How to Make Mental Disorders less Common

By E.M. Gruenberg

ABSTRACT

The author has tried to point out why a public health perspective is a necessary complement to our clinical perspectives. He emphasizes the social responsibility of psychiatrists as physicians to pay attention to activities outside their own speciality which will protect the people's health.

He mentions six preventive programs as being of crucial importance at this stage of our knowledge:

1. **Early detection and effective treatment of syphilis.**
2. **Avoiding excessive dependence on Indian maize.**
3. **Elimination of measles and German measles.**
4. **Reduction in frequency of Down's syndrome live births.**
5. **General protection of fetal development from malnutrition, injury, poisons and infections.**
6. **Protecting the social support systems of people with chronic disorders.**

I will try to point out why public health perspectives are a necessary complement to our clinical perspectives. I will try to emphasize the social responsibility of psychiatrists as physicians to pay attention to activities outside their own speciality which will protect the people's health.

I. Mental Disorders are increasing in frequency.

Psychiatrists and mental health people often say that mental disorders are becoming a more common problem in modern society. When we say a condition is "more common" we speak of the proportion of the population which has the condition at any particular time. This proportion is different at different ages. Look at all psychoses (Figure 1). There are two mechanisms by which we can be confident that mental disorders will become more common in almost all countries of the world. First, the age groups with the highest prevalence rates will grow faster than the rest of the population.

