Their doctor knew that their symptoms were simila

Symptoms: Low mood, suicidal thoughts
Diagnosis: **Depression**

Symptoms: Palpitations, intense anxiety
Diagnosis: **Panic disorder**

Symptoms: Sleep disturbance, hopelessness
Diagnosis: **Depression**

Depression and panic disorde are seen across all age group in both sexes. From the doctor viewpoint, overlapping symptoms can make them appear similar. For the patient the same effective treatment can make a real difference to their quality of life.

Cipram combines proven efficacy with an established safety and tolerability profile which makes it a logical first choice for patients suffering from depression or panic disorder. For effective relief from depression and panic disorder, prescribe Cipram - the most selective SSRI - and make a real difference to your patients.

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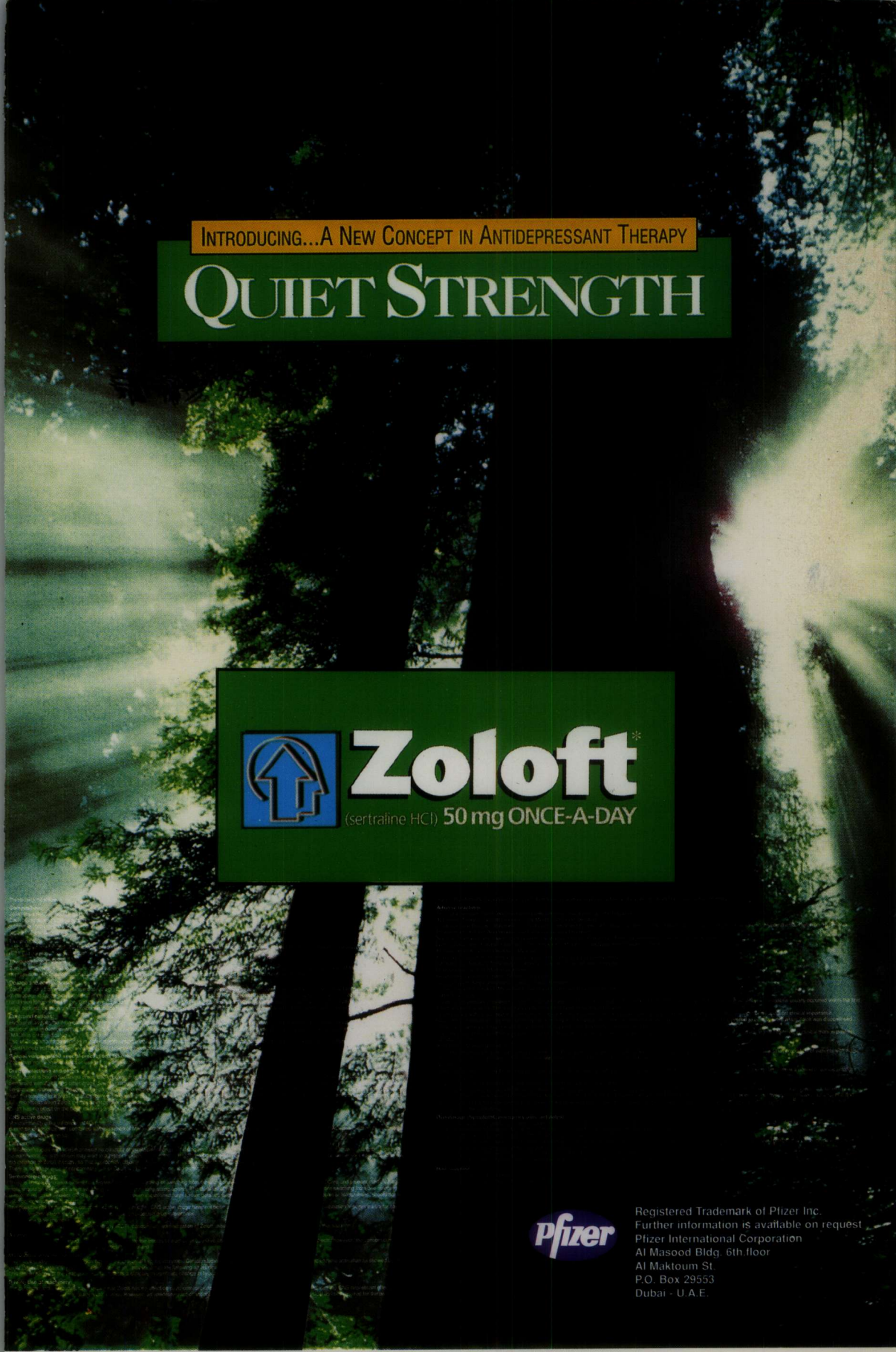
They just know that Cipram makes a real differenc

Abbreviated prescribing information. Presentation: 'Cipramil' tablets 10 mg: PL 0458/0057, each containing 10 mg of citalopram as the hydrobromide. 28 (OP) 10 mg tablets £10.09. 'Cipramil' tablets 20 mg: PL 0458/0058, each containing 20 m citalopram as the hydrobromide. 28 (OP) 20 mg tablets £16.79. 'Cipramil' tablets 40 mg: PL 0458/0059, each containing 40 mg of citalopram as the hydrobromide. 28 (OP) 40 mg tablets £28.38. **Indications:** Treatment of depressive illness in 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 2 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 mainten 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 indiv 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:*** Re 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:** Combinec 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 machir 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 MAO inhibitor treatment. Use a low starting dose for panic disorder, to reduce the likelihoc an initial anxiogenic effect (experienced by some patients) when starting pharmacotherapy. **Drug Interactions:** MAO inhibitors (see Precautions). Use lithium and tryptophan with caution. Routine monitoring of lithium levels need not be adjus **Adverse Events:** Most commonly nausea, sweating, tremor, somnolence and dry mouth. With citalopram, adverse effects are in general mild and transient. When they occur, they are most prominent during the first two weeks of treatment and us attenuate as the depressive state improves. Withdrawal symptoms have been reported with SSRIs. Abrupt withdrawal of citalopram should be avoided. **Overdosage:** Symptoms have included somnolence, coma, sinus tachycardia, occasional nodal rhy episode of grand mal convulsion, nausea, vomiting, sweating and hyperventilation. No specific antidote. Treatment is symptomatic and supportive. Early gastric lavage suggested. **Legal Category:** POM 24.1.95. Further information available upon req Product licence holder: Lundbeck Ltd., Sunningdale House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes, MK7 8LF. 'Cipramil' is a Registered Trade Mark. © 1998 Lundbeck Ltd. Date of preparation: January 1999. 1298/CIP/501/056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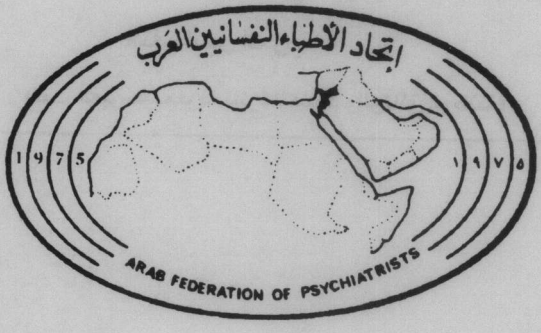

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: ١ - الطب النفسي - دوريات أ - اتحـاد الأطباء النفسانيين العرب

(تمت الفهرسة بمعرفة دائرة المكتبات والوثائق الوطنية)

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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 بمسافات مزدوجة على صفحات A4 بحواشي ٣ سم. ويجب أن لا تزيد العناوين الفرعية عن ثلاث مستويات ويراعى 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 والنتاج ثم الخلاصة.

الصفحة الثالثة: تحتوى 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 الأبجدي. ويفضل كتابة أسماء المشاركين في المرجع إلا إذا زاد العدد عن ستة فيكتفي بكتابة (وجماعته et al).

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Forensic Physicatry in Islamic Law and Sharia

Kutaiba Chaleby

الطب النفسي القضائي في قوانين الأحوال الشخصية الإسلامية

الدكتور قتيبة الجلبي

الملخـــــــص

يتناول المقال الجوانب المتعددة من الطب النفسي القضائي والتي تتعلق بالحالة العقلية وأثرها في الزواج والطلاق وتأثير حالة الغضب والمؤثرات العقلية على صحة الزواج والطلاق. كما تطرق الى جوانب أخرى في الزواج وذلك في قوانين الأحوال الشخصية الاسلامية.

الأهلية العقلية في الزواج و الطلاق

في معظم القوانين الوضعية في العالم يكون هنالك حد أو قدر معين من الأهلية العقلية التي يجب أن يكون عليها الشخص الراغب في الزواج قبل أن يكون ذلك الزواج صحيحاً. و تقدر تلك الأهلية بأن يكون الراغب أو الراغبة في الزواج ذات قدرة عقلية يفقه فيها معنى الزواج و العلاقة الجنسية، و الواجبات التي تترتب على ذلك. أما في الشرع الإسلامي فان ذلك الشرط لا يفرض توافره، فيمكن للطفل الذي في الخامسة من العمر أو اقل أن يتزوج من خلال الولي.

زواج الصبي: لا يحق للصبي في سن دون السبع سنوات من العمر أن يزوج نفسه، و لكن هذا لا يعني أنه لا يستطيع أن يتزوج. إنما الذي يتولى تزويجه هو الولي، و يكون الزواج صحيحاً تترتب عليه جميع الأحكام الشرعية. و لكن إذا كان الولي غير الأب أو الجد، فالزواج صحيح إلا انه غير لازم. أي ان يجوز لكل من الصغير أو الصغيرة أن يفسخ هذا الزواج عند بلوغه. و لكن إذا كان الولي الأب أو الجد فانه يبقى صحيحاً لازماً في حق الصغير و الصغيرة (التقرير و التحبير ج[٢] ص ١٧٤).

أما إذا كان الطفل أكثر من السبع سنوات من العمر، فانه يستطيع ان يزوج نفسه من دون الرجوع الى الولي ابتداءً. و لكن هذا الزواج سوف لن يكون صحيحاً إذا لم يوافق عليه الولي. فإذا وصل الصبي سن البلوغ أصبح باستطاعته أن يتزوج من دون الرجوع الى أية ولاية.

أما الطلاق فانه لا يمكن ان يتم من خلال ولي. فلا يملك الولي ان يطلق و لو كان في إمكانه ان يزوج أصلاً. فلا يملك الطفل في سن أقل أو أكثر

من السابعة أن يطلق، لأن الطلاق في الإسلام يتطلب قدرة أي أهلية عقلية خاصة لهذا الغرض. من المهم أن نذكر هنا أن كل ما يتعلق في الأهلية في الزواج المطبقة على الصبي يمكن أن يقاس عليها في الجنون و العته. أي أن زواج المجنون من خلال الولي صحيح مهما كانت درجة أو شدة الجنون، كذلك لا يكون طلاقه صحيحاً إلا إذا كان ذو عقل راجح. ان تفاصيل القدرة أو الأهلية العقلية في الطلاق تحتاج الى مجال خاص بها و لذا فإنها سوف تناقش في الفصل المختص بقوانين الأحوال الشخصية في فصل قادم (التقرير و التحبير ج[٢] ص[١٧٤]، الزواج و الطلاق في الإسلام ص[٤٧]).

لقد أعطى العلماء المسلمون للشرائع التي تنظم الأسرة، اهتماماً كبيراً من خلال دراساتهم على مدى القرون الطويلة. و من تلك الدراسات، هناك الكثير من الفصول و الأبواب التي شملت ما يهم الطب النفسي و القضايا الشرعية المتعلقة به. و ذلك عندما يناقشون الحالات النفسية و العقلية التي يكون عليها أحد أفراد الأسرة، و يؤثر ذلك بطبيعة الحال في حكم القاضي و ما يراه مناسباً لمصلحة تلك الأسرة و الصالح العام من خلال الشرع و حدود الله. لقد اجتهد الكثير منهم في قضايا تكون في عصرنا هذا من اختصاص الطب النفسي. و لقد كانوا مصيبين في معظم ما توصلوا له من يكون عليه صحة الزواج في ما يتعلق بالأمراض العقلية التي تجعل أحد الزوجين في حكم الجنون.

استنتاجات طبية نفسية، و سوف نناقش تلك القضايا بما نستطيع من إمكانيات.

آن دور الطب النفسي في النظم و الشرائع التي تخص الأسرة أو العائلة، تتعين بالكلمة المستعملة هنا ألا و هي "الأسرة". فنحن نعرف أن الطب النفسي لا يمكن أن يمارس ممارسة صحيحة الا بدراسة الأسرة و العائلة. و بما أن القضايا الشرعية التي تشمل نظم الأسرة هي قضايا تتعلق بالزواج و الطلاق و حضانة الطفل و مشاكل الإساءة الى الأطفال، لذا كان الطب النفسي أحد المصادر الأساسية التي تقيم عليها تلك القضايا. لقد اخترنا أن نعطي فصلاً خاصاً بموضوع الإساءة الى الطفل و شهادته لأنه موضوع قائم بذاته على الرغم من أنه جزء من القضايا العائلية، و لأنه في كثير من الأحيان يشمل من يكون خارج العائلة مثل قضايا الاعتداءات الجنسية على الأطفال و غيرها. و من هنا سوف يكون نقاشنا في هذا الفصل محصوراً في قضايا الزواج و الطلاق و حضانة الطفل.

أثر الجنون في صحة الزواج

لقد مر في أعلاه تفصيل ما يتعلق بالأهلية العقلية في كل ما يكون عليه الراغب في الزواج من رجل أو امرأة من شروط تحدد الأهلية العقلية المطلوبة في الشرع الإسلامي. أما الآن فسيشمل نقاشنا ما لقد اختلف كثير من الفقهاء في حكم أثر الجنون في النكاح. و قال كل من المذهب المالكي و الشافعي

و الحنبلي على أن الجنون يعتبر عيباً في النكاح، سواء أكان ذلك الجنون مطبقاً، أم متقطعاً، و سواء أصيب به الزوج أو الزوجة. و لقد اعتبروا حالة الجنون عيباً يعطل الاستمتاع المتوقع من الزواج. و من هنا أعطوا حق الخيار للمرأة في فسخ الزواج. و الحق في فصل الزواج مختص في قرار المرأة فقط، لأن الرجل له حق الطلاق في أي حال.

ثم فصل المذهب المالكي في ذلك بأن بين أن الخيار في فسخ الزواج يكون فقط عند كون الجنون موجوداً قبل أو حين عقد النكاح. فإذا طرأ الجنون بعد عقد النكاح فهناك تفصيل في الموضوع، فإذا أصيب به الزوج فان للزوجة الخيار في الفسخ و ذلك لدفع الضرر الداخل عليها. أما ان ابتليت به المرأة فلا يعطى الزوج الخيار في الفسخ، و لكن بالطبع هذا سوف لن يحرمه حق الطلاق ان شاء.

أما الشافعية و الحنابلة فلقد فصلوا بأن الخيار في فسخ النكاح يجب أن يكون مشروطاً بعدم العلم بحالة الجنون تلك حال كتابة عقد النكاح. أما إذا كان هناك علم مسبق به فلا خيار يعطى بالفسخ.

أما فقهاء الحنفية، فلقد ذهب معظمهم الى موقف مختلف تماماً. و ذلك إذ قالوا بأن الخيار بفسخ الزواج لا يجوز بسبب الجنون مهما كانت الظروف. فهم لا يعطون الزوج و لا الزوجة الحق في الفسخ بسبب مرض عقلي يؤدي الى الجنون. إلا أن القلة من الحنفية قد أعطى الخيار للزوجة و ليس للزوج، و ذلك لأن الزوج له حق الطلاق أصلاً (من الموسوعة الفقهية الكويتية ج[١١] ص[١٠٨].)

الطلاق و الأهلية العقلية له

لقد أعطى الشرع الإسلامي الأصول التي تنظم الطلاق أهمية كبرى. فعلى العكس من الزواج الذي هو خير في مجمله، يكون الطلاق شر لا بد منه في الغالب. و لهذا فان الإسلام سهل الزواج و جعل الشروط المتعلقة به سهلة للغاية، فحتى المجنون و المعتوه و الطفل يحق له الزواج عن طريق الولي. ان الطلاق محكوم بشروط أصعب، فبينما لا تكون هناك أهلية عقلية مشروطة للزواج، إلا أن الطلاق مشروط دائماً بوجود العقل والعتة. و لقد شرع ذلك سبحانه و تعالى حفاظاً على تكامل العائلة و تماسكها. و لسوف نرى أن وجود العقل الخالي من الاضطرابات النفسية التي تسبب الجنون ليس هو الشرط الوحيد في صحة الطلاق، و لكن يستوجب على هذا العقل أن يكون خالياً من المؤثرات الحسية و الدوائية أو المخدرات أو المسكرات، بل حتى حالة الغضب الشديد مرتبطة في صحة الطلاق بحال من الأحوال.

