Debbie doesn't know that Cipramil is now indicated for panic disorder

... she just knows her doctor made a logical choice

As a patient with Panic Disorder, Debbie is beginning to appreciate the value of the Cipram treatment that her doctor has newly prescribed.

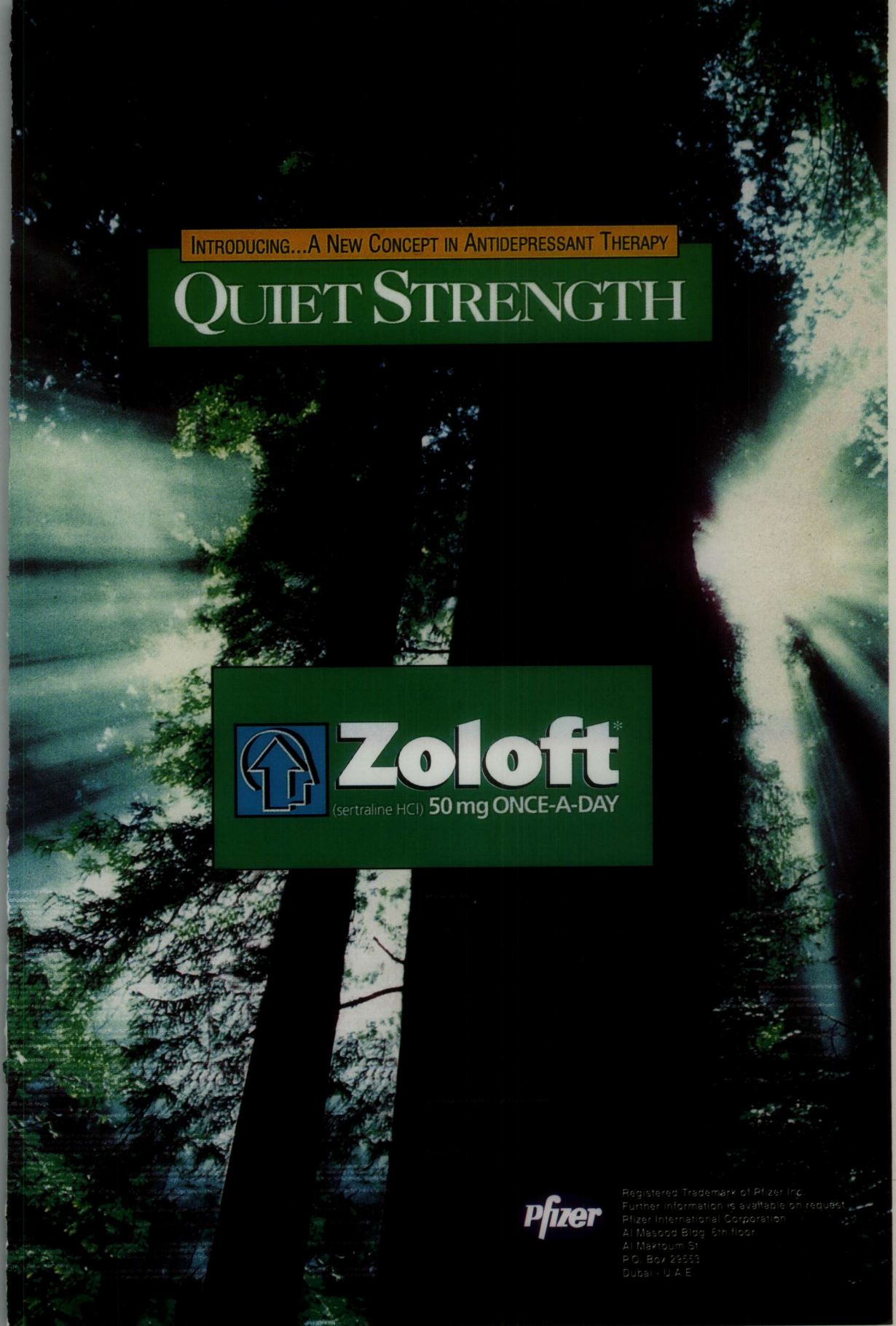
Of course, Debbie would no more talk of the recently extended indication for Cipram than its high selectivity[1,2], good tolerability[3], and low risk of drug interactions[4,5,6]. She just recognises the difference that Cipramil makes to the stability and quality of her life.

Lundbeck

Cipram▼
citalopram
now indicated for panic disorder

Presentation: 'Cipramil' tablets 10 mg: PL 0458/0057, each containing 10 mg of citalopram as the hydrobromide. 28 (OP) 10 mg tablets £12.77. 'Cipramil' tablets 20 mg: PL 0458/0058, each containing 20 mg of citalopram as the hydrobromide. 28 (OP) 20 mg tablets £21.28. **Indications:** Treatment of depressive illness in the initial phase and as maintenance against relapse/recurrence. Treatment of panic disorder, with or without agoraphobia. **Dosage:** ***Treating depression: Adults:*** 20 mg a day. Depending upon individual patient response, this may be increased in 20 mg increments to a maximum of 60 mg. Tablets should not be chewed, and should be taken as a single oral daily dose, in the morning or evening without regard for food. Treatment for at least 6 months is usually necessary to provide adequate maintenance against the potential for relapse. ***Treating panic disorder:*** 10 mg daily for the first week, increasing to 20 mg daily. Depending upon individual patient response, dosage may be further increased to a maximum of 60 mg daily. Depending upon individual patient response, it may be necessary to continue treatment for several months. ***Elderly:*** 20 mg a day increasing to a maximum of 40 mg dependent upon individual patient response. ***Children:*** Not recommended. ***Reduced hepatic/renal function:*** Restrict dosage to lower end of range in hepatic impairment. Dosage adjustment not necessary in cases of mild/moderate renal impairment. No information available in severe renal impairment (creatinine clearance <20ml/min). **Contra-indications:** Combined use of 5-HT agonists. Hypersensitivity to citalopram. ***Pregnancy and Lactation:*** Safety during human pregnancy and lactation has not been established. Use only if potential benefit outweighs possible risk. **Precautions:** Driving and operating machinery. History of mania. Caution in patients at risk of cardiac arrhythmias. Do not use with or within 14 days of MAO inhibitors: leave a seven day gap before starting MA inhibitor treatment. Use a low starting dose for panic disorder, to reduce the likelihood of an initial anxiogenic effe (experienced by some patients) when starting pharmacotherapy. **Drug Interactions:** MAO inhibitors (see Precautio Use lithium and tryptophan with caution. Routine monitoring of lithium levels need not be adjusted. **Adverse Even** Most commonly nausea, sweating, tremor, somnolence and dry mouth. With citalopram, adverse effects are in gene mild and transient. When they occur, they are most prominent during the first two weeks of treatment and usually attenuate as the depressive state improves. **Overdosage:** Symptoms have included somnolence, coma, sinus tachyca occasional nodal rhythm, episode of grand mal convulsion, nausea, vomiting, sweating and hyperventilation. No spe antidote. Treatment is symptomatic and supportive. Early gastric lavage suggested. **Legal Category:** POM 24.1.95. Further information available upon request. Product licence holder: Lundbeck Ltd., Sunningdale House, Caldecotte Business Park, Caldecotte, Milton Keynes, MK7 8LF. ® 'Cipramil' is a Registered Trade Mark. © 1997 Lundbeck Ltd. of preparation: April 1997. 0897/CIP/501/

1. Hyttel J. XXII Nordiske Psykiater Kongres, Reykjavic, 11 August 1988:11-21. 2. Eison AS et al Psychopharmacology 1990; 26 (3): 311-315. 3. Wade AG et al. Br J Psychiatry 1997; 170: 549-553. 4. Sindrup SH et al. Ther Drug Monit 199 11-17. 5. Van Harten J. Clin Pharmacokinetics 1993; 24: 203-20. 6. Jeppesen U et al. Eur J Clin Pharmacol 1996; 51: 7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(تمت الفهرسة بمعرفة دائـرة المكتبات والوثـائق الوطنية)

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المجلة العربية للطب النفسي (١٩٩٨)، العدد (١)، المجلد (٩)

معلومات هامة للناشرين

لقد صدرت المجلة العربية للطب النفسي عام ١٩٨٩ من قبل اتحاد الأطباء النفسانيين العرب. وينشر في المجلة أبحاث علمية أصيلة، مراجعات علمية ومقالات تهتم بالعمل السريري. ويمكن أن تكتب المقالة باللغة العربية أو الإنجليزية مع ملخصين باللغة العربية والانجليزية. ويتم قبول الأوراق العلمية التي تتمشى مع أخلاقيات القوانين المحلية والدولية. ويمكن أن ترسل المقالات إما الى رئيس التحرير أو نائبه أو المحررين المشاركين. وتقيم كل الأوراق من قبل محكمين دوليين.

المقالة : ترسل بنسختين مطبوعتين بمساقات مزدوجة على صفحات A4 بحواشي ٣ سم. ويجب أن لا تزيد العناوين الفرعية عن ثلاث مستويات ويراعي عند كتابة المقال أن تخصص الصفحة الأولى لعنوان الورقة باللغة العربية والإنجليزية مع أسماء المشاركين بها دون ألقاب بما لا يزيد عن ٤٠ حرف.

الصفحة الثانية: ملخص باللغة العربية لا يزيد عن مائتين وخمسين كلمة منظم حسب أهداف الدراسة وطريقتها والنتائج ثم الخلاصة.

الصفحة الثالثة: تحتوي على أسماء المشاركين وعناوينهم وعناوين المراسلة.

يمكن أن تخصص صفحة للشكر للأفراد والمؤسسات التي دعمت البحث.

أما الملخص باللغة الإنجليزية فيفضل أن يكون على صفحة منفصلة بعد المراجع.

الجداول: يجب أن تطبع الجداول بمسافات مضاعفة وعلى صفحات خاصة وترقم وأن يكون لها اسم مختصر.

الإيضاحات: كل الإيضاحات من صور أو رسومات يجب أن تكون ضعف الحجم الذي ستظهر به بالطباعة حتى يمكن تصويرها.

قائمة المراجع: يجب أن يتبع أسلوب فانكوفر بحيث تظهر المراجع حسب الترتيب الذي ظهرت به في المقالة وليس حسب الترتيب الابجدي. ويفضل كتابة أسماء المشاركين في المرجع إلا إذا زاد العدد عن ستة فيكتفي بكتابة (وجماعته et al).

١. اسماعيل، عزت (١٩٨٤)، جنوح الاحداث، وكالة المطبوعات: الكويت.

٢. الشيخ، سليمان الخضري (١٩٨٢) دراسة في التفكير الخلقي لدى المراهقين والراشدين، الكتاب السنوي في علم النفس.

٣. الخطيب، جمال والحديدي، منى والسرطاوي، عبد العزيز (١٩٩٢). ارشاد أسر الأطفال ذوي الحاجات الخاصة. دار حنين، عمان، الأردن.

المجلة العربية للطب النفسي

Church House Conference Centre, London, UK

22 - 24 October 1998

Patron: Her Majesty Queen Elizabeth II

Partners for Mental Health: Nations for Mental Health

An International Symposium to celebrate the 50th Anniversary of the World Federation for Mental Health.

Theme

Worldwide attention has been focused on mental health needs as never before: by the newly heard voice of mental health service users and families, as well as by significant reports from the World Bank and other international bodies. These add substantially to the unending efforts of organisations and individuals over many years. This symposium will set in motion a new collaborative process between the World Federation for Mental Health, the World Health Organization and other agencies at global, regional national and local levels. It will act as an essential support for the new WHO Nations for Mental Health programme and contribute to the changes in attitude and practice that concerned people are striving for. The occasion of the 50th anniversary of WFMH, founded in London in 1948, provides a unique opportunity to take a major step forward in the process.

Language

The symposium language is English. For budgetary reasons there will be no interpretation.

Timetable, Venue and Hotels

The symposium will start at 9.00 am on Thursday 22 October and will end at 4.00 pm on Saturday 24 October 1998. A detailed programme will be circulated in May 1998.
Church House Conference Centre, overlooking Westminster Abbey, is a building of international significance and has been the venue for many historic meetings during the last 60 years. A location map, together with details of nearby hotels offering discounted rates to delegates, will be sent with acknowledgment of registration.

Registration

Places are limited and early application, on the attached registration form is recommended closing date for registration 1 October 1998. The registration fees are as follows:

Before 1 May 1998: - WFMH members 275.00 - Non-members 300.00

After 1 May 1998: - WFMH members 315.00 - Non-members 340.00

The registration fee covers conference documentation, lunches and refreshments, but not accommodation. Payment can be made by sterling cheque drawn on a UK bank or by credit card (subject to a 5% transaction surcharge). Provisional bookings made by telephone or mail cannot be confirmed until the fee has been received. In the event of cancellation before 1 October the registration fee will be refunded less a 20% administrative charge. We regret there are no refunds for cancellations after 1 October but substitute delegates will be accepted.

Symposium Secretariat

For further information on any aspect of the symposium please contact Karen Stone or Rosemary McMahon at:
Professional Briefings, 120 Wilton Road, London SW1V 1JZ, UK
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Fax : +44(0)171-233 7779
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The Arab Journal of Psychiatry (1998) Vol. 9. No. 1

المحتويات

XIth World Congress of Psychiatry

August 6-12, 1999

Hamburg

organized by

The World Psychiatric Association (WPA) in collaboration with the Deutsche Gesellschaft fur Psychiatrie, Psychotherapie und Nervenheilkunde (DGPPN)

President of the Congress

N. Sartorius (Switzerland)

Congress Venue
The scientific program will take place at the Congress Centrum Hamburg - CCH, the Radisson SAS Hotel and the main building of the University of Hamburg. The CCH and the Radisson SAS are in one building complex, the University is adjacent to it. With its many congress halls and modern technical equipment it is the right venue for a successful world-congress.

Deadlines

April 1997	First Call for Papers
April 1998	Preliminary Program
February 1, 1999	Final Program Proposals and Abstracts
February 1, 1999	Fellowship Application
February 1, 1999	Advance Registration
July 1, 1999	Final Pre-Meeting Registration

Languages of the Congress
English, French, German, Japanese, Russian, Spanish

Registration Fees

	Before February 1, 1999	After February 1, 1999
Delegates	DM 800,	DM 950
Reduced fees (Trainees & others)	DM 500,	DM 600,
Accompanying Persons	DM 250,	DM 300,

Fee Includes
- Attendance to the Scientific Sessions ں
- Social Events. Opening Ceremony, Closing ں
-Ceremony, and one other Social EvenT
-Delegates Bag, Documents, Book of Abstracts ں
- Final Program and other Congress Material
- Medical Insurance ں

The Arab Journal of Psychiatry (1998) Vol. 9 No. 1 Page (47 - 55)

Mental Health Law in Tunisia: Its Context, Its Characteristics and Its Repercussions on the Psychiatrics Hospitalization

N. Ayadi, A. Jaoua

قانون الصحة العقلية في تونس: اطاره، خصائصه ونتائجه على الايواء بالمستشفيات

ن٠ العيادي، ع٠ الجوة

الملخـــــص

قانون ٩٢/٨٣ المتعلق بالصحة العقلية، وبشروط الايواء في المستشفى بسبب اضطرابات عقلية، جاء بعد فراغ قانوني طويل استمر ٣٦ سنة بعد استقلال البلاد٠

في هذا المقال، سنحاول تدارس الظروف التاريخية والاجتماعية والسياسية، والصحية التي حفت بهذا القانون، والتي بلورت الحاجة اليه، وساهمت في صدوره٠

ثم نستعرض أهم بنوده، لنختم بتقييم نتائجه على الممارسة الطبية النفسية، وعلى الايواء بصفة خاصة٠

المفاتيح: الصحة العقلية، القانون، الايواء٠

المقدمـــــة

لقد عرفت شروط الايواء، بسبب مرض عقلي، في تونس فراغاً قانونياً، لمدة طويلة٠ في عهد الحماية، لم يكن القانون الفرنسي لسنة ١٨٣٨، المتعلق بايواء المرضى العقليين، ينطبق إلا على الفرنسيين أو أمثالهم (إسرائيليين أو أوروبيين)[١]، الذين كانوا يأوون بمستشفى منوبة، بضاحية تونس العاصمة بينما لم يتمتع التونسيون بأي قانون في هذا المجال، الى غاية سنة ١٩٥٣، تاريخ صدور أمر من الباي، بتنظيم الايواء الوجوبي للمجرمين غير المسؤولين عن أفعالهم٠ وقد انتظرت تونس المستقلة منذ سنة ١٩٥٦، ٣٦ سنة، لسن قانون خاص بالصحة العقلية، وذلك عام ١٩٩٢ وهو القانون المعروف برقم ٩٢/٨٣، الذي جاء لينظم الايواء، والإقامة، والخروج من مستشفيات الأمراض العقلية (أو النفسية كما يقال

أيضـا)، وكذلـك لحمايـة الحريـات الفرديـة، وضمان كرامة المريض العقلي.

في هذه الدراسة، سنحاول وضع هـذا القـانون فـي إطاره التـاريخي والاجتمـاعي، والسياسـي وكذلـك الصحـي للبـلاد التونسية، مـع تركـيز علـى أهـم بنـوده، ثـم نختـم بتقييمـه، وبحـث تـأثيره فـي الممارسة الطبية النفسية، اليومية، وعلـى الايـواء، بصفة خاصة.

لمحة عن الرعاية النفسية بتونس

أحدث أول مستشفى للأمراض العقلية بتونس زمن الحماية الفرنسية، سنة ١٩٣١ [٢]، بمنطقـة منوبـة، إحدى ضواحي العاصمة. وهو عبارة عن نسـخة من المستشفيات العقليـة الفرنسـية. وقـد انتظـرت تونس المستقلة أربع سنوات، أي الى سنة ١٩٦٠ لإصـدار منشـور وزاري، يلحـق مستشـفى الأمـراض العقليـة، ببقيـة مستشـفيات البـلاد فيمـا يخص قواعد الايواء، ويقضي بتسـميته "مستشـفى الرازي". وقد بلغت طاقـة ايوائـه آنـذاك ١٠٢٥ سريراً[٣]، لتنخفض تدريجيـاً بدايـة مـن الثمانينيـات، الـى حوالـي النصـف حاليـاً وذلـك نتيجـة الاتجـاه المعـاصر الداعـي لمداواة المريـض العقلـي فـي محيطه الطبيعي.

