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Psychiatry in Egypt To-Day

(A PERSONAL VIEW)

Part II : Practice and Theory

In part I of this article, I have attempted an introductory portrayal of the Egyptian trial to acquire its independent nosological discipline which ultimately came to adopt what I named "an Egyptian version of the ICD-8". To come now to introduce how psychiatry is practiced in Egypt and what are the underlying theoretical formulations, I found it too difficult to be put down on paper. Among the sources of difficulty are the lack of official inter-centre exchange of data, the deficiency in inter-psychiatrist language (though the DMP-I has been introduced since 1975, it is seldom used) and the scanty available published data on both theory and practice.

That is why this second part should be taken within its limitation, as no more than the personal view of the author. The information presented came from both available publications and some personal communications.

A — PRACTICE

One can make a general, relatively safe, statement that psychiatric practice in Egypt to-day is following, more or less, the Anglo-Saxon model. No particular discipline dominates the practice as a whole apart from sporadic trials in experimental and/or private centres. It seems natural in a developing country (with 1/160.000 psychiatrist/citizen ratio) for the psychiatrist to adopt every possible "useful" idea, and to apply any practical healing method in his trial to cope with his out-weighing responsibilities. Any higher specialization or depth inclination at this stage of our development, is a sort of luxury.

1 — Physical therapy :

This type of therapy, generally referring to electroshock therapy, is still widely used all over the country in state hospitals, general clinics and private clinics. However, the use of ECT is generally declining. It has kept in time with the international pace, i.e. it has dropped markedly in the sixties to regain partial status in the seventies. The use of anaesthesia and muscle relaxants is steadily increasing, and the unilateral technique is also widely spreading. In centres adopting a milieu policy (Shaheen and Rakhawy, 1977) ECT is integrated as a part of a lengthy therapeutic plan.

In the early sixties, intensive physical therapy was tried in the form of artificial hybernation through intragastric cooling (Askar **et al.,** 1963), but this has never been repeated on account of the difficulties in technique. Cerebral stimulation was widely used in the sixties and is still applied to a lesser extent till now. It has been used mainly for neurotics, with or without abreaction, with ultrashort acting barbiturates. The latter is also used solely or as a vehicle in psychotherapy for ventilation, abreaction and narcosynthesis. Electrical sleep has been tried in a few private centres with limited results, but its use has never propagated.

2 — Pharmacotherapy :

There is no doubt that pharmacotherapy in Egypt, like any other place in the world, is taking more and more the upper hand in psychiatric practice. This looks both rational and practical. Almost all groups of psychoactive drugs are widely used in Egypt nowadays. Assessment of the effectiveness of drug therapy has been predominantly oriented on the symptom free level, although occasionally psychometric tools are used; but still to assess certain quantitative changes rather than any dynamic alteration. This therapeutic line was partially limited by the cost-benefit financial handicaps. Certain critical sounds have been heard warning against the overuse of such drugs, in preference to psychological handling or less frequently as an echo for the antipsychiatric movement. Really no practical substitute has been offered, and the revived enthusiasm for ECT here and there, is the only accessible compensatory tool.

3 — Psychotherapy (and related procedures) :

Inspite of the fact that psychotherapy is not widely practiced as an independent procedure in its classical sense; one cannot exclude that real psychotherapeutic healing is underlying all physical and chemical manipulations of psychiatric patients. The less schizoid cultural traits (relative to western cultures), the enthusiastic doctor-patient relationship and the high, dependable social status of the physician in our society could all participate in explaining the indispensible, rather constant, psychotherapeutic relation regardless of what comes next. However, certain state and private centres put a special emphasis on psychotherapy **per se.**

Classical psychoanalysis is still practiced, and the psychoanalytic movement is led by Prof. M. Zewar. Late Prof. Askar, the leader of psychiatry in Egyptian universities, practiced psychoanalysis and psychoanalytically oriented psychotherapy throughout his thirty three years of practice in Egypt. The influence of both pioneers on colouring the psychotherapeutic practice with analytical concepts in Egypt is positive and continuing. M. Shaalan, who is relatively maintaining this psychoanalytic orientation, has given more to group therapy than to individual psychoanalysis. As a group therapist, he teaches 'group as whole, psychioanalytically oriented techniques. The author's eclectic approach to psychotherapy over 20 years has ended in developing his own group therapy technique investigated in a process research by Hamdi (1978). It is said to be an "individual in the group" approach, which is growth oriented, deliberately reactivating the malorganized personality compromise into a dialectic synthetic confrontation.

Behaviour therapy, taken as a version of psychological therapy, has its place by now in psychiatric practice in Egypt. Trial to handle different ailments included a wide variety of disorders starting from enuresis (Okasha, 1966) to change of habits of chronic schizophrenics (Soueif) and bio-feedback in cases of vaginismus (Okasha, 1978). Prof. M. Soueif is taking an active role in introducing behaviour therapy, teaching its theoretical basis and participating in its practice.

Milieu therapy in the proper sense is rather rare. However, Shaheen and Rakhawy (1977) report the emergence of a specially planned milieu therapy; whose results are still limited and follow up is necessary before generalizing and finally evaluating its preliminary promising results.