إن ارتباط حق الطلاق بالرجل و من دون إبداء الأسباب، كانت في رأينا سبباً آخر لوضع شروط صعبة في هذا الحكم. فنحن نعرف أن الإسلام عندما أعطى الرجل ذلك الحق لم يكن معناه أن الرجل حر يطلق متى يشاء و يرجع زوجته متى

يشاء. فالإسلام قد حرم الظلم، و الطلاق الجائر من دون سبب، لا يقره الشرع و يكون الرجل آثماً أمام الله إذا لم يستخدم حق الطلاق بصورة صحيحة و عادلة. من هنا كانت التشريعات التي تحكم وقوع الطلاق مرتبطة بالحالة العقلية للرجل. كما أن وضع الطلاق البائن و كونه غير رجعي بعد الطلقة الثالثة إلا في حالة زواج المرأة من رجل آخر و طلاقها منه، يجعل أمر الطلاق أكثر خطورة. هذا بالإضافة الى أن الطلاق يكون واقعاً بمجرد النطق به، ولا يمكن أن يؤخذ الا في موقع الجد. فأي لفظ يقال يحمل معنى الطلاق، سوف يجعل الطلاق حالة واقعية و يتحتم أن يتحمل الزوج و الزوجة نتائجها. و هذا يعني أنه في حالة لفظ الطلاق و وقوعه سوف لن يزيله أي ندم يبدر من الزوج و لو أبداه بعد دقائق من لفظ الطلاق البائن. و لقد قال رسول الله (ص) " ثلاثة جدهن جد و هزلهن جد النكاح و الطلاق و الرجعة" و في رواية و العتق (سنن أبي داود ج[1] ص[٥٠٧]). ولذا فان وقوع الطلاق محكوم بتمام صحة آلة العقل و خلوها من أي مؤثر ضار. كما يشترط أن تكون آلة العقل تلك عاملة بصورة صحيحة و قاصدة لكل كلمة تقال و مدركة لمعناها.

في نقاشنا للأهلية العقلية في وقوع الطلاق، سوف نقسمه الى أربع أقسام: أولاً، عمر الزوج. ثانياً، أثر المرض العقلي. ثالثاً، حالة السكر، إراديا أم قسرياً. و رابعاً، أثر حالة الغضب.

عمر الزوج: ان مناقشة عمر الزوج كعامل من عوامل الأهلية في الطلاق، هي مناقشة أكاديمية بحتة. و السبب أنه في الواقع و ان كان زواج الطفل في أي عمر ممكناً شرعاً و ذلك من خلال الوصي أو الولي. الا أن واقعياً هذا لا يحدث إلا نادراً جداً. كذلك ففي معظم الدول الإسلامية هناك قوانين سنت من قبل الحاكم، تحدد من عمر الزواج و تمنع زواج الطفل الغير مميز أو حتى الطفل المميز.

يأخذ الفقه الحنفي موقف الأغلبية في هذا الموضوع و يمنع وقوع طلاق الطفل في أي عمر. أي أن الطفل لا يستطيع أن يطلق زوجته حتى لو كان عارفاً لمعنى الطلاق و ما يترتب عليه. فهو بذلك لا يكتسب حق الطلاق إلا حين يبلغ سن النضوج الجنسي. أما في المذهب الحنبلي فان الطفل إذا تجاوز سن العاشرة و كان ذا معرفة و تمييز بمعنى الطلاق و ما يترتب عليه حق له طلاق زوجته. و الجدير بالذكر هنا أن الولي أو الوصي و ان كان له حق في تزويج موكله إلا أنه لا يحق له أن يطلق له زوجته.

المرض العقلي: هناك إجماع من كل الفقهاء على أن المصاب بمرض عقلي أي كان نوعه مما يؤدي به الى أن يتصف بالجنون، فان ذلك الشخص غير

مؤهل أن يعطي قراراً بطلاق زوجته. و يقاس على مقياس الجنون كل من كان متخلفاً عقلياً أو كان تحت تأثير مخدر ما إذا كان ذلك المخدر قد أعطي له بصورة قانونية كأن يكون علاج يأخذه أو مسكنات أفيونية لألم يقاسي منه. أما إذا أخذ مادة مخدرة من تلقاء نفسه و لسبب غير طبي أو غير مقبول شرعاً فان طلاقه حين ذلك يدخل ضمن اجتهادات طلاق السكران، و الذي سوف يبحث أدناه.

من الجدير بالذكر أن الفقهاء و ان كانوا قد أقروا بعدم أهلية المجنون لقرار الطلاق، إلا أنهم لم يضعوا أي مقاييس معينة لتقدير حدة ذلك الجنون أو معايير يبنى عليها ذلك القياس ليجعل الفرد المصاب بالمرض العقلي غير مؤهل لقرار الطلاق. و من هنا نرى أن ذلك يجب أن يكون من ضمن ما يجب أن يبحث و يدرس من قبل علمائنا المعاصرين لوضع تلك المقاييس بالتعاون مع الأطباء النفسيين ذوي الخبرة.

تأثير السكر و المؤثرات العقلية الأخرى: تتفق معظم القوانين الوضعية على أن من يتناول مادة مسكرة أو مخدرة و بصورة إرادية، يكون مسئولاً عما يقوم به من أعمال. أي أن أي شخص يقوم بجناية أو جنحة أثناء سكر أو فقدان لوعي نتيجة تناوله مادة مخدرة و بصورة إرادية فانه يحاسب عليها، بغض النظر عن كونه قد قام بذلك العمل و هو في وعي منه أم لم يكن. يتفق الشرع الإسلامي في عمومية هذه المقولة، إلا أنه لطلاق السكران أو من يكون في حكمه من متناولي المخدرات اجتهادات لا بد من تفصيلها.

إننا حتى نتعرف على المقصود فقهياً بالسكران، يجب أن يكون هناك مقياس عقلياً لذلك. أي يجب أن يكون هناك صفات عقلية عامة و خاصة يتصف بها ذلك الشخص الذي سوف يسمى سكرانً. لأننا نعلم أنه لا يمكن أن يعتبر كل من أخذ كمية صغيرة من الكحول سكران. فهناك من الناس من يسكر بكمية كبيرة و من يسكر بكمية صغيرة. فهل نستطيع أن نقيس معنى السكر بأنه السكر الذي يوجب الحد؟. إذا كان كذلك فهناك أكثر من اجتهاد واحد حول الموضوع، فأبو حنيفة مثلا، لا يقيم الحد إلا على من تكون درجة سكره شديدة بحيث لا يفرق بين السماء و الأرض أو بين الرجل و المرأة. فإذا أخذنا بهذا القياس صار من الصعب جداً أن نرى من تنطبق عليه هذه الدرجة من السكر، و بالتالي لزم وجود اضطراب عقلي كبير و مغالي في الشدة حتى نعطي حكمنا و تقيمنا للأهلية العقلية لمن يسمى سكراناً.

في الحقيقة لقد كان رأي جمهور الفقهاء و على كل المذاهب الأربعة، ان السكران مهما كانت درجة سكره و مهما كانت شدة انخفاض مقدرته العقلية، فانه ان لفظ بالطلاق فسوف تكون امرأته طالق، و يكون هذا الطلاق بائن غير رجعي فيما لو كانت تلك الطلقة الثالثة حتى أنه لو ندم ساعة إفاقته. لقد قال ذلك معظم الفقهاء على الرغم من أنهم على علم جيد من أن السكران و خصوصاً من كانت

درجة سكره شديدة، يكون في حالة عقلية غير واعية و غير مؤهلة للاختيار أو القرار العاقل.
لقد أسند العلماء حكمهم هذا الى أن من يسكر أو يتناول المخدر بإرادته، هو اثم كبير. و هو حين يطلق زوجته أثناء سكره فانه يكون مستحقاً لوقوع الطلاق الذي لم يقصده أصلاً، كنوع من أنواع العقوبة عليه لإثمه في تناول المسكر. إلا أن هناك من العلماء من جادل هذه المقولة و قال بأن الحكم بالطلاق كنوع من أنواع العقاب للزوج سوف يؤثر سلبياً على من هم أبرياء، أي الزوجة و الأولاد. و لكن هناك من أعطى تعليلاً آخر لهذا الحكم و هو أن الرجل الذي يتناول الخمر أو المخدر هو إنسان لا يستحق أن يكون زوجا أو أباً.
خالف رأي الفقهاء الأربعة بعض من العلماء، مثل الفراز و أبو الحسن الكرخي. و قال فيه الشافعي في أحد قوليه، و هو في إحدى الروايات عن أحمد، و اختاره الطحاوي من مذهب الحنفية. فهؤلاء قد قالوا بأن طلاق السكران لا يقع مهما كانت درجة سكره خفيفة، الا إذا أصر هو على ذلك الطلاق بعد أن يفيق من أثر الشرب. و العبارة الأخيرة زائدة، لأنه لو أصر على الطلاق في حالة صحوه فان طلاقه يعتبر واقع بحكم حالة الصحو أو الإفاقة التي هو فيها، و لا يطبق عليه حكم السكران. المهم في الأمر أن رأي الفراز و أبو الحسن الكرخي على الرغم من أنه يمثل الأقلية الا أنه استقبل بالقبول أكثر من الآراء الأخرى و ذلك ربما لأنه يحفظ الزوجة و الأولاد من حكم هم ليسوا طرف فيه و ربما كان من غير المعقول أن يعاقب الأب و الزوج و يتضرر من جرائها الزوجة و الأولاد. و لهذا فان بعض الدول الإسلامية مثل مصر و المملكة العربية السعودية أخذت بعدم وقوع طلاق السكران، إذا ندم على ما بدر منه بعد إفاقته. فلقد جاء في المرسوم بقانون برقم ٢٥ لسنة ١٩٢٩ في المادة الأولى منه "لا يقع طلاق السكران و المكره (فقه السنة ج[٢] ص[٢١٢]، الزواج و الطلاق في الإسلام: بدران).

تأثير الغضب على حكم الأهلية في الطلاق

يتميز التشريع الإسلامي بشموليته و دقته. و من الأمثلة الكثيرة على ذلك أنه أعطى للأهلية العقلية في القرارات و الأحكام ما لم يعطيه أي تشريع إنساني مهما تعمق و تبحر في الموضوع. و من ذلك أنه وضع الغضب بمكان لم يضعه أحد من المشرعين فيما سبق كعامل من العوامل التي تؤثر على الأهلية. لقد وضع الشرع الإسلامي عامل الغضب كأحد العوامل التي تؤثر على شرعية قرار الطلاق بالذات و لم يضع هذا العامل في مكان آخر مثل الأهلية في المبايعات و كتابة العقود، لأن حالة الغضب لا يتوقع منها أن تستمر بحيث تؤثر في كتابة عقد أو مبايعة.
ان الحياة الزوجية لا تخلو من المشاحنات و الخلافات. و لكن تلك الخلافات على الغالب لا تسبب قلقاً في تلك الحياة بحيث أن تفسدها و تؤدي الى الطلاق. بل أن معظم الزيجات تتم بالتعايش

مع تلك الخلافات و التأقلم عليها. و كلنا يعلم أن الغضب قد يطغى على الزوج في لحظة من اللحظات بحيث يجعله ينطق بكلمة الطلاق و هو لما يستقر عليه فؤاده. ثم أنه يندم بعد أن يزول عنه الغضب و يبدأ في تحكيم عقله. و لهذا السبب و حفظاً على الحياة الزوجية من الضياع بأسباب خارجة عن حكم العقل، شرع الشارع الحكيم إمكانية عدم وقوع الطلاق، إذا طلق الرجل و هو في حالة غضب و ندم على ما فعل بعد ذلك. لقد روي عن الرسول (ص) عن عائشة و رواه أحمد و أبو داود و ابن ماجة، "لا طلاق ولا عتاق في إغلاق" و فسر الإغلاق بالغضب، و فسر بالإكراه و فسر بالجنون. قال ابن تيمية كما في زاد المعاد: حقيقة الإغلاق أن يغلق على الرجل قلبه فلا يقصد الكلام أو لا يعلم به كأنه انغلق عليه قصده و إرادته. و يدخل في ذلك طلاق المكره، و المجنون، و من زال عقله بسكر أو غضب، و كل ما لا قصد له، ولا معرفة له بما قال.

ان مجرد التراجع عن الطلاق بعد اللفظ به غير كافي لإلغاء وقوعه. يجب أن يثبت أن ما قيل بمعنى الطلاق لم يكن في حالة غضب أو لم يقصد منه الطلاق أصلاً. لم يختلف الفقهاء على مبدأ عدم صحة طلاق الغضبان، و لكنهم اختلفوا في درجة أو شدة أو نوع الغضب الذي لا يقع معه الطلاق. و لهذا فقد درس فقهائنا حالة الغضب و عينوا لها درجات، يحكم على أثرها بوقوع الطلاق أو عدم وقوعه بسبب الغضب. و لهذا فهم قد قسموا الغضب على ثلاثة أقسام أو درجات كما قسمه ابن القيم في كتابه زاد المعاد:

١- الغضب الذي يسبب زوال العقل بحيث أن لا يفقه معه الرجل ما يقول. و يكون الرجل غير عارف لما يفعل. أي أن ضجة الغضب تلك قد أدت الى حالة تشبه الجنون. و من الممكن تشبيه تلك الحالة في ما نعبر عنه في كلامنا المعاصر في الطب النفسي بالجنون المؤقت. و هذا النوع من الغضب لا خلاف عليه بين العلماء على أن الطلاق لا يقع معه.

٢- أن يستحكم به الغضب و يشتد و لكنه لا يزيل عقله بالكلية. و هنا لا يمكن أن نقيس حكم الجنون على الغضبان، لأنه لا زال محتفظاً به و واعياً لما يقول. و لكن شدة الغضب تلك تكون من الحدة بحيث تحول بين الرجل الغاضب و النية التي في قلبه. فقد يقول ما لا ينوي فعلاً على عمله. أو أنه يعني ما يقول و لكنه يندم بعد تلفظه بكلمة الطلاق أو معناها. و حكم هذه الدرجة من الغضب فيها خلاف بين الأئمة. فالأغلبية من الفقهاء من رأى ان الطلاق يقع. و لكن هناك من يرى أنه لا يقع. و قول ابن القيم ان هذا النوع من الغضب على الرغم من أنه لا يقاس على الجنون، لأن الرجل يكون مدركاً لما يقول و عالم به، ولكنه غير قادر على تحكيم عقله بحيث أن يستطيع إدراك نيته الحقيقية. و لهذا فانه في تلك الحالة سرعان ما يدرك خطأه بعد زوال

الغضب و يندم على ما بدر منه. و من ذلك المنطلق فقد قال ابن تيمية في أن الطلاق لا يقع في تلك الحالة إذا رأى القاضي ذلك. أي ان القرار الأخير للقاضي، هو سوف يقدر الموضوع و يقيس درجة الغضب و يحكم بوقوع الطلاق أم لا، فإذا رأى القاضي بأن الغضب و ان كان لم يفقد الرجل إدراكه و لكنه أفقده القدرة على تحكيم النية، و دليل ذلك ندمه بعد أن تلفظ كلمة الطلاق و زوال حالة الغضب تلك، عندئذ سوف لن يكون الطلاق واقعا. ان القرار بعدم قياس هذا النوع من الغضب على الجنون لاحتفاظ الشخص الغاضب بإدراكه، جعل حكم كثير من الفقهاء بوقوعه، و لهذا فان أكثر علماء المذاهب يحكمون بوقوع ذلك الطلاق (الفقه على المذاهب الأربعة للجزيري ج٤ ص٢٩٤).

٣- أن يكون الغضب في أول أمره، فلا يغير عقل الغضبان بحيث أن يقصد ما يقوله و يعلمه، ولا يكون غضبه حائلا بينه و بين قدرته على عزم النية. و هذا النوع من الغضب يقع به الطلاق بإجماع الأئمة.

طلاق السفيه

السفيه هو من فقد الأهلية أو الكفاءة العقلية في التصرف في ماله، و ذلك لعدم قدرته على التحكم في نزواته و ليس من الضرورة أن يكون عديم الكفاءة في الأمور الأخرى، فقد يكون في كامل ذكائه و تقييمه للواقع حوله.

على الرغم من وجود بعض الخلاف بين العلماء في صلاحية أو أهلية السفيه بأن يتزوج أو يزوج السفيه بمعنى أصح، الا أنهم يعطون الحق للسفيه بأن يطلق زوجته في أغلب الظروف ان شاء. فالحنفية: يقولون بأن حكم السفيه البالغ صحيح في التصرفات التي تحتمل الفسخ ولا يبطلها الهزل مثل النكاح و الطلاق و العتق. أما المالكية: فقد أعطوا حكم السفيه نفس حكم الصبي المميز في التصرفات مثل كتابة الوصية و غيرها، أي أن تصرفاته تصح إذا كان فيها نفعا محضا فقط، فإذا غمت الفائدة أو النفع وجب إذن الولي أو الوصي. أما الشافعية: فانهم يرون أن تصرف السفيه المحجور عليه يقع باطلا في النكاح و لكنه صحيح في الطلاق و المراجعة. و يقول الحنابلة: بأن الولي إذا أذنه بأن يتزوج فباشر بذلك بنفسه فانه ينفذ، أي أنه لا يستطيع الزواج إلا بإذن وليه، إلا إذا كان الولي متعسفا و منعه من الزواج و كان بحجة ذلك كأن لم يكن متزوجا. ولذلك يصح للسفيه أن يطلق زوجته من دون إذن الولي و يخلعها بمال يأخذه.

الخلع

لقد أعطى الإسلام حق الطلاق للزوج، و لكن يحدث أن تبغض المرأة زوجها، أو تلقى منه ما يشق عليها أن تحمله أو تتضرر من بقاء الزوجية

و استمرارها بينها و بين زوجها، لأي سبب كان، إذا حدث ذلك كله أو بعضه فلقد شرع الإسلام مخرجا لذلك، من دون أن تلجأ الى القضاء، و هو أن تقدم لزوجها شيء من المال تفتدي نفسها به. و هذا جوهر ما يسمى بالخلع.