Figure 1 shows the point prevalence rates of the serious mental

Prevalence of all Psychoses* and
% Increase in Egyptian Population 1975 - 2000**

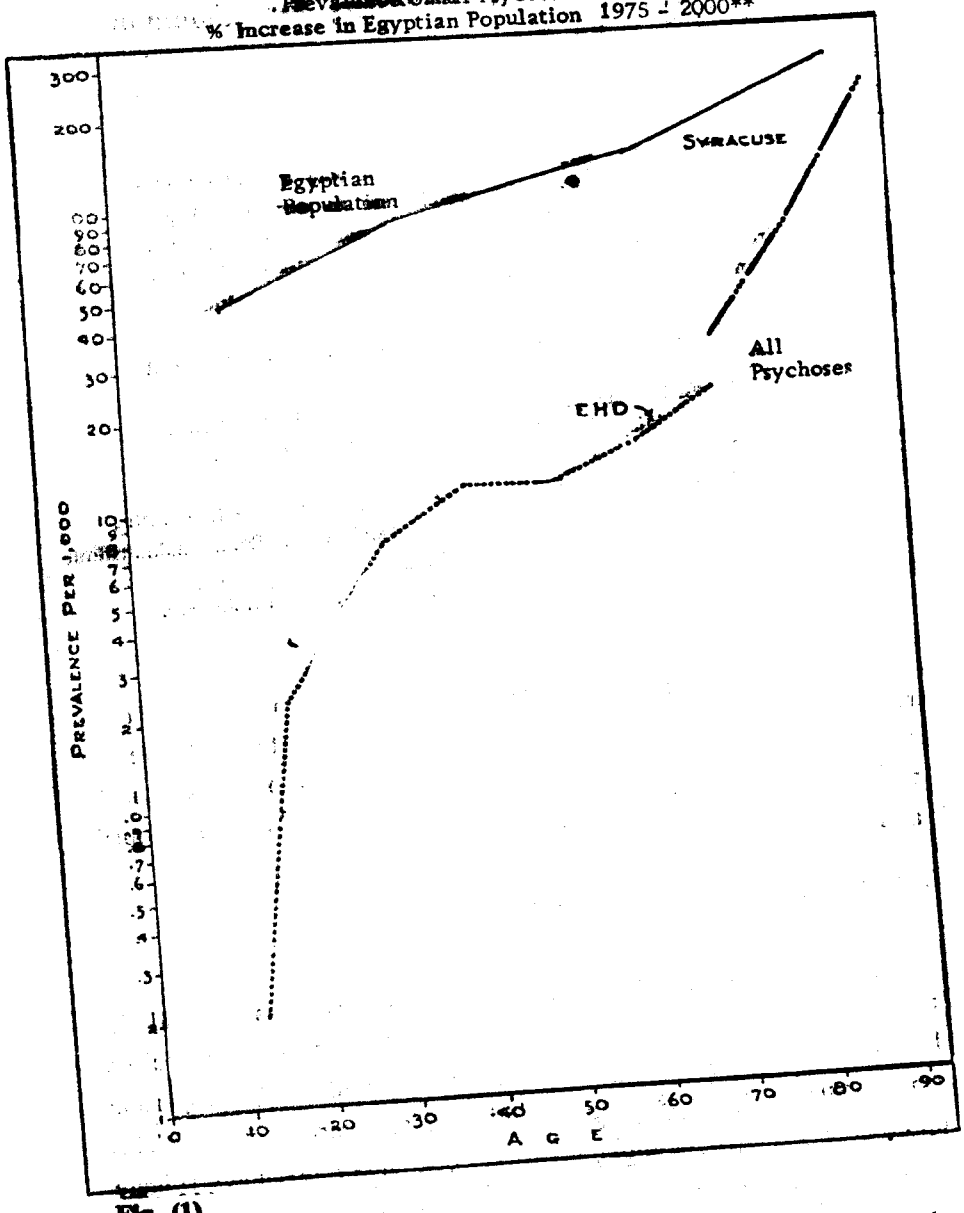

Fig. (1)

* Adapted from Gruenberg, E. M. : Epidemiology of Mental Disorders and Aging, Chapter 10 in Moore, J. E. ; Merritt, H. H. ; and Masseling, R. J. : The Neurologic and Psychiatric Aspects of the Disorders of Aging. Baltimore, Williams & Wilkins Co., 1956.

** Estimates from Population Division, United Nations (1976). Population by Sex and Age for Regions and Countries, 1950-2000, as Assessed in 1973: Medium Variant, ESA/P/WP.60.

disorders-psychoses. (I have substituted "point prevalence rate of psychoses" for the "proportion of the population with psychoses" to accustom you to this piece of epidemiological terminology.) The point prevalence rate is a useful ratio to think about when thinking of diseases as public health problems. The point prevalence rate is the proportion of the population ill with a given condition at any one moment in time.

The upper line in the figure shows how each age group will grow between now and in the year 2000. As you can see, as your population grows, these age groups with high prevalence rates of psychoses will grow disporportionately more rapidly and therefore the number of people with serious chronic mental disorders will grow faster than your population as a whole.

Secondly, I have pointed out in several publications that a number of serious disorders which we do not know how to prevent are becoming more common due to new medical techniques that cure the fatal complications of chronic illnesses.

As a result, each episode of these chronic illnesses becomes lengthened and by that mechanism the proportion of the population which is ill at any one moment in time is rising. I first was able to demonstrate this objectively with respect to senile dementia in Southern Sweden in collaboration with Professor Olle Hagnell a few years ago. Others have demonstrated the same type of mechanism with respect to Down's syndrome where the life expectation of a newborn infant with this terrible congenital handicap has increased several folds in the last forty years. Once people become ill with these conditions their chances of staying alive have increased at the same time that our ability to terminate the illnesses has not increased. We estimate that schizophrenia — which has always been associated with a higher mortality rate than that of the general population — is also increasing in point-prevalence rate.

So you may remain confident that no matter how successful we are

in our preventive programs there will be a growing need for clinicians who specialize in psychiatry during your life time. In fact you know very well that you will never be able to provide the services to the mentally ill that are needed so you should not be afraid of effective prevention methods.

We cannot do all that we would like to do, but we should, at least, make certain that we are doing what we know how to do to reduce the burden of mental disorders.

The way to reduce the burden of mental disorders is the same as the way to reduce the burden of any other group of disorders: first, prevent what we know how to prevent; second, terminate or mitigate illness that we know how to terminate or mitigate; third, reduce the disabilities suffered as a result of illness where we know how.

II. Mental Disorders which are now being prevented.

2.1. Syphilis of the Central Nervous System

Before the Second World War as many as ten percent (10%) of all admissions to mental hospitals in some of the states of my country were for psychotic conditions due to syphilis of the central nervous system. When I was an intern we were just introducing malaria treatment for central nervous system syphilis. Today psychiatrists hardly ever see a case of central nervous system syphilis psychosis. This is due to the early and effective treatment of primary and secondary syphilis with the same drugs which cure pneumonia. Penicillin has defeated tertiary syphilis, but this is a very clumsy way of controlling a disease of such widespread importance. In my country syphilis infection became more common than ever after we learned to cure it and the need to maintain constant vigilance and assure effective treatment in its early stages absorbs a great deal of public health and medical personnel. We still do not know how to control syphilitic infections in our population but we do know how to keep each case from progressing to the point where the central nervous system is seriously damaged.

