

The Brother-Sister Syndrome in Arab Family Life
Socio-cultural Factors in Arab Psychiatry:
a Critical Review^{1*}

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The role of Western theory and the extent to which it has influenced the diagnosis of some types of mental illness in Arab countries are discussed. The need for case-specific sociocultural factors is pointed out in reference to specified issues in selected psychiatric works. The impact of the brother-sister relationship on Arab culture and its inexplicable absence in psychiatric studies are presented, and contrasted to the impact and conspicuous presence of the Western mother-son model.

The following statement addresses two interdependent aspects of psychiatric and psychological studies and practices in a number of Arab countries. These are: a) the role played by Western theory, as conceptualized and applied by native Arab scholars, and b) the extent to which these academic perceptions have influenced the diagnosis of some key psychological phenomena in Arab communities.

That mental health and emotional disorder among members of a given community are strongly influenced by the dominant social and cultural conditions is a generally accepted thesis. Like many other modern "sciences" psychiatry and its allied fields and practices were introduced in their original Western contexts to Arab academic scenes. Western terminology, concepts, and diagnostic guidelines dominate Arab psychiatric and psychological theories and practices. It was not until recently that attempts were made to provide Arabic translations for key psychological terms.

A number of published psychiatric reports, especially during the 1950's and 60's, stressed the sameness of the Arab patterns of emotional morbidity and those of European countries. Bazzoui and Al-Issa (1966:826) <314>

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wrote that "there is no evidence that any difference exists between the types of mental illness encountered here (in Iraq) and in the West"; Kline (1963:768) reported that in Kuwait "the overall incidents of mental disease is not appreciably different from that in Egypt or the Western World." Other studies recognized the presence of some differences but argued that "the similarities were more striking than the differences" (Elsarrag, 1968:945).

Arab psychiatrists, however, register their awareness of the influence of social and cultural factors on the types and patterns of mental illness in a given society. This awareness by and large has remained on the theoretical level; in actual practice, they tend to view mental illness in Arab communities in predominantly Western terms.

The insufficient emphasis on the specifics of native social and cultural conditions seems to make the diagnosis and, consequently, the treatment more dependent on the psychiatrist's own interpretation of the local case as compared to the Western theoretical model. Thus, published surveys of classified cases representing the spectrum of mental illness in Arab countries which share in essentially the same culture show wide margins of dissimilarities.

The occurrence of acute schizophrenia, for example, among the in-patients in mental institutions was reported to constitute 15.3% of all the cases in Egypt (Okasha *et al.*, 1968); 35% in Kuwait (Kline, 1963), but--by contrast--a staggering 85% in both Iraq and Saudi Arabia (Bazzoui and Al-Issa, 1968; Zarroug, 1975). Considering the fact that Kuwaiti culture and society are very similar to those of Saudi Arabia, the difference in the above cited figures is striking. The same argument may be made concerning the difference between the Kuwaiti and Iraqi cases.

A longitudinal comparison of the ratio of schizophrenic cases to other types of psychological disorder in an Iraqi institution manifests the same pattern of inconsistency. In December 1964 these cases constituted 85% of the total (Bazzoui and Al-Issa, 1966); meanwhile, in the period between July 1966 and June 1967 they constituted 69.8% (Bazzoui, 1970). It is unlikely that this relatively sharp decline of more than 15% during a two-and-one-half year interval was due to change in the pattern of psychological morbidity in Iraq.

Another example of diagnostic disparity can be observed in the rate of the occurrence of acute anxiety. This type of disorder was reported to be 22.6% in Egypt (Okasha *et al.*, 1968); by contrast, it was a significantly low 0.24% in Kuwait (Kline, 1963), while in neighboring Iraq it was 3.75% (Bazzoui and Al-Issa, 1966), or approximately thirteen times its rate in Kuwait. Similarly, hysteria and acute hysterical features involved 11.2% of the patients in Egypt (Okasha *et al.*, 1968), and 5.2% in Kuwait (Kline, 1963); although hysteria did not appear in the 1966 survey from Iraq, hysterical illness was reported to be very common in its grand forms among the naive and uneducated rural inhabitants (Bazzoui and Al-Issa, 1966). Yet, in the 1970 survey by Bazzoui, hysterical features were reported at the rate of 7.5%.