معنى الخلع: هو في اللغة النزع و الإزالة. و الخلع في الشرع هو إزالة ملك النكاح الصحيح بلفظ الخلع أو بما في ما معناه كالمبارءة، و ذلك لتفرقته عن الطلاق. و ثانيا أن يكون بمقابل عوض من قبل الزوجة، و ثالثا أن يكون الخلع حال قيام الزوجية. و رابعا أن يرضى كل من الزوج و الزوجة و تقبل الزوجة دفع البدل. فالخلع بذلك يتميز عن الطلاق بكونه أولا يتم باتفاق الطرفين، بينما لا يشترط رضى الزوجة في إيقاع الطلاق. كذلك فان رجوع الزوجة الى الزوج لا يتم الا بموافقتها حتى لو كانت في العدة، بينما يحق للرجل استرجاع زوجته من دون الحاجة الى أذنها قبل انتهاء العدة في المرتين الأولى للطلاق. و منها أيضا أن للزوج أن يرد زوجته و يخالعها لعدد غير محدود طالما كان ذلك برضاها، بينما يكون الطلاق بائنا بينونة كبرى بالمرة الثالثة فقط (الزواج و الطلاق في الإسلام ص[٣٩١] لبدران).

الأهلية العقلية في الخلع: بينما يكون الطلاق مرتبطا بأن يكون الرجل أي الزوج في حالة نفسية مستقرة يكون فيها ذا كفاءة عقلية تسمح له بأن يكون مؤهلا عقليا لأن يطلق زوجته. إلا أن الحال في الخلع مختلف قليلا، و ذلك لأن الخلع عملية تتطلب اتفاق الزوجين معا. و من هنا فالخلع يتطلب أن يكون كل من الزوج و الزوجة في حالة عقلية تسمح لهم بمثل هذا الاتفاق. فيشترط في كل من يلتزم العوض أن يكون أهلا للتصرف المالي. و هو العاقل المكلف الرشيد. فلا يصح للصغيرة، أو المجنونة، أو السفيهة أن تخالع زوجها بمال. كما لا يصح للصغير أو المجنون أن يطلق زوجته. و بخلاف السفيه فانه يسمح له أن يطلق ولا يصح له أن يلتزم المال. و في ذلك بعض من تفاصيل المذاهب.

قالوا الحنفية مثلا، بأن لا يصح للصغيرة أن تلتزم العوض المالي، و لكن إن خالعها زوجها فهي سوف تبين منه إذا كانت أكبر من سبع سنوات من العمر و تعرف أن الطلاق يعني الفرقة، و لكن في تلك الحالة أن العوض المالي سوف لن يلزمها. فكأنه قد تبرع بخلعها. و يستطيع أبي الزوجة أن يخلع ابنته الصغيرة ثم كبرت و أجازت ذلك الخلع فان عليها العوض المالي. أما إذا خالعها من ماله الخاص، فان الخلع يصح سواء أن أجازت ابنته ذلك بعد أن تكبر أم لم تجز. و ذلك لأنه يستطيع أن يخلعها من ماله من دون رضاها على أي حال حتى لو كانت راشدة و ذلك لأن الطلاق أصلا بيد الرجل و له أن يخلع زوجته إن شاء بالاتفاق مع أبو الزوجة، إلا أن هناك من الفقهاء من لا يقر ذلك، لأن اتفاق الأب مع الزوج من دون إجازة الزوجة سوف يسمى طلاقا و ليس خلعا. أما إذا كانت الزوجة سفيهة، أي أنها مبذرة للمال و مفسدة

له في وجه غير شرعي، فان مخالعتها لزوجها لا تصح لأنها غير مؤهلة لأن تتصرف في المال فيكون فراقها طلاقا و ليس خلعا. و لكن في بعض المذاهب يصح للسفيهة أن تخلع زوجها إذا وافق وليها على ذلك. و لكن في البعض الآخر مثل المذهب الحنبلي فانه لا يجوز للولي أو الوصي أن يجيز أو يقوم بقبول العوض المالي للزوجة السفيهة. و كذلك يحرم على الزوجين أن يتخالعا في زمن المرض، و لكن إذا وقع الخلع بينهما في مرض الزوجة فان الطلاق البائن ينفذ ولا يتوارثان و لو حصل الموت و هي في العدة(الفقه على المذاهب الأربعة ج٤ ص٣٩٨).

Abstract

Forensic psychiatry aspects concerned with various Islamic legal issues is discussed regarding marriage, divorce and the influence of mental status in various psychiatric conditions.

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على الجهد المبذول في هذا الكتاب، وأعرب عن أمله أن يكون هذا الكتاب خطوة أخرى نحو تضافر الجهود المخلصة للتخلص من هذا الوباء الفتاك. تحدث الكاتب عن المشكلة بأرقام وحقائق وتطرق للمنظور الإسلامي في التدخين، وبحث الجوانب الاقتصادية لهذه الآفة ويحث الإعتمادية عليه وكيفية مواجهة المشكلة والإقلاع عن التدخين، وتحدث عن الوسائل النفسية لعلاج المدخنين، ولي تحفظ بسيط على تحويل سلوك عادة التدخين لأمر طبي بحت يحتاج لعلاج طبي، قد لا يكون ذو مردود طيب، إذ سيلجأ المدخنون للأطباء النفسيين، فقط لإثبات أن العلاج فشل معهم، وأن إستمرارهم هو بسبب فشل الطب، وإني من الذين يفضلون القول أن الطب النفسي قد يساعد بعض المدخنين الذي يتأثروا من توقيفه، والتدخين يمكن أن يخفف من الآثار التي تظهر في أول اسبوعين خصوصاً، وناقش في نهاية الكتاب عدة جوانب في الإقلاع عن التدخين. الكتاب سلس القراءة شامل جامع رغم صغر حجمه، وهو مفيد لكل المهتمين بقضية مكافحة التدخين.

الطب النفسي المبسط

كتاب من ثلاثمائة صفحة صادر عن جامعة الملك سعود وهو مترجم من قبل الدكتور طارق بن علي الحبيب، وهو كتاب إنجليزي كتبه الدكتور جيمس ويليس والدكتور جون ماركس والكتاب الأصلي بعنوان (Lecture Notes on Psychiatry) طبعة ١٩٩١، واستغرب بداية تغيير اسم الكتاب واختيار طبعة قديمة نوعاً ما، وهذا كتاب جيد في محتواه وفصوله المختلفة، إلا أنه يثير مشكلة قديمة حديثة وهي الترجمة للمصطلحات الطبية والنفسية، وخلال المؤتمرات العربية وإجتماعات إتحاد الأطباء النفسيين العرب، حسم الموضوع لصالح إستعمال المعجم العربي الموحد الصادر عن مجلس وزراء الصحة العرب وإتحاد الأطباء العرب، والذي يعتبر مقبولاً لمعظم الكتاب العرب، ومن الأمثلة على اختلاف الترجمة، كلمة ضلالات بدل التوهم وهي ترجمة (Delusion)، ومع أن الدكتور طارق قد التزم بهذا المعجم في معظم فصول الكتاب. والكتاب بشكله المترجم مفيد جداً لطلاب الطب والتمريض وعلم النفس وعلم الاجتماع، وكذلك للأطباء العامين، والقارىء الباحث عن ثقافة نفسية علمية رصينة.

الدكتور وليد سرحان

مفاهيم خاطئة عن الطب النفسي

من إصدارات إتحاد الأطباء النفسانيين العرب للدكتور طارق الحبيب، الاستشاري والاستاذ المساعد في الطب النفسي ورئيس قسم الطب النفسي بكلية الطب والمستشفيات الجامعية في جامعة الملك سعود بالرياض، والكتاب في طبعته الثانية يقع في ثمانين صفحة من القطع المتوسط، بدأه بتعريفات عن أفراد الفريق النفسي ومهامها. تم التطرق الى ثلاثة عشر مفهوم خاطىء عن الطب النفسي تشيع بين الناس في عالمنا العربي، وقام الدكتور طارق بتفنيدها بأسلوب علمي واضح، وأولها الاعتقاد الخاطىء أن المرض النفسي لا يصيب الصالحين والاتقياء وما يعنيه هذا من تناقض مرفوض بين الدين والطب، والمفهوم الثاني والثالث والرابع تطرقت للأدوية النفسية بأنها مهدئة ومخدرة ولا يمكن لها أن تعالج المعاناة النفسية الغير محسوسة، وفند في المفهوم الخامس فكرة أن المرض النفسي لا يشفى وفي السادس فكرة أن العلاج النفسي هو كلام، وفي المفهوم السابع ناقش الدكتور طارق مصدر الأخطاء عند الناس من وسائل الإعلام، وفي المفهوم الثامن ناقش مفهوم الناس أن أعراض جسدية لا يمكن أن تكون الأعراض لأمراض نفسية، وفي التاسع والعاشر تطرق لربط الأمراض النفسية بالجنون والتخلف العقلي، وربط الوسواس القهري بالشيطان. وفي المفاهيم الخاطئة الثلاثة الأخيرة وضح أن الطب النفسي ليس غربي ولا مستورد، وأن الطب النفسي لا يتعارض مع الدين ولا العلاج بالقرآن الكريم، وأن الطبيب النفسي هو طبيب قد اختص في هذا المجال، وأن الصورة عن الطبيب كما يتوقعها الناس خاطئة، وبإعتقادي أن كل ممارس للطب النفسي يتعرض يومياً لهذه المفاهيم ويطلب منه التصدي لها، فهو كتاب قيم للطبيب المختص، ولأفراد الفريق النفسي وللقارىء العادي.

مشكلة التدخين والحل

كتاب من القطع المتوسط في مائة وعشرين صفحة، كتبه الدكتور لطفي عبد العزيز الشربيني. وصدر عن دار النهضة العربية في بيروت، قدمه الدكتور حسين الجزائري المدير الإقليمي لمنظمة الصحة العالمية للشرق الأوسط، الذي قال أن وباء التدخين يختلف عن سائر الأوبئة بأنه وباء يروج له، ووجه الشكر للكاتب

sexual dysfunction in an Arab-Islamic society highlighting many interesting points in Saudi Arabia, which reveals many points practitioners can always feel it. In chapter fourteen the editor ask the difficult questions (Does the Muslim religion make a difference in psychopathology?) where he has also differentiated between Islamic psychiatry and psychiatry in the Islamic world.

I would commend the editor and contributors on the courage to sail in such a wavy area of research, and coming up with many enlightening results, the book has very comprehensive lists of references, and covered a huge area of research, it is written and presented nicely and easy to read.

I recommend that all Arab psychiatrists and Muslim psychiatrists to read it, as well any psychiatrist in the world who deals with Arab and Muslim patients. This book is worth translation to French and Arabic, and it is a stimulus for other colleagues, psychiatrists and psychologists to focus more on this deficient area, which the book has uncovered.

Walid Sarhan

مراجعة كتـــب

الإدمان ورحلة الشقاء

كتاب باللغة العربية السلسة من القطع المتوسط يقع في ٨٥ صفحة، كتبه الدكتـــور علاء الدين بدوي فرغلي الطبيب النفسي والصيدلاني خالد بن صـــالح الصـــواف، وكلاهما له خبرة علمية ثرية وتماس مباشر مع مشكلة الإدمان، والكتـــاب عـــرّف المصطلحات المختلفة للادمان والاعتمـــاد النفســـي والجســـدي والتحمـــل، وأورد تصنيف للمواد التي تؤدي للإدمان، وفصل كـــل مـــن الكحوليـــات، والأفيونـــات، والحشيش، والكوكايين، من حيث المنشأ والتـــاريخ والشـــكل وأثـــار الاســـتعمال والانسحاب، وخصص الحديث عن الامفيتامينات والمنومات والمواد الطيارة، ثـــم انتقل للمهلوسات وأثار النيكوتين والكافيين، وبالتالي شمل كل المؤثـــرات العقليـــة بالاضافة للمخدرات، وتحدث عن آثار التعاطي الصحية والنفســـية والاجتماعيـــة، وعن سبل العلاج والمكافحة وتطرق للجهول التي بذلـــت فـــي المملكـــة العربيـــة السعودية، والكتاب سهل القراءة ويعطي الثقافة اللازمة في هذا الموضوع للأبـــاء والمربين ورجال الإعلام والدين والقانون، وهو إضافة رائـــدة للمكتبـــة النفســـية العربية، ولا بد من تواجده في كل مدرسة وبيت، وممـــا جعـــل الكتـــاب جذابـــاً للقارىء استعمال الصور التوضيحية الملونة.

Book Review

Al-Junun: Mental Illness in the Islamic World
Edited by Ihsan Al-Issa

International Universities press, inc. 2000

A recently published book by the international universities press, inc.. This is a book with eighteen contributors who are known in the Islamic and Arabic countries, the book is a huge effort to shed light on this issue of mental illness in the Islamic world, the first chapter by the editor discussed religion and psychopathology, a very complicated topic, but a large number of researches were reviewed in different psychiatric disorders, in different parts of the world with a lot of inconsistency, except for criminal behavior and drug abuse, in the second chapter the editor wrote a comprehensive review of psychiatry in Islamic civilization. Kutaiba Chaleby wrote the third chapter about Forensic psychiatry and Islamic law, with many interesting conclusions and clarification.

An example of north African Islamic country was Algeria, for which the editor allocated the fourth chapter to talk about the cultural aspects of psychiatric disorders and the cultural specific family stress. Chapter five is written by the known scholar Fakhr El-Islam who worked and lived in Qatar and Kuwait, he reviews the socioeconomic changes, illness behavior, the boundaries of mental health and pattern of symptomalogy and finally the treatment availability in those two countries, chapter six about mental health in Iran, written by a group of researchers, giving an idea about Iran and psychiatry in the Islamic Republic, covered the history, modern psychiatry, epidemiology and special features of mental illness in Iran. Chapter seven is written by Azhar and Varne exploring mental illness and its treatment in Malaysia, where the influence of culture on mental illness is evident with the famous example of koro, amok and latah, an interesting discussion of new approach of cognitive therapy based on Qur'an and Hadith, chapter eight written by Mubbashar about Pakistan, where Islamic, European and cultural influences are playing a big role in shaping up mental illness in the Islamic Asian country. Chapter nine is about psychiatry in Saudi Arabia written by Al-Subaie and Alhamed with description of traditional medicine covering (whishrak, Demonic possession, Ain, Sihr, Zar) and the healing techniques like (Kayy, Qur'an recitation, Zar, Herbs, Dietary restriction, seclusion and electricity). They discussed the current status of psychiatric services, and the future hopes. Chapter ten is written by Takriti and Ahmed from Jordan about anxiety disorder and treatment in Arab Muslim culture, covering the prevalence, O.C.D and its content in this culture, they emphasized the importance of social phobia, and discussed other phobias and discussed the higher prevalence of some simple phobias like dog phobia, the drug therapy and psychotherapy in individual and group setting are discussed. The editor discussed the mental health of Muslim immigrants in Europe and he joined Jawahir to talk about psychotherapy in Islamic society, such treatment is closely related to culture and belief systems of people. Chapter thirteen is by the editor and Mona Al-Sawaf covers sex and

Letter to the Editor

Dear Sir,

I read with interest the paper of Qureshi etal, Factitious Disorders, 1999, 10, 2, 128-135, I would like to mention the following:

1. I think it is very difficult to give a discussion and reach a conclusion on a very small number of patients (5) and to give the sociocultural and clinical factors. Following them up for over a decade with multiple interviews does not give strength to that discussion and conclusion which is reached to by the author?
2. Regarding the references, ref 36, 37 although are the same ones but quoted separately in the paper as in page 133.
3. I was not satisfied by the use of certain abbreviations in the paper, for e.g. MS multiple sclerosis or Munchausen's Syndrome?
4. The author use of certain terms rather confusing imprecise and misleading among them, pseudopathological lying and dysfunctional marriages, ... etc.

Thank you, with my best regards.

Yours Sincerely,

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Mental health education should be conducted by knowledgeable staff using the media to introduce available services and to educate the public[34]. One third of Saudi sample acquired their knowledge about mental illness from faith healers, and more than a third from social encounters and prior personal experiences[38]. Professional's contributions are still much below the required.

In summary, this study confirms that the quality of psychiatric education in medical school can positively influence career choice of students. Psychiatric educators, therefore, have good reason to enhance their programs in hopes of increasing the number of their graduates who choose to become psychiatrists.

Cultural beliefs against psychiatry are still strong and need to be changed. This requires a collaborative work of several agencies including medical schools, the media as well as the religious professionals who can employ certain Islamic beliefs and values in favor of psychiatry and have a great influence on the public in Saudi Arabia.

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الملخـــــص

إن اتجاهات طلبة الطب لها أثر مهم في اختيار الطب النفسي كتخصص. ولزيادة جذب الطلبة نحو الطب النفسي لا بد من فهم رؤيتهم له. أجريت هذه الدراسة لمعرفة أثر التدريس في الطب النفسي على رأي الطلبة نحوه. وشملت طلاب وطالبات السنة الرابعة في جامعة الملك سعود بالرياض للعام الدراسي ١٩٩٧م، حيث أعطوا استبانه خاصة بدراسة الاتجاه نحو الطب النفسي قبل وبعد التدريب في الطب النفسي.

إن التوجه العام نحو الطب النفسي تحسن بصورة واضحة عقب الدورة التدريبية للطلاب والطالبات على حد سـواء وارتبط ذلك أيضا بزيادة الرغبة في هذا المجال. أبدى عدد من الطلبة أسباباً متنوعة لعدم رغبتهم في اختيار الطب النفسي كتخصص. من أهم تلك الأسباب اعتبار هذا التخصص وصمة اجتماعية غير مقبولة، إضافة الى تصورهم أن الطب النفسي غامض وغير علمي. نوقشت النتائج وآثارها وعلاقتها بالتدريب في الطب النفسـي فـي البيئـة السعودية.