2.2. **Pellagra Psychosis**

Pellagra psychosis at one time accounted for almost ten percent (10%) of the admissions to the mental hospitals of South Carolina, U.S.A. The discovery by Goldberger and Sydenstricker that this disorder of the skin and nervous system was due to a specific nutritional deficiency is one of the great chapters in the history of public health. No investigations have done more to clarify the intimate connection between the general living conditions of people and the specific disorders from which they suffer. It is particularly appropriate here to mention the fact that they were influenced in their thinking by Dr. F.M. Sandwith who described pellagra at the Cairo Lunatic Asylum in 1889 when he was honorary physician to the Kasr El-Aini. He associated pellagra with diets based on Indian maize. Goldberger and Syndenstricker showed conclusively by 1927 that pellagra is associated with a diet almost entirely composed of foods derived from Indian maize without supplementation from other sources.

Rose showed that this was the general situation regarding pellagra in Southern Europe, Northern Africa, and other parts of the world and also that only populations whose diet was planned by an institution or by an industrial or cash crop labor employer developed this condition. The systematic planning of feeding of working populations has attracted some administrators to the possibility of providing practically all the calories needed from Indian maize which is a very cheap source of energy. When people are free to buy a diet to suit their own tastes they will vary it sufficiently to avoid pellagra. In my country pellagra has become almost unknown as a cause of psychosis or otherwise. This has not been due to an organized public health program by the state of South Carolina or by the United States Public Health Service. On the contrary, it has become obsolete with social changes and general education of the public particularly by the agricultural extension service in the areas where the studies were made. This disappearance of the disease Table 1 (a slide from the Group for the Advancement of Psychiatry's Pamphlet) as a result of general information spread without an

TABLE I

Psychoses With Pellagra, Rate Per 100,000 Civilian Population and As Percent of All Diagnoses to the South Carolina State Hospital, For Selected Years

YEAR	NUMBER		RATE PER 100,000 POPULATION[1]		PERCENT PELLAGRA CASES OF ALL DIAGNOSES	
	First Admissions	Resident Patients	First Admissions	Resident Patients	First Admissions	Resident Patients
1920	19	24	1.13	1.43	2.97	1.09
1922	49	28	2.88	1.64	7.55	1.17
1923	57	35	3.35	2.06	8.05	1.45
1924	50	27	2.93	1.58	7.01	1.07
1933	43	84	2.45	4.80	5.14	2.43
1935	27	29	1.53	1.64	3.99	0.81
1940	14	11	0.74	0.58	1.34	0.24
1941	21	20	1.12	1.07	2.07	0.43
1942	12	9	0.65	0.48	1.23	0.19
1943	5	6	0.28	0.34	0.53	0.13
1944	2	2	0.11	0.11	0.20	0.04
1945	4	4	0.22	0.22	0.36	0.08
1946	0	1	0.00	0.05	0.00	0.02
1947	1	1	0.05	0.05	0.08	0.02
1948	1	1	0.05	0.05	0.07	0.02

[1] Population sources:
1920, 1922-1924—Statistical Abstract of the U.S., 1933 Bureau of the Census;
1933 and 1935—Population Special Reports, Series P-45, No. 4, Bureau of the Census;
1940-1948—Population Estimates Series P-25, No. 47, Bureau of the Census.

from Group for the Advancement of Psychiatry: Problems of Estimating Changes in Frequency of Mental Disorders. Report No. 50. Formulated by the Committee on Preventive Psychiatry. New York, 1961.

organized public health program illustrates a general principle of public health: as the great public health leader of Yugoslavia, Andrei Stampar, once said "the health of the people is the concern of the people themselves." The health of a population depends in the first place on their standard of living. In the second place, on their general level of education. And in the third place on the specific hazards to their health that they are exposed to and what they know they can do about it.

I put so much emphasis on pellagra because it is still reported as endemic in your country. It is not expensive to eliminate but the methods for doing so require an examination of the feeding patterns in certain industrialized sections of the country. Certainly, psychiatrists should concern themselves with a condition which produces psychoses and is so readily prevented.

(Both the pellagra-producing diet and the spirochete were imported to your country from America. I am telling you how we now prevent them).