وفي إطار لامركزية العلاج أحدثت أقسام للطب النفسي ضمـن المستشـفيات فـي داخـل الجمهوريـة بكل مـن: صفـاقس سنة ١٩٦٣، المنسـتير سـنة ١٩٨٤، القـيروان سـنة ١٩٩١ . كمـا أقيـم المستشفى العسكري بتونس سنة ١٩٧٢ [٤]، عـلاوة على عيادات خارجية للطب النفسي بكل من قـابس (١٩٦٤) ومدنين (١٩٦٧)، وسوسة (١٩٧٨)[٥] .

ورغم تعدد الأقسام فان طاقة الإيواء الكلية لكـامل البلاد بقيـت هـي نفسـها تقريبـاً أي حوالـي ١٠٠٠ سرير سنة ١٩٩٣ [٦]، نتيجـة خفـض عـدد أسـرة مستشـفى الـرازي كمـا أسـلفنا. ولـم يكـن عـدد الأطباء النفسيين يتجاوز الخمسـة إبـان الاسـتقلال، اثنان منهـم مسـلمان وفـي الثمانينيـات ارتفـع عـدد الأطبـاء حتـى بلـغ عشـرين طبيبـاً وعددهـم حاليـاً ١١٢ طبيباً، إضافة الى عشرة آخريـن بالخـارج، وحوالي الثلاثين بصدد التكوين[٣] .

وبالنسبة لنمط الايـواء، فانـه باسـتثناء المجرمين غـير المسـؤولين عـن أفعـالهم، والذيـن ينضـوون تحت راية الايواء الوجوبي، كان إيـواء المرضـى العقليين على اختلاف نوعيـة مرضـهم، يتـم وفقـاً لرغبة المريض. ولم يكن الأطباء الأوائل يـرون حرجاً في ذلك، بل ربما كانوا يفضلون استمرار ذلك، لإدراكهم أن ثمة مشاكل وتعقيدات إدارية قـد تبرز عند قوننـة هـذا القطـاع الصحـي، هـذا مـن ناحية ومن ناحية أخـرى رفضـت القوننـة للتفـاؤل المفـرط الـذي كـان يعلقـه الأطبـاء علـى الأدويـة النفسية (Psychotropes)، التي وقع اكتشـافها فـي الخمسينيات[٤]:

١٩٥٤ ، Antidepresseurs١٩٥٧

Anxiolytiques، ١٩٥٢ Neuroleptiques

بعض خصوصيات المجتمع والثقافة التونسيين

لعبت الروابط العائلية القوية، للأسرة التونسية، وانتشار الفكر الإسلامي، وما يحمله من قيم التكافل والتآزر، دوراً مهماً في تقبل المريض النفسي، واندماجه ضمن المجتمع، وكذلك في السعي الى علاجه بالطرق التقليدية، التي يطغى عليها الطابع الديني (زيارة الأولياء الصالحين، تلاوة آيات من الذكر الحكيم...). وما زال الكثيرون يرون أن اللجوء الى العلاج التقليدي يندرج ضمن المحافظة على العادات، والتقاليد، والتمسك بالهوية العربية الاسلامية. ويرون أن المعالجة بالطب النفسي الحديث، واللجوء الى المستشفى، يعد نوعاً من مسايرة الغرب، والانسياق في تيار الغرب، وفي النهج الذي رسمه المستعمر، بما يحمله من أفكار وعلمانية، رافضة للجانب الديني والروحاني. ولعل هذا من عوامل انتشار الطرق العلاجية التقليدية الى يومنا، وهي تلاقي رواجاً أكثر من الطب النفسي الحديث[٧] كما أن التصور التقليدي للمرض النفسي لا يزال متغلغلاً في مجتمعنا، الذي يرى فيه تأثير سحر، أو جان، أو تعويذة شريرة،.... وبالتالي فان دواءه لا يمكن أن يكون إلا باللجوء الى الله، أو الاستعانة بأوليائه الصالحين. بينما يداوي الطبيب النفساني بمواد كيماوية، من صنع الغرب الملحد المستعمر.

وقد ساهم اعتماد بعض الأطباء النفسيين الكلي على الدواء الكيماوي، مع تجاهل الجانب الإنساني والعلائقي للمريض، في النفور من الطب النفسي الحديث، وهو على هذه الصورة.

كما كان لغياب قانون يحدد، وينظم قطاع الصحة النفسية في تغذية هذا النفور، وفي إذكاء الخوف من اللجوء الى الطبيب النفسي ولو للاستشارة، اذ بإمكانه إيواء من يريد من القادمين إليه بالمستشفى، لو عنّ له ذلك!!.

تبلور الحاجة الى قانون للصحة العقلية

رأينا كيف أن نواة الطب النفسي بتونس أنشأها المستعمر الفرنسي، كما أن معظم الأطباء التونسيين درسوا في فرنسا، وخاصة الأوائل منهم. كل هذا جعل نظام الصحة النفسية بتونس مرتبطاً ومتأثراً بنظيره الفرنسي بدرجة كبيرة.

ولعل تأخر صدور قانون للصحة النفسية، يعود أساساً الى تنامي النزعة المضادة للطب النفسي "Anti-Psychiatrie"، بأوروبا في الستينيات، أي بعيد الاستقلال، وكذلك الى الانتقادات الحادة التي تأججت في تلك الفترة ضد قانون ١٨٣٨، مما حدا الأطباء التونسيين وأصحاب القرار، الى التريث، مفضلين "غياب القانون، على وجود قانون سيء". كما أن عجز جيراننا الجزائريين عن تطبيق قانوني الصحة النفسية، الأول (١٩٧٥) والثاني (١٩٨٥)[٨]، لعدم ملاءمتهما للواقع الميداني، قد دعم هذا الموقف المتريث.

لكن الارتفاع المتزايد في طلب خدمات الطب النفسي، الناتج أساساً عن التغيرات الجوهرية التي شهدها المجتمع التونسي منذ الاستقلال، وخصوصاً في السنوات الأخيرة، متأثراً بالنمط الغربي وبالتفكير العلماني، زاد في إلحاح الحاجة الى قوننة علاج المرضى العقليين. فكانت الأيام المغاربية الفرنسية، التي تنظمها سنوياً "الجمعية التونسية للطب النفسي"، الاطار الذي تلاقحت فيه الأفكار؛ لتفضي سنة ١٩٨٦ الى بلورة مشروع "البرنامج القومي للصحة النفسية" الذي تبنته الحكومة سنة ١٩٩١ [٦]، بدعم من منظمة الصحة العالمية (O.M.S)، والذي من بين أهدافه إحداث قانون للصحة العقلية.

وقد كان للتغيير السياسي الذي حصل سنة ١٩٧٨ في أعلى هرم السلطة، منادياً بدولة القانون، تأثيره لتحريك وحفز المسؤولين على بلورة هذا القانون، ثم جاء صدور القانون الفرنسي الجديد للصحة العقلية يوم ١٩٩٠/٦/٢٧ ليدعم هذا التوجه، ويسرع في إصدار القانون التونسي، الذي لوحظ تشابهه الكبير بنظيره الفرنسي[٩] .

قانون ٩٢/٨٣ المتعلق بالصحة العقلية وبشروط الإيواء في المستشفى بسبب اضطرابات عقلية[١٠]:

هذا القانون الذي صدر يوم ٣ تموز ١٩٩٢ دخل حيز التطبيق يوم ١ حزيران ١٩٩٣ منذ البداية، ينص القانون على أن إيواء المرضى بسبب اضطرابات عقلية، يجب أن يتم في دائرة احترام الحريات الفردية، وفي ظروف تضمن الكرامة البشرية. كما يعطي الحق للمصاب باضطراب عقلي، في الإسعافات الطبية، والمعالجات البدنية المناسبة، وكذلك في التعليم، والتكوين، وإعادة التأهيل. وهو يحميه أيضا من كل استغلال، أو تجاوز، أو معاملة غير إنسانية، أو مهنية.

أما فيما يخص الإيواء، فقد قسمه القانون الى صنفين:

١- **الإيواء الحر:** وهو مماثل للإيواء في بقية الأقسام الطبية، ويمكن أن يكون بالمستشفى العمومي، أو الخاص.

٢- **الإيواء بدون رضا المصاب:** لا يتم إلا إذا:

- جعلت الاضطرابات المصاب بها من المستحيل التحصيل على رضاه.
- استوجبت حالته إسعافات مستعجلة.
- كانت حالته تمثل تهديداً لسلامته، أو لسلامة غيره.

ويجب أن يقع الايواء بمستشفى عمومي حسب احدى الطريقتين التاليتين:

* **بطلب من الآخرين:** ويراد بالآخرين: احد الأصول (أب أو أم)، أو الفروع (ابن أو بنت)، أو الحواشي (أخ أو أخت)، أو القرين، أو الولي الشرعي للمريض.

ويستوجب:

في الحالات العادية:

- مطلباً في الايواء معللا، ومكتوباً وممضى، من طرف الآخرين.
- شهادتين طبيتين، لم يمر على تحريرهما أكثر من ١٥ يوماً، تنصان على ضرورة ايواء المصاب بدون رضاه، على أن تكون احدى هاتين الشهادتين صادرة عن طبيب نفساني استشفائي.

في الحالات الاستعجالية:

تكفي شهادة طبية واحدة من طبيب نفساني استشفائي.

* **وجوباً:** وهو من اختصاص رئيس المحكمة الابتدائية، التي يوجد بدائرتها محل إقامة الشخص الذي تتطلب حالته الايواء ويمكن أن يتم حسب احدى الطرق الثلاثة الآتية:

في الحالات العادية:

يقع إعلام رئيس المحكمة، بطلب كتابي صادر عن أي سلطة صحية عمومية، أو عن وكيل الجمهورية ويكون مرفوقاً بشهادة طبية.

يقرر رئيس المحكمة الايواء الوجوبي بمستشفى عمومي، يذكره للغرض، وذلك بعد سماع المريض، ويحدد مدة الاقامة التي لا يمكن أن تتجاوز الثلاثة أشهر، يمكن تجديدها كلما دعت الضرورة لذلك، بعد أخذ رأي معلل من الطبيب النفساني الاستشفائي المباشر.

في الحالات الاستعجالية:

في حالة ظهور خطر وشيك يهدد سلامة المريض، أو الآخرين، يقرر وكيل الجمهورية كل التدابير الوقتية اللازمة لايواء المريض بالمستشفى مع التكفل بانهاء الأمر في ظرف ٤٨ ساعة لرئيس المحكمة الابتدائية المختصة ترابيا، وعلى هذا الأخير البت في مطلب الايواء الوجوبي دون تأخير، بعد الاطلاع على شهادة طبية محررة من طبيب نفساني بالمؤسسة التي قبل بها المريض. وفي حالة عدم صدور هذا القرار من رئيس المحكمة، فان التدابير الوقتية تعتبر باطلة بانتهاء مدة ٨ أيام.

في حالة عدم تحمل المسؤولية: (تطبيقاً للفصل ٣٨ من المجلة الجنائية):

عندما ترى السلطة القضائية أن الحالة العقلية لشخص تحصل على قرار في حفظ التهمة، أو اخلاء سبيل، أو عدم سماع الدعوى، تطبيقاً للفصل ٣٨ من المجلة الجنائية، يمكن أن يشكل تهديداً لسلامته، أو سلامة الآخرين، فانها تأمر بالايواء الوجوبي، وتعلم بذلك وزير الصحة العمومية بدون تأخير.

وتجدر الملاحظة الى أن الايواء الوجوبي يتطلب وجود خطر على سلامة المريض، أو سلامة الآخرين بينما الخطر على الأشياء المادية وحدها لا يسمح باللجوء الى هذا النوع من الايواء. كما تضمن القانون إمكانية أن يحكم رئيس المحكمة الابتدائية على المريض

بالمثول لدى المؤسسة التي حوته، في فترات دورية، تحدد له من طرف الطبيب المباشر، ليخضع لفحوص المراقبة، ولكل ما تتطلبه حالته الصحية عند الاقتضاء.

هذا بالإضافة الى إلزام الطبيب بفحص المريض الذي أوته المستشفى بدون رضاه، خلال الـ ٤٨ ساعة الأولى للايواء، وعلى الأقل مرة كل شهر، وكذلك قبل الخروج، مع تحرير شهادات وصفية في كل مرة: "شهادة الـ ٤٨ ساعة"، "الشهادة الشهرية"، و"شهادة الخروج".

الانعكاسات العملية للقانون ٩٢/٨٣

من أبرز نتائج تطبيق هذا القانون، ارتفاع نسبة الايواء الوجوبي بصفة متواصلة، منذ بداية العمل به[١١] (انظر جدول رقم ١) ومرد ذلك عدة عوامل، منها:

- تملص بعض العائلات من مسؤولياتها، باللجوء الى هذا النمط من الايواء، الذي يجنبها أتعاب، ومشاكل، ومصاريف التنقل، حيث تتولى السلطة الأمنية التكفل بذلك بالنسبة للمرضى الذين سيتم ايواؤهم وجوبيا. ويتفاقم هذا الأمر لدى الأسر المعوزة أو القاطنة في المناطق النائية.
- اللجوء السريع لدى بعض السلطات الأمنية أو القضائية، للايواء الوجوبي مفضلين مراعاة النظام العام والأمن، على احترام الحريات الفردية للمريض. وفي بعض الأحيان يخلط بعضهم بين المرض العقلي، والخطورة، حيث يتصورون أن المرض العقلي في حد ذاته، يشكل خطراً محتملاً، يبيح الايواء الوجوبي للمصاب به. فكثيراً ما نرى قرارا بالايواء الوجوبي، لا تبرره الحالية السريرية للمريض، حيث أن حالته النفسية لا تشكل أي خطر، أو تهديد للنظام العام، أو سلامة الآخرين كما هو الحال بالنسبة لبعض المتخلفين ذهنياً[١٢].

وفي المقابل، فقد انخفضت نسبة الايواء الحر بصفة حادة بعد أن كانت تشكل الأغلبية الساحقة لطرق الايواء قبل صدور القانون.

كما لاحظنا تنامي انتداب المرضى من الذهانيين، ممثلين أساساً في مرضى فصام الشخصية والذهان الزوري[١٢،١٣] (انظر الجدول رقم ٢)، الذين غالباً ما تطول مدة إقامتهم بالمستشفى كما أسلفنا، بينما يتزايد اجتناب إيواء الأنواع الأخرى من المرضى العقليين.

وقد يعود ذلك إلى وعي الطبيب بضرورة تفادي خلط أصناف مختلفة الحدة، أو الخطورة من المرضى مع بعضهم ضمن نفس القسم، خصوصاً أمام عدم توفر أقسام مفتوحة، مهيأة لاستقبال مرضى الإيواء الحر، كما ينص على ذلك القانون، وتحول الأقسام الموجودة للطب النفسي، الى أقسام مغلقة، بحكم الغالبية الساحقة

للايواء بدون رضا المصاب (على حساب الايواء الحر)٠

كما ارتفع معدل مدة الاقامة، من ١٨ يوماً سنة ١٩٩٢ (أي قبل تطبيق القانون) الى ٣٣ يوماً سنة ١٩٩٣، لينخفض قليلاً سنة ١٩٩٥ الى ٢٧ يوماً (هذه الأرقام تخص قسم الطب النفسي بصفاقس)[١٣] ويعزى ذلك أساساً الى:

- ارتفاع نسبة الايواء الوجوبي كما أسلفنا٠
- عدم تجاوب بعض القضاة مع الطبيب النفساني، بتجاهل طلبه رفع الايواء الوجوبي٠
- التعطيلات الادارية، التي كثيراً ما تؤخر قرار الرفع ووصوله٠

هكذا نرى أن قانون ٩٢/٨٣ قد سحب من الطبيب أمر خروج المرضى العقليين الذين وقع إيواؤهم وجوبيا، مما ينجر عنه غالباً، إطالة لا مبرر لها، وفي بعض الأحيان تكون ضارة٠ وقد نتج عن ذلك اكتظاظ الأسرة بأقسام الطب النفسي، حيث ما انفك معدل امتلاء الأسرة يتفاقم، منذ تطبيق هذا القانون[١٣] (انظر الجدول رقم ٣)٠

وخلاصة القول، ان قانون ٩٢/٨٣، جاء كنتيجة حتمية للحاجة الملحة الى قوننة قطاع الصحة العقلية، في ظل غياب قانون واضح وشامل ينظم هذا القطاع، وفي اطار حرص تونس العهد الجديد على تكريس دولة القانون ومسايرة ما يحدث في البلدان المجاورة، وخصوصاً فرنسا، التي تربطنا بها عوامل قوية ومتعددة (تاريخية، سياسية٠٠٠٠)٠

وقد أتى هذا القانون بالعديد من النقاط الايجابية، لفرض احترام المريض العقلي، وانصهاره ضمن المجتمع ولمراعاة حريته الفردية٠

لكن بعض النقائص ومواطن الضعف، ظهرت لاحقاً، بعد تطبيقه، وتستدعي مراجعته، وتنقيحه، بالتعاون، والتشاور بين المعنيين به من القطاعين الصحي، والقضائي٠ كما يجب الحرص على تطوير الأقسام الاستشفائية، وتجهيزها بما يلزم من العناصر المادية والبشرية للمحافظة على حسن سيرها وجدواها وتسهيل الاستجابة لمتطلبات القانون بكافة حيثياته، وتطبيق المبادىء التي جاء بها على الميدان٠

جدول رقم ١: تطور الايواء الوجوبي

		١٩٩٣	١٩٩٤	١٩٩٥	١٩٩٦
مستشفى الرازي بمنوبة	العدد	١٢٧	٤٧٩	٥٥٠	٦٥٨
	النسبة ٪	٧	٢٦	٣٠	٣٧
مستشفى الهادي شاكر بصفاقس	العدد	٤٤٥	٦٠٣	٦٥٨	٧٣٥
	النسبة ٪	٣٤	٣٩	٤٠	٤٢

جدول رقم ٢: نسبة الذهانيين المقيمين بالمستشفى

السنة	١٩٩٢	١٩٩٣	١٩٩٥
النسبة ٪	٦٥	٧٨	٨٧

جدول رقم ٣: تطور امتلاء الأسرة

السنة	١٩٩٢	١٩٩٣	١٩٩٥
نسبة الامتلاء ٪	٦٨ر٥	١٠٣	١١٠

Abstract

The act 92/83 which is concerned with mental health and the conditions of hospitalisation have come about after a long absence of legislation which lasted for 36 years following independence.