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expected. For example, even before the clerkship 90% agreed that 'psychiatric skills are essential in general practice'.

There was a substantial percentage (18%) of students who see psychiatrists as 'more emotionally unstable than other doctors' even after the clerkship (21%). This finding though disappointing is not surprising since the image of psychiatrists as emotionally unstable is enduring[29]. This will have adverse effects on the choice of psychiatry as a career and need a special attention and consideration from psychiatrists, particularly in the Arabic world where the media frequently stigmatize the psychiatrists.

Similar specific attitudes were found among both sexes with no exceptions. This is in contrast to Abdul-Rahim and El-Assra[20] who found that female students generally expressed more favorable specific views about psychiatry than their male colleagues, but questioned the suitability of female doctors to work as psychiatrists.

Wilkinson et al[14] reported that the majority of males agreed, whereas the majority of females disagreed, with the statement 'psychiatry is too inexact; it seems to lack a proper scientific basis'.

Some earlier studies[12,30,31] found that psychiatric students career attitudes are already well defined before instruction in psychiatry, and are little influenced by subsequent training. However, the present study showed that the psychiatric clerkship was followed by a significant rise in the proportion of students who considered specializing in psychiatry.

This is compatible with Wilkinson et al[14] and a previous study on Saudi Medical Students[21].

Therefore, student's motivation for psychiatry can be significantly enhanced by the way in which the subject is taught[9,32]. This is of particular importance in Saudi Arabia where the generous financial incentives that are granted to psychiatric specialists fail to attract enough number of Saudi doctors, and personal interest was the major reason for the respective choice[33].

The reasons given by students against choosing psychiatry as a career are particularly informative.

Students expressed a high degree of stigma attached to the field of psychiatry. This has been reported before in Saudi Arabia[20,21,34].

The stigma attached to mental patients is sometimes extended to the people who care for them and teachers of psychiatry[35].

Professional stigma, however, is probably more potent than cultural stigma[36]. The cultural attitude of the students to the specialty of psychiatry may act as an opposing force against the favorable effect of psychiatric training[20], specially in an impressionistic, judgmental society like Saudi Arabia[34].

Therefore, as well as acquiring knowledge and appropriate skills, it is important for the students to free themselves from the prejudices they carry concerning mental patients and the people who care for them.

Eagle and Marcos[37] have stated that those students choosing psychiatry are the least likely to be influenced by their parents.

Though negative influences may remain outside the control of clinical tutors, stigma can partly be combated by emphasizing the neurobiological basis of mental disorders, which has emerged through neuroscience research over the last decade[36].

Public attitude towards psychiatry needs to be improved to neutralize the antipsychiatric influence of the society.

examination but not at the end of their first postgraduate year, about 2 years after the clerkship. Therefore systemic follow-up study is required. We hope to follow-up this group of students when they will have already chosen their specialties.

Nevertheless, improvement in the students attitudes towards the subject will affect closer liaison with psychiatry and early referrals and closer working[4]. Future generations of medical students may then become more attracted to the specialty. In the United States a 40% increase in recruitment reported from those medical schools where liaison work was the main focus of teaching[25].

Scher etal[7] have found that medical schools providing longer psychiatric clerkship produce more psychiatrists.

The student's specific attitudes to psychiatry were favorable, in the main. Two specific attitudes merit special consideration here. First is item 8 "psychiatric patients hardly ever get better", there was a significant positive change in the students attitude in this regard, the finding that accords with that found by Wilkinson[14]. This could partly be explained by the successful steps taken in the development of the course.

Students were involved in the out-patient and consultation psychiatry where they could see relatively rapid obvious improvement in the patients psychological conditions in contrast to the situation of the course before improvement where students interview mainly chronic psychotic in-patients who have multiple relapses inspite of regular medication.

Second is item 14 "Too little time is devoted to psychiatry in the medical curriculum" the percentage of students who agreed with this statement rose significantly after the course.

Psychiatry constitutes only 2 credit hours in the curriculum and is taught in a 12-week period along with Ophthalmology (4 credit hours) Otolaryngology (4 credit hours) and Dermatology (2 credit hours).

That psychiatry should occupy a major part in the medical curriculum is now generally agreed. There are three reasons for this agreement. First, the general approach of psychiatry, which stresses the unity of body and mind, is important in the whole of medical practice. Second, skills that are learned in psychiatry are important for all physicians-for example, the ability to form a good relationship with a patient, to assess the patient's mental state, and to impart distressing information. Third, psychiatric problems are common among patients seen by specialists in other branches of medicine – for example, it is known that about 15% of medical out-patients given a medical diagnosis have an associated psychiatric disorder[26]. Psychiatric teaching need to be consisted with the medical school curriculum as a whole. Psychiatrist, therefore, need to be involved in the planning of the overall medical curriculum.

Recently there has been an increasing concern about undergraduate medical education in Saudi Arabia[27,28] suggesting curriculum reform.

Significant positive changes in the student's attitudes were also observed in four other specific attitudes 2,10,12,16, indicating more positive attitudes towards psychiatry and psychiatrists.

In several of the remaining items, the great majority of students have reported positive attitudes before commencing the psychiatric clerkship, and changes in a favorable direction would hardly be

Table 3: Changes in Intention to Specialize in Psychiatry

After Clerkship	Before Clerkship		
	Yes possibly	Doubtful / no	Total (%)
Yes possible	4	23	27 (20)
Doubtful / no	3	103	106 (80)
Total (%)	7 (5)	126 (95)	133 (100)
McNemar test: $X^2 = 13.8846$, $P < 0.0002$ (two-tailed)			

Main reasons against choosing psychiatry as a future career

1. Psychiatry constitutes a social stigma (N – 43).
2. Psychiatry is vague and too unscientific (N = 39).
3. Treatment in psychiatry is ineffective compared to surgery and medicine (N = 31).
4. Dealing with psychiatric patients and getting deeply involved with them could lead to psychiatric illness on the long run (N = 23).
5. Psychiatric patients could be dangerous to psychiatrist (N = 12).

Discussion

Students attitudes have implication for recruitment into psychiatric specialty and the treatment of the mentally ill, who may be encountered in any branch of medicine. For these reasons their views merit consideration

Medical student's attitudes to psychiatry are based upon opinions they form in childhood and at school and university, and upon influences they encounter during pre-clinical and clinical profession[23].

This study was undertaken following a substantial improvement in the psychiatry course in the Medical College at King Saud University in Riyadh in 1994. More emphasis has been made on clinical practice, with participative learner-centered, problem-solving teaching. Students were enrolled in out-patient and consultation-liaison psychiatry along with in-patient classic psychiatry teaching.

In order to avoid the possible source of error in this study that students were unwilling to reveal their real attitudes (in case strongly critical views prejudiced their chances in the oral examination) students were urged to fill questionnaires with absolute frankness and assured that the examiners would not see them before examination.

Therefore, it seems likely that the present data reflect the students real views. Before the psychiatric clerkship, less than a third of the subjects had a favorable general attitude to psychiatry but after the clerkship a marked encouraging significant shift in a favorable direction occurred.

This finding agrees with several western studies[8,19] and replicates a previous finding on Saudi medical students[20].

The finding that the students general attitudes to psychiatry positively correlated with their intention to specialize in the subject does not necessarily imply that the percentage of school graduate choosing to specialize in psychiatry is going to increase, since these positive changes in attitudes to psychiatry may not be enduring, as indicated by Burra et al[12].

Sieva Kumar etal[24] found that the improvement in the attitude to psychiatry among medical students was maintained at the time of their final (MB, BS)

Table 2: Response (in Percentages) of 133 Medical Students on the Questionnaire Measuring Attitudes toward Psychiatry

No.	Specific Attitudes	Before Training		After Training	
		Agree	Disagree	Agree	Disagree
1	Psychiatrists are failed physicians	5	95	4	96
2	Psychiatrists are less dogmatic than other doctors	10	90	33	67
3	Psychiatrists tend to be more emotionally unstable than other doctors	18	82	21	79
4	Psychiatrists are held in poor regard by most other doctors	22	78	24	76
5	Psychiatrist try to treat the whole patient and not just the disease	90	10	95	5
6	Psychiatrists are at the forefront of the movement to humanize medicine	88	11	88	12
7	The problems presented by psychiatric patients are interesting and challenging	89	11	92	8
8	Psychiatric patients hardly ever get better	68	32	43	57
9	Psychiatric patients tend to make more emotional demands on their doctors than other patients	83	17	82	18
10	Within medicine, psychiatry is one of the less important specialties	28	72	8	92
11	Mental illness presents us with one of the great intellectual challenges in the field of medicine	80	20	79	21
12	Psychiatry is too inexact; it seems to lack a proper scientific basis	38	62	17	83
13	Psychiatrist are more concerned than other doctors to establish rapport with patients	96	4	93	6
14	Too little time is devoted to psychiatry in the medical curriculum	44	56	57	43
15	Psychiatric skills are essential in general practice	90	10	95	5
16	The practice of psychiatry is unrewarding because the treatment is so lengthy and the results so inconclusive	62	38	45	55
17	Empathy with patients is as important as factual knowledge in clinical medicine	90	10	93	7
18	Psychiatric patients, generally speaking, are not easy to like	44	56	49	51

Table 1: Change in General Attitude to Psychiatry

After Clerkship	Before Clerkship		
	Favorable	Unfavorable	Total (%)
Favorable	46	45	81 (61)
Unfavorable	7	45	52 (39)
Total (%)	43 (32)	90 (68)	133 (100)
McNemar test: $X^2 = 26.3269$, $P < 0.0010$ (two-tailed)			

Male responses, however, were not statistically different from female ones. The student's general attitudes to psychiatry (before and after clerkship) positively correlated with their intention to specialize in the subject.

Before clerkship: Spearman correlation coefficient = 0.23 N = 133 P < 0.02.

After clerkship : Spearman correlation coefficient = 0.29 N = 133 P < 0.01

Specific Attitudes

The different response of the students before and after course are summarized in table 2.

A statistically significant difference was shown for item 2 (McNemar test, X^2 = 16.1731, P < 0.0010), item 8 (McMemar test X^2 = 7.6825, P < 0.0056), item 10 (McMemar test X^2 = 17.3611, P < 0.0010), item 12 (McMemar test, X^2 = 20, 2500, P < 0.0010), item 14 (McMemar test X^2 = 4.1967, P < 0.0405), and item 16 (McMemar test, X^2 = 15.6129, P < 0.0010).

Males and females responses were analyzed in relation to the sex variable before and after the course. The sexes did not show any statistical difference.

Intention to Specialize in Psychiatry

The proportion who answered that they might possible specialize in Psychiatry rose from 5% to 20%, the difference being significant (Table 3).

A significantly higher proportion of the male students showed an intention to specialize in psychiatry than female students (P < 0.0142).

Main reasons for intending to enter psychiatry

1. Psychiatry deals with emotions, thinking and behavior which are the distinguishing features of Human (N = 11).
2. The problems presented by psychiatric patients are stimulating and interesting (N=8).
3. Psychiatry helps in self and others' understanding (N = 7).

Britain[14,15], Ireland[16], Scotland[17], France[18], and Australia[19].

In Saudi Arabia Abdulrahim and El-Assra[20] found a favorable attitude change after a Psychiatric training program, and Soufi and Raoof[21] reported a significant difference in attitude between students who studied an elective course on psychosomatic medicine and those who followed only the conventional classic psychiatric teaching.

The present study attempted to examine the Saudi medical student's view of psychiatry prior to and after a 12-week psychiatric clerkship, following a substantial improvement of the undergraduate clinical psychiatric course.

Methods

A prospective investigation has been chosen to elicit and monitor attitudes to psychiatry held by one-year intake of medical students.

The 1997 group of fourth-year clinical medical students at King Khalid University Hospital (KKUH) King Saud University, Psychiatry Division, were given the British Questionnaires of Wilkinson et al[14], an attitude-to-psychiatry questionnaire, on the first day of their psychiatric clerkship before an introduction to the division of psychiatry, and again in the end of the clerkship 12 weeks later (with instruction in English).

The students were instructed to answer all items quickly and were assured about the confidentiality of the responses and that the whole issue had no bearing what so ever on their examinations.

The questionnaires included items on general attitude measured on a five-scale from 1 'very favorable', to 5 'very unfavorable'. Point 3 was 'mixed feelings'. The 18 specific attitudes (Appendix) pertained to psychiatry, psychiatrist, psychiatric patients and psychiatric treatments. Nine of the items (2, 5, 6, 7, 11, 13, 14, 15, 17) expressed positive views, and nine (1, 3, 4, 8, 9, 10, 12, 16, 18) implied negative ones.

These attitudes were measured on a 4-point scale from 1 'strongly agree' to 4 'strongly disagree'. There was no 'mixed feelings' category.

Finally, the students were asked to indicate their likely intention to specialize in psychiatry on a 5-point (likert-type) scale from 1 'yes-definitely' to 5 'no-definitely', and to state their main reasons for either intending or not intending to take up psychiatry as a career.

The data were coded, transferred onto punch cards and analyzed by computer using Statistical Package for the Social Science[22].

Chi-square techniques (McNemar test) were applied to contingency tables. Spearman correlation coefficient was used to test the correlation of the students' general attitudes to psychiatry with the intention to specialize in the subject.

Results

There were 133 students (83 males, 50 females) and all completed and returned the questionnaire at the beginning and end of the course (100% response rate).

General Attitude

Before the course, 32% of the students showed a favorable response, while 68% had unfavorable attitudes.

After, the course, the favorable response rose to 61% while the unfavorable attitude dropped to 39%. The change is statistically significant (Table 1).

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Saudi Medical Students' Opinion of Psychiatry Before and After Psychiatric Clerkship

Mohammed Alsughayir

رأي طلبة الطب في الطب النفسي قبل وبعد الدورة التدريبية

محمد الصغيـــــــر

Abstract

Medical student's attitudes have implications for recruitment into psychiatric specialty. Efforts to increase the number of psychiatrists entail understanding how students perceive psychiatry. To study the effect of psychiatric training program on the attitudes of undergraduate medical students, one year intake of fourth-year medical students at King Saud University were given an attitude-to-psychiatry questionnaire before and after their training.

After the psychiatric clerkship there was a significant favorable change in the general attitude in both sexes which positively correlated with the intention to specialize in psychiatry.

Intention to specialize in psychiatry increased after the training specially in male students. However there were some reasons against choosing psychiatry as a future career, reported by a group of students, including perceiving psychiatry as a social stigma, vague and too unscientific specialty.

The implication of these findings are discussed in relation of psychiatric training program in Saudi Arabia.

Introduction

An efficient psychiatric care delivery system requires an adequate number of Psychiatrist in relation to the population of a particular country.

In 1987, of the 11326 doctors available in Saudi Arabia, only 10% were Saudis[1]. The four Colleges of Medicine in Saudi Arabia produce about 300 doctors annually. Therefore, it is estimated that 7130 Saudi doctors will be produced by the year 2000, Constituting 51% of the manpower requirement of the Country[2].

The number of Saudi Psychiatrist is still quite restricted. Efforts to increase the number of Saudi Psychiatrists require adequate understanding of how medical students perceive Psychiatry.

The inability to attract medical students to specialize in psychiatry has always been a serious challenge and threat to psychiatric recruitment worldwide[3,4].

Yager et al[5], Sierles[6], and Scher et al[7] found that medical students consider psychiatry as a low-status and low-prestige specialty.

Exposure to clinical psychiatry has been shown to bring a positive change of attitude towards psychiatry in a number of studies, in the United State[8,10], Canada[11,13], Great

الملخـــــص

يشيع في المجتمعات العربية الاعتماد بأن تلبس الجن سبب الاضطرابات العقلية في الإنسان ومـن ثم يؤخذ كثير من المرضى لمعالجين يدّعون بأن لهم القدرة على طرد الجن من جسم المريـض. ولمثل هذا الاعتقاد كما لمثل طرق العلاج تلك آثار سلبية على المريض.

وصفت هنا حالة توضح هذا، واتخذت مدخلاً لنقاش موضوع التلبس واستخراج الجن. وظننـا أن الخلط يأتي من عدم التفريق بين الإيمان بوجود الجن كمخلوقـات أوجدهـا الخـالق سـبحانه وتعالى وبين المفاهيم النابعة من العادات والتقاليد والتي تعطي للجن لدى بعض النـاس مقـدرات هي أقرب للوهم منها إلى الحقيقة. ونرى أنها بحاجة إلى اجتماع ذوي الخبرة في الطب والديـن لفرز الخطأ من الصواب في هذا المجال.

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and tradition. This issue has several aspects: First, the belief in the existence of Jinn as independent beings sharing this universe with humans.

Secondly, the idea than Jinn enters the bodies of humans influencing their behaviour and causing ill health. Thirdly, the practice of exorcism by using harsh physical methods. It is useful to consider these aspects separately.

The first aspect is a matter of belief shared by many followers of various religious faiths. For Moslems, it is one of the fundamental issues of faith. It is mentioned in the Holy Quran and no true Moslem denies the existence of Jinn as one of the creations of Allah. Hence, for us this is not a subject of debate.

