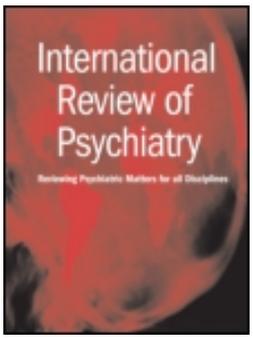

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Overview of the family structure in Egypt and its relation to Psychiatry

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Abstract
The family is the basic unit of any society and culture. The concept, structure, and function of the family unit vary considerably across different cultures; however, its role continues to be imperative to the development of individuals and their psychological make-up. All societies have a concept of 'family', its relative importance, structure, and functions; however, this varies according to the particular culture. In the Arabic culture, as well as other collectivistic cultures, the extended family is often regarded as the basic unit. The family is the foundational and basic social unit that fosters the stability, well-being and sustainability of society. The quality of family relationships shapes and influences the social, psychological, and biological development and functioning of its members. This may be especially relevant to individuals with mental health problems. The people of ancient Egypt valued family life highly, and this is the case even now. They treasured children and regarded them as a great blessing. If a couple had no children, they would pray to the gods and goddesses for help. They would also place letters at the tombs of dead relatives asking them to use their influence with the gods. The importance of family has not changed dramatically even though the structures are beginning to. In this paper we highlight changes in family set-up and the state of family therapy in Egypt.

Introduction

Egypt is the most populous country in the Middle East and the third most populous on the African continent, with a population of around 81 million according to CAPMAS (2012). The population grew rapidly from 1970–2010 due to medical advances and increases in agricultural productivity. The population is concentrated along the Nile (notably Cairo and Alexandria), in the Delta and near the Suez Canal. Approximately 90% of the population adheres to Islam and most of the rest to Christianity (CIA, 2012). Some 97% of Egypt's population live on only 4% of the land, around the Nile valley (Okasha & Okasha, 2000a).

Mental disorders have been recognized in Egypt for millennia; 5000 years ago, they were considered to be physical ailments of the heart or uterus, as described in the Ebers and Kahun papyri (Okasha, 2001). These disorders carried no stigma, as there was no separation then between the psyche and the soma. Both physical and mental disorders were treated as physical disorders in the sleep temple (Okasha & Okasha, 2000b). The first mental hospital in the world was established in Baghdad in the year 705 AD followed by one in Cairo in the year 800 AD then Damascus in 1270 AD. After the Arab invasion of Spain, mental hospitals started in Seville, then spread throughout Europe (Okasha & Okasha, 2010). In the fourteenth century the first psychiatric unit was established, in Kalaoon Hospital in Cairo, which was a general hospital with four separate units; surgery, ophthalmology, internal medicine, and psychiatry (Okasha, 2004).

Egypt has more than 1300 psychiatrists (one psychiatrist for approximately 70,000 citizens), more than 1300 psychiatric nurses and about 200 clinical psychologists, with hundreds of general psychologists working in fields unrelated to mental health services. There are around 9000 psychiatric beds in Egypt in the government, university and private sectors (Okasha & Okasha, 2010).

The family is the basic unit of any society and culture. The concept, structure, and function of the family unit vary considerably across different cultures; however, its role continues to be imperative to the development of individuals and their psychological make-up (Bigner, 1989). The traditional collectivistic nature of the Arabic culture with its extended families and male-dominant hierarchy has its unique influence on family functioning as well as shaping individual roles within society (El-Islam, 2001), in particular, with respect to women who may unfavourably face role limitations and subordination (Douki et al., 2003).

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All societies have a concept of 'family', its relative importance, structure, and functions; however, this varies according to the particular culture. In the Arabic culture, as well as other collectivistic cultures, the extended family is often regarded as the basic unit. Some relatively recent contemporary western models that support individualism are dominated by the nuclear family structure (El-Islam, 2001).