In this article we will be studying the historical, sociological, political and health factors that influenced the evolution of such an act. Finally, we will examine the important sections of it and evaluate the impact of such acts on the practice of psychiatry and patterns of hospitalisation.

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من التراث العلمـــــــــي

الفصل الثالث من المجلد الأول
من كتاب القانون في الطب
لابـــــن سينـــــــــا

في أنواع الرياضـــة

الرياضة منها ما هي رياضة يدعو اليها الاشتغال بعمل من الأعمال الانسانية، ومنها رياضة خالصة وهـي التي تقصد، لانها رياضة فقط وتتحرى منها منافع الرياضة ولها فصول، فان من هذه الرياضة ما هو قليل ومنها ما هو كثير، ومن هذه الرياضة ما هو شديد، ومنها ما هو ضعيف، ومنها ما هو سـريع، ومنهـا مـا هـو بطـيء ومنهـا مـا هـو حثيث أي مركب من الشدة والسرعة، ومنها ما هو متراخ وبين كل طرفين معتدل موجود. وأما أنواع الرياضـة، فالمنازاعـة والمباطشة، والملاكزة، والاحضار، وسرعة المشي، والرمي عن القوس، والزفن والقفز الى شيء ليتعلق بـه، والحجل على احدى الرجلين، والمثاقبة بالسيف والرمح، وركوب الخيل والخفق بـاليدين، وهو أن يقف الانسان على أطراف قدميه ويمد يديه قدّاما وخلفاً ويحركهما بالسرعة، وهي من الرياضة السريعة. ومن أصناف الرياضـة اللطيفـة اللينة الترجيح في الأراجيح، والمهود قائماً وقاعداً ومضطجعاً، وركوب الزواريق والسماويات. وأقوى من ذلك ركوب الخيل والجمال والعماريات، وركوب العجل. ومن الرياضات القوية الميدانية، وهو أن يشد الانسان عـدوه فـي ميدان ما الى غاية، ثم ينكص راجعاً مقهقراً فلا يزال ينقص المسافة كـل كـرة حتـى يقـف آخـره علـى الوسط. ومنهـا مجاهدة الظل والتصفيق بالكفين، والطفر، والزج واللعب بالكرة الكبيرة والصغيرة. واللعب بالطبطاب، والمصارعـة، واشالة الحجر، وركض الخيل، واستقطافها، والمباطشة أنواع: فمن ذلك يشبك كل واحد من الرجليـن يـده علـى وسط صاحبه، يدخل اليمين الى يمين صاحبه واليسار الى يساره ووجهه اليـه ثم يشيله ويقلبـه، ولا سيما وهـو ينحنـي تـارة وينبسط أخرى.

ومن ذلك المدافعة بالصدرين، ومن ذلك ملازمة كـل واحـد منهمـا عنـق صاحبـه يجذبـه الـى أسفل، ومـن ذلـك مـلاواة الرجلين والشعزبية وفحج رجلي صاحبه برجليه وما يشبه هذا من الهيآت التي يستعملها المصارعون. ومن الرياضـات السريعة مبادلة رفيقين مكانيهما بالسرعة وموائرة طفرات الى خلف يتخللها طفرات الى قدام بنظـام وغير نظـام. ومـن ذلك رياضة المسلتين، وهو أن يقف انسان موقفاً ثم يغرز عن جانبيه مسلتين في الأرض بينهما باع فيقبـل عليهمـا نـاقلاً المتيامنة منهما الى المغرز الأيسر والمتياسرة الى المغرز الأيمن ويتحرى أن يكون ذلك أعجل ما يمكن.

والرياضات الشديدة والسريعة تستعمل مخلوطة بفترات أو برياضات فاترة. ويجب أن يتفنن في استعمال الرياضات المختلفة ولا يقام على واحدة ولك عضو رياضة تخصه. أما رياضة اليدين والرجلين فلا خفاء بها، وأما الصدر وأعضاء التنفس، فتارة يراض بالصوت الثقيل العظيم وتارة بالحاد ومخلوطاً بينهما، فيكون ذلك أيضاً رياضة للفم واللهاة واللسان والعين أيضاً، ويحسن اللون وينقي الصدر ويراض بالنفخ مع حصر النفس، فيكون ذلك رياضة ما للبدن كله ويوسع مجاريه وأعظام الصوت زماناً طويلاً جداً مخاطرة وادامة شديدة تحوج الى جذب هواء كثير وفيه خطر. وتطويله محوج الى اخراج هواء كثير وفيه خطر. ويجب أن، يبدأ بقراءة لينة ثم يرفع بها الصوت على تدريج، ثم اذا شدد الصوت وأعظم وطول، جعل زمان ذلك معتدلاً فحينئذ ينفع نفعاً بيناً عظيماً، فان أطيل زمانه كان فيه خطر للمعتدلين الصحيحين. ولكل انسان بحسبة رياضة، وما كان من الرياضات اللينة مثل الترجيح فهو موافق لمن أضعفته الحميات وأعجزته عن الحركة والقود والناقهين، ولمن أضعفه شرب الخريف ونحوه، ولمن به مرض في الحجاب، واذا رفق به نوم وحلل الرياح ونفع من بقايا أمراض الرأس مثل الغفلة والنسيان وحرك الشهوات ولبه الغريزة، واذا رجح على السرير كان أوفق لمن به مثل شطر الغب والحميات المركبة والبلغمية ولصاحب الحين وصاحب أوجاع النقرس وأمراض الكلى، فان هذا الترجيح يهيء المواد الى الانقلاع واللين لما هو ألين والقوي لما هو أقوى.

أما ركوب العجل فقد يفعل هذه الأفعال لكنه أشد اثارة من هذا وقد يركب العجل والوجه الى خلف فينفع ذلك من ضعف البصر وظلمته نفعاً شديداً. وأما ركوب الزواريق والسفن فينفع من الجذام والاستسقاء والسكتة وبرد المعدة ونفختها وذلك اذا كان بقرب الشطوط، وذا هاج من غثيان ثم سكن كان نافعاً للمعدة. وأما الركوب في السفن مع التلحيج في البحر فذلك أقوى في قلع الأمراض المذكورة لما يختلف على النفس من فرح وحزن. وأما أعضاء الغذاء فرياضتها تابعة لرياضة سائر البدن. والبصر يراض يتأمل الأشياء الدقيقة والتدريج أحياناً في النظر الى المشرفات برفق. والسمع يراض بتسمع الأصوات الخفية وفي الندرة بسماع الأصوات العظيمة وله عضو رياضة خاصة به. ونحن نذكر ذلك حفظ صحة عضو عضو وذلك اذا اشتغلنا بالكتاب الجزئي وينبغي أن يحذر المرتاض وصول حمية الرياضة الى ما هو ضعيف من أعضائه.

الا على سبيل التبع مثلاً من يعتريه الدوالي فالواجب له من الرياضة التي يستعملها أن لا يكثر تحريك رجليه بل يقلل ذلك ويحمل برياضته على أعالي بدنه من عنقه ورأسه وبدنه بحيث يصل تأثير الرياضة الى رجليه من فوق. والبدن الضعيف رياضته ضعيفة. والبدن القوي رياضته قوية. وأعلم أن لكل عضو في نفسه رياضة تخصه كما للعين في تبصر الدقيق، وللحلق في اجهار الصوت بعد أن يكون بتدريج، وللسن والأذن كذلك وكل في بابه.

The Arab Journal of Psychiatry (1998) Vol. 9. No. 1

نبذة مختصرة عن حياة المرحوم
الدكتور محمد حسين تاج الدين

- ولد في بغداد بتاريخ ١٩٢٢/٩/١٥ .
- درس في بغداد تخرج من المتوسطة الشرقية عام ١٩٣٧ - ١٩٣٨ .
- تخرج من الثانوية المركزية عام ١٩٣٩ - ١٩٤٠ وكان الثاني على العراق.
- تخرج من الكلية الطبية العراقية في تموز عام ١٩٤٦ .
- حصل على دبلوم الأمراض العصبية والعقلية من كلية طب قصر العيني في جامعة فؤاد الأول في القاهرة عام ١٩٤٩ .
- حاز على شهادة DPM من الكلية الطبية الملكية البريطانية في انكلترا عام ١٩٥٣ .
- طبيب مقيم في مستشفى الشماعية (الرشاد) حالياً عام ١٩٥٤-١٩٥٨ .
- افتتح عيادة خاصة عام ١٩٥٥ في الباب الشرقي ببغداد.
- أصبح مدير مستشفى الرشاد عام ١٩٥٩ .
- تقاعد عام ١٩٧١ .
- أصبح عضو في الكلية الملكية البريطانية لأطباء النفس في سنة ١٩٧٣ .
- أستمر في عيادته الخاصة الكائنة في الباب الشرقي في بغداد حتى وفاته.
- توفي أثر حادث سير مؤسف في الأردن بتاريخ ١٩٩٧/٨/٢٥ .

له عدة بحوث منها :

- الادمان والكحول "Alcohol Across History in Mesopotamia"
- مدلول الكلمات بين الطبيب والمريض.
- وسائل الدفاع والأمراض النفسية.
- مقال عن موضوع المسنين (حيث كان يزور المسنين في مستشفى الرشاد ويتفقد أحوالهم).
- عضو في اتحاد الأطباء النفسانيين العرب والجمعية الطبية البريطانية وجمعية أطباء النفس العراقية.

The Arab Journal of Psychiatry (1998) Vol. 9. No. 1

تعزيـــــة

الدكتور عوني جورج سعد

خسر الأردن لا بل العالم العربي أحد رواد الطب النفسي الذي كان له الفضل في إثـراء المهنـة الطبيـة بكثـير من العطاء المهني والعلمي والانساني.

تخرج الدكتور عوني سعد من جامعة جلاسـكو وبعد التدريـب فـي حقل الطـب النفسي فـي الخدمـات الطبيـة الملكية وفي جامعة لندن حاز على شهادة العضوية للكلية الملكية للأطباء البريطانيين وعاد ليعمـل جـاداً علـى رفع مستوى الطب النفسي في بلده.

وعندما بدأ عمله في القطاع الخاص عمل جاهداً علـى تأسيس جمعيـة أطبـاء الأمـراض النفسية ضمـن نقابـة الأطباء الأردنية وقد كان أول رئيس لهذه الجمعية لدورتين متتاليتين. كما أصبـح رئيسـاً لاختصـاص الطـب النفسي في المجلس الطبي الأردني لدى تأسيسه. وقد حـاز علـى شـهادة الزمالـة فـي الكليـة الملكيـة للأطبـاء البريطانيين في عام ١٩٨٧ . وقد أصبح عضواً فـي اللجنـة الاستشـارية للمجلـة العربيـة للطـب النفسي منـذ تأسيسها في عام ١٩٨٩ .

ولدى تأسيس مستشفى الرشيد للطب النفسي كان عضواً في اللجنة التنفيذية وكـان مسؤولاً عـن لجنـة الحفـاظ على النوعية والجودة في العمل الطبي.

وقد أثرى مهنة الطب النفسي في كثير من المحاضرات واللقاءات العلمية وكان حريصاً على الـتزود المسـتمر في الحقل العلمي بحضوره للمؤتمرات والندوات في أنحاء المعمورة.

لقد كان الدكتور عوني سعد ناقداً ثاقب الفكر يحمل هموم مهنته ووطنه. لقد كان زميلاً لي منذ بدايات عملنـا في الطب النفسي وقد عرفته عن كثب وعرفت فيه مفكراً ومتحدثاً لاذعاً وذو دعابة فريدة تحمل روح السخرية من القدر. لقد كان غيابه صدمة أصابت زملائه والمجتمع الأردني لا بل العالم العربـي كافـة. ولا شـك أنـه سيترك فراغاً مهنياً ليس من السهل ملئه.

سيظل يفتقدك مريضك الذي أعطيته الشفاء وزملائك الذيـن عرفـوك وأحبـوك وحتمـا ستفتقد زوجتـك وبنـاتك وجميع أهلك.

د. عدنان التكريتي

Calls for Papers

Papers are invited to be presented in the Congress Scientific and Professional Conference. Towards a Better Future. The Conference language will be Arabic and English.

Within the spirit of the Conference theme, papers may deal with any aspect of psychiatry or Behavioural Sciences. The main topics proposed are:

- **Psychopharmacology**
- **Behavioural -Cognitive Therapy**
- **Schizophrenia**
- **Suicide**
- **Trans-Cultural Psychiatry**
- **Psychogeriatrics**
- **Depressive Disorders**
- **Behavioural Sciences**

Papers should describe original work or opinion of the author(s). They may have been published prior to the Congress or may be unpublished.

Papers should not have been presented at a previous Pan Arab Psychiatric Congress, but may be progress reports from previous Congress papers. If previously published, the author(s) should indicate that permission has been given for the paper to be presented at the 1999 Congress and re-published in the Conference Proceedings. Credit will be given to the previous publisher.

The first submission should be an abstract of the paper in Arabic or English, to be received in Bahrain by June 30, 1998. Final papers, with illustrative material, copies of presentation aids, etc., must be received in Bahrain by November 15, 1998. These deadlines cannot be extended.

Abstracts will be reviewed by the Scientific Committee, which comprises:

Chairman - Dr Ahmed Al Ansari

Members
- Dr Charlotte Kamel
- Dr Ahmed G Raees
- Dr Randah R Hamadeh
- Dr Reginald Sequeira
- Dr Rafea Ghubash
- Dr Mehdi M Al Qahtani

Authors will be advised that their abstract has been selected for the conference in good time for the preparation of the final paper.

Authors please note that, in addition to 35mm slide, overhead and video projection, the Convention Centre is equipped with state-of-the-art computer aided presentation facilities, and final papers may be submitted on diskette written in any Windows format, or in hard copy.

Abstracts should be sent to Ali M Matar M.D, M.P.H., Bahrain Medical Society, Psychiatric and Behavioural Sciences Association, PO Box 26136, Manama, Bahrain.

FIRST ANNOUNCEMENT & CALL FOR PAPERS

' Towards A Better Future

The 8th Pan Arab Psychiatric Congress

Gulf International Convention Centre, Gulf Hotel, Bahrain

February 9-11, 1999

ORGANISED BY:

Bahrain Medical Society
Psychiatric and Behavioural Sciences Association
Chairman of Congress:

Ali M Matar, M.D., M.P.H.
P.O. Box 26136, Manama, Bahrain
Tel: (973) 742666 Fax: (963)715559

About the Congress

The Eighth Pan Arab Psychiatric Congress, under the theme Towards a Better Future, takes place in Bahrain from February 9-11,1999, at the superb new, purpose-built Gulf International Convention Centre.

As in previous years, the Congress will comprise the Executive Meeting of the Pan Arab Psychiatric Federation together with the Scientific and Professional Conference. All arrangements for the Congress are being handled by the Psychiatric and Behavioural Sciences Association, a branch of the Bahrain Medical Society. Registration Forms, hotel travel and visa arrangements will be published shortly.

The purpose of the Notice is to inform you that the 1998 congress will take place in Bahrain and to call for Conference Papers.

The Organising Committee comprises:

Chairman - Dr. Ali M Matar

Members - Dr. Ahmed Al Ansari
Dr. Banna Buzaboon
Dr. Hamid Al Yamani
Dr. Mohsen Turif
Dr. Mona Balooshi
Dr. Adel Al Offi

The Arab Journal of Psychiatry (1998) Vol. 9. No. 1

Book Review

Ethnicity, Immigration, and Psychopathology
Edited by I. Al Issa & M. Tousignant

This new book published this year by plenum press, with thirteen writers, as well as the two editors, the book is 300 pages of medium size.
The first editor Al-Issa is a psychologist and the second is a researcher in Human and social ecology, both working in Canada.
From the title of the book one can immediately guess the difficulties, which will face editing such book, it is an area rather complicated, with so many factors and variables and scattered literature.
The book is in 6 sections and 16 chapters, it is covering in depth certain areas of the topic, but can't be considered comprehensive by any means, for example the problem of Palestinian refugees, which is probably one of the most important in this century is not mentioned and the book contained historical and demographic details more than psychopathology.
The first section introduced the concepts of ethnicity, immigration prejudice and discrimination. The second section dealt with ethnic groups and immigrants in north America, covering selected group like South East Asians in Canada and Africans in U.S.A.
The third section concentrated on Europe, primarily the East Germans, North Africans, and Turks, while section four was focusing on the native people of Canada and New Zealand, this section is rather confusing and difficult to read.
In section five the editors collected information about Jamaican in U.K. and Canada, and gave enough space for the Jews inside and outside Israil, with a chapter about gypsies luckily enough the editors didn't overlook the difficulties facing such a challenging task, so they wrote section six on these difficulties.
The book is highlighting the topic of cross cultural psychiatry and psychopathology with its relation to ethnicity and immigration.
It is a good addition to the international library, stimulating reading for mental health workers, and definitely exposes the shortcomings of research in this area, the book contained good list of references, that may be of help for other colleagues, who would like to embark on writing more and researching the subject. I think it is an invitation for Arab researchers to work on the refugees in the Arab countries and on the Arabic groups living in different parts of the world.