The second aspect that Jinn can enter human bodies and cause mental disorder is not like the first one. Moslem scholars are not at one heart as far as this is concerned. Opinions are divided according to their interpretation of the Prophet sayings (Hadith). Contemporary supporters of the idea that Jinn enters human bodies and cause mental disorder often base their idea on anecdotes that Jinn is hard talking through patient's mouths. They also quote some scholars of religion[2]. The present case casts a heavy shadow of doubt on the truth of this king of Jinn talk. What are thought to be Jinn talk may in fact be conscious efforts by patients to free themselves from torture by exorcists. On the other hand it may be that some patients are suggestible and under the influence of the exorcist or faith healer utter what they think the healer wants them to say. Another plausible explanation is that the surroundings created by the healer make these patients act out their inner feelings like what goes on in psychodrama or zar partics.

The third issue of possession and exorcism concerns the treatment of the supposedly possessed. Faith healers in the Arab world usually use physical and non-physical methods. Non-physical methods like invocations, which are based on the Prophet tradition, are religiously sanctioned. Religious beliefs and values may be used to enhance the effect of psychotherapeutic techniques in non-psychotics[3]. It instill self-confidence in-patients and give them emotional support. On the other hand the use of harsh physical methods with the pretext of inflicting pain on the Jinn inside the human body is harmful and may be life threatening. Such a practice is not wholly a matter of religious belief. It is a custom where amateurs and quacks can do more harms than good.

In some western countries there is a movement towards opening a dialogue between experts in religion and in medicine to clarify issues related to possession and exorcism for the ultimate good of the psychologically disturbed patients[4]. In the middle East there is even a greater need. Well-informed individuals from both fields need to come together to discuss the issue. They need to ferret out facts from fiction so as to preserve the right and good and to weed out the wrong and bad.

known psychiatric illness in the family. She had a normal and a healthy childhood. She had ten years of successful schooling and she left school to get married.

After the initial dose of parenteral Haloperidol, she was maintained only on Clonazepam 2 mg. t.d.s. orally. On her second day in the hospital, she became calm. She continued to improve and in a few days, her mood was appropriate and both her talk and behavior were rational. Relevant investigations including blood count, ECG, Chest x-ray, Thyroid function test were normal. She remained well until she was discharged from hospital with the diagnosis of bipolar affective disorder and a maintenance dose of Clonazepam. After six months she was taken off drug treatment and at one-year follow-up she was maintaining good health.

The patient was able to give a very lucid history of her condition and the various methods of treatment she had. She talked with bitterness about her experience with particular faith healers. She described in detail and in a clear manner her encounters with the faith healers. She said she recovered from her first episode of illness in hospital and was discharged in satisfactory condition to continue treatment at home. A few days after her discharge, her family decided to stop the prescribed medicine and took her to a faith healer. There, the faith healer made her lie down on the floor and asked the accompanying family members to hold her body firmly. There were four of them who held her legs, hands and shoulders. Then the healer gripped her neck and pressed tightly and was shouting repeatedly: "confess, confess". She said, she felt suffocated and was frightened. She struggled to free herself but over-powered by those holding her. The healer let go a little and she could ask him what to confess. He said, "O Jinni, confess who you are" and again he pressed tightly on her neck and was demanding a confession. She found herself obliged to "confess" or she would suffocate and in a shrieky voice, she said, "I am Abdul Salam". The healer released his grip and she thanked God for the relief. Soon after, the healer took her by the neck and again pressed and shouted; "from where are you?" She said, now having learned the trick how to free herself, she quickly replied, "from Morocco". At this point, the healer was triumphant and told the relatives that the patient was truly possessed by a Jinni who just identified himself.

She said she was conscious all through and she deliberately produced these "confessions" to escape the suffering caused by the faith healer.

She had subsequent visits to that and other healers. In all these visits, she was physically tortured by the healers. In her last visit, she was beaten and bruised.

Discussion

The present patient was diagnosed by the faith healer as a case of possession. To cast out the demon the faith healer squeezed the neck of the patient intermittently but for prolonged periods. The patient deliberately faked the name and place of the supposed Jinn in order to save her life, which was under great threat. She was fully aware of circumstances and was in full control of her acts.

Much of the confusion in the issue of Jinn (demon) possession and exorcism as due to the indiscrimination between the belief in the existence of Jinn as a matter or religious faith and the practice of exorcism as a healing method influenced by custom

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Case Report

Possession and Exorcism
An Illustrative Case

Yahia O. Younis

التلبس واستخراج الجن

يحي يونس

Abstract

It is a common belief in our culture that jin is the main causative factors in mental disorders. This leads to apply practices such as exorcism to heal it. A case illustration is presented and discussed.

Introduction

The belief than Jinn (demon) enters human bodies and causes mental disorders is wildly held in several contemporary Arab countries[1]. This belief is based on anecdotes of Jinn heard talking through patients' mouths. Hence, often mentally disturbed patients in such communities are taken to faith healers for treatment. Such a belief and such a practice have wide implications for the course of illness and its sequelae in these patients.

The following is a description of a case in which Jinn was thought to be the cause of mental disturbance, because the faith healer was thought to be able to make the Jinn confess through the patient's mouth. The patient was then subjected to physical torture to drive the Jinn away.

Issues related to this are highlighted and discussed.

Case

A young female in her early twenties, a citizen of one of the Arab countries, married and has children was brought to hospital in excitement. On admission, she was screaming, signing in a loud voice, clapping or throwing her hands sideways, restless and potentially aggressive. She had to be physically restrained before she was sedated by drugs. When she calmed down, two hours after admission, she was examined physically; she had bruises of different shapes and sizes on the skin of her back, chest and neck. No other physical abnormality was detected.

Her elder brother said that she had two similar episodes of mental disturbance before. The first one occurred four years ago, on the third day of her first delivery. She remained in hospital for about a month and was discharged in a satisfactory condition. She was then taken to several faith healers. In-between the attacks, she remained well though on no medication. In this last episode she was taken to a faith healer before she was brought to hospital.

She is the youngest of six siblings. Her father died several years ago and her mother is alive and well. There is no

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الملخـــــص

هذه دراسة للاكتئاب في كبار السن المراجعين لعيادات الصحة الأولية في البحرين. الهدف منها تحديد إمكانية تطبيق مقياس كبار السن للاكتئاب (GDS 15) وتقدير انتشار الاكتئاب بين المسنين المراجعين لمراكز الرعاية الصحية الأولية. إن مقياس GDS 15 استعمل كأداة كشف والذين سجلوا عليه خمسة نقاط أو أكثر أعيدت مقابلتهم لتأكد من وجود الاكتئاب. أظهرت النتائج أن مقياس GDS 15 كان صادق وثابت في كشف الاكتئاب. وظهر أن ١ر٢٣% من عينة الدراسة كانوا يعانوا من ظاهرة الاكتئاب، وكانت الاناث ٣ر٢ أكثر اكتئاباً من الرجال، وكان معدل العمر ٧٦ر٦٧ ± ٣٦ر٦، ولم تظهر أي علاقة بين العمر والاكتئاب. ولم يكن أي من حالات الاكتئاب المكتشفة قد لوحظ من قبل أطباء الرعاية الصحية الأولية. ويعزى فشل التشخيص هذا لقلة التدريب في الطب النفسي وعدم كفاية الوقت المخصص لكل مريض.

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of the General Hospital in Bahrain[14]. Contrary to this result, D'ath et al (1994) have found that the rate of depression 'caseness' is almost identical in elderly men and women[12]. They did not defend this result, rather they cast doubts on its validity as they, like others, believe that depression whether based on GP or community studies is always higher among women. They also provided some explanation of this unexpected result by stating that the sample size might have been too small to detect a stiatistically significant gender difference.

The relationship between age and depression has been investigated in the present study in two different approaches. In the first, the age variable had been collapsed into two groups for persons aged 60-74 and 75 and above respectively. Mean difference in the GDS 15 scores between the two age groups has been statistically tested. The other approach relied on correlation analysis between age and GDS 15 score. Both approaches have indicated that age has no statistically significant relationship with depression. Other studies have arrived at the same conclusion, for example D'ath et al (1994), who further argued that the dissociation between age and depression was consistent with relevant epidemiological literature[12]. Mirowsky and Ross (1992) have studied in-depth the likelihood of an association between age and depression by addressing the question, Is being older depressing? The answer seems to be no[15]. They reported that age, per say, is not a risk factor for depression though the latter may be more prevalent among persons above 60 years of age because of other reasons such as widowhood, economic hardship, physical degeneration and the loss of personal control. They also asserted that old Americans who do not suffer personal, status and functional losses apparently have low rate of depression.

What factors contribute to the occurrence of depression among elderly Bahrainis? Unfortunately, we do not have an answer to this question simply because relevant information was not ascertained in the present study. This shortcoming opens the door for further research focusing mainly on the answer to the above question.

It has repeatedly been reported in literature that under-diagnosis and under-treatment of depression among elderly primary care attendees is common[5,7,6]. Along this line, the present study revealed that none of the depressed elderly patients was identified by a GP. The reasons for that could be shortage of time as the GP has to see 12 patients per hour, the GP may concentrate more on physical problems of elderly patients who are expectedly more vulnerable to multiple physical illnesses and the lack of depression screening tools in primary health care centers in Bahrain.

In the end, we cannot ignore reporting the limitation of our study, namely, its restriction to only one health center (out of 19 health centers in Bahrain) and its relatively smaller sample size. In conclusion, this study confirms that GDS 15 can be used as a tool to identify elderly patients with depression in primary care health centres in Bahrain. Also in the training of family physicians, due emphasis is laid upon the psychological disturbances in the elderly population, increasing their awareness in diagnosis and helping them to provide more appropriate and cost-effective treatment for elderly patients.

tool of depression among elderly Bahraini people.

Moreover, the validity of GDS 15 has been assessed by reinterviewing all sample patients who scored five or more. The results were such that all those patients were found to be clinically depressed: one other important piece of evidence on the applicability of GDS 15 in Bahrain.

Interestingly, age and gender breakdowns of our sample patients were found to be compatible with similar breakdowns in the entire Bahraini population in the age span 60 and above. In our sample 84% were in the age interval 60-74 and the remaining 16% in the interval 75 and above, while for the entire population (60+) the corresponding figures for both age groups are 82.6% and 17.4% respectively. The 1:1 male to female ratio of our sample patients is nearly the same as that of the whole population (60+)[10]. The equality of numbers of male and female patients participated in our study is an evidence that elderly Bahrani males and females are equally likely to visit health centers in the morning. This is not an unusual situation, as males beyond 60 years of age have no constraints to visiting health centers in the morning since most of them are retired. Noteworthy is that when age condition is removed, previous studies carried out on health centres morning attendees revealed a tangible excess of female over male attendees[11].

The results of the present study showed that about 23.1% of study patients were depressed on GDS 15 scale. The presence of depression was confirmed by a clinical assessment. Hence, the mentioned result may reflect the true prevalence of depression among elderly Bahraini primary care attendees. Our results seems to be lower, to a varying extent, than the results of other studies carried out in different countries. For example, D'ath et al (1994) pointed out that depression in their study sample amounted to 34% on GDS 15 scale[12]. They explained this relatively high prevalence of depression among elderly by stating that elderly depressed patients were more likely than their non-depressed counterparts to visit their GP more frequently and thus be identified early by surgery-based screening. Closer to our results, Madianos et al (1992) reported that 27.1% of elderly people in Athens were identified as depressed cases using the Center for Epidemiological studies of Depression (CES-D) scale and only 9.5% of the sample were diagnosed as suffering from clinical types of depression[13]. In this context it is very important to point out that the purpose of the comparisons above is merely to get insight into the performance of GDS 15 in our sample in relation to other similar studies. In fact we cannot rely on these figures to establish real differences in the prevalence of depression among elderly as they are influenced by differences in methodology and sampling errors. With regard to gender difference, the present study showed that the prevalence of depression among elderly females is more than twice as high as among elderly males. This result is not surprising as it is in line with the main bulk of literature in this field. There is a consensus among psychiatrists that depression hits females in larger proportions than males. Speaking about Bahrain, Al Haddad et al (1994) have demonstrated that psychiatric morbidity in primary care setting is more common among females than males[11]. The same finding was reached in a study on patients

Out of a total of 104 patients, 24 patients (23.1%) were depressed as they scored five or more on the GDS 15. As for male/female differential the study indicates that out of 51 males, seven (13.7%) were found to be depressed, while out of 53 females, 17 (32.1%) were depressed. Evidently depression among females is more than twice (2.3 times) as high as among males (Table 2).

Table 2: Results of GDS 15 Screening According to Gender

Gender	Cases		Non-Cases		Total	
	Number	Percent	Number	Percent	Number	Percent
Total	24	23.1	80	76.9	104	100.0
Males	7	13.7	44	86.3	51	100.0
Females	17	32.1	36	67.9	53	100.0

In order to examine whether the reason of attendance to primary care clinic has a relationship with depression among elderly attendees, a formal statistical test (cramers phi) was carried out and results showed no significant statistical association between both factors $\emptyset = 0.05$, $P < 0.05$).

The mean GDS 15 score for total attendees was 2.4, (range 0-15). The mean GDS 15 score for females was 3.4 (range 0-15), while for males it was 1.4 (range 0-15). The distribution of GDS 15 total scores is shown in figure 1.

Testing the hypothesis that depression among attendees beyond 75 years of age is the same as among those in the age interval 60-74, the results indicates that depression does not vary significantly in the two age groups ($X_2 = 0.002$, $P < 0.90$). Moreover, a correlation analysis between age and GDS 15 scores gives further evidence that age and GDS 15 scores are statistically uncorrelated ($r=0.07$, $P < 0.05$).

All patients who scored (5 or more) on the scale were re-interviewed and were found clinically depressed. Files of those found depressed were reviewed and it was found that none of them was diagnosed by GPs as having depression.

Discussion

The dominant social values and norms of Bahraini population as well as its indigenous cultural standards are certainly different from those of western societies in which GDS 15 was originally developed and applied. Therefore, one ought to be cautious before applying such a depression detection tool in a country like Bahrain. This is in fact the reason why the primary objective of this research has been determined to be the investigation of whether GDS 15 has been subjected to a series of verification tests which have been carried out in both an independent pilot study and the main study itself. In the pilot study a limited case – control experiment was carried out on 24 known clinically depressed patients (Based on ICD 10) as cases and 24 clinically disease-free people as control. The result of this experiment has indicated that GDS 15 is valid in terms of its discriminative and convergent performances. In the main study, reliability has also been checked by applying Cronbach's test as well as test re-test correlation analysis. The results are again found to be supportive to the applicability of GDS 15 as a screening and detecting

The GDS 15 test consists of 15 questions, ten of those questions when answered with "yes" give a positive score (Indicating depression); in the remaining five the answer "No" scores positively. The scores were then summed to give a total of 0-15, with a score of five or more indicating probable depression. An English copy was translated into the Arabic language, then translated back to English and checked for accuracy.

Before applying the test for screening, discriminative validity and convergent validity of the test were investigated by a pilot study that was done on 24 individuals as controls and 24 cases of depression based on the ICD-10 criteria. The results showed that:

1. Discriminative Validity: The mean score difference between depressed and control groups was highly statistically significant ($Z=6.0$, $P < 0.001$).
2. Convergent Validity: There was a statistically significant correlation between all questions with each other and between each questions and total GDS 15.

In the main study, those who scored five or more of the GDS 15 were re-interviewed to verify the presence of clinical depression and their files were also examined to verify whether the GPs had recognized the presence of depressive symptoms.

GDS 15 scores were analysed to measure depression prevalence among elderly primary care attendees. A comparison has also been made to ascertain gender differences and whether depression varies with age for those elderly people.

Results

A total of 120 patients were approached, 13 were excluded because of pain. Out of the remaining 107 patients three refused to participate, while 104 patients answered the questionnaire. The mean age was 67.76 $\pm$ 6.36 years. Eighty four percent aged 60-74 years and 16% were 75 years and over. The male to female ratio of the total attendees was approximately I:I (Table 1).

Table 1: Demographic Characteristics of Study Patients

Characteristics	Number	Percent
Total	104	100.0
Gender		
Males	51	49.0
Females	53	51.0
Age		
60 – 74	87	83.7
75 +	17	16.3

Reliability and internal consistency of the test showed:

1. Cronbach's alpha = 0.76 which indicated high internal consistency of the test.
2. Test re-test analysis (using sperman's correlation co-efficient) revealed that the re-test scores were highly correlated with the main survey scores ($r=0.97$, $P < 0.01$).

must be considered, particularly in view of the multiple medications often taken by the elderly. Also the presence of psychosocial stresses and economic pressures unique to the elderly may also cause depressive symptoms. Due to the many physical illnesses, social and economic problems of the elderly, individual health care providers often conclude that depression is a normal consequence of these problems, an attitude often shared by the patients themselves. All of these factors conspire to make the illness undiagnosed and more importantly under treated.

Elderly people may be depressed due to awareness of decline, or due to changes in mood associated with the aging process or a degenerative brain disease. In contrast, depression in elderly persons with a history of previous psychiatric illness may be attributed to a lifelong vulnerability to mental health problems[4].

The detection and treatment of depression in elderly patients attending primary care, has been the subject of much research. Williamson et al (1964) and Iliffe et al (1991) both suggested that general practitioners (GPs) under-diagnose depression[5,6]. In contrast, MacDonald (1986) found that GPs had no difficulty in diagnosing depression in their elderly patients but seldom initiated treatment or made psychiatric referrals[7].