It is unlikely that these significant differences are due to the use of nationally

non-representative samples, or to shifts in cultural and social patterns. With the exception of variations attributable to social class, life style, and religious differences, e.g., one Jewish patient = 100% (Bazzoui, 1970:199), both the numbers of patients and the time periods involved in these surveys seem adequate. The differences are more likely a product of how psychiatrists diagnosed the indigenous symptoms in terms of Western theoretical models.

Some follow up studies recognize on an ideal level the inapplicability of Western-specific psychiatric models in their original contexts to Arab cases (Bazzoui, 1970; Zarrouk, 1978); meanwhile others attempted to include sociocultural factors as a variable in the cases under investigation (Okasha and Demerdash, 1975). However, the impact of this recognition on actual psychiatric practices has been minimal, and remains limited to referring to generalized and indiscriminating categories of a population (i.e., rural vs. urban; white collar vs. blue collar; Kuwaiti vs. Egyptian). The areas of deficiency in utilizing sociocultural factors in diagnosing psychiatric cases may be summarized as follows:

Inaccurate Perception of Specialized Native Concepts and of their Precise Role in the Patient's World View.

A number of psychiatric writings reveal a lack of understanding of some cultural qualities of the factors involved in mental disorder. Satan (the devil), for example, is often accredited with certain functions alien to his entity as perceived and defined in the patient's culture; one such inappropriate function is to possess the body of a human (Kline, 1963. Okasha 1966. Elsarrag 1968; Zarrouk, 1978). This idea contradicts the views held in indigenous cultures. Among Muslims, the devil may obsess but may not enter the body of a human being. It is the jinn who are the agents of possession (Bazzoui and Al-Issa, 1968; El-Shamy, 1970); a person believed to be possessed by jinn receives sympathy and assistance, while a person possessed by the devil (if that were possible) would be despised and rejected.

The "auditory hallucinations" which are attributed to Satan (Elsarrag, 1968; Okasha, 1966) are incongruent with the traditional beliefs according to which Satan is perceived in daily lives: the devil instigates evil ideas, and generates compulsions for and tendencies towards "sinful" acts through inaudible means of communication. Jinn, on the other hand, are believed to be audible. Similarly, Zarrouk (1975) reports "fairies" as a part of the ³¹⁶ hallucinatory perceptions of Saudi patients. No such beings exist in the Arab pantheon of supernatural entities. Although the English words "fairy" and "devil" may have been used to present to Western readers concepts and beings alien to Western culture, these inaccurate usages tend to blur the original facts and compromise the accuracy of the psychological phenomenon under investigation. Fairies, as defined in European lore, and jinn as perceived in Arabic traditions, are not identical.

The Tendency to Treat Shared Cultural Experience as Idiosyncratic

Following the parameters outlined by Lowe (1973), Zarrouk (1975) investigated the frequency of visual hallucinations in schizophrenic patients in Saudi Arabia. He concluded that, contrary to the dominant theoretical views, visual hallucinations in schizophrenia are of common occurrence in that country. His conclusion was based,

partly, on cases in which patients reported that they have visually perceived jinn; such perceptions were diagnosed as symptomatic of schizophrenia.