Walid Sarhan

cultural attributes which has made this dichotomy less meaningful over the years. I so doing, the author has highlighted the effects of mass media and market economy which has led to the emergence of a "global village", with more similarities than differences. My own reading of the situation is that, what is more important in an individual's view of whether he/she feels and "insider Vs an outsider" to his/her own cultural context be it in the family, the peer group, the society etc. When there is conflict and confusion about this sense of belonging, the resulting distress can take the form of eating disorders. By pursuing dieting, thinness and other norms that are considered desirable and important, one tries to identify with and thus establish a "sense of belonging" in the given context. Thus, in those societies where thinness and dieting are given undue importance, the prevalence will naturally be higher. More and more societies, through changes in cultural norms are subscribing to these ideals and considering these qualities as desirable. Thus we are seeing an increase in the prevalence rates of eating disorders across al societies and cultures.

My main criticism of the book is that the author does not suggest anything particularly novel, a fact acknowledged by herself in the preface. However, the strength of the book lies in the fact that extensive data has been gathered from available literature, and the material has been presented in a way that is understandable. Health professionals interested in eating disorders and transcultural psychiatry will want to access a copy, and I would certainly recommend it to medical libraries.

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The Arab Journal of Psychiatry (1998) Vol. 9. No. 1

Book Review

Culture and Weight Consciousness
By Mervat Nasser
London: Routledge

There is a rising tide of interest in eating disorders from a broad range of health professionals. This book contains an overview of the existing literature on issues relating to culture and eating disorders.

The opening chapter sets the scene by outlining the current understanding about the sociocultural causation of eating disorders. In the second chapter an argument is made against the hypothesis that Anorexia Nervosa is a culture bound or ethnic disorder, using new epidemiological evidence about it's existence in cultures earlier thought to be protected from having such disorders. But what if the culture itself is changing in all societies and geographical locations, thus leading to the emergence or increase in prevalence of these disorders worldwide? The author then takes it further to specific cultures/societies and argues that the western value system is more likely to be adopted as the general value system by the younger generation all over the world and that the world is becoming increasingly homogeneous through the effects of information technology and mass media. In the next chapter, the case of the other women is examined through the experiences of women in the Far East and Middle East. Women in Islam and the Egyptian experience are well covered by the author who has the advantage of having been born into and lived in the culture she describes. However, I would like to point out a factual error with regard to the Hindu tradition in India. In some parts of India (example: Kerala), not only that women have the right to inherit, a matriarchal system of inheritance is followed in the Hindu tradition.

In the final chapter, the discussion is about the current limitations of the concept "culture". The author has focused her line of thoughts on the west/non-west dichotomy, and the ever evolving and ever changing nature of

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طرق البحث:

في دراسة مقارنة تقادمية تم فحص ستين مريضاً (٤٥ أنثى، ١٥ ذكراً) في عيادة الغدد الصم بمدينة الحسين الطبية والذين حولوا بأعراض تشابه أعراض التسمم الدرقي، وكان متوسط أعمارهم ٢ر٣٢ سنة، وأربعين شخصاً كعينة ضابطة (٣١ أنثى، ٩ ذكور) متوسط أعمارهم ٨ر٣٣ سنة٠

أجريت لهم فحوصات سريرية ومخبرية متضمنة الصور الفوق صوتية للغدة الدرقية، فحص وظائف الغدة الدرقية وفحوصات للغدد الكظرية لأبعاد احتمالية وجود ورم الكروماتين القاتم٠ والتي أظهرت جميعها نتائج سلبية٠ ثم تم إجراء مقابلات مع أخصائي الأمراض النفسية نفسه، والذي استعمل النسخة العربية لمقياس نوبات الهلع ومواصفات دليل التشخيص الإحصائي الرابع (الأمريكي)٠

النتائج:

خمسون مريضاً من أصل ستين (٣ر٨٣٪) من عينة الدراسة مقابل ١٦ مريضاً (٤٠٪) من العينة الضابطة تم تشخيصهم على أنهم يعانون من نوبات هلع وكان الاختبار الثابت Z = ٤ر٢٤٣٨ وقيمة P . ٠٥ر٠ وقد كان ٧٥٪ منهما اناثاً٠

كانت الأعراض الأكثر تكراراً هي صعوبة التنفس في المجموعتين (٨٠٪، ٤٠٪) ثم الخفقان ٣ر٧٣٪، رجفان اليدين ٨ر٧١٪، التعرق ٦٣٪ في عينة الدراسة٠ نسباً أقل تكراراً تم الحصول عليها في العينة الضابطة٠ أما أكثر الأعراض شدة فكانت الخوف من الموت، الخفقان، الرجفان والتعرق الشديد في عينة الدراسة ونوبات البرودة والحرارة، وصعوبة التنفس والتنمل في العينة الضابطة٠

الخلاصة:

تخلص هذه الدراسة الى أن اضطرابات الهلع هي كثيرة ما بين المرضى المحولين بأعراض تشابه أعراض التسمم الدرقي ويمكن أن يحصلوا على انتباه أكبر ومن ثم على تشخيص ومعالجة أفضل إذا ما تم التعاون ما بين أطباء الصحة والأطباء النفسين٠

depressive disorder 26% and generalised anxiety disorder in 18.6%[20]. The prevalence in women is about twice that in men as demonstrated in this study which support a previous study by Ahmad and Takriti[21] who found that females scored higher in rating the severity of symptoms.

In this study non of the patient had received psychiatric assessment previously, this may be indicative of the shortage of knowledge of some psychiatric disorders in primary care clinics, where significant number of patients present with somatic complaints with no organic base.

This might be supported by the hypothesis that emotional factors have physiological concomitants, and they may have one or more of several effects such as reduction or change of the quality of emotions, motivation of conductive behavior or health ego defense mechanism and coping strategies, aimed to relief distress and being communicated as somatic symptoms and foster adoption of the sick role[15] which might explains why non of our patients had not consulted a psychiatrist.

This study is statistically and clinically significant and support the extensive body of literature which highlights the primary care intervention for patients with psychiatric disorder[3,16,18].

The findings of this study suggest that the management of functional somatic symptoms is optimal if patients are well listened to, and when more knowledge about psychiatric disorders is obtained by physicians mainly GPs, which will lead to more appropriate care, rather than to replay on extensive and expensive diagnostic evaluation.

Conclusion

This study concludes that panic disorder is more common than expected and that patients with thyrotoxic symptoms can receive more appropriate diagnosis and management if collaborative efforts are made between physicians and psychiatrists. Careful and early psychiatric assessment will prevent exposing some of them to individual suffering and chronocity, medical work load and a costly inconvenient time consuming physical investigations.

الملخـــص

مقدمة:

كثير من المرضى الذين يراجعوا العيادات الخارجية يشكون من أعراض بدنية لا يوجد لها أساس عضوي، بل أنهم يعانوا من أعراض اضطرابات نفسية مختلفة مثل الاكتئاب والقلق.

أهداف الدراسة:

الهدف من هذه الدراسة هو معرفة نسبة المرضى الذين يعانوا من نوبات الهلع ما بين المرضى المحولين الى عيادة الغدد الصم بأعراض مماثلة لأعراض التسمم الدرقي.

Table (3): Severity of Symptoms in both Groups

No	Symptoms	Non		Mild		Moderate		Severe	
		case	control	case	control	case	control	case	control
1	Shortness of breath	12	24	21	5	14	8	13	3
2	Feeling dizzy or faint	18	29	14	3	17	6	11	1
3	Palpitation, pounding heart	16	34	10	2	13	3	21	1
4	Trembling or shaking	17	29	15	2	13	7	15	2
5	Sweating	20	37	14	1	11	2	15	0
6	Nausea & abdominal discomfort	22	32	16	3	8	4	14	1
7	Chest pain	20	38	10	2	21	0	9	0
8	Derealization Depersonaliza-tion	39	35	4	3	9	2	8	0
9	Feeling of choking	21	30	10	4	19	5	10	1
10	Numbness, paresthesias	22	32	11	2	18	3	9	3
11	Chills or hot flushes	19	29	11	2	20	5	10	4
12	Fear of dying	20	38	5	1	11	1	24	0
13	Fear of losing control, going crazy	25	26	14	4	10	6	11	4

Discussion

The results of this study have showed by no doubt an increase in panic disorder among patients with symptoms mimicking thyrotoxicosis. Condition which may predominate the clinical picture leading to non-recognition by GPs[3].

This study addresses the significant number of patients who present with recurrent somatic complaints suggestive of thyrotoxicosis, where the majority of them fulfilled the criteria of panic disorder.

More than 80% of patients had panic disorder Vs 40% in control group with a significant trend of $p < 0.0003$. The six months prevalence of panic disorder is about 6-10 per 1000, the life time prevalence is 7-20 per 1000. It's well known that panic attacks occur in generalized anxiety disorders, phobic anxiety depressive disorders and acute organic disorders[14]. In another study panic disorder was found to be comorbid with agorophobia 12%, social phobia 10.6%,

Table (2): Frequency of Symptoms Scored on Panic Scale in Both Groups with Statistical Significance

	Symptoms	n = 60%		n = 40%		P
1	Shortness of breath	48	(80%)	16	(40%)	< 0.0003
2	Feeling dizzy or faint	42	(70%)	11	(27.5%)	< 0.0003
3	Palpitation, pounding heart	44	(73.3%)	6	(15%)	< 0.0003
4	Trembling or shaking	43	(71.7%)	11	(27.5%)	< 0.0003
5	Sweating	40	(66.7%)	3	(7.5%)	< 0.0003
6	Nausea & abdominal discomfort	38	(63.3%)	8	(20%)	< 0.003
7	Chest pain	40	(66.7%)	2	(5%)	< 0.0001
8	Derealization Depersonalization	21	(35%)	5	(12.5%)	= 0.0055
9	Feeling of choking	39	(65%)	10	(25%)	= 0.0004
10	Numbness, paresthesias	38	(63.3%)	8	(20%)	< 0.0003
11	Chills or hot flushes	38	(68.3%)	11	(27.5%)	< 0.0003
12	Fear of dying	40	(66.7%)	2	(5%)	< 0.0001
13	Fear of losing control, going crazy	35	(58.3%)	14	(35%)	= 0.0129

the control group (z static = 4.243, corresponding to $p < 0.0003$). The rest scored limited symptoms of panic disorder on this scale (less than 4 symptoms). Females showed a higher preponderance of the disease than do males as there are 39 females and 11 males in the study group Vs 13 females and 3 males in the control group who had this disorder.

The most frequent symptoms scored on the scale were shortness of breath 80% in both groups followed by palpitation in the study group and feeling dizzy, trembling and chills and hotness in control group. There was a significantly higher frequency of presenting symptoms in the study group compared with control ($p < 0.0003$) Table 2 shows the frequency of symptoms scored on panic scale in both groups with statistical significance.

The most severe symptoms scored were found to be fear of dying in 24 patients in study group Vs none in controls, palpitation 21 patients Vs 1 in the control group, trembling and seating in 15 patients in the study group Vs 1 and 2 respectively in the control group. Table 3 shows the severity of symptoms scored on panic scale.

Table (1): Panic Scale Symptoms

		Non	Mild	Moderate	Severe
1	Shortness of breath	0	1	2	3
2	Feeling dizzy or faint	0	1	2	3
3	Palpitation, pounding hear	0	1	2	3
4	Trembling or shaking	0	1	2	3
5	Sweating	0	1	2	3
6	Nausea & abdominal discomfort	0	1	2	3
7	Chest pain	0	1	2	3
8	Derealization Depersonalization	0	1	2	3
9	Feeling of choking	0	1	2	3
10	Numbness, paresthesias	0	1	2	3
11	Chills or hot flushes	0	1	2	3
12	Fear of dying	0	1	2	3
13	Fear of losing control, going crazy	0	1	2	3

Ahmad 1993[19] have demonstrated an increase in the presence and frequency of panic disorder among medical patients and that these patients were seen more frequently in out-patient medical clinics. They have been exposed more to clinical, laboratory and even to interventional tests and procedures.

Recent reports suggest a high prevalence of panic disorder in patients presenting with irritable bowel syndrome. Wood noted that 26% of his patients with panic disorder experienced a significant gastrointestinal symptoms[9]. These were also supported by other studies[10,11]. Studies conducted on patients presented to E.N.T clinics with dizziness reported a significant number to have panic disorder; Egger et al[12] found 28% of his patients presenting with dizziness have panic disorder, while Clark et al[13] reported that 20% of patients studied with dizziness met the criteria of panic disorder. The prevalence of panic disorder in a control Jordanian group is 14%[20].

An increased frequency of thyroid disorder has been reported among women with agoraphobia or panic disorder[17,18].

Aim of the Study

The aim of this study is to identify the patients presenting with panic symptoms among those referred to Endocrine clinic with multiple recurrent somatic symptoms suggestive of hyperthyroidism.

Method and Sample

A comparative, prospective study was conducted at King Hussein Medical Center (KHMC) from April to December 1996 on sixty patients (45 females and 15 males) with a mean age of 32.2 years (17 - 45), referred to the Endocrine clinic from out-patient medical clinics with symptoms suggestive of hyperthyroidism with a duration of 6 - 8 weeks. Compared to age matched group n = 40 (31 females and 9 males) with a mean age of 33.8 years. A written consent was obtained from all patients involved and control group.

These patients were assessed by one of the endocrinologists participated in the study by history, physical examination, thyroid ultrasound and screening tests for pheochromcytoma and all found to have negative results in both groups.

Each patient was then interviewed and assessed individually by specialist psychiatrist using the Arabic version of panic scale and DSM IV criteria[8]. Which consist of 13 symptoms, each symptoms graded from (0 to 3) according to severity (Table 1), and four questions concerning duration, number of symptoms, its frequency and thoughts preceding or following the symptoms.

According to this scale the diagnosis of panic disorder requires at least four symptoms in each attack of panic and more than four attacks have occurred in four weeks, or none attack has been followed by four weeks of persistent fear of another attack. The results were statistically evaluated by difference between two percentages (z static) and chi square.

Results

50 patients (83.3%) out of 60 patients were found to meet the criteria of panic disorder according to the scores on the Arabic version of panic scale and the DSMIV criteria Vs 16 (40%) out of 40 patients in

Conclusion

This study concludes that panic disorder is rather common in patients presenting to endocrine clinics and therefore such patients can receive more appropriate diagnosis and management if collaborative efforts are made by physicians and psychiatrists.

Key words: Panic disorder, Thyrotoxic-like symptoms, Out-patient clinics.

Introduction

Panic disorder which is a subdivision of anxiety disorders, is characterized by abrupt unexpected and recurrent episodes of fear or apprehension and associated autonomic symptoms involving cardiorespiratory, neurological, gastrointestinal, and other symptoms (hot flushes, sweating) as well as cognitive symptoms such as fear of dying or losing control of one's physical or mental function[8].

Many studies conducted on out-patients medical clinics on patients with multiple recurrent unexplained symptoms seeking medical care revealed significant psychiatric disorders. Lowy[1] has estimated that 30-80% of patients who consult physicians have functional (psychogenic) complaints. While other studies of primary care practice have revealed that 68-92% of patients are without serious physical illness (Backett)[2].

Examination of the literature shows that the problem in presentation of depression seems not to be that depressive features of these disorders are absent, but the key symptoms are obscured by great deal of somatic noise[3].

Studies of psychiatric disorders in primary care have reported that approximately 50% of cases identified at a single screening exercise have been ill for at least a year[4].

In general medical practice hypochondriasis and somatization disorders are common and consume a disproportional large fraction of physical services, diagnostic procedures and therapeutic resources[5].

Goldberg and Blackwell[6] reported that a substantial proportion of patients (20-25%) consulting their General Practitioners (GPs) are suffering from some form of psychiatric disturbance. The composition of such morbidity has been reported to be almost wholly affective in nature and largely mild in severity[7]. This was supported by Blacker and Clare who demonstrated that 26% of primary care depressives had some somatic symptoms which featured prominently in their presentation[3].

It has been demonstrated in a number of studies that GPs fail to detect between 33% and 50% of cases of psychiatric disorders presenting to them[3]. The reasons for GPs failure to recognize cases of psychiatric disorders have been discussed at length by Goldberg and Huxley[16] who divided them into patients factors (chief of which is the tendency to somatize psychological symptoms) and GP factors (which include diagnostic bias and accuracy). A third reason of non-recognition of disorder is the nature of the primary care system itself. The average duration of a consultation in primary care is about 7 minutes during which time the GP must select which aspects of the patients complaints he regards as important[3]. Suleiman and

The Arab Journal of Psychiatry (1998) Vol. 9 No. 1 Page (34 - 46)

Panic Disorder Among Patients Presenting to Endocrine Clinic with Thyrotoxic Like Symptoms

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نوبات الذعر (الهلع) ما بين مرضى عيادة الغدد الصم الذين يعانون من أعراض مماثلة لأعراض التسمم الدرقي

عبد الكريم الخوالدة، فارس حداد، عمر ملكاوي، تيسير أحمد، محمد الشوبكي

ABSTRACT

A considerable number of patients who may present with panic like symptoms as part of anxiety disorders in out patient medical clinics have no organic basis for their complaints, but it has been established that such patients are suffering from different types of anxiety and mood disorders.

Objective

The aim of this study is to identify panic disorder among patients presenting with thyrotoxic like symptoms at endocrine clinics.

Method

A comparative prospective study was conducted at the Endocrine Clinic at the King Hussein Medical Center (KHMC). A study group of sixty patients (45 females and 15 males) mean age 32.2 years (17 - 45), and 40 subjects as a control group (31 females and 9 males) mean age 33.8 years were seen, evaluated and examined at the King Hussein Medical Center (KHMC); tests included thyroid ultrasound, thyroid function tests and test for phaeochromocytoma were negative in all patients included.

These patients were assessed by the same specialist psychiatrist using the Arabic Version of Panic Scale which is derived from Diagnostic and Statistical Manual of Mental Disorder (IV edition).

Results

Fifty out of sixty patients (83.3%) were found to have panic disorder in the study group vs. 16(40%), in the control group (z static = 4.2438; $p < 0.0003$), the majority being females 75% ($p < 0.05$).

The most frequent presenting symptoms were shortness of breath in both group (80%, 40% respectively), followed by palpitation in study group 73.3%, trembling (71.7%) and sweating (63%). Lower frequencies were obtained in the control group. The most severe symptoms were fear of dying, palpitation, trembling and sweating in the study group, while chills or hot flushes, shortness of breath and numbness predominated in the control group.