2.3. **Measles and Rubella**

The great Arabic physician, Rhazes, is generally credited with the first clinical description of measles. He recognized it as a relatively minor common infection to be distinguished from smallpox, scarlet fever, and other common infections. He also recognized that it sometimes led to brain inflammation and serious encephalitis and occasionally to death. His observations on this important disease were largely forgotten until after the great English physician of the seventeenth century Thomas Sydenhan, rediscovered measles as a separate common infection in childhood.

In general there has been a tendency to underestimate the importance of measles in medical circles mainly because there was nothing that could be done about it. It was one of those infections generally contracted in childhood which seemed inevitable because it was so highly infectious. However, those who paid close attention to the disease

recognized that the virus could produce very serious damage and sometimes caused death. Fifteen years ago a vaccine was developed to provide artificial immunity against measles. Because the importance of the disease was not considered very great, the experts permitted private licensing of the vaccine and watched for its effectiveness and safety, but it was not distributed as a public health measure. This situation has changed significantly in the last few years.

Rubella or German Measles had been regarded as an even more minor infection than measles until the Australian ophthalmologist Gregg, in 1941, first observed an epidemic of congenital cataracts following an epidemic of German measles and connected the two. Later it was shown that German measles contracted during the first trimester of pregnancy not only produced congenital cataracts but many other congenital abnormalities, and also serious forms of mental retardation.

As a result of various studies we know that both measles and German measles can produce serious brain damage with resulting mental retardation. We also know that there is a spectrum of damage of the developing central nervous system which can occur either early in pregnancy or early in childhood that produces a wide range of syndromes: epilepsy, school failure, mental retardation, impulsive behavior disorder, and other signs of what now is called "minimum brain damage" including the currently popular "hyperactive syndrome."

The vaccines for measles and rubella are now safe. They have become so widespread that the transmission of these two viruses has been interrupted for considerable periods in many communities. But (1) early vaccines were not always potent, (2) even potent vaccines do not produce lasting immunity if vaccination is done before the first birthday and (3) the immunization programs have not always been diligently pursued. So a significant unimmunized population is developing in older age groups in my country.

A few months ago our Surgeon General, Dr. Julius Richmond, succeeded in getting our government to adopt a policy to interrupt trans-

mission of measles virus within the United States by 1982. It is expected that other countries will soon follow. The program's focus is on interrupting measles virus transmission but divalent vaccines which immunize against rubella are recommended.

In communities where measles usually occurs before the first birthday it may be necessary to vaccinate young infants which requires a different kind of campaign. Unless the first is successful a second campaign to revaccinate the same children at school age may become necessary.

If this is done and the World Health Assembly adopts measles and German measles' eradication as a global policy, we can look forward to the day when these two significant causes of brain damage are no longer present and have been exterminated as we expect smallpox to be exterminated in the near future. Only then can we look forward to a time when we will no longer have to immunize every child against these two viruses. That is the ultimate type of prevention and the ultimate type of cost containment from disease and disability.

The move to interrupt measles virus transmission illustrates a fundamental principle about the relationship of mental health experts to the rest of the health professions. The vaccine for eliminating the measles has been present for several years. Until health personnel pointed out the long-term consequences for significant numbers of young children, immunization programs lagged. The motivation to launch the current campaign to interrupt the transmission of measles was provided when mental disorder epidemioligists made the life-long handicaps obvious.

From this we should learn at least one psychiatrist in each country should stay familiar with the techniques of protecting the brain from injuries, poisons, malnutrition and genetic defects so as to interact effectively with your colleagues in the Ministry of Health. When we see a case of defective impulse control in a youth (or in an adult) which we attribute to brain damage we usually cannot tell what the cause of the brain damage was. We do not know which ones were due to measles, which ones were due to an episode of malnutrition, or a minor injury during

delivery. These are not distinguishable from one another clinically when they become manifest in later life. We can only encourage the prevention of all forms of brain damage which are technically preventable and thus reduce the frequency of such cases.

2.4 Chronic Social Breakdown Syndrome

We now know that many serious mental disorders (schizophrenia, post-traumatic psychoses, manic-depressive psychoses, serious depressions, degenerative nervous system diseases associated with psychoses) all produce a secondary syndrome of decompensation in self care and social functioning. This syndrome, which sometimes becomes chronic and is called "deterioration," needs to be recognized as a separate complication of these psychoses for several reasons. First the symptom manifestations are similar regardless of the underlying mental disorder. Second, there are two ways to prevent these manifestations from becoming chronically disabling.