Marriage and divorce

In Egypt and other Islamic countries, couples often become engaged at a very early stage in relationships in order to be accepted in the society, unlike in the west where lengthy relationships usually precede marriage. In 2006, 63.5% of the Egyptian population were married (with the mean age at first marriage 25.9 years), 0.8% divorced, 6.3% widowed, and 28.9% never married. The marriage and divorce annual publication statistics 2010, issued by the Central Agency for Public Mobilization and Statistics (CMPAS 2012), showed an increase by 13.9% in marriage, while divorce certificates increased by 5.6%; 66% of these divorces were khula which is the right of a woman in Islam to seek a divorce or separation from her husband. A Muslim wife has the right to seek a release from the marriage bond, through the court to grant her divorce, over-ruling the husband's refusal (CAPMAS, 2012; Handoussa, 2010).

Family and psychiatry

The quality of family relationships shapes and influences the social, psychological, and biological development and functioning of its members. This may be especially relevant to individuals with mental health problems. However, the impact of family problems in developing countries is also modified by the different behaviour of families in eastern cultures. The Arab family runs the affairs of its healthy and sick members alike. Although extended family households have been largely replaced by nuclear families, the latter have maintained a 'functional' extended family by frequent visits, telephone contacts, business and property partnerships, and arrangements of marriages within their bigger family network. The functional extended family provides substitutions for parental loss or absence, mediation in conflicts (including marital and intergenerational conflicts), preferential employment of kin, and help with expenses of healthcare. The forecare and aftercare of the sick are family responsibilities in Arab countries (El-Islam, 2001).

However, women in Arab culture are exposed from childhood to various behaviour controls. Their behaviour is continuously under scrutiny and criticism, for either social or religious reasons (Okasha et al., 1994). Women with mental illness are a particularly disadvantaged group, with associated family dysfunction compared to normal population, and low satisfaction with their quality of life. In addition, families care more for the treatment of their male patients than female which is reflected by El Ghamry et al. (2010), who found that for their study for family psychoeducation families of male patients were twice as likely to agree to join the study (66.7% versus 33.3%). Family intervention is a cost-effective therapeutic modality that can improve both family functioning and quality of life (Okasha et al., 1994).

Invariably, in common with other societies, the role of stigma in Egyptian society is also important as it is often associated with a withdrawal of social support, demoralization, and loss of self-esteem, and can have far-reaching effects on daily functioning, particularly in the workplace. Stigma affects the family as well. Withdrawal and isolation on the part of family members as a result of stigma are associated with a decrease in social network size and emotional support, increased burden, diminished quality of life, and exacerbations of medical disorders (Phelan, 1998).

The organization of most families undergoes a variety of changes, including alienation of siblings, exacerbation or even initiation of marital conflict, severe disagreement regarding support versus behaviour control, and even divorce. Almost every family undergoes a degree of demoralization and self-blame, which may be inadvertently reinforced by some clinicians (Gabbard, 2009).

These critical family and psychosocial factors are likely to lead to onset and relapse of psychosis via a general and constitutional sensitivity to external stimulation, and a major discrepancy between stimulus complexity and intensity and cognitive capacity. Cognitive deficits, behavioural changes in the patient, effects of the psychosis on the family, and characteristic family coping styles converge, generating external stresses that induce a spiralling and deteriorating process that ends in a major psychosis. These factors are potential targets for family psycho-education (Gabbard, 2009).

Research conducted over the last three decades has supported evidence-based practice guidelines for addressing family members' needs for information, clinical guidance, and ongoing support. One of the findings is that altering key types of negative interaction, while meeting the needs of family members, dramatically improves patient outcomes and family well-being (Dixon et al., 2000).

Family intervention alters critical environmental influences by; reducing ambient social and psychological stresses, reducing stressors from negative and intense family interaction, building barriers to excess stimulation, buffering the effects of negative life events (Mueser & Glynn, 1999). It is a cost-effective

therapeutic modality that can improve both family functioning and quality of life (Ragheb et al., 2008).

Family intervention for the severe psychiatric syndromes – psychotic and severe mood disorders – has been established as one of the most effective treatments available, complementing but nearly doubling the treatment effects of medication. Often subsumed under the term family psycho-education, it is a method for incorporating a patient's family members, other caregivers and friends into the acute and ongoing treatment and rehabilitation process (Gabbard, 2009).

The 2009 Schizophrenia Patient Outcomes Research Team psychosocial treatment recommendations provide a comprehensive summary of current evidence-based psychosocial treatment interventions for individuals with schizophrenia (Kreyenbuhl et al., 2010).