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خلال ١١ جلسة بمعدل اثنتان أسبوعياً ولمدة ٦ أسابيع. اشتملت المهارات الاجتماعية على مواضيع متنوعة منها مهارات الانضباط في الصف وأخرى حول الاتصال المؤثر وحل المشاكل والتعامل بكفاءة مع التوترات النفسية. جرى تحديد معدل استعمال المهارات المعطاة قبل وبعد الجلسات من قبل الأهل والمدرسين. بين كل من الأهل والمدرسين زيادة ذات دلالة احصائية على معدل استخدام هذه المهارات في الحياة اليومية بعد انتهاء فترة التدريب. في المستقبل يفضل أن يكون تقييم استخدام المهارات واتقانها لفترة طويلة وأن تجري على عينة أكبر مع وجود عينة ضابطة.

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A student t-test for pairs was then used to compare the mean score of pre- and post-test of treatment.

Results

Table 1 shows the ratings of teachers and parents before and after exposure to the SST. Both parents and teachers significantly recorded an increase in the frequency of desirable skills after the period of training.

Discussion

The measurement of effectiveness of SST in skill acquisition is not frequently reported due to the complexity in measuring changes in social skills[22]. The SST program under discussion is the first of its kind in the Gulf region. The evaluation of such a program is highly recommended in order to justify the efforts of introducing it to other settings, such as pre-schools and schools. The study concludes that the mechanism of practicing social skills in the program seems to be highly effective in terms of skill acquisition for a short term period of time. Teachers reported a higher frequency of learned skills than parents. This could be explained by the fact that the majority of such skills are more related to class situations. This study suffers from obvious short comings, such as a short duration of assessment, the lack of a control group and a small number of SST subjects. However we are planning to conduct another assessment after one year of exposure to the program. The addition of a control group, despite the knowledge that one is difficult to obtain, is nonetheless essential, and therefore should be considered in future research.

Table 1: Teachers and Parents Rating of the Social Skills Pre and Post SST Program

	Mean Pre Scores	Mean Post Scores	T Value P
Teachers	17.56	44.69	8.32 < .0001
Parents	18.25	39.75	6.64 > .0001

الملخـــص

تهدف الدراسة الى تقييم برنـامج التدريـب علـى المهـارات الاجتماعيـة للأطفـال ذوي المشـاكل السـلوكية والذين ينتسبون الى قسم الرعاية اليومية والنهار به بوحدة الأطفال النفسية من ناحية اكتساب واتقـان هذه المهارات. تكونت عينة التجربة من ٨ أطفـال من الذكور من عمر ١٠ - ١٤ سنة (٣ فـي البرنـامج اليومي، ٥ في البرنامج النهاري). شارك هؤلاء الأطفال في التدريب علـى المهـارات الاجتماعيـة من

adolescents with social phobia, where-by improvement has been maintained for over a one year period[18,19].

SST was initialed in the Child and Adolescent Psychiatric Unit, Bahrain, in 1992 as part of a structured program designed for children with mainly behavior problems. SST is administered to the inpatient unit (12 beds for both sexes) and to selected out-patient candidates who attend an after school program on a day care basis. The SST program is administered twice weekly for 45 minutes each session. The SST is conducted by the unit nurses, who have received SST prior to their work in the unit along with minimum supervision from the unit psychologist. In the sessions the conductor follows the four basic components of structure learning; modeling, role playing, performance feedback and transfer of training. The program includes 25 topics where-by the child has to practice them in different situations, including school, home and neighborhood. The topics (n=25), cover areas such as class survival, developing friendships dealing with feelings, alternatives to aggression and dealing with stress. In this study the SST program in the unit was evaluated to see whether the recipients had acquired learned skills.

Method

The study used an experimental design without a control group. The subjects consisted of eight boys aged 10-4 years who were referred to the Child Psychiatric Unit, Psychiatric Hospital for the management of severe behavioral problems at home/school. These behaviors included non compliance to regulations, verbal and physical aggression, disruptive behavior in classes and poor school performance. On admission they received a diagnosis of oppositional defiant disorder, attention deficit hyperactivity disorder and adjustment disorder according to DSM-IV[20].

Five subjects were referred to SST in the after school program by teachers from a public school. Three subjects were from the inpatient residents who had recently jointed the SST program. All the subjects were from families with multiple health and social problems, including poverty. Children who had previously received SST or had a diagnosis of mental retardation were excluded from the study. The subjects participated in eleven sessions, consisting of 45 minutes each session on a twice weekly basis for 6 weeks. The topics covered in the sessions included, listening, asking for help, saying thank you, introducing one self, joining in, playing a game, apologizing, dealing with anger, asking permission, avoiding trouble and saying no.

Teachers and parents filled social skill check list which was translated into Arabic, 21 prior to SST (pre-test), and 6 weeks later, after completion of the eleven sessions (post-test). In the check list, the frequency of behavior is rated as almost never, seldom, sometimes often and almost always. The pre- and post-test rating for the inpatient subjects was completed by the unit's teacher, primary nurse and parents, and by school teachers and parents for the day care attenders.

The Arab Journal of Psychiatry (1998) Vol. 9 No. 1 Page (32 - 36)

Brief Report:

Effectiveness of Social Skills Training Program for Children with Conduct Problems: Skill Acquisition

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فاعلية برنامج تدريب المهارات الاجتماعية للأطفال ذوي الاضطرابات السلوكية: اكتساب المهارات

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ABSTRACT

The Social Skills Training Program (SST) for children with behavioral problems attending an inpatient/day care program were assessed in terms of skill acquisition. Eight boys, aged from 10-14, of whom three were attending the inpatient program and five the day care program, were exposed to 11 sessions of skills training twice weekly for 6 weeks. The sessions included topics related to classroom behavior, effective communication, problem solving and coping with stress. The subjects performance of these skills were measured by parents and teachers before and after the training period. Both parents and teachers reported a significant increase in the frequency of use of these skills. The generalization of these learned skills should be assessed in the future using a larger control sample.

Introduction

Social Skills Training (SST) is a program that applies the behavior techniques or learning activities that enable patients to acquire instrumental and affiliative skills in domains required to meet the interpersonal, self-care and coping demands of community living[1]. The WHO defines social skills as "skills for enhancement of psychosocial competence: i.e. those skills that enable individuals to deal effectively with the demands and challenges of everyday life[2]. SST has been applied to both adult and child psychiatric populations. In adults SST has demonstrated beneficial effects for psychotic, non-psychotic, developmentally disabled and legal offender patients. The patients who received SST showed diminished psychiatric symptoms related to social dysfunction and a broadening of their repertoire of skills. The acquired improvement persisted for a few months after training[1,3,7]. In children SST has been introduced for behavior disorders, delays in development and intellectual impairment[8,16]. Moreover, SST has significantly reduced the severity of depression among adolescent males[17]. SST has also been applied with good results to

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Due to the implementation of this pre-admission contract, Mr. C's frequency of inpatient admission has decreased from one admission a month to only one admission every 12 weeks. Every admission has not exceeded 48 hours and he has not requested to leave AMA.

Conclusion

The protection and structure of psychiatric unit can be gratifying to patients with deliberate self-harm behaviors[1,5]. The application of pre-admission contracts with deliberate self-harm patients could decrease the frequency of such behaviors[6]. The provision of an intensely supportive treatment environment that allows the maintenance of such contracts could be beneficial for both patients and their treatment teams.

The difficulty in managing patients who inflict deliberate self-harm may be minimized by using the concept of a pre-admission contract. Prior knowledge concerning the patient's pattern of behavior during previous hospitalizations helps establish such a contract. Strict adherence to the terms of the contract by all staff is necessary in order to further delineate the efficacy of such contracts. However, further controlled studies are required in order to assess the actual successfulness of pre-admission contracts.

الملخـــص

تهدف هذه المقالة الى تحديد مدى فاعلية انجاز عقود شخصية مع مرضى ذات الايـذاء القصـدى، من خلال دراسته ثلاث حالات اكلينيكية في مـدة الطـوارىء بقسم الأمـراض النفسية، وكنتيجـة لانجاز هذه العقود الشخصية فان نسبة ايذاء الذات القصدى قد انخفضت،

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threatening suicide if her admission to a psychiatric hospital was denied. Prior to each admission to PEC she agreed to sign a personal contract titled, "Special pre-admission contract between Ms. B. and her treatment team". Cutting my wrists or any attempt of self-mutilation are behaviors which interfere with my treatment and progress. In an effort to achieve maximum therapeutic results while I am at PEC I agree to these procedures: 1) When I feel the urge to cut myself I will approach the staff and express my feelings, 2) The staff will talk to me and assess my ability to control these urges, 3) If the staff assessment reveals that I can control these urges I will agree to accept one to one observation for a period of one hour, 4) If the staff sense that I cannot control the urge to cut myself I will agree to be escorted to PCR and stay without restraint for one hour, 5) Any attempt to harm myself while in PCR will result in applying full restraint for a period of two hours. This pre-admission contract will be signed by Ms. B., the psychiatrist, psychologist, nursing staff on all shifts and Ms. B's case manager.

As a result of this pre-admission contract Ms. B has been able to control her urges, has not cut her wrists and she has been able to actively participate in planning her follow-up out-patient appointments. Ms. B. has been admitted to PCE twice over a period of nine months, and her stay each time has not exceeded 72 hours. In the past Ms. B's admissions averaged one every three months, each length of stay exceeding two months.

Case C

Mr. C. is a 32 year old divorced male. In the last three years he has repeatedly sought admission to the long-term psychiatric hospital with the chief complaint being, "I am going to cut my head with a sword". His suicidal intentions are usually precipitated by overwhelming feelings of loneliness, emptiness and boredom. However, after each admission to the psychiatric hospital his suicidal ideations would subside and he would refuse to attend the various therapeutic activities on the ward. He would refuse to comply with the rules, e.g., refusing to give up his belts, boots and cigarette lighter, claiming that he is not "sick" like the other patients. Almost always after a two week hospitalization he would demand to leave against medical advice (AMA). Mr. C. was referred to PEC from the long-term psychiatric hospital.

In an attempt to help Mr. C. benefit from his treatment while at PEC, he agreed to sign the following pre-admission contract. 1) I will abide by the ward rules, that include giving up my belts, my boots and my lighter which are to be kept in the safe, and to wear the special hospital gown, 2) I will refrain from cursing, name calling, screaming, yelling or being threatening, 3) My participation in all the scheduled therapeutic activities is mandatory, 4) I agree to stay in PEC until my treatment goals are achieved, and I will not request to leave AMA, 5) If any part of this contract is violated I will agree to give up my privileges of watching TV, playing table games or using the phone for three consecutive shifts.

hospital are clinically indicated[4]. The therapeutic efficacy of establishing a pre-set, non-negotiable pre-admission contract with BPD is discussed in the following three illustrative case reports.

Case Reports and Description of Contracts

The three patients described had deliberate self-harm behavior and were admitted to a Psychiatric Emergency Center (PEC). Patient's past psychiatric records were reviewed to identify patterns of behavior each patient exhibited and to document previous length of hospitalization. Each individual contract was then developed in collaboration with the patients treatment team.

Case A

Mr. A is a 26 year old single male who regularly attended a day hospital program at a local Mental Health Center. He episodically experienced overwhelming feelings of hatred towards his psychotherapist and fantasized about killing him. He felt guilty for having these homicidal thoughts and threatened suicide if he was not admitted to the long-term psychiatric hospital.

The following describes the pre-admission contract entitled, "Special pre-admission contract between Mr. A., and the PEC staff". Certain behaviors have been observed which interfere with my treatment and progress, such as 1) Bringing sharp objects, e.g., broken ashtrays, spoons, forks, broken aluminum cans, et., in an attempt to cut my wrists, 2) Running on the hospital floor, 3) Banging on the wall, 4) Jumping to the ceiling, 5) Throwing mattresses and bed sheets, 6) Destroying unit properties. In and effort to help me benefit from my treatment while at PEC staff will point the specific maladaptive behavior and will offer support to help me control that behavior. If I am uncooperative with staff support, I will be given the option of staying for one hour in the Protective Custody Room (PCR) without restraint. If the maladaptive behavior continues while I am in the PCR restraint will be applied for two hours. In addition I will agree to the following: 1) When I feel I am about to lose control I will ask to be escorted to PCR, 2) I will allow staff to approach me and help me when my behavior seems to be getting out of control. This pre-admission contract will be signed by Mr. A., the psychiatrist, head nurse, social worker, the nursing staff on all shifts and Mr. A's psychotherapist. As a result of this pre-admission contract Mr. A's has been able to control his maladaptive behaviors, his suicidality has subsided and he was discharged to out-patient follow-up with his same psychotherapist at the local Mental Health Center. His admissions to PEC averaged one admission every three months and has not exceeded 24 hours. In the past his hospitalization at the long term psychiatric hospital lasted three months.

Case B

Ms B. is a 24 year old married female. She periodically experienced recurrent thoughts and irresistible urges of self-mutilation. Superficially cutting her wrists with razor blades she would then present herself to a local hospital emergency room

The Arab Journal of Psychiatry (1998) Vol. 9 No. 1 Page (27 - 31)

Contracting with Deliberate Self-Harm Patients Attending A Psychiatric Emergency Center

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ABSTRACT

Objective

To determine the effects of pre-admission contracts in preventing deliberate self-harm in patients attending a psychiatric emergency unit.

Method

Three case studies are described to illustrate examples of pre-admission contracts in patients with deliberate self-harm.

Results

The initiation and maintenance of pre-admission contracts did decrease the frequency of deliberate self-harm.

Conclusion

The difficulty in managing deliberate self-harm can be minimized by the initiation of pre-admission contracts. To further prove the efficiency of such contracts more controlled studies are needed.

Key words: Contracts, deliberate self-harm, psychiatric emergency units, hospitalization.

Introduction

The treatment of deliberate self-harm behavior has been characterized as an arduous task[1]. Indeed early clinical descriptions of self-harm behavior arose out of the treatment difficulties these patients posed by the frequency of psychiatric hospitalization as well as their self-destructive behavior[2,3]. Since the protection and structure offered by the inpatient milieu can be gratifying to these patients self-harm may be performed in order to postpone discharge from hospital. In order to help avoid such occurrences preventive strategies, consisting of writing individual contracts with patients, which include limits, at the time of arrival at

Table (2): Academic, Health and Life Events/Conditions Characteristic as Factors Associated with Symptoms of Depression

	Depressed N = 79		Non - Depressed N = 426		P Value
	n	%	n	%	
School performance					0.958
60 - 70	30	38.0	156	36.6	
70 - 80	27	34.2	145	34.0	
> 80	22	27.0	125	29.3	
Health Problems					
Migraine	18	22.8	60	14.1	0.049
Asthma	7	8.9	22	5.2	0.194
Life events					
Car accident	25	31.6	145	34.1	0.679
Changing house	13	16.5	55	12.9	0.396
Bereavement	17	21.5	87	20.4	0.824

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Table (1): Personal and Family variables among depressed and non-depressed girls

Personal Factors	Depressed N=79		Non-depressed N=426		P value
	n	%	n	%	
Enjoy freedom within the household:					. 001*
Yes fully.	13	16.5	117	27.5	
Yes, sometimes.	35	44.3	244	57.3	
No.	31	39.2	65	15.2	
Family cares about me					.001*
Yes, fully.	27	34.2	284	66.7	
Yes, to some degree.	43	54.2	136	31.9	
Never.	9	11.4	6	7.6	
Family shares my feelings & worries					.001*
Yes, fully	13	16.5	135	31.7	
Yes, to some degree	36	45.6	253	59.4	
Never	30	37.9	38	8.9	
Contented with myself:					.001*
Yes, fully	10	12.7	179	42.0	
Yes, somewhat	40	50.6	207	48.6	
Not at all	29	36.7	40	9.4	
Have a private room :					.018*
Yes	21	26.6	173	89.0	
No	58	73.4	253	81.4	
Average income per month					.401
<Dhs 5000	4	4	40	9.4	
Dhs 5000-10000	33	41.8	182	42.7	
>Dhs 10000	42	53.2	204	53.2	
Mother alive					. 619
Yes	78	98.7	417	97.9	
No	1	1.3	9	2.1	
Father alive					.086
Yes	75	94.9	377	88.5	
No	4	5.1	49	11.5	
Mother's Nationality					.003*
UAE	64	81	391	91.8	
Non-UAE	15	19	35	8.2	
Parents Separated					.089
Yes	9	11.4	26	6.1	
No	70	88.6	400	93.9	

* Chi Square, Statistically significant

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The prevailing feeling of the depressed girls seems to be that of isolation and social restriction. While it is true that social restriction is something that may be culturally determined in this society irrespective of depressive feelings, there seems to be more to the sense of isolation than just being part of a depressive state. This point is highlighted more by the fact that a sense of family cohesion and an extended family support network are characteristic of this society. The absence of any significant association between depressive feelings and loss of a parent(s), life events such as car accidents, change of home or bereavement could be explained by the existence of very close family ties and available social support which may help to minimize the negative psychological impact of these adverse life events. Nonetheless, depressed girls feel very isolated although despite the fact that they live in a cohesive and supportive environment.

Having non-UAE citizens as mothers was reported as a discriminating factor for depressive symptomatology. The explanation for this may be found in the social resistance to such cross-national marriages in UAE society which tends to isolate the children of such marriages.

CONCLUSIONS

This study is the first among UAE teenage girls. The prevalence rate of serious depressive symptoms and of a probable depressive syndrome was relatively high; possibly as high as would be expected in the Industrial World. The most vulnerable age group seems to be those girls aged 14-15 years. Given the relatively less adverse environmental influences (particularly economic) in this society, one would be inclined to think of constitution and genetics as being relatively more influential factors in the genesis of mood disorders in this population. Genetic studies would help unravel this issue. In any case, school health should be able to monitor depressive symptomatology and provide early intervention when necessary.

