represented as 2·5 per cent. of all our attendances. Idiocy and imbecility were very rarely encountered and most of the cases fell in the category of feeble-mindedness. The majority were undifferentiated subnormality, but some were the consequence of a febrile illness, possibly encephalitis.

Personality Disorders

Aggressive psychopaths are rarely met with in psychiatric clinics as they are usually dealt with in prisons. Our main cases of personality disorders (2·1 per cent.) were those described as inadequate, emotionally callous personalities, usually drifters with a bad work record, multiple marriages and sexual offences associated with hypochondriasis. Addiction represented 0·9 per cent. of all our attendances. Alcoholism is rare in Egypt, as alcohol is prohibited by the Moslem religion. Alcoholics are usually found among the middle and upper classes. The commonest types of addiction we face are opium, barbiturates and meprobamate. Addicts seek treatment because of social and family pressure, or lack of economical means, or inability to obtain the drug.

Hashish represents a major problem in Egypt. It has been known in the Middle East for 500 years, and probably much longer, that the flowering tops of cannabis indica or sativa have

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a pleasant intoxicating effect. It is used chiefly because it has been held, very debatably, that it acts as a sexual stimulant and prolongs the sexual act. It is unlikely that there is any specific effect, but it may serve as an aphrodisiac by inhibiting higher moral control and releasing instinctive desires. It is rare to find a hashish smoker presenting himself at the psychiatric clinic, in spite of the fact that it is a common habit, as most people do not consider it an addictive drug. There is no increased tolerance, no need to increase the dose and withdrawal symptoms are minimal, facts which lead many experts to consider it a habit forming rather than an addictive drug. The chronic hashish psychosis described by earlier observers have proved to be, in most cases, schizophrenia complicated by symptoms of cannabis intoxication.

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

The majority of hashish takers started its use before the age of 20 years. Their conscious motives in taking hashish for the first time were in the following order; conformity to a group of personal friends, seeking euphoria, curiosity, trying to appear like "real men", and lastly the desire for sexual excitement. Positive family history of hashish dependence was marked. Soueif (1967) found that hashish takers were found to suffer from some manifestations of anxiety as defined by a few items selected from the Taylor anxiety scale. He also found some perceptual disorders under the immediate effect, of hashish, namely distances seeming longer, sizes appearing bigger, contours of objects became blurred, colours looked brighter. Some complained of memory impairment for recent events and of flights of ideas. The majority of patients stated that they had competent thought processes and could often work adequate solutions for their problems. Hashish takers presenting to our clinic did not show evident social deterioration, and their referral was because of family pressure for financial reasons. Obvious deterioration was noticed when its dependence was mixed with that on other drugs or opium. Productivity may be impaired under both conditions of being drugged and craving for the drug, but this effect is usually transitory. Most of our hashish takers were holding jobs satisfactorily and leading their marital life successfully.

Epilepsy presented as 4 per cent. of our psychiatric clinic. The main form was grand mal fits always associated in the minds of lay people with hysterical fits. Less than one-quarter of our epileptics showed personality disorders. Many of them used to seek traditional native treatments, as the disorder is believed to be due to a possession by an evil spirit.

Conclusion

Our present preliminary clinical observations are intended to give a sketch of the nature of psychiatric morbidity in Egypt. Although the incidence and the content may be different from European and other African psychiatric illnesses, most of the illnesses can be grouped under the same psychiatric nomenclature.

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