The short version of the Geriatric Depression Scale (GDS15) has been recommended by the Royal College of General Practitioners as the depression screening instrument of choice[8]. Evans and Katona (1993) have shown that the Geriatric Depression Scale (GDS) in its 30 item version, compared to diagnosis based on detailed psychiatric interview, has better sensitivity and specificity than a GPs own diagnosis on direct questioning[9].

Iliffe et al (1991) have suggested that detection of depression by case note recording is probably a more accurate reflection of a GPs actual detection rates in practice. They have shown that with this measure, the GPs rate of detection of depression in elderly patients is very low[6].

Untreated depression costs money because physical illnesses require more medical services, living arrangements become institutional and employment is lost. These costs should be substantially preventable with presently validated case recognition and treatment techniques. Consequently screening and detection of depression in the elderly attending primary care using GDS is vital to minimize suffering of the elderly and many other consequences of under treatment.

The aims of this study are the determination of applicability of the 15 item Geriatric Depression Scale (GDS 15) as a screening diagnostic tool in primary care and the detection of depression in elderly primary care attendees in Bahrain.

Method

The study was conducted at a primary health care center in the central region of Manama, which serves a population of approximately 23865.

All patients aged 60 years an over, attending the Salem El Sabah Health Center as outpatient in the period from 17/6/1996 to 3/7/1996 were approached in the waiting room by the researcher and were asked the 15 questions of the Geriatric Depression Scale (GDS 15). Patients who were in pain were excluded from the study.

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Depression in Elderly Primary Care Attendees In Bahrain

M.K. Al Haddad

الاكتئاب في كبار السن المراجعين لعيادات الصحة الأولية في البحرين

محمد الحداد

Abstract

This is a study of depression in elderly patients attending primary health care in Bahrain. The aim of the study was to determine the applicability of the Geriatric depression Scale (GDS 15) and assess the prevalence of depression among the elderly attendees of the primary health centres.

The GDS 15 was used as a screening tool and those who scored five or more on the Scale were re-interviewed to verify the presence of depression. Results showed that the GDS 15 was a valid and reliable tool for detection of depression and found 23.1% of the study population had depression, females were 2.3 times more depressed than males, the mean age was 67.76 $\pm$ 6.36 but no correlation was found between age and depression. None of the diagnosed depressed patients were previously identified by the primary care physicians.

Lack of psychiatric training and insufficient time allocated for patients are among the main reasons for failed diagnosis.

Introduction

Depression in the elderly is a persistent or recurrent disorder that can result from psychosocial stress or physiological effects of diseases and can lead to excess disability, cognitive impairment, increased symptoms from medical illness, physiological effects, increased utilization of health care services and increased rates of suicide and nonsuicide mortality[1].

Depression is the most common psychiatric disturbance among the elderly population. According to the National Institute of Mental Health (NIMH) Epidemiological Catchment Area (ECA) study, symptoms of depression occur in 27% of the elderly in community dwellings, with the rate of major depressive disorders being approximately 1%. This figure is considerably higher for the institutionalized and medically ill elderly for whom the prevalence of major depressive disorder ranges from 5% to 43%. For all forms of depression, the incidence is greater for women than for men[2].

Buckley et al (1987) in the Edinburgh study reported, 55% of the elderly to have psychiatric disorders, 50% of patients in mental hospitals were found to be over 65 years of age. About 44% of those over 65 years scored depressed on Zung Rating Scale, however only 20% of these elderly depressives were found to be referred to psychiatrists within the first six months of their illness[3].

Depression can be produced by many medical conditions commonly found in the elderly. In addition, iatrogenic depression

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women appear unescorted by men outside the home; but this interpretation applies only to homemakers rather than female students and working women. Moreover, being a homemaker does not exclude the possibility of having latent symptoms of agoraphobia with panic disorder. Hypotheses concerning clinical attributes need to be confirmed using clinical populations. Indeed, much of what is known about anxiety in Arab countries is based on evidence obtained from sub-clinical populations. Anxiety research is needed in clinical settings, especially settings associated with the anxiety disorders.

Higher scores of female than male students in the UAE, Lebanon and Canada support other findings in other Arab countries such as Egypt[5] and Lebanon[4] as well as in Europe and North America[11]. These gender differences across cultures are unlikely to be solely due to specific cultural factors such as the status of women in different societies. We utilized the four-factor structure of the BAI initially identified by Beck and Steer for the group comparisons and theoretical discussion. It is recognized that this structure need to be examined in the Arab culture. We attempted a preliminary factor analysis but felt that the resulting factor structure was too unstable to warrant presentation. A larger sample is required. It should be mentioned that exploratory factor-analytic studies of the BAI in North America have reported two, three and four factors, suggesting that the BAI factor structure is unstable and population-specific[9,11]. Regardless of the variability in the number of factors, there seems to a consensus that the dimensions of subjective, neurophysiological, panic and autonomic anxiety symptoms have a degree of empirical validity. Further study of the symptom clusters of the BAI in clinical and nonclinical Arab populations is needed.

الملخـــص

ترجم اختبار بك الى العربية، وأعطي الى مجموعة من طلاب جامعة الإمارات العربية المتحدة، لأجـــل دراســة عمومية النتائج التي توصل اليها العيسى وبيكال وفنك[1] ولهذا قورنت استجابات طلاب الإمارات مع الطلاب اللبنانيين والكنديين. وجد الباحثون أن الثبات (الاتساق) الداخلي لاختبار بك باللغة العربية لايختلف عنه باللغة الانجليزيـــة. وتشير النتائج الى أن درجات طلبة الإمارات تشابه درجات الطلاب اللبنانيين وتختلف عن درجات الطلاب الكنديين. وسواء أعطي الاختبار باللغة العربية في الإمارات أو باللغة الإنجليزية في لبنان وكندا، فإن درجات النساء تفـــوق درجات الرجال. أما فيما يتعلق بدرجات المقاييس الفرعية للاختبار والتي تعكس الأعـــراض النيوروفزيولوجيـــة والذاتية وأعراض الهلع (الذعر) وأعراض الجهاز العصبي الغير إرادي، فإنها لا تختلف بين طلبة الإمارات ولبنـــان ما عدا درجات الهلع، والتي هي أعلى في الإمارات منها في لبنان. وكذلك توجد اختلافـــات بيـــن الطـــلاب فـــي الإمارات وفي لبنان ببعض الأعراض المدرجة في المقاييس الفرعية ولو أن ثبات هذه النتـــائج لـــم تقـــرر بعـــد. وبصورة عامة، فإن هناك حاجة لدراسة تجمعات أعراض القلق باستعمال قطاع من السكان المرضى والأسوياء في البلاد العربية.

Difficulty breathing	الصعوبة بالتنفس	.54
Fear of dying	أخاف أن أموت	.47
Autonomic	**الجهاز العصبي الغير إرادي**	
Feeling hot	الشعور بالسخونة	.54
Face flushed	احمرار الوجه	.48
Indigestion or discomfort in abdomen	عسر الهضم	.46
Sweating (not due to heat)	التعرق ليس بتأثير الحرارة	.45

Table 2: Means, SDs of UAE, Lebanese and Canadian Subjects across the Neurophysiological, Subjective, Panic, and Autonomic Subscales Divided by Gender

Groups	BAI Subscales			
	Neurophysiological	Subjective	Panic	Autonomic
UAE females	4.4 (3.4)	7.2 (3.7)	3.7 (2.6)	3.5 (2.1)
Lebanese females	4.9 (3.7)	7.3 (4.4)	2.5 (2.4)	4.0 (2.7)
Canadian females	2.9 (3.2)	4.6 (3.7)	1.2 (1.8)	2.5 (2.2)
UAE males	3.4 (2.9)	5.5 (3.4)	2.5 (2.1)	2.9 (2.0)
Lebanese males	2.9 (2.9)	5.2 (3.5)	1.4 (1.8)	3.4 (2.3)
Canadian males	2.0 (2.6)	3.4 (2.8)	.6 (1.0)	1.0 (2.2)

Discussion

The subjective and somatic symptoms of the BAI are likely universal, making the Arabic translation of the test relatively straightforward. It appears that whether the BAI is given to Arab students in its English version in Lebanon[1] or in its Arabic version in the UAE, Arab participants tend to obtain significantly higher scores than Canadian students. The Spielberger STAI has also been used in other studies in both Arabic[5] and English[3,4] with similar results indicating that Arab students are significantly higher in anxiety than their American counterparts. Thus, Arab students are not only expressing symptoms of an existential nature, as measured by the STAI, but also cognitive and somatic symptoms known to characterize individuals who frequently present with panic and somatization symptoms. The reasons for high levels of anxiety symptoms in Arab College students need to be addressed. Data from focus groups discussions with men and women might be utilized to identify specific concerns as well as to develop strategies to reduce these concerns and symptoms.

The high scores of female and male students in the UAE on the BAI contradict the belief that agoraphobia is rarely encountered in the Gulf communities[10]. Low rates of agoraphobia are explained in terms of the rarity of situations in which

that both groups are reliably different from their Canadian female counterparts. Differences between the UAE females and Canadian females on BAI items were significant and similar to the previous Lebanese – Canadian comparisons[1]. UAE males differed significantly from Lebanese males on the following items: numbness and tingling, unable to relax, terrified, choking, difficulty breathing and face flushed. Lebanese males scored significantly higher than UAE males on feeling hot, scared, and indigestion or discomfort in the abdomen.

Table 1: Item-Total Correlation's of the Arabic Version of the Beck Anxiety Inventory

Neurophysiological	**نيوروفزيولوجيه**	
Dizzy or lightheaded	الدوخان (أو الشعور بالدوار)	.57
Unsteady	عدم التوازن (السيطرة)	.56
Shaky	مهزوز (مرتجف)	.56
Hands trembling	ارتعاش اليدين	.52
Wobbliness in legs	ارتعاش في الساقين	.45
Faint	الإغماء	.35
Numbness or tingling	الشعور بالخدر والتنميل	.33
Subjective	**ذاتيـــة**	
Scared	مرعوب (الشعور بالفزع)	.67
Fear of losing control	الخوف من فقدان السيطرة علـــى الأمـــور (امتلاك الأمور)	.63
Terrified	الشعور بالرهبة (الفزع)	.58
Nervous	عصبي	.54
Unable to relax	عدم القدرة على الاسترخاء	.50
Panic	**الهلع (الذعر)**	
Feelings of choking	الإحساس بالاختناق	.62
Heart pounding or racing	تسارع دقات القلب	.58

highest mean item-total correlation's occurred with the subjective factor (.57), followed by the panic factor (.56), the neurophysiological factor (.94), and the autonomic factor (.48). All the correlation's were significant ($p < .001$) and were similar in magnitude and pattern to those in the Lebanese and Canadian samples as well as an American study based on a student sample[9] where the item-total correlation's ranged from .41 to .70. The internal consistency of the Arabic BAI was evaluated by computing Cronbach's alpha. The Arabic scale had an internal consistency within the UAE sample ($r = .87$). The value is comparable to the .98 value previously reported for both the Lebanese and Canadian samples.

Group Comparisons

The mean total BAI score for the UAE students was 17.1 (9.5), which is more similar to the Lebanese students (16.9; 10.3) than the Canadian students (10.2; 8.2). The UAE students scored significantly higher than the Canadians ($t = 10.0$; $p < .001$) but were not significantly different from the Lebanese. The mean total BAI score for the UAE females was 18.8 (9.5), for the UAE males 14.3 (8.8); for the Lebanese females 18.7 (10.9); for the Lebanese males 13.4 (8.0); for Canadian females 11.3 (8.8); and for Canadian males 8.5 (6.9). Overall comparisons of males and females showed that females were significantly higher than males in their BAI scores ($p < .001$). Separate two-way analyses comparing the two female groups and two male groups in the UAE and Lebanon revealed no significant differences.

Table 2 presents the means and standard deviation for the males and females from each of the three countries across the Neurophysiological, Subjective, Panic and Autonomic subscales of the BAI. Four separate two-way analyses of variance using location and gender as factors showed that the main effects for groups on all the four subscales were highly significant ($p < .001$). Post-hoc t-tests revealed that UAE female students and Lebanese female students were significantly different from Canadian females on all four subscales. UAE females and Lebanese females differed from each other on the panic subscale with the UAE females obtaining the highest mean score ($p < .001$). UAE males also scored significantly higher ($p < .001$) on the panic subscale than Lebanese males. The scores of the UAE males on the other subscales tended to be similar to Lebanese males.

The final analysis compared the groups on the specific symptoms of the subscales of the BAI. UAE females were significantly higher than Lebanese females on the following subjective items: fear of worst happening, terrified, and losing control. They also scored higher than Lebanese female students on 3 of 4 of the panic subscale symptoms-difficulty breathing, choking and fear of dying. They also scored higher on the autonomic symptom of face flushed. On the other hand, Lebanese females scored significantly higher than UAE females on 2 autonomic symptoms – feeling hot and indigestion / discomfort in the abdomen and 2 neurophysiological symptoms – unsteady, shaky, and 1 subjective symptom – unable to relax. It remains to be determined whether these symptom differences between UAE females and Lebanese females are reliable. It is clear, however,

and the most common somatization disorder seen in medical practice[6]. Thus, high scores on the BAI are of particular concern given that they may lead to full-blown panic or more limited somatization symptom presentations. Previous reports indicate that panic symptoms with and without agoraphobia and somatization symptoms are prevalent in the Arab Middle East[7,8]. The purpose of this study was to replicate as well as extend the previous observations of anxiety-proneness in Lebanese students to a sample of college students from another Arab country.

The first study of the BAI in Lebanon applied the English version of the test to bilingual students at the American University of Beirut[1]; but without an Arabic version, the application of the test to other Arab populations would be limited. The BAI deals with psychological and physiological symptoms that is universal making the questionnaire readily translatable into other languages. A preliminary examination of the BAI items suggested that the symptoms measured by the BAI are also readily translated into Arabic. The present study utilized and Arabic version of the BAI with college students in the United Arab Emirates (UAE). The scores of these students were compared with the scores obtained from Lebanese and Canadian students using the English version.

Methods

Subjects

The subjects comprised three groups of undergraduate students from the AUB in Lebanon, the University of Calgary in Canada and UAE University in the UAE. A total of 206 Lebanese students completed the BAI (mean age 19.9 years; SD = 1.5) with 56 males and 120 females indicating their gender. A total of 557 Canadian students (mean age 20.8 years; SD = 5.1) completed the questionnaire, with 213 males and 316 females indicating their gender. The total number of the UAE subjects was 240 (mean age 20.0 years; SD = 2.6) with 150 females and 90 males indicating their gender. The Lebanese and Canadian subjects were described in our previous paper[1].

Arab Translation of the BAI

While the English version of the BAI was given to the Lebanese and Canadian groups, a translated Arabic version was used with the UAE subjects. One the present authors (Al Zubaidi) translated the BAI into Arabic in consultation with other psychologists in the UAE University. The BAI was also translated by two psychologists at San'a University in Yemen[1]. When examined independently in Canada by Ihsan Al-Issa, the two translated versions were almost identical. The Arabic version maintained the same 21-items using a four point scale ranging from "Not At All" (أبـــداً) for a zero score to "severely – I could hardly stand it" (لا أستطيع بشكل حاد تحملـــــه). Respondents were asked to indicate the degree to which they have been "bothered" (المدى الـــذي يعانيـــه) by each symptom over the past 7 days.

Results

Internal Reliability

Table 1 presents the Arabic and English versions of the BAI with the item-total score correlation's. The item-total correlation's ranged from 0.33 to .67. The

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Beck Anxiety Inventory Symptoms in Arab College Students

Ihsan Al-Issa, Abdulgawi Al Zubaidi, Donald Bakal and Tak S. Fung

قياس بيك للقلق لدى طلاب الكلية العرب

إحسان العيسى، عبد القوي الزبيدي، دونالد باكال وتاك فنج

Abstract

Objectives: The purposes of this study were to translate the Beck Anxiety Inventory (BAI) into Arabic and administer the translated version to a group of university students in the United Arab Emirates. The UAE student responses were compared with those previously obtained from Lebanese and Canadian students[1].

Method: The Arabic BAI was administered to 240 students at the UAE University.

Results: The internal reliability of the Arabic version of the BAI was found to be similar to that of the English version reported in the United States. The results extended our earlier observations in that the UAE students, like their Lebanese counterparts, scored significantly higher than Canadian students on the BAI. The higher scores of females than males on the Arabic BAI confirmed the previous study based on the English version. With the exception of the panic subscale, the UAE students were generally similar to the Lebanese students in their responses to the neurophysiological, subjective and autonomic subscales of the BAI. There were some significant symptoms differences within the subscales between the UAE and Lebanese students but the reliability of these item differences remains to be determined.

Conclusion: The study found additional evidence for high levels of cognitive and somatic symptoms of anxiety in Arab students and indicated the need for the further study of the origins of anxiety in these individuals.

Key words: Beck Anxiety symptoms, Arabic version of Beck anxiety Questionnaire, anxiety in nonclinical samples.

Introduction

In a previous study by Al-Issa, Bakal, and Fung[1], Lebanese College students, particularly females, were observed to have higher scores than Canadian students on the Beck Anxiety inventory (BAI)[2]. The observed high anxiety scores of Lebanese students are consistent with previous studies using the Spielberger State-Trait Inventory (STAI) in Lebanon[3,4] as well as in Egypt[5]. The STAI describes anxiety in psychological and cognitive terms while the BAI gives more consideration to somatic symptoms of anxiety. Moreover, the somatic symptoms assessed within the BAI are the basis of both panic disorder

الملخـــص

يصف الكاتبان الاضطرابات النفسية المحتملة عنـــد التوقـــف عـــن تنـــاول MAOI (مثبطات الأنزيم المؤكسد لأحاديات الأمين) في كبار السن. وتتراوح الأعـــراض ما بين الكآبة، الضلالات، القلق الحاد، الهذيان والهلوســـات. ويعـــرض ثـــلاث حالات للتدليل على ذلك.