Belief in jinn is, without a doubt, an universal component of Arab and Islamic cultures on all levels; this belief constitutes a part of the religious experience. Muslim theologians judge disbelief in jinn as heresy. The jinn are perceived in anthropomorphic terms concerning some of their physical characteristics and, particularly with reference to their social acts; jinn societies are believed to mirror human ones (El-Shamy, 197). Among traditional groups, these supernatural beings are thought of as multiple and are perceived in highly specialized roles vis-a-vis humans. Commonly, jinn are seen (visual hallucination), heard (auditory hallucination), and felt the source of hallucination is on or inside the person's body). So powerful is the belief in jinn that early Muslim jurisprudence legislated for cases in which humans were married to jinn. The nature of the belief in jinn was discussed in a 9th century work; in *Al-Hayawan*, Al-Jahiz--an Arab rationalist (d. 868 or 9)--pointed out the erotic nature of certain aspects of this belief, and postulated that belief in jinn originated among the Bedouins as a hallucinatory product of what we may now label "sensory deprivation" which characterized life on the empty and still desert.

Of the five examples cited by Zarroug (1975) as schizophrenic, cases numbers 1 and 3 in which the patients reported interacting with jinn represent common and routine experiences characteristic of 'normal' people. Treating such culture-bound perceptions as symptomatic of schizophrenia seems to account for the inordinately high percentage of its occurrence in reports from Saudi Arabia, and Iraq (Bazzoui and Al-Issa, 1966).

The Tendency to Localize a General Socio-cultural Factor

In a study based on a limited sample, Okasha and Demerdash (1975) explain why Kuwaitis seem to be more sexually active before puberty when compared to Egyptians and Palestinians. The writers propose that this difference may be attributed to the Kuwaiti patrilocal patterns of residence (though, they use the term "patriarchal"). Under the patrilocal conditions, young boys are exposed to the sexual interactions between their older male siblings and their wives and emulate the sexual activities of their elders.

This explanation is applicable to a great number of Arab communities. Traditional Arab societies are described in anthropological literature as typically patrilocal, patriarchal, and patrilineal (Peristiany, 1976). Naturally, variations within this pattern do exist. The conditions of the patrilocal pattern may have been absent in the case of the uprooted Palestinian subjects. However, these conditions are common in both rural and urban traditional Egyptian communities and, therefore, may not be the only contributing factor. The differences in this respect, may be a product of conditions generated by economic, social class, and regional cultural differences rather than by broad national factors.

The Tendency not to Correlate Traditional Culture Specialties to Role-Playing

Not all traditions found in a culture are necessarily shared by all members of that culture. Certain patterns of behavior may be expected of a specific group and not of

others. Arab women are expected, in accordance with traditional culture, to act hysterically under conditions of frustration and stress (e.g., death); this is also the case with males who have certain physical or kinship qualities (e.g., being born prematurely, or having a hysterical maternal uncle). Members of the community not only tolerate their hysterical behavior, but often reward it. A woman's failure to show the 'correct' hysterical responses in a funeral, for example, may be interpreted in negative terms, and therefore penalized. Among Arabs, hysteria has often been reported as a predominantly female disease (Elsarrag, 1968; Okasha, 1966; 1969:67).

The higher ratio of hysterical reactions among Egyptian female university students (Okasha *et al.*, 1977), and their appearance--contrary to prevalent academic views--among other members of the educated classes (Okasha *et al.*, 1968) can be, at least in part, caused by a cultural role-playing rather than by actual psychological morbidity. The argument put forth by a number of psychiatrists (Slater, 1961) that hysteria is not a primary psychological malady tends to reinforce this cultural role-playing observation.

The Tendency to View Psychiatric Disorder in Static, or in Hemispheric (Western vs. non-Western) Terms

Cultures and social institutions change constantly, but at various rates. ³¹⁸ A culture-bound illness develops, persists or diminishes on a major scale according to the sociocultural conditions.