The first and most popular method is to administer neuroleptic drugs. Others in this symposium will have dealt with these at great length and I only mention them here because the acute episodes of decompensation with the ordinary manifestations of severe psychoses can be quickly terminated in many instances by these drugs. In addition, in some cases long-term medication can hold these symptoms in abeyance for a long period of time. The dangers of doing this are well-known and the current serious problem which results from our inability to know which patients who are on chronic medication continue to have these needs will be discussed by others. The need for drug holidays to determine who can be safely removed from medication is a current matter of great concern to psychiatrists throughout the world.

The other method for preventing chronic decompensation is less widely understood among psychiatrists. This is the organization of rapid, relevant responses to the signs of decompensation in people with serious mental disorders. The ready availability of the neuroleptic drugs should be combined with readily available personal attention and efforts to

understand the mental and social problems of the patient. The presence of a competent diagnostician and the capability of defining the current crisis in terms of a specific problem which the clinician will undertake to deal with specific aspects while expecting the patient to actively participate in efforts to help him or her and explaining to the family and friends that a quick resolution of the crisis can be expected. By such methods it has been shown that the probability that the patient will become severely handicapped in functioning is greatly reduced. These methods were demonstrated before the advent of the neuroleptic drugs and have been fairly carefully studied. They depend for success on the meticulous preservation of the patient's social support systems, families, friends, neighbourhood, general practitioner, and relationships at work and social institutions. Now for chronic mental disorders it is necessary to set up a long-term treatment relationship even though great intensity of attention is generally needed only rarely and for short time periods. The availability of acute treatment acts as a protector of the patient's social support system. The ability to call on professional help in times of crisis prevents the family and friends from developing rejecting attitudes towards the patient and his problem. Some have called this long-term relationship "burden sharing." Short-term hospitalizations are sometimes needed to assert the presence of this willingness to share responsibility and sometimes to speed the process of resolving a crisis in the course of the disorder. (I think that it is appropriate to point out here that our speciality—psychiatry—has long been fascinated with the organization of psychiatric services.) The reorganizations of services for the mentally ill are not a new phenomenon but have been going on throughout the history of modern psychiatry. Some reorganizations are probably beneficial. Others make no difference. Some are undoubtedly harmful. But the one thing we can predict is that there will be more reorganizations. For a country that does not have a very rigid form of organizing its psychiatric services it is well to take a long and perhaps cynical view of the experience of Western Europe and the United States. We should probably recognize that the actual techniques we have which make a major difference in the course of mental disorders are more important than who pays us to apply them, how well the clinic is furnished and exactly which

organization of the various health services is involved. One of the them is the qualifications the therapist has. The motivations for paying attention is the need for social justice and the feeling of the people that when someone is ill they are entitled to the best health services available. This is a respectable motive which led Bismark to organize the health insurance of Germany and the British to organize their National Health Service after the second World War. Another motivation is the great burden that medical care can become for a national economy. This is moving many countries which are heavily industrialized into considering schemes for organizing medical care as a cost containment device. This is very conspicuous in my country. I predict the current endeavours will not succeed in cost containment but mention it only to contrast it with the third reason for being concerned with the organization of health services. The third which should concern us deeply professionally is that there are significant differences in the effect of services when they are organized differently and that the people's health can be affected by the organization of services. Effectiveness is often mentioned as an argument for a reorganization but it is rarely taken seriously. I wish to point out to you that the prevention of serious mental deterioration requires a particular organization of services. Clearly what I said earlier about interrupting the transmission of viruses requires an organized campaign. The prevention of chronic disability requires that the people treating individuals with chronic psychoses not be too isolated from the social network in which the patient is embedded and recognize the importance of the patient's human and social relationships. But recognition is not sufficient in itself. The clinician in an isolated mental hospital cannot do that and isolated mental hospitals are a form of treatment organization which we are learning to avoid. But we have not yet learned how to avoid it completely.

All I can say here is that I advise you not to import social institutions intact from other countries. You should study their known failures by looking for examples of those institutions in other countries where they have been given up. Each country must adapt mankind's knowledge and experience to its own specific institutions. I think it is reasonable to expect some of us from industrialized countries to learn some new things from people in countries such as yours.