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the association between this drug and breast cancer. Other possible triggers included an increasing fear about how she would manage in old age particularly if her husband dies before her.

Her mental state examination showed high levels of anxiety and depression at the moment associated not only with suicidal ideation but some degree of suicidal planning and her past behaviour would suggest that there is significant risk of this.

It was decided to keep her on the current dose of medication as previous experience with the above mentioned two cases showed that altering the MAOI anti-depressant is unlikely to be successful, and it is very difficult to wean people off Parstelin even during periods of remission, let alone when they are unwell.

Discussion

All previous reports and studies that were undertaken on the withdrawal of MAOI were mainly done in adult general psychiatry settings. A majority of the patients who used MAOI when they were first introduced are now in their old age. They all had had constant long-term use of the drug and they were often advised never to stop taking it. In some cases, patients were given permission to vary the dose according to the symptoms. The MAOIs were prescribed for cases of 'a typical depression' which often-meant depression that was associated with neurotic symptoms and personality disorders.

There are many factors that might cause old age psychiatrists to try and stop or reduce MAOI. Physical illness and the needs of the patient for medication or surgery is one factor illustrated in the second case. The onset of depression in old age that does not respond to increasing doses of MAOI is the second factor. Other aspects might be related to the onset of dementia and increasing confusion in addition to other physical complications and drug interactions of the MAOIs themselves.

These three cases presented to Maidstone Old Age Psychiatry Service during a one-year period. We have experienced great difficulties in withdrawing the first two cases, as reported above. If we try to draw lessons from these cases the following strategies could be considered:

1. As it has been suggested in the literature on younger adults, and as we have seen in the first two cases, stopping MAOIs can be associated with severe withdrawal symptoms that need to be considered in evaluating the cost-benefit of this decision.
2. The patient needs to have a full explanation of the possible symptoms that s/he has to experience if s/he stops the MAOI.
3. Trials of alternative strategies that do not involve stopping the MAOIs should be considered. This may include increasing MAOI doses or augmenting it with l-tryptophan or tricyclic antidepressants, and psychological treatment.
4. If there is no alternative to stopping the MAOI then this should be considered under an inpatient admission and adequate treatment of both the underlying depression and the withdrawal symptoms should be used.

April Marplan was withdrawn prior to prostate surgery. This was an opportunity to switch him to Moclobemide which was introduced in May 1996, started in combination with L-Tryptophan, but following the introduction of Moclobemide he started to develop an odd mental state, possibly toxic. On 24the June 1996 he had a TIA leading to drooping on the left side of his mouth, and at that stage L-Tryptophan was stopped, but Moclobemide was increased to 450 mg daily. By the 8the July he had developed an acute psychotic state. He had locked himself in his car and refused to come out, saying that his wife had been replaced by an impostor. He thought that his house had been booby trapped, with marked apprehension that something awful was going to happen, that he would be "executed". He appeared to be more confused and disorientated although no formal assessment of his cognition was done at that time. He had a number of delusions that appeared to be fairly fixed and congruent with his mood, including a conviction that he had lost his faith and was damned. He had other delusions that appeared to be more fluctuating and mood incongruent.

These delusional ideas persisted for some time, in spite of the withdrawal of Moclobemide, and the addition of neuroleptics to control them, but he was quite susceptible to the extra-pyramidal side effects of both Stelazine and Pimozide which were both tried. He was eventually sent home on no medication, with persistent low mood.

Case 3

Mrs. B is a 72 year old retired language teacher of Swiss origin who lives with her English husband in their house in Maidstone. Her psychiatric history started in the early 1960's when she became depressed after her husband moved from Scotland to Maidstone and she was left with two small children at home, a husband out at work in an unfamiliar environment where she knew no-one. Drug therapy with anti-depressants was initiated without much apparent success, but she eventually felt that she benefited from Stelazine. However with 2 years she had experienced a relapse of her depression requiring inpatient treatment with ECT and drug therapy. Her condition improved, but this was only sustained for about 2 years prior to further relapse requiring a second inpatient admission with ECT and drug therapy. She then appeared to be well with drug therapy until 1975 when a further relapse necessitated a repeat admission to hospital and ECT treatment. Since then she had been maintained on Parstelin and Librium, in varying doses, and has been reasonably well since.

However, in 1996 she started experiencing a relapse in the form of recurrent depressive mood swings, necessitating increasing the doses of Parstelin and Librium. On every occasion when she has tried to reduce this dosage it had been accompanied by deterioration in her mood and she seemed to have this mood disturbance over 12 months or so. It was difficult to tell whether there was any particular precipitant to the latest episode of depression but she recalls that it followed experiencing pain in one of her breasts. This was investigated by mammography which showed an abnormal lesion which has subsequently proved to be benign. She may have had a heightened fear of breast cancer because she had been taken Premarin for years and is aware of

physical and the psychiatric condition of the patient might make it necessary to stop the MAIO. The scenarios presented in the following three case histories help to illustrate the difficulties and complications experienced by clinicians undertaking such a decision.

Case 1

MRS G is a 75 year old widow who lives on her own in her house following the death of her husband. The history of her psychiatric disorder started in 1963 when she was admitted after a depressive episode and was given the diagnosis of 'Hystero-depressive state'. She was treated with Parstelin with good effect. In 1967 she spontaneously stopped the Parstelin because she had headaches. She gradually started becoming more depressed, agitated and tearful and to become anxious while outdoors. Her psychiatrist started her on Tofranil and Stelazine to replace the Parstelin. However, despite using maximum doses her condition continued to worsen steadily. Her husband described her as being uncontrollable, not eating or sleeping and wandering the house crying. She was admitted to hospital and was treated with ECT with no effect. Parstelin was restarted and she improved dramatically within one week. She was discharged on Parstelin and advised to be on it for life.

In 1995 her husband died and she started feeling depressed and lonely since she had to live on her own. In May 1996 she started feeling very depressed and anxious. However, it was difficult to treat her effectively as she was already on Parstelin. At her request another attempt was made to reduce the Parstelin to stop and replacing it with a safer and more effective antidepressant. Moclobemide was tried as it is a new, safer MAOI. Her situation worsened and in addition to having anxiety restlessness and constant tearfulness, she had nausea and vomiting. She was admitted to hospital in June 1996 when Moclobemide was stopped and replaced with Lofepramine. On admission she was found be mildly anxious and depressed, and had biological symptoms of depression including early morning wakening, diurnal variation in mood and reduced appetite. Although the nausea gradually stopped and she started sleeping better she continued to feel depressed and anxious and she asked to be put back on Parstelin. On starting the parstelin she started feeling less depressed and anxious and was discharged home.

Case 2

MR B is a 75 year old retired Anglican Minister who lives with his wife and has 2 children and 5 grandchildren. His psychiatric history started with anxiety and depression first in 1961. He was treated with Marplan to which he had a good response. In 1985 an attempt was made to replace Marplan with an alternative antidepressant but this had failed and he was then advised very strongly to continue the Marplan on a permanent basis. He continued this until 1994 when, after a fall, a CT scan of head showed multiple infarcts in his brain. In March 1995, he had a depressive episode which improved with Marplan and Ativan in combination, but his mood deteriorated when Marplan was reduced and attempts made to withdraw him from Ativan in February 1996. In March 1996 he was taking Marplan 60 mg daily with the introduction of L-Tryptophan. In April 1996 L-Tryptophan was increased to 500 mg tds, but on the 12th

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Case Report

MAOI Withdrawal Phenomena in the Elderly

Walid Abdul-Hamid, Martin Smith

ظاهرة انسحاب مثبطات الأنزيم المؤكسد لأحاديات الأمين في كبار السن

وليد عبد الحميد، مارتن سميث

Abstract

The authors describe withdrawal symptoms of MAOI in the elderly. They include depression, agitation, paranoid, delirious and hallucinatory disorders. Three cases have been illustrated.

Introduction

In 1965, La Gassick[4] described the course of replacing Tranylcypromine with placebo. Since then it has been reported that stopping an MAOI can cause severe withdrawal symptoms that can resemble a wide variety of psychiatric syndromes from severe agitated depression to paranoid psychosis and symptoms ranging in severity from mild discomfort to incapacity[1].

In a review of the literature, Dilsaver (1998)[1] described the effects of stopping the administration of monoamine oxidase inhibitors (MAOIs) drugs such as phenelzine and tranylcypromine. Symptoms of withdrawal include severe anxiety, delirium, pressured speech, sleeplessness or drowsiness, hallucinations, delirium, and paranoid psychosis. MAOI withdrawal resembles in symptoms and psychopathology the discontinuation of amphetamine after prolonged usage[1].

Halle & Dilsaver (1993)[3] subjected five patients to the withdrawal of tranylcypromine and described the withdrawal symptoms experienced by them. These patients suffered from severe depression or impairment of cognition. The authors suggested that the titration or the discontinuation of tranylcypromine should be under the supervision of physician. Tyrer (1984)[5] reported the results of stopping the medication of 51 psychiatric outpatients who had been regularly taking a tricyclic antidepressant or the MAO inhibitor phenelzine for at least 3 months. The author found that severe withdrawal symptoms were more likely with patients taking phenelzine. The author suggested that gradual reduction of dosage is the best form of withdrawal for MAO inhibitors.

Old age psychiatrists and geriatricians are often faced with the problems of looking after patients who have been treated for years with MAOIs. An unpublished part of a database[2] showed that for the year 1996 approximately one third of GPs prescriptions of MAOIs were for patients over the age of 65 (personal communication with Compufile). The

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that overweight may be considered as more attractive to them. We found a consistently positive correlation between the degree of dieting and psychiatric symptoms as obtained by the SRQ. Most girls in the extreme dieters group showed higher scores on psychiatric morbidity than other girls. This is similar to the findings of others[6,29,30] and lends credence to the view that, as in clinical eating disorders, some forms of dieting may not be simply an innocuous method of weight control. As in Cooper and Goodyer's[7] study, this possibility increases with age. In that study as well as in the present one, psychiatric symptoms were significantly more prominent in the older age group of dieting girls.

Conclusions

The published reports on the extent of dieting among Western teenage girls are not surprising. For many women in western cultures, dieting and weight preoccupations have a "normative behavior". However, given the enormous media coverage and the globalization of the media, cultural differences are disappearing. There are many striking similarities between the present study and other Western studies, which indicate that contrary to a common opinion, dieting is not a purely Western phenomenon. Body image perception seems to have crossed the cultural boundaries and this seems to be, at least partly, due to the effect of the media as evident from our findings. Almost 80% of our sample of girls get their information on dieting and body weight and shape from magazines, TV and radio with the majority (67.2%) of them reporting women's magazines as the primary source of information. Although we do not have enough clinical data to confirm the existence of clinical eating disorders, our findings are consistent with the suggestion that extreme dieting, as Patton et al[6] suggest, lie "on a spectrum with clinical eating disorders".

الملخـــص

هدف هذه الدراسة هو قياس مدى إنتشار و درجة الحدة و الجوانب النفسية المصاحبة للحمية بين الفتيـلت المراهقات في مجتمع الإمارات . الطرق : لقد تم جمع أربعمائة و خمسون استمارة تحوي إستبيان الحمية و كذلك استبيان SRQ-20 للجوانب النفسية عبئت من قبل فتيات مجتمع الإمارات. النتائج : حوالي ١٦% من العينة كانت تعاني من الوزن الزائد ، ٩% يتبعن نظام حمية حاد و ٣٨% يتبعن نظام حمية معتـدل. إن مستوى تطبيق الحمية أظهر إرتباطاً وثيقاً بمؤشر رشاقة الجسم و كذلك بمجموع نقاط الـــ SRQ-20 الخاص بالجوانب النفسية. إن اتباع نظام الحمية كان بين الفتيات اللاتي يبدو لأنفسهن أو للآخرين أنـــهن بدينات، أو اللاتي لهن صديقات يتبعن نظام حمية أو هناك شخص في العائلة يتبع الحمية أو يعاني مـــن البدانة. خاتمة : إن الحمية منتشرة بين الفتيات في مجتمع الإمارات كما هي في المجتمعـــات الغربيـــة و كذلك تتأثر بنفس العوامل. إن بعض مظاهر الحمية بين الفتيات العربيات قريبة من التوصيف الرســـمي لاضطرابات الغذاء.

13% of girls and 5% of boys were dieting at the time of the assessment. Half of the dieting pupils were within the normal weight range[24]. In England[7] about 7.5% of a community sample of girls reported significant food avoidance behavior. However, it was only among 15-16 years olds that this was associated with some psychological disturbance. Among an Australian sample of 14-16 year old girls[6], the prevalence of dieting was 57%. Over one-third (36%) of the total sample had used at least one "extreme" dieting method in the past month, i.e., "crash" dieting, fasting, slimming tablets, diuretics, laxatives, and/or cigarettes to lose weight. Of the total sample, 77% wanted to lose weight and 51% had tried to lose weight in the past month. We found that more than one third (36%) of teenage girls were significantly dieting, in addition to 9% who were extreme dieters. Furthermore, over 57% of girls whose weight was within the normal range were dieting. Our findings are in line with these studies and show very similar trends.

The influences on, and the correlates of dieting behavior are also similar to Western based studies. Patton et al[6] found that Body mass index was positively associated with concern about body weight and shape and with the frequency of dieting. Others reported similar findings and added that extreme concern with weight and shape was most common among the obese preadolescent and adolescent girls, but dissatisfaction was also present among the underweight females. Fifty percent of the girls who were below the national age-standardized 15th percentile for BMI reported their ideal weight is less than their current weight[25].

Environmental influences particularly peer group's perceptions and attitudes, role models and learned behavior seem to be influential in this respect. In a sample of Australian teenagers the motivating factors for disordered eating and unhealthy dieting behaviors were peer pressure, media pressure, and the perception that extreme dieting strategies were harmless[26]. As evident from our results, peer's perception of a particular girl's body weight and shape is very closely related to dieting and in some cases extreme dieting. Furthermore our finding that the degree of dieting was consistent with BMI is in line with other studies.

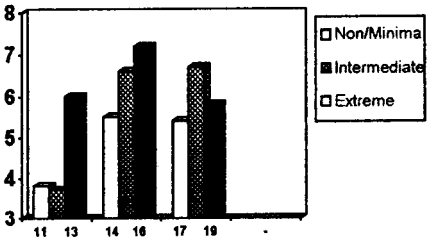
There is some evidence that parental factors are associated with a wide range of weight loss behaviors in girls. In a study of 232, teenage girls in New Zealand, a significant association was found between girl's perceptions of the impact of being thinner, dieting beliefs, dieting behaviors, and parental encouragement to diet[27]. Our study also showed that there was a correlation between dieting and family history of obesity.

Beliefs about body weight and shape are also important in determining dieting behavior. A replication of an American study of body shape preference was conducted in a group of 218 Arab students in Cairo, Egypt[10]. Compared to American girls, Arab girls felt their ideal weight and shape should be significantly less than their current weight. Although this study shows a clear preference for thinness in the Arabic culture, this is by no means a universal finding in the Arab World. A study of obesity among female University students in the United Arab Emirates[28] found that even moderately overweight females expressed desire to gain more weight and

value = 3.54, p = .03) with the ADS scored indicating a clear association between psychiatric symptoms and the level of dieting. Figure 1 shows the mean SRQ values in the three dieting groups by age group.

The mean SRQ scores were significantly higher in 14-16 year olds particularly among extreme dieters. Furthermore the differences between mean SRQ scores in the dieting groups were greatest among 11-13 year olds. This perhaps indicates a greater vulnerability to psychiatric disturbance among this age group of dieters.

Figure 1: Mean SRQ scores for the three dieting groups by age



Discussion

Eating behavior has recently been of interest in the UAE. Two relevant studies have been recently carried out, but their main focus was on obesity; dieting receiving little attention. Both studies indicate that a significant proportion of females (adults and adolescents) are overweight. First, Musaiger and Radwan[19] found that 19% of UAE University female students were overweight and 9.8% were grossly obese.

Second, a cross-sectional study[20] involving a sample of 825 secondary school students aged 15 to 21 years, found that 17.4% of girls were either overweight or obese (BMI > 25). This is similar to our figure of 15.9%.

There are very few studies on dieting and eating behavior conducted in other Arab countries, and they indicate that a similar picture to what we found is present. Two matched samples of Arab female undergraduate students attending London and Cairo Universities were recruited to determine the relative prevalence of abnormal eating attitudes[21]. According to responses obtained by the Eating Attitudes Test (EAT), 22% of students in the London group and 12% in the Cairo group scored positively. Six cases among the London sample fulfilled diagnostic criteria for bulimia nervosa, but no cases of either anorexia or bulimia were identified in the Cairo group. Among a population of secondary school girls in Egypt, 11.4% scored positively on the EAT questionnaire and were subsequently interviewed. Three cases (1.2%) clearly fulfilled criteria for a diagnosis of the full syndrome of bulimia nervosa. Twelve pupils (3.4%) showed sufficient concern over their weight to qualify for diagnosis as a partial syndrome of bulimia nervosa[12].

