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Depression and Suicide in Egypt

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ABSTRACT

Depression was known in Pharaonic Egypt and we can trace descriptions in odes and poems in some Egyptian papyri (1800 B.C.) (Okasha, 1978). According to Egyptian beliefs, suicide was irrelevant and so was dealt with on a marginal level. It was asserted that in Africa the majority of manic-depressive illnesses are manic in form. Our study in Egypt did not substantiate these data and less than one in five of our manic-depressives showed a manic picture.

A survey in the psychiatric out-patient clinic revealed affective disorders in 24.2% with neurotic depression 10.4%, manic-depression 8.6% and involutional melancholy 5.2% (Okasha, 1977). Suicidal attempt and suicide were commonest among depressives especially in the young age group. A recent study in Cairo by Okasha et al (1979) gave a rough estimate of suicide at 4/100,000 and attempted suicide at 38/100.000. Cross-cultural comparison between Egyptian, Indian and British depressives showed that Egyptians have a significant increase in suicidal tendencies but not in actual suicide or attempted suicide. A survey of suicidal feelings among non-consulting medical students will be discussed.

TRANSCULTURAL STUDIES OF DEPRESSION

Murphy (1965) tried to draw profiles of depressive symptoms reported from different European countries. It was noticed that the

French have a rather low incidence of suicide with a high incidence of somatic preoccupation, the Germans a high incidence of anorexia, the Polish a higher incidence of preoccupation with poverty and the Scandinavians a high frequency of guilt feelings and suicide. Pancheri (1975) concluded that the diagnostic criteria of depressed neurotic psychopathology seemed to be much stricter in the Swiss population than in the Italian one and that some manifestations of anxiety and depression are tolerated more readily in an Italian context that in the Swiss.

The transcultural diagnostic problem was also encountered in the U.S./U.K. diagnostic survey (Cooper et al., 1972). There were twice as many schizophrenics in the New York sample and five times as many psychotic depressives and twelve times as many manics in the London sample. This difference is most probably related to different diagnostic habit patterns (Willis, 1976).

Yap (1958) has noticed the absence of delusions of sin in the Chinese as well as Japanese depressives. He also refers to the frequency of hypochondriacal depressives among the Chinese (Tejer et al., 1971).

Rao (1966) reported that the symptoms of anxiety, agitation, somatic complaints and suicidal tendencies were found to be commoner in South Indian depressives. Also agitation was commoner than retardation. Depressive disorder was thought to be virtually non-existant in Africa (Carothers, 1951). Baasher (1966) in the Sudan and Okasha (1967) in Egypt found the incidence of affective disorders in the out-patient clinics 33% and 24.5% respectively. Collamn (1961) in Senegal noted that the depressions are characterized by ideas of persecution, anxiety, hypochondriasis and somatic complaints made an excellent response to ECT.

AFFECTIVE DISORDERS IN EGYPT :

No known physician's title suggests specialization in mental diseases, although psychic and mental symptoms are mentioned in many papyri, mamely Ebber's papyrus (1600 B.C.) translated by Ebbell (1926). In many odes and poems we can find descriptions of depressions (Ghaliongi, 1963). Many observations attributing depressive illnesses to vascular causes were stated in the 'Book of the Heart'. The heart and the mind meant the same thing in the ancient Egyptian Language, e.g. happy = Long of heart; depressed = short of heart; attentive = counted of heart.

Suicide has not been dealt with in Egyptology except on a marginal level. According to the Ancient Egyptian beliefs, suicide was irrelevant (Okasha, 1978).

By destroying the body (instead of having it embalmed according to traditions and nourished by offerings) the soul would lose the house into which, according to the Egyptian belief, she must return every night in order to be renewed and to be reborn the following mornning at sunrise, i.e. to live eternally. Here we are confronted with the very essence of the Egyptian ethics. The Egyptians felt not only the "Ba", i.e. the soul, but the whole organs of the body as the heart, liver, kidneys to be God's responsibility, the dwelling places of the divine powers to the extent that eating and drinking becomes virtually a duty of man towards these divine powers. The question whether suicide is sinful and thus subject to eternal condemnity becomes irrelevant, if the mere preserving of the corpse by embalming it and supplying it and with offerings suffices to keep the soul alive it apparently no longer matters if man reached death by committing suicide or by awaiting it deliberately, as long as the corpse itself is not extinguished by fire or drowning. Apart from Cleopata's suicide, this problem was not an issue in Ancient Egyptian literature.

It was usually asserted that in Africa the majority of manic-depressive illnesses are manic in form. We could not confirm this observation in our study in Egypt since less than one in five of our manic-depressives presented with a manic picture. The incidence of such disorders among our out-patients was about 24.5%, with reactive depression accounting for 15.7%, manic-depression 8.6%, and involutional melancholy 5.2%.

Some workers have denied the existence of 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 insomnia is not characteristically described as associated with early morning waking. Patients tended to be wakeful throughout the whole night. The patient lost interest in most things except religious duties in which he 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 pain, 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 it is 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 depressed Europeans. A tendency towards chronicity is very rare in affective disorders in Egypt. The response to electropiexy 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 that a patient who has received ECT will need it all his life.

