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Melancholy in Muslim cultures

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Abstract. *Depressive disorder in Muslims has cultural inputs that affect its genesis, prevention, symptomatology and management. Cousin marriage which is favoured in Muslim cultures is associated with greater family incidence. On the other hand early adequate substitution of parental care deprivation in childhood may have primary preventive effects on the development of depression in adulthood. Somatic symptoms form the front of many depressive disorders. Guilt feelings lay in the background of as many Muslim depressives as Christian depressives in an Egyptian study. However suicidal thoughts are considered blasphemous and severely depressed Muslims stop at the level of death wishes. Family contributes to the triangular family-patient-doctor relationship instead of the dyadic Western patient-doctor relationship. Community care of the depressed includes the family much more than any other welfare agency.*

Keywords: Depressive disorder, Muslim, Arab, suicidal thoughts.

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INTRODUCTION

The culturally shared code of conduct in most Arab countries derives largely, though not solely, from religions which arose in this area. Some implicit beliefs and explicit practices have been transmitted across generations from earlier periods of history. Depression arises in, and impacts, this rich matrix of mental life. The genesis, pattern and management of depression reflect this culture.

CULTURE AND GENESIS OF DEPRESSION

Togetherness characterized the Arab community since pre-Islamic ages. Belonging to an extended family or tribe is an important identity attribute. Cousin marriage within the extended family makes a positive family history more likely in Arab patients with depression than in western cultures. On the other hand, early adequate substitution for loss of maternal care in childhood protects against the development of adulthood depression (Bowlby, 1977). Unconditional family support buffers a lot of daily stress that could otherwise precipitate depressive disorder. In studies of intergenerational conflict in Arabian families (El –Islam, 1976, El –Islam, Abu-Dagga, Malasi & Moussa, 1986) the conflict led to professional and/or traditional help seeking because the compromised intra-family support could not prevent the onset of depressive symptoms in vulnerable family members of either generation.

The pronatalist Arab Culture was reinforced by the inception of Islamic religion when the Koran (Muslim Holy Book) described wealth and offspring as the beauties of secular life (Koran Ch 18 Verse 46). Women were endowed with the monorole of producing and mothering children. Women who failed to fulfil this role and produced a few or no children developed a recalcitrant syndrome of somatized depressive symptoms (El- Islam, 1975). In one Arabian Gulf community where this syndrome was initially described,

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the syndrome eclipsed two decades after its description as women were accorded multiroles in all walks of life (El-Islam, 2006).

Muslim men are allowed by the Islamic religion to marry 1-4 women at the same time. Women in polygamous marriages were found to have more depressive symptoms than women in monogamous marriages in a sample of outpatients in Kuwait. (Chaleby, 1985). Survival of a woman as a single wife in marriage of affluent Muslims is so exceptional among conservative Muslims that it is regarded as the seat of envy by other women in the community (El-Islam, 2001). Muslim women know that the Islamic religion allows no contraception but they have to use contraceptive methods out of economic necessity because of the cost of raising children. Women who have this cognitive dissonance were found to be significantly more likely to have depressive symptoms in association with contraception than women without cognitive dissonance (El-Islam, 1988). Ostracizing from family support after a depressive parasuicide was more frequently followed by recurrences of parasuicide than containment of the parasuicidal individual in a nurturing family atmosphere (Suleiman, Moussa & El-Islam, 1989).

PATHOPLASTIC EFFECTS OF MUSLIM CULTURE ON DEPRESSIVE SYMPTOMS

For Muslims like many other cultural groups, the heart is the seat of emotions and the complaint of "heartache" is strongly suggestive of depressive suffering (El-Islam, 2002). It corresponds to gloomy or dejected feelings in western patients. In Muslim depressed patients cardiac hypochondriasis is significantly more frequent than gastrointestinal hypochondriasis which distinguishes depression in the west (El-Islam & Mirza, 1988).

Islamic religious contents abound in Beck's depressive triad in Muslims. The past is occupied by magnifications of minor religious wrongdoings. The present is pervaded by helplessness of the Muslim depressives associated with their feelings of lack of God's blessing in current affairs. Future hopelessness relates more to the after-life than to future secular life. Depressed Muslim patients have a "blameful" self with morbid self-reproach out of keeping with the nature and magnitude of conceived wrongdoings. This differs from healthy self-criticism because it is not associated with self-instruction to do better in future. With multiple self-reproachings the Muslim depressive may conclude that he/she is worthless of life or that life is not worth going through. Progress of depression is associated with death wishes and the invocation of God to end one's life. Further progress to suicidal thoughts, suicidal attempts and self-inflicted death is rare even in the most severely depressed Muslim patients because this is blasphemy which is punishable by eternal hell in the after-life. Guilt feelings which abound with religious contents (El-Islam, 1969) are found on probing the background of the mental state of Muslim depressed patients. The replacement of depressive guilt by somatic symptoms in Muslim patients' foreground misled western scholars who concluded the rarity of guilt in non-Christian depressives (Murphy, Wittkower & Chance, 1967) and led to the wider conclusion that non-Christians form a shame- rather than a guilt-culture. Most Muslim depressives feel guilty about, and ashamed of their poor adjustment or adaptation at the same time (El-Islam, 1969).