الملخـــص

أجريت هذه الدراسة على عينة من طالبات المدارس الثانوية في مدينة العين بدولة الإمارات العربية المتحدة بواسطة استبيان من خمس مواد لدراسة مقدار الإعاقة المصاحبة للاكتئاب. شملت العينة ٥٠٥ طالبات تراوحت أعمارهن ما بين ١٣ و١٨ سنة وتبين أن ٦ر٥١٪ يعانين من أعراض واضحة للاكتئاب بينما ذكرت ٢٣٪ من العينة أنه تراودهن أفكار انتحارية. من ناحية أخرى كانت أعراض الاكتئاب أكثر نسبياً عند الفتيات اللواتي نتجن عن زواج مختلط بينما لم تثبت أية علاقة في تلك العينة بين الاكتئاب وعوامل أخرى تتعلق بالاسرة. يبدو أن الاكتئاب عند الفتيات في العين ضعيف العلاقة بالعوامل البيئية والاجتماعية وربما كان له علاقة بالعوامل الوراثية.

income group to 15.5 in the highest income group.

Table 2 shows the differences between depressed and non-depressed in relation to school performance and three main categories of life events.

There were no significant differences between depressed and non-depressed respondents in relation to all those variables.

DISCUSSION

The first question is whether this approach in investigating significant depressive symptoms in teenagers is valid and reliable. With respect to validity, the instrument used is one which has been widely used in several studies among adolescents, although it was originally developed for use with children. For example, Yule & Udwin [7] found that adolescent survivours of a shipping disaster scored higher than controls on the Birleson Scale. Others[8] found good correlations betwen the Birlerson Scale and other instruments designed to measure hopelessness. Eapen & Daradkeh[2] found it to be equally useful in screening for depressive symptoms in a community sample of adolescents. The question that remains is "How useful is the scale as a diagnostic tool?" There is no doubt that the ideal design of a study looking into the prevalence of depression as a syndrome is that which involves two-phases; one for screening and a subsequent phase of clinical interviews among certain proportions of high and low scorers. However, for our sample it was very difficult to carry out a second phase because of logistic and resource problems. We therefore chose to increase specificity by increasing the cut-off point and to add a dysfunction scale questionnaire based on self-report. This -we believe- has increased the validity of our approach. The Alpha Coefficient of Reliability of the Birleson Scale in this study sample was 0.74, which suggests a reasonable level of internal consistency and reliability.

Despite the socio-cultural differences the rates of significant depressive symptoms and suicidal ideation among this sample are remarkably similar to those reported in the Western World[3, 9,11]. Significant depressive symptoms were reported by 47% and suicidal ideation was reported by 114 subjects (23%) of our sample. This may suggest that depressive symptomatology in teenagers is less likely to be influenced by culture and social class and that some genetic or constitutional factors are more important. Two factors lend support to this hypothesis; first the subjects of this study came from a relatively affluent background, and even when differences in family income existed within this population it made no difference to the prevalence of significant depressive symptomatology, as defined in this study. Secondly, marriage within the extended family is quite common in this society, which may suggest that genetic loading for depression is likely to be higher. The fact remains that depression as a symptom (and probably as a syndrome) is common in this population and needs to be closely monitored. It could be that affluence brings its own brand of social difficulties; for teenage girls in this society it is likely to be social isolation that increases the vulnerability to depression.

responses were delivered within 48 hours.

Statistical Analysis:

The statistical package programme SPSS/PC was used to obtain frequency, percentages, cross-population, mean, standard deviation, minimum and maximum values. The Chi-square test was used to ascertain the association between two or more categorical variables. In 2x2 table the Fisher Exact test was used instead of Chi-square, particularly when the sample size was small. The level $p < 0.05$ was considered as the cut-off value for significance.

RESULTS

The study sample comprised 505 (25%) of the target population (1,981). The response rate was 100%. The respondents were aged between 13-18 years. The mean age was 16.4 years (SD 1.2). About two thirds were aged 16-17 years. The scholastic performance of 6.9% of the students were ranked as poor and 9.3% as excellent (>90). All were UAE nationals.

Prevalence of significant depressive symptoms

According to the Birleson scale 238 girls (47%) scored above a cut-off point of 14 which would indicate significant depressive symptomatology[2]. The mean scores seem to show no significant differences between the different age groups, with values ranging fom just under 14 to just under 16. A notable exception was that girls aged 13 years showed a markedly low mean score of about 6, as shown in Figure 1. The age of 14 seems to herald the appearance of significant depressive symptoms.

We chose to be more rigorous for the purposes of this study and preferred an increase in specificity rather than sensitivity. To increase the chances of possible 'caseness' it was stipulated that possible 'cases' of depression would be those who scored above 14 on the Birleson Scale and above two on the dysfunctional score. According to these criteria we found that the number of such possible 'cases' were 79 (15.6% of the total population). The mean Birleson scores for the suspected 'cases' are shown in Figure 2, and indicate that the highest scores are within the age group of 14 years. By the age of 18 years the mean score shows significant reduction. On the other hand, the highest proportion of suspected 'cases' fall within the age group of 15 year as shown in Figure 3.

Some of the possible concomitants of depression in young women were investigated. They included personal, family, physical health and life events variable. Table 1 shows the results in relation to those variables.

Among personal and family variables, those which described a sense of isolation and lack of attention by the family were more significantly associated with depression. Girls who came from a marriage between a UAE father and a non-UAE mother were significantly more likely to show depression. Contrary to expectations family income and parental loss did not discriminate between depressed and non-depressed girls. The mean scores for the three groups of family income ranged from 15 in the lowest

major depression (within one month) was 3.6% in previous years being 6.0 %. For partial syndrome the corresponding rates were 8.9% and 20.7% respectively[3].
The current study aimed at evaluating the prevalence of significant depressive symptomatology among a community sample of UAE teenage girls. This, apart from its epidemiological value had the added interest of looking at depressive sympotomatology in an affluent community which is often described as free of economically determined adverse social circumstances.

Method

Study Area

The study was carried out in Al Ain City which is situated in the eastern part of the Abu-Dhabi Emirates, lying to the east side of the foot of the mountains of the Sultanate Oman. The population estimated in 1992 was 270,800, according to the Ministry of Health Annual Report[4].

Population

The target population of this study was UAE female citizen students in secondary schools. The study was designed as a cross-sectional survey. From five secondary schools in Al Ain central city, two schools were selected at random and all UAE female citizen students in these schools were selected.

Instruments

1. The Birleson Depressive Symptoms Rating Scale[5] was chosen to detect depressive symptoms. This scale, which is widely used, has been well validated in community samples[2,6]. The scale was developed to detect symptoms of depression in children, but subsequent studies found it to be equally useful in adolescents (see below). It consists of 18 items. The subjects were instructed to select from three given alternatives, the response that best described how they had felt over the previous two weeks. Responses are made to statements on a three-point scale; most, sometimes and never. Each answer scored 2, 1 or zero respectively. An Arabic translation of this instrument was prepared after translation and back-translation. The Arabic version was tested among 50 subjects as a pilot and showed that it was reasonably understandable. Some minor alterations in the wording were made.
2. A 5 item questionnaire to probe into dysfunctions which may result from depressive symptoms was devised to ask about the existance of problems in the following areas: weight loss, school performance, school attendance, family relationships and relationships with friends. Students were asked if they have had any problems (scores 1) or no problems (scores 0) in the aforementioned areas.
3. Another questionnaire covering some possible correlates of depressive symptoms as listed in table 1 was also used. Respondents were asked to take the questionnaires home and provide their responses without any help from family members or relatives. All

The Arab Journal of Psychiatry (1998) Vol. 9 No. 1 Page (19 - 26)

Depressive Symptoms in a Community Sample of UAE Teenage Girls

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الأعراض الاكتئابية في مجموعة ذات فئة عمرية ما بين ١٠ - ٢٠ سنة في البنات

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ABSTRACT

A sample of female secondary school students in Al Ain City, United Arab Emirates, were screened using the Birleson Depression Self-Report Scale and a 5-item Dysfunction Related Scale to estimate the prevalence of significant symptoms of depression, and their personal and social concomitants. Of 505 female students aged between 13 and 18 years, 79 (15.6%) scored above a cut-off point of 14 and reported depressive symptoms which were associated with significant personal dysfunction. Overall 23% reported significant suicidal ideation. Depression was significantly associated with mixed nationality marriage, but not with family income, life events or parental loss. The results indicate that depression among teenage UAE females is not uncommon and that socio-environmental factors are less relevant aetiological factors.

Young people under the age of 18 form the largest group of the population in the UAE according to the most recent official census statistics released to the press, but not yet officially published. In an attempt to plan the development of psychiatric services for young people, including adolescents, we needed to establish the prevalence of a number of psychiatric conditions among this population. Depression among young people had a very high priority. Until now no definite study has been undertaken in the UAE or in the Arabian Gulf area. Many studies in the same field have been performed in the western world and do indicate that feelings of misery, unhappiness and low mood are quite common amongst adolescents. The question of how many would actually show a depressive syndrome has yielded highly variable rates. The Isle of Wight study[1] showed that among 14-15 year olds about 42% of boys and 48% of girls reported significant depressive feelings, while the prevalence of depressive disorder was about 2%. A more recent UK based study of depressive symptoms among 140 secondary school students (male & female) aged 12-16 years reported that 5.8% had a clinical diagnosis of depression[2]. Another UK community study of 1.072 adolescent girls (11-16 years) showed that the prevalence for current

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الملخـــص

حصلنا على تقـارير ذاتيـة مـن عينـة مجتمعيـة مـن الأولاد المراهقين فـي مدينـة العين فـي دولـة الإمارات العربية المتحدة، تكونـت العينـة مـن ٤٤٦ مراهقاً ملئوا استبيان المـزاج والمشـاعر، استناداً الـى نقـاط فصـل متنوعـة أفـاد مـا بيـن ٩ر٩٪ و٧ر٣٠٪ مـن أنهـم يعـانون مـن أعـراض اكتئابية. هذه النسبة مشابهة أو أكثر بقليل من النسب التي وردت في دراسات عالمية أخرى.

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The Isle of Wight Study[12] reported the prevalence of depressive disorder to be about 2% while Cooper & Goodyer[9] reported the prevalence for current major depression (within only a month) in their community sample of girls as 3.6%. Another UK based study of depressive symptoms among 140 secondary school students (male & female) aged 12-16 years reported that 5.8% had a clinical diagnosis of depression[15]. Comparable figures were obtained in Canada[16,17].

In the area of depression there is evidence that it is fairly reasonable to make an assumption of "caseness" on the basis of reports from the child, as this usually relates to feelings whereas reports from others are more useful in relation to behavioural diagnoses[6,18]. This is particularly so among adolescents where there is evidence that the level of agreement between reports obtained from children with reports obtained from parents is substantially higher among children aged 14 to 18 years than those aged 10 to 13[19]. What may also enhance the validity of our results is the fact that this study used a depression questionnaire rather than a broadband general psychopathology screening instrument which makes reports given by the respondents more likely to be accurate as previously empahsized[6].

Two main findings emerge from this study, firstly it appears that significant depressive feelings among teenage boys are at least as common as one might encounter in Western countries, and that UAE native boys are more likely to show such symptoms than other Arab boys. In fact, even if a substantially high cut-off score is employed the rate of depression is at least marginally higher than that in other countries.

Cross-cultural studies, with which our findings are consistent, seem to indicate that race has little effect as a vulnerability factor[20]. However differences within cultures seem to exist. Native teenage boys are more likely to be depressed than children of Arab expatriates. Given their relatively less adverse socio-environmental influences (particularly economic), one would be inclined to think of constitutional, genetic and family factors as influential variables in the genesis of mood disorders in this population. Genetic studies and studies of other family influences may help unravel this issue.

Age differences in this study are consistent with other studies. As Harrington[21] indicated, "the most consistent finding from epidemiological studies of depressive phenomena in young people has been the association with increasing age". This seems to be true across cultures and societies, as the present study has indicated.

In conclusion, the indications are that depression among Arab teenage boys in the UAE (particularly native boys) is as significant a problem as it is anywhere in the world. There is already enough evidence to support similar claims in teenage girls in this country[3]. In total the evidence supports the need for a more in-depth investigation of depression among young people in this young and developing country.

other half being 16-18 years old. About 55% were of UAE nationality, the remainder being other Arab nationals. The mean age of the population was 15.38 years (SD 1.4) and there appeared to be significant difference between the two nationality groups (15.4, SD 1.4 for UAE boys and 15.3, SD 1.4 for other Arab boys).

The MFQ had an alpha coefficient of internal consistency of .89, suggesting good internal consistency. It is important to note that there is no normative data for the MFQ in Arab community samples, and therefore the best predictive cut-off score for this population is not known. However, several Western studies seem to indicate that the cut-off score that best predicts clinical depression seems to lie between 27-35[6,9,11]. Table 1 shows the prevalence of significant depressive symptoms at various cut-off scores.

Table (1): Prevalence of Depression at Various Cut-Off Points

Cut-off Score	Prevalence (All)	Prevalence (UAE Nationals)	Prevalence (other Arabs)
27	30.7%	34.5%	25.9%
29	24%	25.9%	21.7%
31	20.4%	25.1%	18.2%
33	17.3%	21.4%	14.8%
35	15%	16.8%	12.8%
37	9.9%	11.1%	8.4%

The mean score for the whole populations was 21.4 (SD 11.5). As a group UAE nationals showed a mean score of 22.5 (SD 11.7) while other Arab Children had a meanscore of 20.1 (SD 11.1), a statistically significant difference (t-test p = .025). Older adolescents (age 16-18 years) showed a mean score of 22.9 (SD 12.2), while younger adolescents (13 - 15 years) has a mean score of 20 (SD 10.6), a statistically significant difference (t-test, p = .007).

Discussion

Many studies in the western world indicate that feelings of misery, unhappiness and low mood are quite common amongst adolescents, especially symptoms that do not amount to criteria for major depressive disorder. However, the Isle of Wight Study[12] showed that among 14-15 year olds, about 42% of boys and 48% of girls reported significant depressive feelings. Cooper and Goodyer[9], estimated that 20.7% of their sample had experienced depressive symptoms of a lesser severity during the previous year. Others[13] estimated that around 20% of adolescent girls from among the general population of London had significant mood disturbance. Angold[14] pointed out that the variations in prevalence rates in the general population are largely related to differences in definitions and methodologies employed by various studies. The question of how many would actually show a depressive syndrome has yielded highly variable rates.

Methodology

Population

The study population included adolescents who attend a secondary school for boys in the centre of Al Ain City, which is situated in the eastern part of Abu-Dhabi Emirate and whose estimated population in 1994 was about 280,000[1]. There were 576 boys on this particular school's register. All 531 boys who were present on the day of the survey participated in the study and were given the Child Version of the Mood Questionnaire to be completed by self-report under strict examination conditions.

Instrument

The Mood Questionnaire was developed as a screening tool for an epidemiological study of depression[5] with a child self-report version and a parent version. It derives its items from the symptoms of the DSMIII-R for Major Depressive Disorder and consists of 33 items. Symptoms are recorded over the previous two weeks and the possible responses are "true", "sometimes" and "not true". Each would attract a score of 2, 1, and 0 respectively. Costello and Angold[6] considered it as an effective tool for screening for Major Depressive Disorder. Furthermore, an evaluation of its psychometric properties[7] by comparing it to the Schedule for Affective Disorders and Schizophrenia - Child Version (K-SADS)[8], found that both the child and parent versions had high internal consistency (alpha = .94 and .92 respectively). However, they found a less favourable correlation between parent's reports and child's reports, the correlation between the two being 0.51. The child version had moderate diagnostic accuracy at interview for major depression while the parent version had a low diagnostic accuracy. The mean score for the child version for cases with major depression at interview was 36.9 while the parent version for the same interview showed a mean score of 26.6. Non-depressed cases scored 20.5 and 18.2 on the two versions respectively. It can be concluded that the Mood Questionnaire seems to be an effective instrument of screening for depression. Given the limited objective of this study, particularly as there was no attempt to determine the exact prevalence rate of depression in this population, the child version was chosen as the measurement instrument. An Arabic version of the child version was prepared. It was translated by the author. Back-translation was performed by two non-medical individuals who were fluent in both languages and two medical professionals who were not psychiatrists. There were disagreements, the four individuals discussed the differences and agreed on a consensus wording. Some minor changes were necessary in the literal translation in order to convey the concepts of the items, such as "I felt grumpy and cross with my parents", and "I thought I could never be as good as other kids".

Results

The total study population targeted was 531 boys. All returned their questionnaire forms but 85 (16%) were either incomplete or had not been filled at all. We have no way of telling whether this was related to depressive symptoms or not. This left 446 completed forms to include in the analysis. Almost half were 13-15 years of age; the

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Self-Reported Depressive Symptoms Among Male Adolescents in the UAE

Harith Swadi

الأعراض الاكتئابية المعلنة من قبل الأولاد المراهقين

حارث سوادي

ABSTRACT

To test the feasibility of screening for depression in teenagers, self-reports of depressive symptoms were obtained from a community sample of teenage boys in Al Ain City, UAE. The sample, which consisted of 446 boys provided self-reports using a translated version of the Mood and Feelings Questionnaire. Utilising various cut-off points the sample reported significant depressive symptoms varying between 9.9% and 30.7%. These rates were comparable to, or slightly higher than those reported elsewhere in the world.

The most recent official census statistics show that young people under the age of 18 form the largest group in the population of the UAE. The population of the UAE in 1994 was 2.3 million, of which 34% were under the age of 15 and 57% were under the age of 45. Males represent just under 60% of the population. Expatriates consist of the total population[1]. In an attempt to plan the development of psychiatric services for young people, including adolescents, we needed to obtain an idea of the extent of a number of psychiatric conditions among this population. Depression among young people had a very high priority, but little has been done to estimate the prevalence of depression in community samples of young people (particularly boys) in the UAE or the Arabian Gulf area. However there are a couple of exceptions. A sample of female secondary school students in Al Ain City, United Arab Emirates was screened using the Depression Self-Rating Scale[2] and a 5-item Dysfunction Related Scale to estimate the prevalence of significant symptoms of depression, and their personal and social concomitants. Of 505 female students aged between 13 and 18 years, 79 (15.6%) scored above a cut-off point of 14 and reported depressive symptoms which were associated with significant personal dysfunction3. In another study the prevalence of depression among 1981 middle-school students (995 boys and 986 girls) in Kuwait was estimated to be 3.7% in boys and 4.8% in girls[4].