Information regarding the incidence of suicide in Egypt is scanty. It lies under a religious taboo. From our clinical observation, we may say that suicide as a whole is not common and that it is not encountered frequently even among depressives, probably of the Moslem religious background. We conducted a recent study in Cairo, this study comprises 200 cases from a total of 1,155 patients who attempted suicide in 1975 and were admitted to the casualty department of Ain-Shams University Hospital in Cairo, which has a catchment area comprising approximately 3 million people. A crude rate of suicide attempts in Cairo would be 38.5 / /100,000. There was a high percentage among the age group 15–44 years with no major differences between the two sexes. Single patients represented 53 / of the total, with students showing the highest risk (40 /). Depressive illnesses, hysterical reactions, and situational disorders, in that order of frequency, were the causes of the attempt. Overdose by tablet ingestion was the most common method used (80 /). Official government records are misleading and do not represent the true rate.

Egyptian depressives have been studied recently (Arafa, 1978; Okasha, 1977) and the following was noticed: 75 / of patients were aged between 20–50 years, 42 / were males, 73 / were married and 27 / were single. The education, occupations, diagnoses, duration and severity of the illness are shown in the tables. Most research workers in Egypt face the socio–economic situation. They usually use the occupational level and income as parameters for defining the social class and it roughly distinguishes between three classes : upper, middle, and lower. It is estimated that 85–90 / of the sample of the study belonged to the lower class.

SYMPTOMATOLOGICAL DIFFERENCES OF EGYPTIAN DEPRESSIVES :

The frequency of symptoms of depression as seen in the 100 patients listed in order of frequency according to Hamilton's rating

scale is shown in the tables. Arafa (1978) attempted to compare the Egyptian study with a similar Indian one and two British studies to find any variable qualitative differences between the Egyptian depressives and others. The results and their significance are shown in the table. The following features could be observed :

1. Symptoms of depressed mood, anxiety, somatic complaints and suicidal tendency are significantly more frequent in the Egyptian study compared to that of Carney **et al.** The difference is marked in somatic symptoms (87% versus 13%). In contrast, guilt, insomnia and hypochondriasis are significantly more frequent in the British study but is insignificant in retardation, diurnal variation and paranoid symptoms.

2. No significant difference is found between the Egyptian sample and that of Kiloh **et al.** (1963) as regards initial insomnia, retardation diurnal variation and paranoid trends. Guilt is higher in the British but statistically insignificant. Agitation, hypochondriasis, late insomnia and obsessive trends are higher in Kiloh's study while those of depressed mood, suicidal tendency and anxiety are more frequent in the Egyptian study.

3. The comparison between the Egyptian and Indian studies showed that symptoms of guilt, insomnia, retardation, agitation, hypochondriasis and diurnal variation are significantly more frequent in the Indian sample. It is especially marked in agitation (68% versus 8%).

Frequency Distribution in Percentage of Various Symptoms in the Four Studies.

	Symptoms	Egyptian	Indian (Teja et al.	British (Carney et al.)	British (Kh. & Gsd.)
1	Depressed mood	100	100	60	63
2	Guilt	23	48	59	31
3	Suicidal trends	93	80	48	60
4	Insomnia, initial	55	84	75	61
5	Insomnia, late	23	92	67	37
6	Retardation	40	77	50	36
7	Agitation	8	68	INA**	41
8	Anxiety	99	80	61	48
9	Somatic symptoms	87*	76*	13	INA
10	Hypochondriasis	31	73	51	57
11	Diurnal variation	31	58	41	41
12	Paranoid symptoms	25	14	28	19
13	Obsessional symptoms	18	3	INA	29

* Average of somatic: GI, somatic: general and anxiety: somatic.
** INA = Information not available.

Increased somatic symptoms can be explained in terms of lower differentiation of emotional states or, in other words, an incapacity to verbalize feelings in developing societies and thus stressing the somatic concomitants of emotions. The same applies to people of lower classes and lesser education. Another explanation might be related to the concept of the sick people as the doctors expect physical symptoms in

their practice. Thirdly it can be a defence mechanism against the experiencing of the painful background affect.

Agitation is more frequent and can be explained as being due to the lower level of emancipation of such patients who would more likely express their inner turmoil in an agitated manner with little constraint.

The Egyptian showed a less well-developed individuation and assumption of self-responsibility for one's acts and viewed their life roles more as a part of a social system and thus their guilt feelings take a rather impersonal attitude externally directed while in the Westerner, guilt is internalized, personal and self-centered owing to their greater degree of individual self-responsibility and independent role playing. The Christian religious concept of original sin may also contribute to feeling of self-guilt in the Western depressed patient.

Paranoid symptoms can be explained by the widespread use of projective mechanisms in Africa. Its higher frequency in the British may be due to a more competitive existence of the Westerner which fosters a suspicious, paranoid attitude.