2.5 Amniocentesis for Down's Syndrome

Congenital mongolism, also known as Down's Syndrome, is a devastating condition caused by an extra chromosome acquired at the stage in the development of the maternal egg during which the chromosomes split and one fails to split into the haploid set. This is known as non-disjunction. Diagnosis can be made by amniocentesis with a low risk and (for those who do not have contrary scruples) abortion can be arranged. This lowers the frequency of live born Down's Syndrome cases. A similar effect can be obtained by lowering the age of pregnancy. The annual number of Down's Syndrome cases is being lowered in my country, apparently as much because of a tendency for women to avoid pregnancy beyond the age of 35 as because of the use of amniocentesis.

Neither of these methods are very satisfactory but since the condition is so damaging to the life of the child and the family as a result and since it is the best we know, I mention it here.

The causes of non-disjunction are not yet understood and some hope that future research will provide a way of preventing non-disjunction from occurring in the first place. I do not share this hope myself. On the contrary, I am impressed with the evidence that the majority of conceptions in humans are in fact non-viable. It is my impression that nature's method for quality control of the new born with respect to the number of chromosomes is not a perfect system of egg and sperm production but a rather remarkable system of spontaneous resorbtions and abortions of conceptions which have the wrong pattern of chromosomes. If that line of reasoning turns out to be right and we can learn to correct the failure of discriminatory resorbtion and early spontaneous abortion we can look back on the current period as a clumsy and primitive effort at controlling the frequency of congenital abnormalities of this type.

2.6. Fetal damage from other causes

I earlier mentioned the wide variety of infections, injuries, malnutrition which can damage the fetus early in development. The first three

months of gestation are particularly vulnerable, we are currently in a historical period when this possibility of damage is particularly focused on medications. But there are hazards to the fetus during pregnancy besides drugs. The proper nutrition of the mother is clearly very important, even before she becomes pregnant. Attention to the general health of young women, maternity benefits, relief from heavy labor, and good general hygiene during pregnancy are extremely important. Here again, the psychiatrist is in alliance with colleagues from the other health professions and is obviously in alliance with the general knowledge of the population as a whole.

III. Health Promotion

The term health promotion is frequently used to describe general measures which lower the likelihood of many diseases and injuries rather than any particular disorder. Technology aimed at specific diseases is very valuable but much more is involved in the protection of a community's health. From the time of the Hypocratic physicians, doctors have known that the general hygiene of a community affects the probability of many illnesses.

In this location in 1978 it should not be necessary to point out that peace is a pre-requisite for any country to realize its maximum potential for health.

The preservation of peace is needed to provide adequate food and shelter which is the basic need of every population. Each child's nutrition is important. Each child in a family can get better nutrition if the family's income is not shared with too many younger and older siblings. Also each child can get better mothering if the next child comes 3 years later instead of 10 months later. Family planning helps to protect the child's health and also the mother's health. It is appropriate for us as psychiatrists to share our understanding of these things with our governments and with social movements to spread education about contraceptive methods.

The general education of a population is important because it deter-

mines the ability of each individual to realize the widest range of potentialities in mental development. Specific education of the public regarding means for protecting itself against disease is also important and does not depend very much on general education. Many pieces of information are passed on among the people even when they are not able to read or write. I mentioned the spontaneous disappearance of pellagra in our cotton mill communities of South Carolina as an example.

Knowledge about sanitation is important. But as people come to live in cities and densely populated areas the community must organize sanitary measures to protect the population against the contamination of food and water by human waste.

REFERENCES

Aykroyd, W.R. (1970) *Conquest of Deficiency Diseases-Achievements and Prospects.* Geneva : World Health Organization.

Balfour, J.G. (1876) An Arab Physician on insanity. *J Ment. Sci.*, 22, July.

Gopalan, C. (1977) Malnutrition: The major health problem of the world (Editorial). *Internat'lJ. Hlth. Ed.*, xx, 2 : 74-77.

Gopalan, C. and Naidu, A. Nadamuni (1972) Nutrition and fertility. *The Lancet*, 18 : 1077-1079.

Gopalan, C. and Rao, K.S. Jaya (1975) Pellagra and amino acid imbalance. *Vitamins and Hormones*, 33 : 505-528.

Goplan, C., Swaminathan, M.C. and Vijayaraghavan, K. (1973) Effect of caloric supplementation on growth of undernourished children. *Amer. J. Clin. Nutrition*, 26 : 563-566.

Group for the Advancement of Psychiatry (1961) Problems of Estimating Changes in Frequency of Mental Disorders. Report No. 50. Formulated by the Committee on Preventive Psychiatry. N.Y.