A number of studies on Western-specific types of mental disorder tend to overlook this dynamic quality. One such illness is 'guilt' as opposed to 'shame.' An ethnological-folkloristic study (El-Shamy, 1970) and a psychiatric survey (Bazzoui, 1970) have independently concluded that the guilt syndrome is virtually absent among traditional Muslim Arabs. The two critical factors which seem to dissipate the guilt-fraught feelings are: a) fatalistic religious and similar beliefs, and b) the ethos of shared responsibility associated with group cohesion. Naturally, the erosion of these two factors due to modernization contributes to the formation of guilt among groups which have not experienced it under previous conditions. Without specifying the social and cultural conditions, Okasha *et al.* (1968) reported that self-reproach and self-depreciation (i.e., guilt) existed among their Egyptian patients but not as a "common feature." In a later study on murderers-- a context which is prone to generate guilt--Okasha *et al.* (1975) report that guilt feelings were present in a marked number of cases; although this study mentions "cultural patterns, traditions or folkways" as contributing factors, the authors do not correlate the presence or the absence of guilt to the motive for the murder or to the specifics of the sociocultural background of the murderer. Traditional groups, especially in southern Egypt and in desert communities glorify "killings" for sexual honor and blood vendetta, and share with the "killer" the consequences of his or her act; meanwhile, murder for "robbery," "rape" or "trivial matters" [are] universally condemned.

Determining the exact sociocultural and personal conditions under which guilt was present, or failed to materialize in spite of the crime, is as important as the mere determining of its presence or absence.

The Dichotomy between the Psychological Theory and Findings, and the Covert Patterns of Cultural Expressive Behavior: The Oedipus Complex and the Brother-Sister Syndrome

Arab psychiatrists and psychologists tend to view the influence of the family either as an undifferentiated mass, or as a replica of the Western model in urban, industrial surroundings. One aspect of Western psychoanalytic theory which was transplanted in Arab psychological literature and practices is the Oedipus theory. Some writers declare their awareness of the ethnological criticism levelled against the claim of the universality of the Oedipus complex theory; but, they proceed to apply it to local cases without taking into account the significant social and cultural factors involved (Ragih, 1964:52-3; Okasha, 1969: 28,388; Elsarrag, 1968; 947). In traditional Arab cultural expressions (folk-lore) the Oedipus complex is practically non-existent. In the Egyptian Folklore Archives, of the first 2,000 tales collected randomly only one is of definite Oedipal nature; also, less explicit expressions of incestuous acts between mother and son or father and daughter are rare and fail to crystallize into the Oedipal model. This folkloristic-cultural pattern is in total congruence with a psychiatric counterpart where--during a seventeen year span--neurosis attributable to seduction by parents was reported to be at the rate of 0.003% (F, 1964: 38). Similarly, in literature (i.e., short stories, novels, etc.) the Oedipus complex is presented through translations or overt imitations of European literary works. Even published collections of psychiatric case descriptions from private practices (El-Rakhwai, 1972; Girgis, 1973) do not include the Oedipal situation.

Arab psychologists readily accept the hostility between parent and child of the same sex, and rivalries among siblings of the same sex as mere rivalries or as a product of the Oedipus complex. Actually, in most cases they are not. They are more often components of a system of affective relationships in which a sister or a brother is the focus of attention of the siblings of the opposite sex. This system may be labelled "The Brother-Sister Syndrome" (El-Shamy, 1973). The syndrome is associated with social and cultural conditions characteristic of the traditional Arab family. These conditions are generated by--and in turn contribute to the strength of--a set of values, beliefs, and associated practices. According to the codes of honor--religious and otherwise, strict rules of separation between the sexes are observed among traditional groups. Yet, maximum exposure is allowed among siblings. It is common, sometimes the rule, for brothers and sisters to share the same bed or at least the sleeping quarters; this practice--often due to economic restrictions--starts in childhood and continues to the age of puberty, or the time of marriage and occasionally beyond it. Consequently, a brother and sister develop a sense of dependency on each other for warmth and security. A child usually learns about the anatomy of the opposite sex through observing a sibling during such routine activities as performing toilet functions, bathing changing clothes play or sleep which are performed mostly away from adults. A child also experiences peer-to-peer relationships with a member of the opposite sex through these very activities. While a boy or a girl--in particular--are strictly prohibited from having a physical contact of any sort (or even 'romantic love') with a peer of the opposite sex, such affectionate activities as tickling, embracing, hair combing, and hand holding, are considered normal between brother and sister and are tolerated. Incestuous tendencies often underlie the brother-sister relationship. However, a common belief that typically "Flesh will not be (sexually) attracted to the same flesh," and the notion that children do not have sexual

drives until they have developed the physical signs of puberty guide the adults' tolerance.