The ideal method to estimate the prevalence of depression in a community is a two-stage design (screening followed by interviews of samples of high scorers and low scorers). However, this was not the objective of this study. The primary objective trial to answer a basic question. Does depression among adolescents in this community justify investigating? For this reason it was decided to carry out a screening exercise. This paper reports the main findings of that investigation.

الملخـــــص

هذه المقالة تتناول الخبرات التدريسية التي درست لطلاب كلية الطب في سني ما قبل التخرج. وقد شملت على مساقات في العلوم السلوكية وتدريس الطب النفسي بأساليب مختلفة كالمحاضرات في الطب النفسي السريري واكتساب الخبرات في المقابلة النفسية وآداب الطب النفسي بالإضافة الى خبرات تتعلق باختصاصات الطب النفسي، العلاج النفسي وطب نفس المسنين وصعوبات التعلم والطب الشرعي وطب نفس الأطفال والمراهقين وسوء استعمال العقاقير. كما تتناول المقالة تقييم الطلاب والتطورات المستقبلية في هذه الخبرات.

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independent examination in the final year, consisting of two papers, a short essay paper and one long essay question; a video-based examination to assess powers of observation and diagnostic ability and a clinical examination. The clinical examination is along the traditional method of a 50 minute interview with a psychiatric patient followed by a clinical examination over 30 minutes with two examiners, one of whom should be a member of the Academic Department of Psychiatry or an external examiner who would both examine the student on the patient interviewed. The student is examined on assessment of the patient, including the accuracy of history obtained and mental state examination, understanding of the patient and the likely diagnosis in the form of diagnostic and aetiological formulation leading to a plan of management complemented with a viva examination based on elements of the clinical presentation.

Future Developments

It would seem that the introduction of interview skills teaching at an earlier stage in the clinical course may have a more formative impact on the students, fostering a psychosocial approach to general medical interviewing and a greater awareness of psychological aspects of medical illness and its management. This possibility is being currently explored with the Department of Medicine, and the use of our package would enrich the contribution to the teaching of the behavioural sciences course and during the general practice block. Furthermore, teaching of psychotherapeutic skills would be worthy of exploration using a modification of St George's Grammar of Psychotherapy package integrated with the teaching of interview skills within the Introductory Course to Clinical Psychiatry.

Perhaps the most exciting development in Liverpool is the transformation of the medical curriculum from a traditional to a problem based learning one and the introduction of a "core" curriculum plus options. It ought to be a true challenge for psychiatry to develop its own "core" curriculum, including essential clinical scenarios and the problem based approach. Dr. Ben Gren, who was previously a lecturer in the Department of Psychiatry in Liverpool has produced a book on Problem-Based Psychiatry (Green, 1996).

history discussion, video extracts and discussion.

In the fifth year a lecture and seminar is held on "Developmental and Family Issues in Adult Psychiatry", within the Introductory Course to Clinical Psychiatry. This covers basic concepts and findings in child development, including the relevance of incidences in childhood with outcomes in adult life. There is a focus on the interplay of factors that may lead to disturbance in adult life. Factors and mechanisms in the inter generation transmission of child and adolescent disturbance and parenting difficulties are reviewed. The relevance of these issues in clinical practice is illustrated through the discussion of case material and presentation of video recordings of interviews with individuals and families.

Alcohol and Drug Misuse

Teaching of medical students on substance misuse has been for many years concentrated at the Regional Alcohol and Drug Dependence Unit based in Chester. Staff on the unit lecture in the University to students while the undergraduates receive further teaching and contact with patients during visits to Chester. The formal teaching deals with the whole range of substance misuse, including a summary of the organic complications. The arrangement is backed by a section in the written material given to medical students and by an excellent handbook provided for them by the Medical Council on Alcoholism.

During visits to the Regional Unit in Chester there are no shortage of patient volunteers, who sit in small groups with the students. This allows patients to discuss freely their problems and is much appreciated.

The provision of teaching at the Liverpool Drug Dependence Clinic has now enabled the Regional unit in Chester to concentrate on alcohol misuse when visited by the students.

Assessment

Assessment of students performance during the course takes a variety of forms. As an informal method in continuous assessment, each student is required to clerk in a patient from each category of mental illness, including schizophrenia, affective disorder, neurotic disorder, personality disorder, alcohol/drug misuse, parasuicide and organic states. Presentations of these patients are made to psychiatric tutors, including senior registrars on the firm, in the setting of ward rounds and out-patient clinics, followed by discussion and a marking of the students performance on the clinical tutors checklist. Each student is required to complete this checklist and hand it in to the Department of Psychiatry at the end of their attachment. There is an end of firm assessment which takes the format of MCQ examination, and students failing the exam are interviewed by the senior lecturer responsible for the undergraduate curriculum. Neither of these assessments are contributory to their final gradings/assessments. The consultants who have been involved in the student clerkship grade the students and can make any comments they wish on a brief questionnaire for every student. The final examination in psychiatry is an

Forensic Psychiatry

All medical students receive on days instruction in forensic psychiatry, at either the Regional Forensic Psychiatry Service, or Moss Side and Park Lane Special Hospitals. The programme is a co-ordinated one and consists of two separate sessions. In the morning there is an overview of the practice of forensic psychiatry, highlighting the various disciplines and knowledge bases involved; the legal system and relevant law, the penal system and penology, the Probation Service and Criminology, the Psychiatric Services and forensic psychiatry. An extensive handout is distributed in advance. It is not the intention that the undergraduates understand all of these areas, or that the tutor necessarily covers them, but solely that students get a broad overview and are allowed to discuss issues which interest them. This approach is almost invariably successful and interesting, with sometimes markedly polarised views emerging.

In the afternoon two patients are presented, chosen to highlight important issues: a chronic schizophrenic who has committed a serious antisocial act and who raises issues of treatability, dangerousness and the need for multidisciplinary and community supervision; the second often a seriously offending psychopath in order to highlight conceptual problems of psychopathy, its treatability and detention for punishment or treatment.

Students are usually entranced by forensic psychiatry patients, and the purpose of the morning session is to stress that serious offending coupled with serious psychiatric illness is rare, and that forensic psychiatry is a much broader discipline with more links with the community, the probation service and petty offenders than with high security hospitals, prisons and "dramatic" patients.

Child and Adolescent Psychiatry

The teaching of child psychiatry occurs in the 4th year during the Child Health Teaching Block, and takes the form of eight one-hour lecture sessions weekly. Not all students can attend every session owing to placements in outlying District General Hospitals.

The aims are to widen perspectives of developmental influences on the child, including individual, family and societal factors; to install knowledge of commonly occurring child psychiatric disorders, the relationship between physical disorders and psychological disturbance, and child mental health services and practice.

The series begins with two sessions covering the nature of child psychiatric disorders and the factors and mechanisms leading to them. Thereafter sessions deal with particular problems, e.g. physical presentation of emotional problems, enuresis, school non-attendance; child sexual and physical abuse; pre-school behaviour problems, autism, brain damage and hyperactivity.

The students are provided with comprehensive handouts in order to enable "lecture" time to concentrate on underlying concepts and the application of knowledge, with particular emphasis on assessment. A variety of teaching styles is employed throughout the lecture course to encourage interest and facilitate understanding, e.g. question and answer, role-play, group case

Psychogeriatrics

Teaching in psychogeriatrics is included throughout undergraduate training, and contributions are made on psychogeriatric topics through each of the five years on undergraduate training.

In year one, as part of the introductory lecture on behavioural sciences, undergraduates are taught an integrated approach in understanding mental disorders in old age and the interlocking nature of medical, psychiatric and sociological problems in the elderly. This model is used to demonstrate aetiology, diagnosis and treatment of individual patients, with particular reference to multidisciplinary team work.

In the second year, as part of the clinical introductory course, there is a video demonstration of approximately one-and-half hours of the major psychiatric disorders met in old age, including pre-and post-treatment of severe depression, paraphrenia and other paranoid states, sub-acute confusional states, florid visual hallucinations, and an edited video tape of an elderly patient developing increasing dementing symptoms over a 2-3 year period.

In the third year there is input into the geriatric module covering two topics. Firstly, recognising psychiatric disorders in acute medical and geriatric settings, and secondly, a tutorial on confusional states, including a simple question and answer problem solving format when dealing with confused patients, either in in-patient settings, emergency clinics or in the patient's own home.

In the fourth year the medical students receive didactic teaching in the epidemiology phenomenology, treatment and management of all major mental disorders in old age.

In the fifth year, during the main psychiatric attachment of medical students, students receive teaching lectures on the assessment of organic mental conditions, with particular reference to the elderly, concentrating on higher mental function as well as cognitive deficits. The students are attached to Mossley Hill Hospital in small tutorial groups lasting one day, and receive information from all members of the multidiciplinary team. Students engage in a role playing exercise to give them insight into the clinical work and ethical problems that relatives may be facing when dealing with a demented patient. The students also discuss how to manage services for demented patients within current budgetary constraints. This appears to be about the only teaching that medical students receive on management of health services, which they greatly enjoy and appreciate.

During the six weeks clinical attachment it is expected that medical students will spend approximately 20-25% of their time seeing older patients. This is the major element in their psychogeriatric training. In almost all hospitals utilised by medical student attachments there are now Consultant Psychogeriatricians appointed who undertake clinical supervision.

Psychogeriatrics aim to provide an integrated teaching approach, not only in psychiatry but also in other areas of medical practice, such as behavioural sciences and during geriatric attachments.

At an introductory lecture, which begins the ethics teaching session, the Grid is explained in more detail. The lecture is followed by a demonstration of how to plat a card game, devised by Dr. Lovett, called Medical Dilemmas. The game is based on the commercial game Scrupples, but differs in that the ethical vignettes are all medical dilemmas. The student class is divided into groups of five or six to play the game and each group is supervised part of the time by the teachers. Students are required to justify their responses to the dilemmas using the Ethical Grid. At the end of the game each group fills in a task form, which is discussed in a preliminary session. The aim of this form is to highlight difficulties students have had understanding any aspect of the Grid.

The session ends with a student-centered case presentation selected from working on the wards or in general practice, which is then discussed. Ending with a real case helps to shift the mental set of the students back from "playing a game" to "decision making in real life".

Students evaluation of this teaching package revealed that 93% found the session interesting, 86% found it relevant to their medical education; 81% found playing the card game useful; 84% wanted more time devoted to teaching of ethics and 22% wanted it to be an examinable subject.

The brief teaching programme, which involves a mixture of didactic teaching and active participation introduces students to a model of approaching medical dilemmas and engages them in an intensified learning experiences through participation in a card game. It could easily form part of a more extensive programme of ethical teaching.

Teaching of Sub-Specialities

Psychotherapy

The current experience of psychotherapy is along the lines of the Nottingham Experiential Day Model (Aveline and Price, 1986).

Psychiatry of Mental Handicap

As the teaching time available is limited (1 day) the emphasis is on providing students with experiences, supplemented by extensive handouts and reinforced by introductory and feedback sessions. The students meet with people with learning difficulties in a variety of settings and talk with them about their lives. They also meet with a group of parents and members of the community support teams to gain an understanding of multidisciplinary team work.

We hope students gain a positive image of people with learning difficulties, identify their needs and that of their families/carers outside of the medical context, and thus will be able to meet their needs more appropriately in their professional lives. Students, although often apprehensive, find the experience of hearing directly from individuals and parents about themselves a very positive one. We hope to widen their experiences by taking the students to more ordinary settings, e.g. colleges and places of work, and extending the use of videos to give them more feeling ordinary life.

used in the lecture to get these points across and to prepare the students in preparation for two experiential workshops which follow. First, the experience of role play in the third year is extended to an experience of real-life interviews in the final year. The first workshop occurs immediately following the introductory lecture and role play and lasts for two hours. The workshop has the following format:

The student interviews a patient for 20 minutes on the presenting complaint in the presence of three peers and a facilitator. Then a second student immediately interviews the same patient for 20 minutes concentrating on the mental state examination. The patient then leaves, although where appropriate the patient is invited to comment on how he/she felt about the interview. The students then fill in their checklists, which are used as a "spring board" for a short discussion in the presence of a facilitator. Two groups of four to five students then pair up and a spokesperson from each group initiates discussion by feeding back the group's experience in the presence of a facilitator. Points arising are discussed and evaluated. This workshop is repeated two days later, starting with a preliminary session which recapitulates on the experience of the previous workshop and the problems and difficulties are discussed. The focus of the second workshop is on the family and developmental history as well as Mental State Examination. The aims of the workshop are to reduce the students concerns about interviewing psychiatric patients, to reinforce students knowledge of basic interviewing skills and to introduce students to the particular skills required in taking a psychiatric history and Mental State Examination. The workshop emphasises the following teaching methods: "hands on" experience of interviewing a patient in front of a small group of peers peer-feedback using checklists which focus on three major aspects of interviewing elicitation of factors, eliciting feelings and control of the interview; facilitation of small group discussions in the presence of a senior psychiatrist. Feedback from the students has been fairly positive. Students found that the actual experience of interviewing a patient themselves preferable to watching a psychiatrist perform the interview by a 3:1 ratio, and requested that these workshops should occur earlier in their training and asked for a continuation during psychiatric attachment.

Teaching of Psychiatric Ethics

Within the introductory course to clinical methods we have previously taught psychiatric ethics in the format of a lecture followed by an ethics debate. For this debate a psychiatric case vignette which highlights an ethical dilemma is provided. A student is identified to propose the motion and a student to oppose it following good preparation, including the reading of relevant literature. The students then join in the discussion from the floor before the summing up by the proposer and opposer, and finally a vote is taken on the motion. This method was deemed less satisfactory than an interactive method using a tool for moral reasoning designed by Dr. Seedhous called the Ethical Grid (Seedhouse, 1988).

we want to improve students abilities in critically evaluating mental health care and so plan to introduce this through project work in a future course.

Lecture Block in the 4th Year

The lecture blocks run over three days and provides an introduction to psychiatry in the framework of a series of clinical lecture blocks. The lectures are didactic, covering prime topics of history and mental state examination, descriptive and dynamic psychopathology, including defense mechanisms, suicide and parasuicide, life crises and physical and psychological treatments with extensive use of videotaped material. Feedback from the students has been satisfactory, although the value of this teaching remains uncertain in view of the time gap before the students start their clerkships in the final year.

Clerkships

The annual intake of 150 to 160 students is subdivided into groups of approximately 40 students for their psychiatric clerkships. The clerkship lasts for seven weeks, with the first week of each block spent in the University Department of Psychiatry on an Introductory Course in Clinical Psychiatry, followed by six weeks attachment to one of the ten teaching units in the Mersey Region, with each unit receiving four to six students from each block. The teaching of sub-specialties occurs on one whole day of each week of the clerkship period, when sub-groups of five to six students rotate for their sub-speciality experience in Psychotherapy, Child and Adolescent Psychiatry, Psychogeriatrics, Psychiatry of Mental Handicap, Forensic Psychiatry and Alcohol and Drug Misuse. On the last day of each block the students sit an M.C.Q. examination in Clinical Psychiatry.

The course has the expressed aim of providing and inductive experience into basic clinical psychiatric skills, including interviewing psychiatric patients, diagnostic and therapeutic skills, including psychotherapy and an experience of psychiatric ethics. The course has been assessed by a detailed questionnaire which showed that the students highly valued this experience in preparation for their attachments. This teaching is supplemented with a large compilation of handouts which have been carefully prepared by the teachers over a number of years and are regularly revised and updated. The handouts provide a basic source of knowledge, complemented by suggested reading in undergraduate texts.

Teaching of Psychiatric Interview Skills

Teaching of interview skills occurs at a number of stages in both the pre-clinical and clinical course (vide supra). This final year course occurs in the Introductory Course to Clinical Psychiatry in he first week of students clerkships. The course starts with an introductory lecture, supplemented with a comprehensive handout on interview skills, which emphasizes the nature of the doctor patient relationship and basic interactive issues, such as room arrangement, non-verbal communication and dress, thereby reinforcing the instruction which students receive whilst in the third year in the general practice attachment. Role play is

Mental Health in the Community Course

This course occurs in the third year and is run jointly by the Department of General Practice (involving Sociology) and the Department of Psychiatry, including the Sub-Department of Clinical Psychology. It takes place three times a year, with fifty students at a time. The course aims to provide a link between behavioural science teaching in the first year and general practice and psychiatry in years four and five; to look at different aspects of mental health. The ways in which problems are dealt with by informal support networks, and their presentation at primary and secondary care levels when these networks can no longer cope; and the wide range of treatment and management options available within a community. It offers students the opportunity to relate these issues to their own mental health if they so wish.

The course has three basic components:

1. Lectures and Seminars. These cover social networks, presentation of mental illness in primary care, roles of psychiatrists and psychologists, counseling and sensitivity training, family therapy and resource allocation. The final session is run as a debate between students and a panel of professionals involved in community care.
2. Visits. Each student undertakes three visits during the week to community based resources, such as day hospitals, hostels, sheltered workshops, or accompanies community psychiatric nurses and social workers on visits to families with mental health problems.
3. Discussion Groups. The final session on Monday and Thursday consists of a discussion group in which students can set their own agendas. They often wish to reflect on their visits, but this is also the forum in which they can relate what they are learning through their own personal experiences.

On the final afternoon there is a written assessment.

Since 1987 the assessment has involved students views of the course as well as testing their own knowledge. They consistently rate the visits and discussion groups very highly while the lectures and seminars evoke a (salutary) mixed response. More generally we ask them whether their opinions and ideas have changed as a result of the course. Two sets of responses were as follows:

Course made you think about your own feelings	68%
Course made you reorganise your knowledge	53%
Course helped you acquire new facts and insights	65%

In addition to the students views we have regular interdepartmental meetings to monitor and amend the course. There are two main areas that we are currently developing. The first is to expand the number of visits to families and individuals rather than community-based institutions so that students get more idea of the significance of informal social networks in mental health care. Secondly

behavioural sciences in clinical work. Experience certainly suggests that they do not. Therefore such lectures emphasise the importance of emotions, not only in a group of psychiatric illnesses but as concomitants of physical illnesses as well as being aspects of normal behaviour. The impact of social factors on physical and mental illness are discussed and a lecture is given on the prevalence and incidence of mental illness and other forms of emotional disturbances. The emphasis throughout is on the holistic approach and the relevance to clinical medicine.