Gruenberg, E.M. (1957) Application of control methods to mental illness. *Amer. J. Publ. Hlth.*, 8 : 944-952.

——— (1956) Epidemiology of mental disorders and aging. In Moore, J.E., Merritt, H.H. and Masseling, R.J. (eds.), *The Neurologic and Psychiatric Aspects of the Disorders of Aging*' Baltimore : Williams and Wilkens Co.

Lemkau, P., Tietze, C. and Cooper, M. (1942) Mental hygiene problems in an urban district. *Ment· Hyg·* xxvi : 1 :100-119.

Roe, D. (1973) ***A Plague of Corn– The Social History of Pellagra.*** Ithica : Cornell U. Press.

Sandwith, F.M. (1889) The Cairo Lunatic Asylum, 1888. ***J. Ment.*** Sci., xxxiv : 148 : 32; 474-490.

Zilboorg, G. (1901) ***History of Medical Psychology,*** N.Y.: W.W. Norton and Co., Inc.

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الملـــــوجز

كيفـتقلل من تواتر الاضطرابات النفسية

يحاول الباحث أن يوضح لماذا أن منظور الصحة العـــامة هو مكمل ضرورى للمنظورات الكلينيكية ، وكذلك يؤكد المسئولية الاجتماعية للأطبـاء النفسيين حتى يهتموا بالنشاطات الخارجة عن دائرة اختصاصهم وذلك من أجل حماية الصحة العامة · ويذكر لنا الباحث فى مقاله ستة برامج وقائية غاية فى الأهمية فى هذه المرحلة من تطور معرفتنا ، الا وهى :

١ ـ الاكتشاف المبكر ، والعلاج الفعال لمرض الزهرى ·
٢ ـ عدم الاسراف فى الاعتماد على دقيق الذرة ·
٣ ـ القضاء على الحصبة والحصبة الألمانية ·
٤ ـ تقليل تواتر المواليد الحية لمرض داون (المنغولية) ·
٥ ـ حماية الجنين من سوء التغذية ، والاصابة ، والسموم ، والعدوى ·
٦ ـ حماية النظم الاجتماعية التى تســـاند أصحاب الاضطرابات النفسية المزمنة ·

ABSTRAIT

L'auteur a essayé de signaler pourquoi une perspective de santé publique est nécessairement un complément à nos perspectives cliniques. Il a souligné la responsabilité sociale des psychiatres comme médecins généralistes pour faire attention aux activités qui se montrent au dehors de leur spécialité, cela peut protéger la santé des gens.

Il a noté six programmes préventifs comme étant d'une importance cruciale.

1) La détection précoce et le traitement efficace du syphylis.
2) Eviter la dépendance excessive sur le mais indien.
3) Elimination de la rougeole et de la rubéole.
4) Réduction de la fréquence du syndrome de Down dans les nouveau-nés.
5) Une protection générale du développement des foetus contre les malnutritions, les lésions, l'empoisonement et les infections.
6) Une protection des systèmes de support social des gens qui sont atteints de maladies chroniques.

Some Transcultural Aspects of Qatari Psychiatric Patients

By M. Fakhr El-Islam

ABSTRACT

The illness behaviour of psychiatric Qatari patients is determined by the nature of their symptomatology. The importance of somatic symptoms in determining the patient role and patient-doctor relationship is discussed in the light of cultural characteristics of the Qatari community. Delusory cultural beliefs related to possession, sorcery and envy provide a conceptual framework for explanation of many disorders. Inter-generational conflict is an important factor in neurotic disorders.

Failure to report symptoms in an abstract fashion is characteristic. The cultural and religious heritage absorbs many features which would otherwise be considered symptomatic of a psychiatric disorder.

Qatar is an Arab state occupying a peninsula approximately at the middle of the western coast of the gulf separating Persia from Arabia. Most Qataris came from Arabs of the parent Arabian peninsula in the early eighteenth century and share with them a common language (Arabic) and a common religion (Islam) as well as a lot of common cultural heritage and tradition. Is it an oil exporting country with a population of about 200,000. Small factories, fisheries and farms subscribe only a little to the country's economy. A lot of foreigners from neighbouring and European countries are employed in professional, skilled and unskilled jobs.

Illness Behaviour

The term illness behaviour has been used (Mechanic, 1966) to indicate how various people recognise that they are ill and what they do about it. In Qatar the concept of illness as well as the action taken by