It has been shown in a comparable socio-cultural ³²⁰ context from Ireland that these conditions are conducive to the occurrence of actual incest. As in the majority of the Irish cases, available field data suggests that brothers and sisters in Arab societies remain "free of gross personality disorder, neurosis or psychosis" (Lukianowitsch, 1972: 309).

Unrewarding and often painful marital experiences contribute significantly to the continuation of the brother-sister bond. Of these the most important seem to be associated with the drastic physiological and psychological effects of clitoridectomy (Elsarrag, 1968; Al-Sa`dawi 1974), arranged marriages and absence of love, painful and often personally humiliating defloration rituals, husband dominance over wife, economic and status insecurity, and heavy household labor required of a new wife by her in-laws. These conditions are often found in patterned combinations depending on the region, social class, religion and similar sociocultural factors.

Within the nuclear family the Brother-Sister Syndrome is manifested through brother-sister love, brother-brother hostility, sister-sister hostility, parents-children hostility, and husband-wife unaffectionate relations. The structure of sentiments in the larger kinship group is congruent with that found in the nuclear family; these sentiments include brother-sister's husband hostility, sister-brother's wife hostility, and child-mother's brother affectionate ties. The child's positive relationship with the maternal uncle is a product of the love a mother has for her brother, and the strong bonds of affection between a child and his or her mother (but not with the father).

In contrast to the Oedipal situation, Arab cultures teem with expressions of love between brother and sister. Hundreds of examples of this vital affective tie can be cited from every branch of actual social life and of culture--formal and informal, past and present; these examples include--to name a few--the following: the ancient Egyptian deities Osiris and his sister Isis; the Semitic religious characters Cane and Able and their twin sisters; the Arab poetess Al-Khansaa (d. 646 A.D.) and her brother Sakhr; Prophet Mohammad's grandchildren Al-Husain (d. 680 A.D.) and his sister Zaynab (now revered saints); the Abbasid Calif Haroun Al-Rasheed (d. 809 A.D.) and his sister Al-`Abbasah; the founder of modern Saudi Arabia, King Saoud and his sister Nora; the main characters in N. Mahfouz's *Trilogy*, Kamal and his sister `Aishah (El-Shamy, 1976); the heroes of the Arabic parallels of the folk tale "Hansel and Gretel" (El-Shamy, 1976; 1980: no. 9); the possessing spirits--of the Egyptian pantheon of jinn associated with the Zar ritual--Mammah and his sister Mustagheethah (El-Shamy, 1974; 1979).

Yet nowhere in psychiatric literature is a treatment of the brother-sister relationship to be found. Even in situations where the psychological data should have ³²¹ led the researcher to investigate this bond, the issue (perhaps defensively) was overlooked (Elsarrag, 1968: 946; Disouqi, 1965:214; `Uwais, 1968:148).

The compelling nature of a priori held theory and its perceived dominance over social and cultural realities is vividly presented in a psychiatric report; a psychotherapist (Fareed, 1964:38) stated that during a period of seventeen years of practice in Egypt "not

once has he arrived at what may substantiate the Oedipal doctrine." Nonetheless, he insisted that "never will he let Freud's idea escape him."

Conclusions

Psychiatry is emerging as a major field for individual and public interest in Arab countries. As psychiatric services are increasingly extended to tradition-bound segments of a population, an understanding of these traditions becomes essential for the accuracy of the diagnosis and the success of the treatment. In this respect, less dependency on Western theoretical models, and more emphasis on indigenous conditions and symptomatic characteristics of a malady are needed. Interdependency between psychiatry and other relevant disciplines (ethnology, sociology, folklore, etc.) should enhance the grounds for a more precise understanding of conditions of mental health and illness, as well as of the society and the culture concerned.

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