Depressed Muslim patients lack initiative and complain of physical and/or mental fatigue rather than feelings of low-spiritedness or inability to experience pleasure. This leads to traditional mis-attribution of their condition to weakness of their personality or weakness of their faith with further lowering of their poor self-esteem and progress into depths of depression. In women with bipolar affective disorder the onset of a depressive episode may be heralded by expression of guilt feelings about giving up the "Islamic" head scarf (hijab) or non-adherence to dutiful filial piety during a previous manic episode. Another depressive prodroma in Muslims involves preoccupation with dead relatives, dreaming about them and frequent visits to their graveyards (El-Islam, Moussa, Malasi, Mirza, 1988).

THE FAMILY AS A CARER FOR THE DEPRESSED

In the Islamic religion filial piety comes next in goodness only after God's worship. Family care is a major responsibility towards its sick, weak or less able members in return for their dutiful filial piety. It is sinful

to disobey or tyrannize one's parents. With the onset of depression a middle-aged Muslim man may dwell on his disobedience of his parents as a child and the parents would immediately indicate their unconditional forgiving. The family is the only social welfare agent for depressed Muslim family members. It provides the sick with nurturing and takes over their social responsibilities in order to maintain their integration in the family unit. Older family members decide on the path of care for a depressed family member e.g. seeking professional and/or traditional help. The Depressed can also seek religious self-help in the form of invocation of God as an external locus of control. The former may involve some ritual performance indoors or outdoors. The latter involves an internal dialogue using religious concepts of stress as a test for one's patient endurance and confidence in future relief when God wills. The Muslim depressed may confess their wrong doings directly to God without intervention of the Muslim religious clergy. Advice on religious self-help is normally provided for the Muslim depressed by other family members (El-Islam, 1967).

THE PATIENT-DOCTOR-FAMILY TRIANGLE

The dyadic patient-doctor relationship in western cultures is replaced by a patient-doctor-family triangular relationship for sick Muslim patients. This is most appropriate for the management of depressed patients. The assessment psychiatric interview is usually tri-partite. The relative escorting the patient meets the psychiatrist before interviewing him/her in order to provide information which the patient is not likely to provide e.g. lack of self-care with the onset of depression. The second part of the assessment is interview with the patient in privacy. The third part is a further interview with the escorting relative who needs information on the patient's state of health and the role of the family in patient care. Confidentiality of patient's health information is preserved by securing his/ her prior agreement on information to relatives and converting the third component of the assessment into a joint interview with the patient and relative at the same time. The patient conveys to the relative the health information provided by the doctor. Follow up and care are the joint responsibility of the patient and family according to the management plan. The family is an indispensable resource (El-Islam, 2005). Family prayers ask God to provide the treating doctor with wisdom in treating the depressed family member.

PSYCHOTHERAPY AND RELIGION FOR THE MUSLIM DEPRESSED

In order to involve the Muslim religion in psychotherapy of the depressed a detailed religious history on each patient should be available to the therapist. Religious inputs are chosen carefully to fit into patients' religious "receptors". Verses from the Koran that emphasize god's forgiveness, acceptance of repentance, reward for restitution and patient endurance and the accountability limits for one 'own deeds are among the more commonly used Koranic verses in order to relieve depression in Muslims by religious support. The "blameful" self gives way to a "secure" self.

Religious healers also provide religious support for the Muslim depressed. Group prayers include sick and non-sick individuals. Faith healers reinforce the attribution of distress of the depressed to supernatural agents (e.g. others' envying evil eyes) by patients and relatives. Some healers practice exorcism for demons (jinn) to which non-desirable patient behaviour may be attributed.

Some patients ask their psychiatrist whether antidepressant medication could act on demons purported to make them depressed. Demonic action is a form of stress that acts in the same way as any secular stress in Muslim depressed patients for whom demons are psychic realities. The biochemical mechanisms evoked by all forms of stress are amenable to the effect of antidepressants. Religious self-help contributes by self-regulation using the system of beliefs and notions that religion provides and by practicing the religious code of worship. Muslim depressed patients and their relatives should accept no harmful interventions from traditional healers and continue their medical psychiatric treatment even if the healers instruct them to discontinue it. The performance of pilgrimage by Muslims is believed to "erase" all their wrong doings and the depressed feel relieved of their burden of sins. Other ritual worship is also held to relieve tension and invite God's blessing e.g. prayers and fasting. Depressed patients resort to these methods of religious self-help concurrently with, or instead of, professional help. Relief is ultimately dependent on god's will and the Muslim depressed make this more likely by ritual performances.

NOTES

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