4 — Non psychiatric healing :

With a limited number of psychiatrists, we have to expect that many other disciplines are participating in psychiatric healing. Egyptian neurologists bear successfully a good deal of the responsibility in treating psychiatric patients. This is particularly relevant when considering the unavoidable mixing between the concepts of neurology and psychiatry by the lay man. Their role is very close to that of the organically minded psychiatrists. In actuality, they also practice a variable degree of psychotherapy whether they do or do not label their therapeutic relation with their patients as such. The same idea can be traced in all other forms of medical practice in our culture; where the psychotherapeutic role of the family doctor and village practitioner is beyond any doubt.

The non-medical healers are still assuming a very active role in the management of certain neurotic ailments, particularly the dissociative and conversion disorders. A certain proportion of such healers, particularly religious healers, are doing a positive job. Favourably, a good number of psychiatrists are not antipathic to this type of healing. Praying, Sheikh-Visiting, Hegab (sacred writing), El-Zikr (Sofi) gathering and El-Zar ceremonies are among such techniques. The latter was studied psychosocially (Okasha, 1966). Some of the less accepted techniques are related to spiritual healing, practiced independently or under the direction of certain spiritual associations.

B — THEORY

Still more and more difficulty is encountered in discussing the theoretical basis underlying psychiatric practice in Egypt. Theorization is deficient in psychiatry all over the world. We have to confess that psychiatric practice is largely based on empirical grounds. All explo-

ratory and interpretative theoretical claims are either part theories only valid in their limited context or are no more than hypotheses. This generalization does not exclude long lived, widely spread theories of psychoanalysis or apparently concrete pharmacotherapy based on strict chemical hypotheses.

To try to search for certain theoretical formulations underlying psychiatric practice in Egypt looks, then, too much or too fanatic. However, I believe that this very fact, i.e. the failure of the existing hypotheses to amount to a valid theory, is in itself sufficient stimulation to the newly emerging practitioners all over the world to participate in theorization and verification. With our national, ambitious and responsible civilized history, we can never be satisfied by a waiting or imitating role.

As few as we are, we can feel relatively satisfied on tracing most of the current theoretical trends in our country. The predominant theory is "no theory" or what we can label under the term 'eclectic' or 'multidimensional approach'. This looks both rational and practical in a developing country. An overall look at the scientific publications, mainly derived from university activities, can reveal this multidimensional, rather heterogenous approach in research covering most psychiatric fields. However, certain varieties of inclinations may be traced through arbitrary grouping. For instance, while we can see the Ain-Shams University school led by Prof. A. Okasha is inclined to reinforce the organic basis of psychiatry (Okasha, 1977), we can notice that the Kasr El-Aini school led by Prof. O. Shaheen is inclined to emphasize the emotional basis of both psychiatric and psychosomatic disorders. Both schools have widely utilised a quantitative approach in evaluating symptoms and therapeutic results. This is manifested in using quantitative psychometric tools in the majority of their research. This quantification trend may denote a decriptive orientation rather than a dynamic one. While in Ain-Shams the incidence of psychiatric morbidity among consulting patients attracted attention early (Okasha, 1966); at Kasr El-Aini and El-Mansoura, later interest in

nosological problems is going on at an active pace. Moreover, special interest can be noticed in the latter centres on studying the influence of our culture on the different presenting symptoms and syndromes. At the same time, Prof. M.S. Gawad and his collaborators have started a series of transcultural and within-cultural comparative studies (Mahfouz, 1977; Arafa, 1978; Gawad **et al.,** 1978). The theoretical background of all such research activities is still predominantly empirical.

A recently established centre in Al-Azhar University led by Prof. M. Shaalan is inclined to establish a humanistic, still analytically oriented, theoretical basis for practice.

Social psychiatry research is met with in various school activities and publications. Prof. F. El-Islam extended his interest in social psychiatry to cultural studies in Qatar after preliminary investigations in Egypt. Prof. M. Kamel did the same trial in Libya.

The overload of administrative and therapeutic tasks put on state and military hospitals have not given any real opportunity for published theoretical formulations by their staff members. Their scientific and practical participation is definitely out of proportion to their publications. However, medico-legal and administrative aspects of psychiatric practice have developed through their responsible standardized activity. The father of psychiatry in Egypt, Dr. M.K. El-Kholi has published a reference on medico-legal psychiatry in Arabic (El-Kholi, 1974 ?) whose cases are taken exclusively from the Egyptian culture.

Certain low whispers resembling anti-psychiatric rebellion are heard every now and then from both Shaalan and the author. Respecting the degree of evolution of our society and the stage of development of our speciality, these whispers have never been developed into a therapeutic nihilistic attitude nor as a destructive **laissez faire** inclination. In reality, it is a trial to synthesize the positive aspects of the antipsychiatric ideas in a responsible frame fitting our cultural needs and tolerance.

The author has published a personal concept on hierarchical levels of mental health with the possible corresponding psychiatric crises

(Rakhawy, 1972). He also published what is called an index and outline of a theoretical conceptualization of brain function in health and disease (Rakhawy, 1977). This hypothesis adopts both the pulsating model of the heart with hierarchical potential behavioural pace makers, and the concept of the brain as an evergrowing reassociating dialectical organ.

To conclude, I can feel that psychiatry in Egypt is not simply a copy of other psychiatric disciplines. I hope that after delineating our starting point, facing the existing deficiencies in our practice and theory as well as in other's all over the world, we ought to become sufficiently stimulated to participate, not only in improving the psychiatric status in our country, but also to face our responsibility in creating new ideas and offering new hypotheses with the hope of overcoming the existing, rather increasing gaps in psychiatric knowledge.

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