Providing a family psycho-educational programme to a sample of Egyptian families of schizophrenic patients appears to have had a positive impact on patients with schizophrenia and their caregivers. This is confirmed by the fact that caregivers in the experimental group showed an overall significant improvement in attitudes and gain in knowledge which were not detected in controls. Moreover, there were significant clinical improvements in patients in regard to the symptomatology and the compliance on treatment. Also, patients' quality of life and social functioning were markedly improved (El Ghamry et al., 2010). The results of Hussein et al. (2006) and Abolmagd et al. (2004) were in line with these results, as Hussein et al. found significant improvement in the social functioning of the case group over 2 years follow up, and Abolmagd et al. found evident improvement in performance on many items of quality of life domains among the trial group as compared to the control group. The difference between the two groups was statistically significant.

Several models of family therapy have evolved to address the needs of family members: individual family consultation (Wynne, 1994), professionally led family psycho-education (Anderson et al., 1986) in single family and multifamily group formats (McFarlane, 2002), modified forms of more traditional family therapies (Marsh, 2001), and a range of professionally led models of short-term family education (sometimes referred to as therapeutic education) (Amenson, 1998). Family-led information and support classes or groups such as those of the National Alliance on Mental Illness are also available (Pickett-Schenk et al., 2000).

However, progress made in the field of formal family interventions in the west has not generally been paralleled by similar advances in developing countries. In many such countries, families have traditionally been partners in the care of individuals with schizophrenia. Yet they have not received the benefits of evidence-based family interventions. The bulk of such evidence from developing nations seems to consist of a handful of randomized controlled trials, mostly from China (Kulhara et al., 2009).

Egyptians do not value long-term confinement of sick family members in institutions or hospitals. In Egyptian culture, as elsewhere in the Arab/Muslim world, primary responsibility for the ill falls to the family, not society at large, and certainly not the psychiatric establishment, at least until the family is no longer able to provide this care. Egyptian families believe that it is their obligation and right to be the caretakers for the sick family member (Okasha, 1991).

Thus, in Egyptian culture, family therapy has a different pattern. Dependence is accepted to extend beyond childhood and even beyond adolescence. Extended families are much more represented in Egyptian society, indicating the need for adequate, different orientation and extended management. Who is to be included as a member of the family to participate in therapy is a matter of debate. This may include members with no blood relation with the patient but who represent definite significant aetiological as well as remedial factors (El-Rakhawy, 2001).

Inevitably this will lead to considerable burden on the families and inversely affect the clinical condition of the patients. Hence, family psycho-education is seen as critical help to Egyptian families. In spite of this, only a few studies have been conducted in this field until now. These include group-based educational interventions with caregivers which appear to improve attitudes of caregivers and reduce burden among them (El-Shafei et al., 2002), and also show reduction in the relapse rate of patients and improvement of their quality of life (Abolmagd et al., 2004).

El Ghamry et al. (2010) used a structured psycho-educational programme in the form of individual family sessions, bifocal format, attended by both patients and their caregivers, in contrast to El-Shafie et al. (2002) where group family sessions were attended by the relatives only.

The behavioural family psycho-educational programme used in El-Ghamry et al.'s (2010) study consisted of 14 sessions administered over six months, which is considered a long-term family intervention, involving educational sessions, interactive communication skills training sessions and interactive problem solving skills sessions, while the other Egyptian studies administered educational sessions (Abolmagd et al., 2004; El-Shafie et al., 2002; Hussein et al., 2006).

Conclusion

There are several priority social determinants in health in the eastern Mediterranean region which

includes Egypt and all the 22 Arab countries. These determinants include women's empowerment, where the low status and gender discrimination at all stages in the life cycle limit women's contribution to their own health and well-being and they are also expected to look after sick members of the family. Other factors include child labour and street children, migrant workers and their health, limited access to health services, social exclusion, low status occupational groups, poor environmental conditions, lack of access to clean water and sanitation, and safe working conditions; the disabled and those with stigmatized diseases are deprived of health and social rights (WHO, 2006). Furthermore, as the WHO report shows, other causes such as air pollution, lifestyles and behaviour, smoking and traffic accidents affect the health of people in several countries in the region. Any interventions therefore have to be at both individual and social levels, which include families.

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