The high incidence of suicidal trends in our Egyptian depressives, in spite of the low rate suicide and attempted suicide, can be explained by the fact that the suicidal act has two components, an emotional one which is part of the disease and an ideational one which causes the execution of the act. So suicidal feelings may be prevalent, but the family cohesion, the lack of social alienation, the religious condemnation of the act and its social unacceptance, can explain the discrepancy between the trend and the attempt or act.

Further study by the author (Okasha et al., 1981) on the prevalence of suicidal feelings in a sample of non consulting medical students revealed interesting results. Five hundred and sixteen final-year non consulting medical students were studied as to the occurrence of di-

fferent degrees of suicidal feelings. A total of 12.6% reported some degree of suicidal feelings during the past year. Responses ranged along a continuum such that subjects reporting the intense feelings also reported the less intense feelings.

In 5.6% of the subjects the maximum intensity was only a feeling that life was not worthwhile, 4% had thought of taking their life, 0.9% had seriously considered suicide or made plans, and 0.4% had made an actual suicide attempt.

Subjects experiencing suicidal feelings in the past year had had more minor psychiatric symptoms, particulary of depression, and had experienced more stressful events and somatic illness. In these respects they resembled the description of completed suicide.

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الموجـــــــز

العلاقة بين الانتحـــار والاكتئاب فى مصر

عرف الاكتئاب فى مصر الفرعونية ، ونســـتطيع أن نجد وصفا له فى الأشـعار والقصائد الغنائية المسجلة على ورق البردى (عام ١٨٠٠ ق.م) (عكاشـة ، ١٩٧٨) . وتبعا للمعتقدات المصرية القديمة ، لم يكن للانتحـــار

اهمية تذكر ولذلك عومل بطريقة هامشية . وقد كان من الشائع قبلا أن مرضى الهوس ـ الاكتئاب فى أفريقيا يظهر فى معظم الحالات فى صورة هوسية .

وقد أجرينا مسحا للمرضى النفسيين بالعيادة الخارجية اظهر أن اضطرابات الوجدان تشكل نسبة ٢ر٢٤٪ من المرضى ، ٤ر١٠٪ منها شخصت عصابا اكتئابيا ، و ٦ر٨٪ مرضى الهوس ـ الاكتئاب ، و ٢ر٥٪ شخصت حالتهم « السوداوية الارتدادية » (عكاشة ، ١٩٧٧) ووجد أن الانتحار ومحاولاته أكثر شيوعا فى مرضى الاكتئاب وبخاصة صغار السن منهم . وتقدر دراسة حديثة أجريت فى القاهرة (عكاشة وآخرون ، ١٩٧٩) نسبة الانتحار تقديرا تقريبيا بنسبة ٤ : ١٠٠٠٠٠ ومحاولات الانتحار بنسبة ٣٨ : ١٠٠٠٠٠ .

وتوضح دراسة مقارنة بين المصريين والهنود والبريطانيين الذين يعانون من الاكتئاب أن المصريين لديهم ميول انتحارية أعلى بشكل دال ، دون أن يظهروا ارتفاعا مماثلا فى الانتحار الفعلى ومحاولات الانتحار . كما سيناقش المقال الشعور بالرغبة فى الانتحار بين طلبة الطب الذين لا يشكون من مرض معين .

ABSTRAIT

La Dépression et le Suicide en Egypte.

La dépression fut reconnue en Egypte pharaonique et on peut tracer ses descriptions dans les odes et les poèmes rapportés dans certains papyrus Egyptiens (1800 B.C.) (Okasha, 1978). Suivant les croyances de l'Egypte ancienne, le suicide était insignifiant et par conséquent il était traité sur un niveau marginal. On a pu prouver qu' en Afrique la majorité des maladies maniaco-dépressives était en forme de manie. Cependant, notre étude en Egypte n'a pas pu prouver ces données et moins que 1 sur 5 de nos malades maniaco-dépressifs a présenté un tableau clinique de manie.

D'ailleurs en faisant le relevé de tous les cas qui se sont présentés à la clinique de consultation psychiatrique, on a pu montrer la présence des troubles affectifs chez 24,2 % avec la répartition suivante : 10.4 % présentant la dépression névrotique, 8.6 % la maladie maniaco-dépressive, 5.2 % la mélancholie d'involution (Okasha, 1977). Les tentatives de suicide te le suicide étaient plutôt fréquents parmi les déprimés et en particulier, chez les plus jeunes parmi ceux-ci. Une étude récente conduite par Okasha et ses compagnons (1979) a donné une estimation approximative du suicide s'élevant à 4/100 000 et celle des tentatives de suicide à 38/100 000. Une étude transculturelle comparant des déprimes Egyptiens, Indiens, et Anglais a montré que les Egyptiens présentent des tendances suicidaires plus importantes que le suicide même et les tentatives de suicide. De même, les résultats de l'étude des idées suicidaires parmi les étudiants de médecine non-consultant ont été discutés.