The tradition of phenomenology in Liverpool dates from the time of the first holder of the Chair, Frank Fish, and has developed in recent research programmes, which emphasise the standardisation of diagnosis, computer methods, prevalence and incidence of mental disorders. A double lecture in psychopathology is given in the introductory course, when the origins of normal emotions are discussed, and then the phenomena of mental illness is reviewed systematically and defined didactically so as to give the student as clear a guidance as possible in identifying the symptoms on which his or her diagnosis may be based. Psychiatry is presented as having defined its terms (perhaps necessarily) more clearly than any other clinical discipline. Some of the classifications of phenomena used are those originally proposed by Fish.

The Clinical Course

Introductory Course to Clinical Methods

After completing five terms of pre-clinical teaching students enter a three-week introductory course in clinical methods during which time they gain experience in various clinical departments. Students spend about one three-hour session in each department. Traditionally the psychiatry contribution took the form of a fairly didactic lecture on the psychiatric interview, supplemented by the use of videotaped material. However in 1986 we decided to change this format instead having small groups of four to five students interviewing volunteer patients. The format undertaken was that each group was assigned to a psychiatrist who explained the procedure and introduce the patient to the group. The psychiatrist then sat in with the group whilst they interviewed the patient for 45 minutes. This was followed by a discussion between students and the psychiatrist, which was not rigorously time-limited, but lasted about 45 minutes. The students attended on one of the four mornings available and all the interviews took place in hospital out-patient clinics.

The course was evaluated using detailed questionnaires, completed by students and by the volunteer patients. Preliminary analysis of the first 92 students who completed these questionnaires showed that students valued the experience: 19% of the students and 28% of the patients reported the interview to be very or fairly stressful; 99% found the exercise to be worthwhile and 92% of the students felt that they had understood the patient well or fairly well, whilst 61% of the patients thought that the students understood them extremely or fairly well.

course. Of these ninety hours, sixty are given to the teaching of psychology and the remaining thirty are given to the teaching of medical sociology. The psychology component is taught mainly by qualified clinical psychologists, although some tutorials are conducted by trainee clinical psychologists studying for their postgraduate Mastership in a Clinical Psychology Degree. The involvement of the trainees in medical education is a deliberate policy designed to improve their understanding of the needs of medical practitioners and to facilitate their future working relationships with the medical profession.

The goals of psychology teaching in the pre-clinical years are: (a) to give medical students an appreciation of psychology as a scientific discipline and (b) to demonstrate the relevance of the discipline to the understanding and management of clinical problems. Thus, although a certain amount of abnormal psychology is taught within the context of an understanding of normal mental functioning, the focus of the teaching is the application of psychology to health problems in the broadest sense. In practice, most of the psychology teaching is captured by the following headings: general psychology, taught mainly in Term one; medical psychology, taught mainly in Term two, and developmental psychology, taught in the final term of the first year.

Only the very basic concepts of General Psychology can be covered in the time available. General psychological topics taught which have a relevance to psychiatry include definitions of "normal" and "abnormal"; normal and abnormal perception; the psychology of emotion; memory and failures of memory (including organic amnesia); learning theory (with some coverage of its applications with respect to behaviour therapy and behaviour modification); and social attribution theory (with discussion of its relevance to the understanding of depression and other psychiatric disorders). Topics in medical psychology which received detailed attention include: doctor-patient communication; the psychology of pain; drug-behaviour interactions; the placebo effect; psychological problems of the elderly and psychological factors in health and disease (e.g. cardiac disease). The developmental psychology component focuses on norms, stages of development and prenatal, perinatal, biological and environmental influences on personality and intellectual growth.

A three-hour combined examination in psychology, medical sociology and biostatistics is sat at the end of the Summer Term of the first year with resits being taken the following September. Feedback from the behavioural science course as a whole has been generally favourable, and in recent years a number of students have expressed interest in spending their elective periods in the Sub-Department of Clinical Psychology.

Three lectures from psychiatrists are delivered during the pre-clinical period as part of the course. The purpose of the lectures are to make students aware of the importance of behaviour, psychology and sociology for medical students. It cannot be assumed that students taking principally anatomy, physiology and other medical sciences appreciate the relevance of

The Arab Journal of Psychiatry (1998) Vol. 9 No. 1 Page (1 - 12)

Education:

The Contribution of Psychiatry to the Undergraduate Medical Curriculum: The Liverpool Experience

M.T. Abou-Saleh

اسهام الطب النفسي لبرنامج كلية الطب

محمد أبو صالح

ABSTRACT

This article deals with the teaching experiences that had been delivered to undergraduate medical students. They included behavioral sciences, psychiatry, clinical interview and medical ethics. In addition, psychotherapy psychogeriatrics, learning disability forensic, child psychiatry and drug abuse it also deals with evaluation of students and future developments.

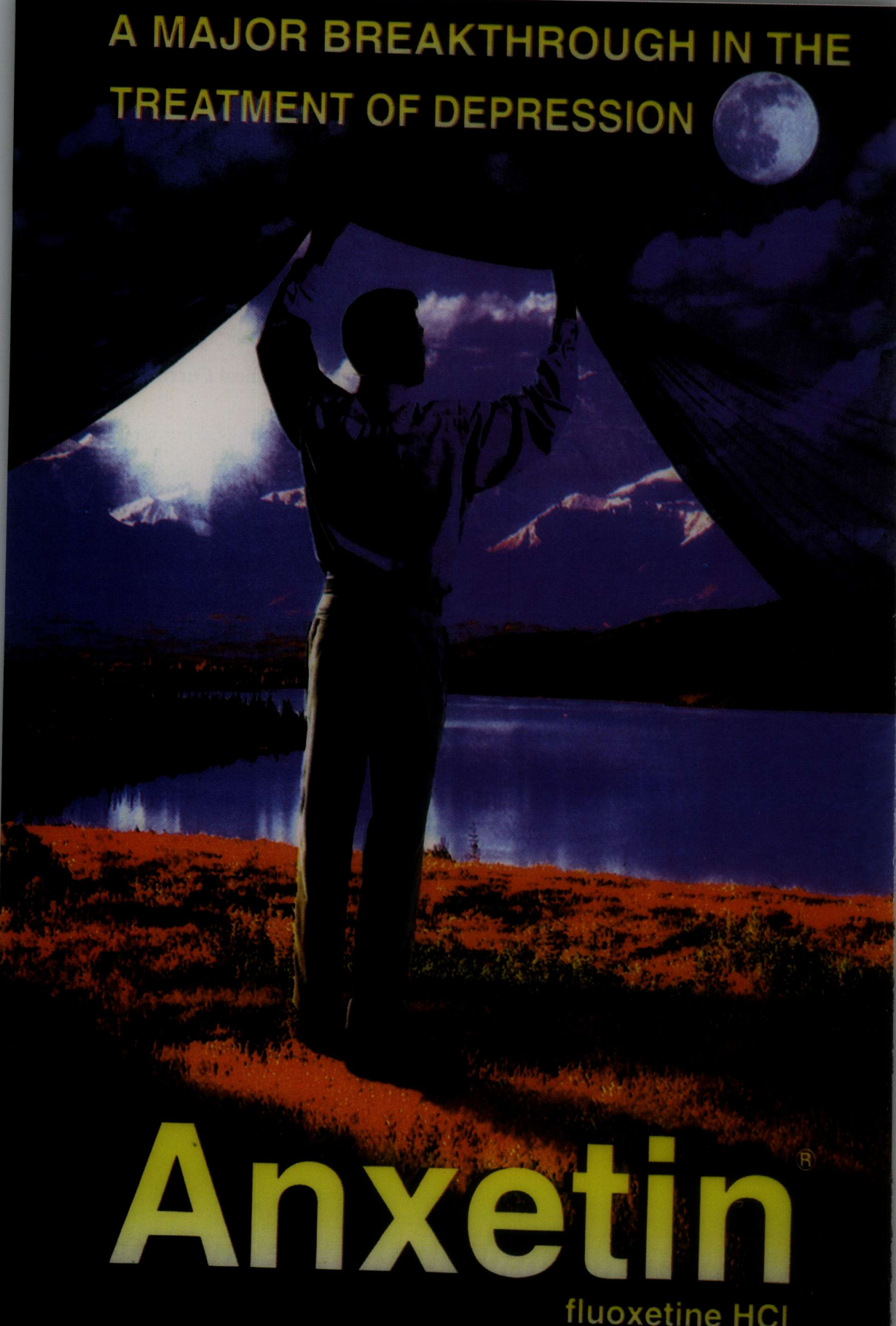
Introduction

In Liverpool medicine is taught over five years with 150 to 160 students in each year. Psychiatry is one of the three major subjects examined in finals, the others being medicine and surgery. The teaching of psychiatry occurs at a number of points in the pre-clinical and clinical courses. The pre-clinical course lasts for two years. Teaching is mainly performed by basic sciences teachers who endeavour to make their subjects relevant to clinical practice. The clinical course lasts for three years and most of the teaching is undertaken by clinicians, with a major contribution from N.H.S senior consultants based at the Royal Liverpool and associated teaching hospitals in the Mersey Region. The academic staffing establishment consists of six professors, two of which are connected in adult mental illness, two in child and adolescent psychiatry; one in forensic psychiatry, one in psychogeriatrics, one reader, four senior lecturers, two in adult (already stated) mental illness, (one in child and adolescent psychiatry) and one in forensic psychiatry. Also 5 lecturers, two of which are specialists in general in adult mental illness, one in child and adolescent psychiatry and one in psychological statistics plus twenty five honorary clinical lecturers (National Health Service consultants).

Behavioural Sciences

The behavioural sciences course is organised by the Department of Psychiatry, with the responsibility delegated to the Sub-Department of Clinical Psychology, which has become a free standing Department in recent years and runs for five terms over two years.

Ninety hours of teaching are devoted to behavioural science during the pre-clinical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Contents

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(للطب النفسي)

Al-Rashid Hospital

(Psychiatry)

مستشفى نفسي خاص

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Manuscripts

Manuscripts must be submitted as an original with two copies and must be typewritten, double-spaced throughout in ISO A4 pages with a margin of 3 cm. Sub-headings in the text should be limited to three grades and should be coded in the left margin. Make the approximate position of figures and tables in the left margin.

The first 3 page of the manuscript should contain the following:

Page 1: Title, running head (Max. 40 letters), title of article in English and names of authors, without titles or addresses.

Page 2: Abstract in English (max. 250 words). It should follow a structured format (objectives, method, results and conclusion). It should include key words (max. 5).

Page 3: Names of authors, titles, and full addresses and address for correspondence.

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Arabic abstract follows the references section (last page).

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Tables should be typed with double-spaced in separate pages. They should be numbered with Arabic (e.g. 1, 2, 3) numerals and have a short descriptive headings.

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All illustrations (footnotes and line drawings) should be submitted camera-ready; line drawings/diagrams should be approximately twice the size they will appear in print.

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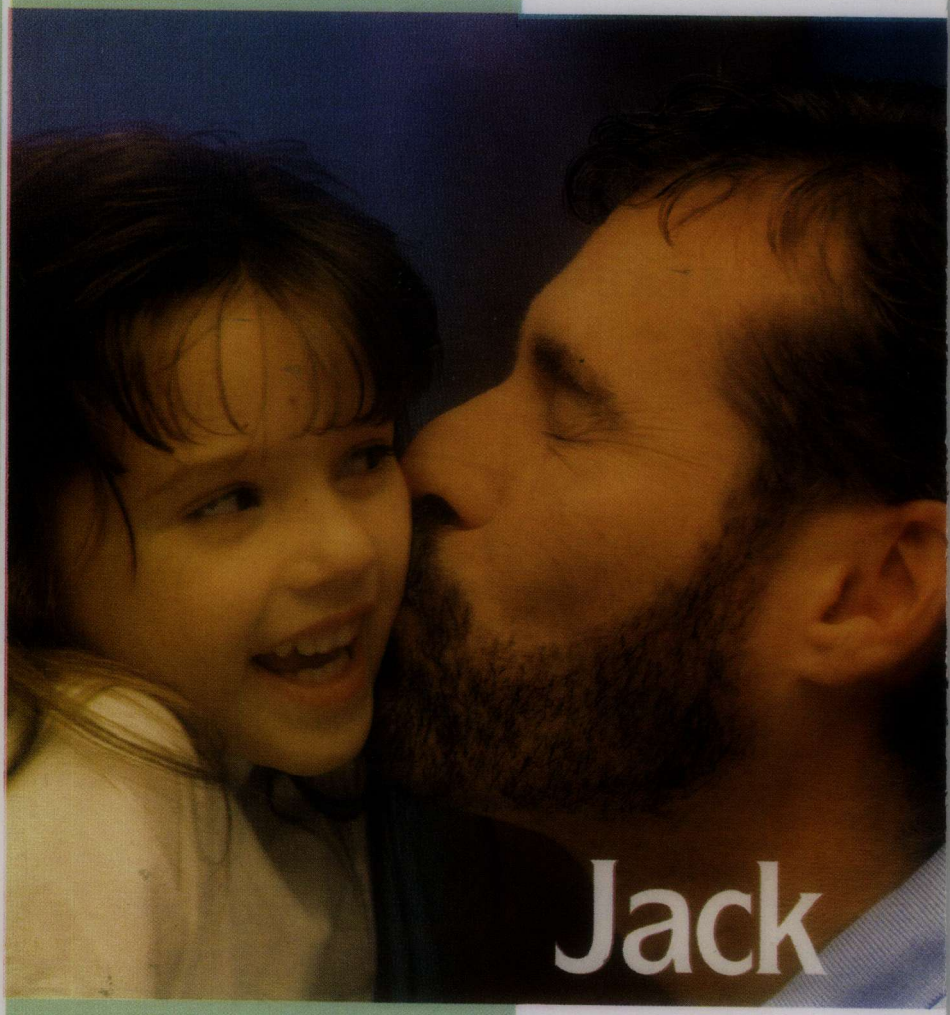

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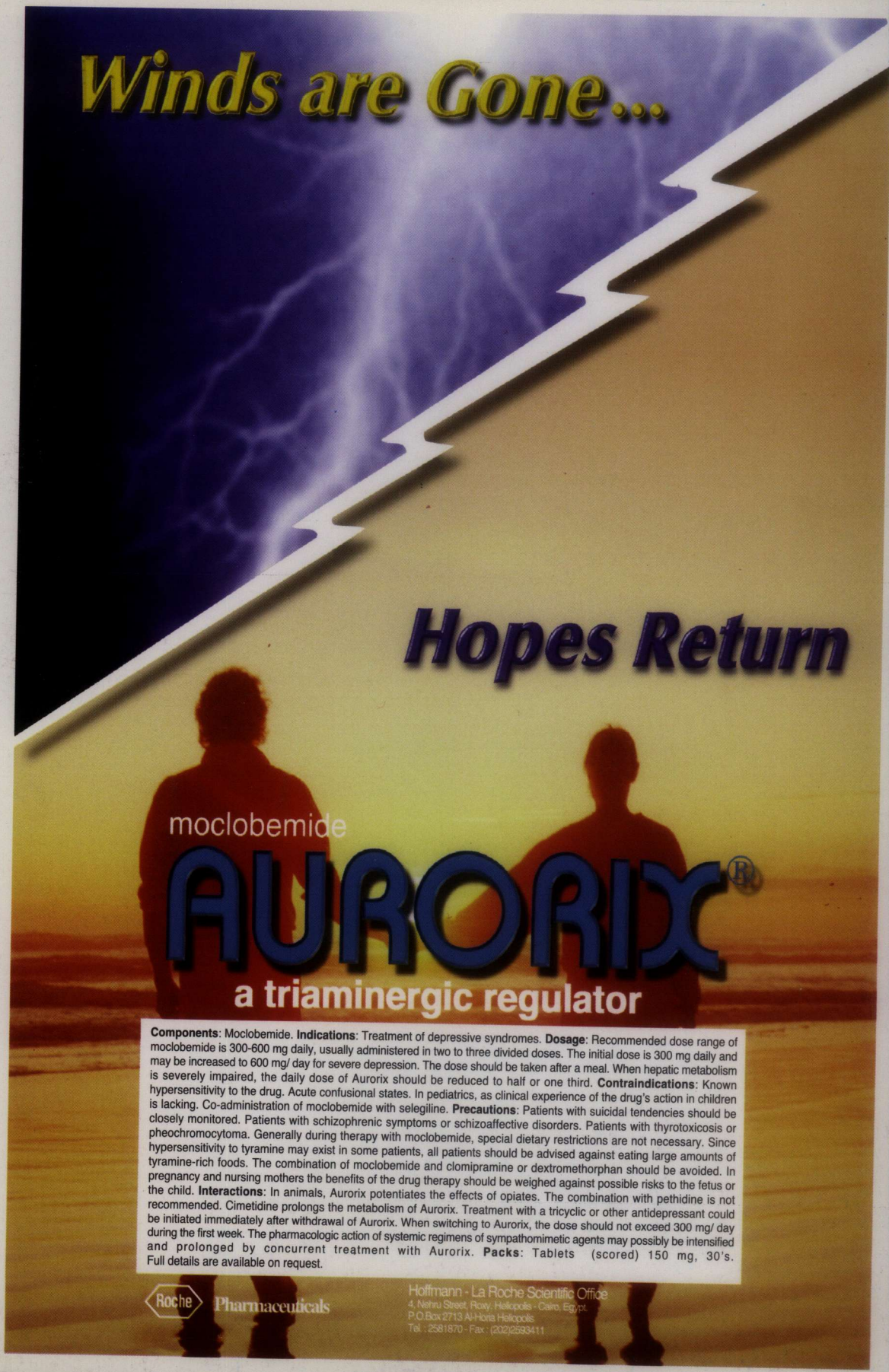

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