Despite differences in methodology, several Western studies indicate that dieting (of varying severity) is a common behavior even among young people of normal weight range. Wooley and Wooley[22] estimated that 72% of adolescents and young adults were dieting. In Canada, it was striking to note that one third of women who had a healthy BMI (20-24), were trying to lose weight. Significantly, 23% of women in the lowest weight category (BMI under 20) wanted to further reduce their weight[23]. In a Dutch study among secondary school children,

dieters were grouped together for analysis purposes as the scores for minimal dieters were so low that they were virtually non-dieters. Table 3 shows the results of that comparison.

Table 3: Correlated of Dieting According to the Degree of Dieting Behavior as measured by the ADS

Variable	Minimal / Non dieters	Intermediate dieters	Extreme dieters	Significance chi square
Age	15.28 (SD 1.65)	15.43 (SD 1.34)	15.22 (SD 1.82)	NS
Body mass index				
=<25	153 (43.2%)	167 (47.2%)	34 (9.6%)	p = .001
>25	32 (37.2%)	39 (45.3%)	15 (17.5%)	
Nationality UAE	170 (54.8%)	111 (35.8%)	29 (9.4%)	NS
Arabs	111 (50.7%)	89 (40.6%)	19 (8.7%)	
Dieting in family				
Yes	105 (44.8%)	100 (42.7%)	29 (12.4%)	p = .007
No	180 (58.8%)	106 (34.6%)	20 (6.5%)	
Obesity in family				
Yes	124 (46.8%)	114 (34.0%)	27 (10.2%)	p = .023
No	161 (58.5%)	92 (33.5%)	22 (8.0%)	
Dieting friends				
Yes	170 (56.5%)	102 (33.9%)	29 (9.6%)	p = .043
No	115 (48.1%)	104 (43.5%)	20 (8.4%)	
Perception of own figure and weight				
Overweight	63 (22.1%)	96 (46.6%)	31 (63.3%)	
Average	136 (47.7%)	86 (41.7%)	14 (28.6%)	p = .001
Underweight	86 (30.2%)	24 (11.7%)	4 (8.1%)	
Peer's perception of respondent's figure				
Overweight	18 (26.4%)	37 (54.4%)	13 (19.1%)	
Average	158 (48.8%)	137 (42.3%)	29 (9.0%)	p = .001
Underweight	109 (73.6%)	32 (21.6%)	7 (4.7%)	
Mean SRQ	5.2	5.9	6.5	Anova F value 3.54 p = .03

Dieting was clearly associated with dieting practices among family members and peer group as well as the peer group's perception of the respondent's body shape and weight. There was also a clear association with the body mass index in which, as expected, over-weight girls were more likely to diet. Dieting was significantly associated with the adolescent's perception of her own body weight and figure. There was no correlation between dieting severity and variables related to the level of education or to socio-economic level.

Analysis of variance showed that the mean SRQ scores were positively correlated (F

Table 1: Socio-Demographic Characteristics of the Population

Variable	N	%
Age group		
11-13	107	19.8
14-16	307	56.9
17-19	126	23.3
Father's Nationality		
UAE	310	57.4
Arab	219	40.6
Other	11	2.0
Mother's Nationality		
UAE	284	52.6
Arab	253	45.0
Other	13	2.4
Educational Level		
Excellent	123	23.1
Above average	185	34.8
Average	210	39.5
Below average	10	1.9
Poor	4	0.2
Economic Level		
Excellent	112	21.1
Above average	226	42.5
Average	180	33.8
Below average	11	2.1
Poor	3	0.6

Table 2: Dieting Scores (ADS) and Body Mass Index Distribution by Age Group

Age group	No dieting (0)	Minimal dieting (1-6)	Intermediate dieting (7-14)	Extreme dieting (15-24)	BMI
11-13 (N = 117)	6 (5.1%)	46 (39.3%)	44 (37.6%)	11 (9.4%)	=<25,90(76.9%) >25,27 (23.1%)
14-16 (N = 307)	35 (11.4%)	135 (44%)	113 (36.8%)	24 (7.8%)	=>25,261 (85%) > 25,46 (15%)
16 – 19 (N = 126)	16 (12.7%)	47 (37.3%)	49 (38.9%)	14 (11.1%)	=< 25,103(81.7%) > 25,23 (18.3%)
All	57 (10.6%)	228 (42.2%)	206 (38.1%)	49 (9.1%)	=<25,454(84.1%) >25,86 (15.9%)

Clearly, only a small minority of the girls are non-dieters. Almost 90% were dieting mostly on a minimal or moderate basis. However, 9.1% were extreme dieters. Interestingly, the prevalence of dieting did not show great variations in the three age groups of 11-13 years, 14-16 years and 16-19.

We compared three groups of dieters on the variables related to attitudes to, and practices of dieting in the family and in the peer group. Non-dieters and minimal

designed to detect non-psychotic symptoms. Each item would attract a score of 1 for a 'yes' response and 0 for a 'no' response. It has been found to have a fairly good sensitivity and specificity and has been successfully used in adolescent populations[17]. El Rufaie & Absood[15] validated the SRQ-20 in a primary care sample in the UAE and found it to be a valid instrument for detecting minor psychiatric morbidity. Our objective was not to detect 'caseness' in the sample. Rather, we used the SRQ-20 as a tool for quantifying psychiatric symptomatology and for that reason we did not attempt to establish sensitivity, specificity or a cut-off point for 'caseness'.

Statistical Methods and Analysis

Data are expressed as mean and standard deviation (SD) unless otherwise stated. Student-t test was used to ascertain the significance of differences between mean values of two continuous variables. Chi-square analysis was performed to test for differences in proportions of categorical variables between two or more groups. In 2 x 2 tables, the Fisher's exact test (two-tailed) replaced the chi-square test if the assumptions underlying chi-square violated, namely in case of small sample size and where the expected frequency is less than 5 in any of the cells. One-way analysis of variance (ANOVA) was employed for comparison of several group means and to determine the presence of significant differences between group means of continuous variables. The level $p < 0.05$ was considered as the cut-off value for significance.

Results

A total of 692 questionnaires were distributed at girls secondary schools according to the stratification process described above. Of the total, 617 were returned. A further 77 questionnaires were rejected because of incompletion leaving a total of 540 usable questionnaires: a response rate of 78%.

Table 1 shows the age distribution, mother's nationality, father's nationality, education level (according to the latest exam results) and living condition (according to the adolescent perception).

The most common measurement of obesity is through the use of the Body Mass Index (BMI) scale. The BMI is considered to be the most convenient and most widely used measure of obesity risk[18]. It is based on the ratio of weight over height squared (kg / M xM). A BMI of 20 to 25 is considered to be within acceptable body weight range. For the purposes of this study, subjects with a BMI of more than 25 will be considered overweight.

The BMI for the whole population was 21.34 (SD 4.73) with a minimum of 13.15 and a maximum of 69.42. Of the total respondent population, BMI calculation showed that 86 (16%) fell above the 25 mark.

According to the ADS, the cut-off points were as follows: 0=non-dieting, 1-6=minimal dieting, 7-14=intermediate dieting, 15-24=extreme dieting.

Table 2 showed the prevalence of dieting according to the 4 categories in three main age groups.

geographical location. Of the schools selected, half the classes were chosen (e.g. 3A, 3C, 3E.....4A, 4C, 4E etc.). In those classes half the student were chosen on the basis of alternate names according to the class registration list.

Instruments

Data were collected by self-report. In addition to weight, height, general demographic variables and attitudes to and practices of dieting amongst family members and peer group, we used the following standardized questionnaires:

1. **The Adolescent Dieting Scale (ADS)**[6]. The Adolescent's Dieting Scale (ADS) consists of 8 items and for each question, there are 4 possible answers "seldom or never, sometimes, often, almost, always". They attracted a score of 0, 1, 2, 3 respectively. The ADS is based on a refinement of a number of other scales for measuring dietary restraint. The authors identified behaviors typical of dieting, but did not include the extreme weight control strategies that are characteristic of clinical eating disorders. They identified nine behaviors which covered three broad dieting strategies (calorie counting, reducing food quantity and meal skipping). The unidimensionality of the ADS was assessed by using a principal component analysis, which showed that, for the nine item scales, there were two main components, one with an eigene value of 5.4 and another with a much smaller eigene value of 1.2. However, they found that one of the items "skipping breakfast" has a low item correlation and therefore carried out a separate analysis without that item. The alpha co-efficient for the eight items scale was 0.88 and it had one principal component with an eigene value of 4.1. On that basis, they considered the 8-item ADS a suitable scale for measuring dieting in a non-clinical population. Three bands of dieting, minimal (total score 1-6), intermediate (total score 7-14) and extreme (total score more than 15) were identified using data obtained from their study.

   Because of the ease of administration, the feasibility of quantification of dieting and understandability and acceptability of this questionnaire, we decided to use it in our survey. Moreover, it seems to be culture free since it inquires about specific behaviors rather than concepts, which may be influenced by cultural factors. We, therefore, did a translation into Arabic with back-translation by a non-clinician who was fluent in both Arabic and English. We piloted the questionnaire on a small number of adolescents who reported that the questionnaire was understandable and easy to answer. There were minimal changes in the wording following the piloting process. For the above reasons, we did not feel that a full validation study of the ADS in this culture was not necessary and was not carried out.

2. **The Arabic Version of the Self-Reporting Questionnaire (SRQ)**[15]. This is a screening instrument for identifying potential psychiatric cases in community settings and is not designed for diagnostic purposes. The original version[16] consists of 20 items

occurrence of psychiatric symptoms in association with dieting seems to be an indication that dieting is not necessarily a healthy method of weight control, at least in some adolescents. Empirical evidence seems to support this view as recently highlighted by Patton et al[6] who found that psychiatric morbidity was clearly associated with extreme dieting and that 62% of extreme dieters reported high levels of depression and anxiety.

Dieting as part of an eating disorder has been well documented and accepted in Western culture, but it was only recently that eating disorders began to be viewed as a cross-cultural phenomena with reports of clinical eating disorders in the Arab World[10,12]. The present study aimed at exploring the extent of dieting in adolescents in the United Arab Emirates and the extent to which it is associated with psychiatric symptoms.

The United Arab Emirates (UAE) lies on the Arabian Gulf. It covers an area about 77000 km^2, which is flat desert up to the mountainous Eastern side of the Peninsula. The UAE consists of a union of seven Emirates, the largest of which is Abu-Dhabi, consisting of 87% of the total area. Before the discovery of oil in 1985, the economy of the country was limited primarily to oasis agriculture, fishing, pearling and trade with neighboring countries. Oil now represents 95% of total exports and 70% of the GPD. The population of the UAE in 1994 was 2.3 million of which males represent just under 60% of the population. Expatriates make 75% of the total population[13]. Of the total population, approximately 25% are UAE nationals, 40% other Arabs, 30% Asians (from the Indian sub-continent and the Philipines) and 5% from Western countries. Most people speak Arabic and/or English, but many other languages are spoken such as Hindi, Urdu, Tagalog and Farsi. About 34% of the total population are under the age of 15 years and 57% under the age of 45 years. By all account the UAE is undergoing rapid socio-cultural change in parallel with economic development. The main features of this change is the speed with which it has taken place and the openness of this society to other world cultures and societies which makes it open to external cultural influences.

Methods

A representative sample of adolescent girls aged 11-19 years were included in this study which was conducted between November and December 1997. The population was derived from secondary schools in Al Ain Educational District. A multi-stage stratified sampling design was developed. In order to secure a representative sample of the study population, the sampling plan was stratified with proportional allocation according to stratum size[14]. Stratification was based upon geographical location of Schools. The sample size was determined with the a priori knowledge that the prevalence rate of dieting in the UAE is more or less similar to Western countries; or that it may be affected by parity, heredity, climate and sociodemographic and environmental factors. Allowing an error of 2.5% and level of significance (Type-I error) of 1%, it was believed that a sample size of 500-600 is adequate to achieve a high degree of precision in estimating the true prevalence rate of dieting in the general population. Schools were then selected according to

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Dieting Among Arab Girls

Harith Swadi , Abdulbari Bener , Fatima Al Darmaki

الحمية عند المراهقات في مجتمع الإمارات

حارث سوادي ، عبد الباري بنر ، فاطمة الدرمكي

Abstract

Objective: to estimate the prevalence and severity of dieting and associated psychosocial correlates in teenage girls in the UAE.

Methods: Self-reports were obtained from 540 teenage girls using the Adolescent Dieting Scale (ADS), and the Self-Reporting Questionnaire (SRQ-20) for psychopathology.

Results: About 16% were overweight, about 9% were extreme dieters and 38% were intermediate dieters. The level of dieting showed a strong association with body mass index (BMI) and SRQ-20 scores> Dieting was more likely in girls who were perceived by peers or perceived themselves as overweight, those who had dieting friends, dieting family members or who had obesity in the family.

Conclusion: dieting is as common among Arab girls as it is in Western societies and is influenced by similar factors. Some aspects of dieting among Arab girls are close to formal eating disorders.

Introduction

Adolescence is a time when social demands influence the individual and when "others" perceptions become very significant to the individual adolescent[1]. In complying with the demands of being socially attractive, dieting as a method of weight control has been a common behavior particularly in Western culture and within particular groups such as adolescents. Attractiveness and sliminess, especially amongst girls have been a target of commercial interest. The cost of weight loss products and services in the United States was an estimated $29 billion in 1988[2] and $31.86 billion in 1993[3].

Studies of teenage girls in western countries seem to indicate that most adolescents are on a diet at some time. For example, earlier studies[3,4] suggest that up to 80% of teenage girls are on a diet at some point. An Australian study[6] found that dieting is not only common amongst girls but it is also increasing amongst boys. In their study, they found that 38% of girls and 12% of boys were categorized as "intermediate dieters" and 7% of girls and 1% of boys were "extreme dieters". Others[7] found that concerns about weight and body shape are not uncommon among 11-12 year olds as they were reported by 11.1% of a community sample of girls. There is also some evidence that concerns about weight can arise at an early age[8]. Some case reports have been described pre-pubertal children suffering from anorexia nervosa[9].

While dieting may be viewed as a useful exercise in body weight control, the

الملخـــــص

لقد عرض الكاتب حالة سوء إستعمال مادة الديكستروميثورفان وقد قام المريض بتعاطي العقار على شكل علاج مضاد للسعال لمدة ثلاث سنوات وبجرعات عالية، أدت الى حالة حادة من الذهول والذهان الحـــاد (عدم ترابط الكلام، الهلوسة والسلوك المضطرب). وقد شفي المريض بعد إعطاءه مضادات الذهـــان بشكل سريع. وقد راجع الكاتب أدبيات تعاطي الديكستروميثورفان وناقش الحالة.

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he came to hospital. Detailed medical history, revealed that he is using cough syrup-Romilar[R]-Roche with an average of two bottles daily for the past three years after the sudden death of his wife. He consumed 6 bottles of Romilar. In the day of his arrival to U.A.E. (Each bottle 100 ml, containing 15 mg of Dextromethorphan per 5 ml) a total dose of 1800 mg.

Discussion

The usual oral antitussive dose of Dextromethorphan (DM) for adults is 10 – 30 mg every 4 to 8 hours to a maximum of 120 mg / daily. Those who abuse it usually use oral doses of 300 mg to 1050 mg / daily. Mr. B is used to take 600 mg / day for the past three years.

During this period he did not suffer from nausea, abdominal pain or dizziness which are the common symptoms observed in doses above 1500 mg / daily[9]. The psychological effect of dextromethorphan and it's potential for abuse has been well documented[4,5,9]. The patient may take higher doses in order to intensify or prolong its psychological effects[9]. Although there is no clear evidence that it produces physical withdrawl symptoms, it has a strong psychological dependency effect and intense craving[4]. DM in therapeutic doses may be associated with mild and infrequent occurrence of drowsiness, fatigue and dizziness[1]. Higher doses (ie up to 10 mg/kg/day) have been associated with light-headedness, nystagmus and slurred speech[7].

C.N.S. side effects with subjective symptoms are commonly reported in those who abuse it such as: ataxia, hypertonia, paralysis, stupor, coma, dilated pupils (light-reactive), tremor, anxiety/panic attacks, dysphoria, euphoria, sleep problem, forgetfulness memory loss, increased perception, hallucinations, flight of thoughts, increased sense of self, synesthesia, (association of sound with colour), restlessness and psychosis. Mr. B exhibited intense restless behaviour, thought disorder with disorganized speech, dysphoria, memory blackout and insomnia. His short psychotic episode which responded well to antipsychotics with complete relief, and negative past personal history of psychotic illness, alcohol, hashish or narcotic abuse proved that Mr. B psychotic reaction was DM induced. Psychotic symptoms and mood disorders have been reported by several authors in those, who abuse the drug[6,3,2,5]. Mr. B admitted that he feels elated after its use and it seems that the patient abused it for its euphoric effect. Serotonin syndrome might be observed in patients who abuse dextromethorphan and concurrently prescribed SSRI's[8]. The symptoms which results from this combination (hypomania, confusion, agitation, myoclonus, tremor and incoordination) overlap with dextromethorphan C.N.S effects, unless a recent drugs history intake is taken and potential serotonergic agents are excluded, diagnosis may be confused. Physicians have to be aware of drug induced change of behaviour and psychotic reaction reminiscent of those induced by LSD reaction especially in patients seen in emergency setting with attention to detailed drug history and substance abuse as this saves time and investigations and increase knowledge and experience of Psychoactive substances which could be abused by patients.

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Case Report

Dextromethorphan Abuse Inducing Psychotic reaction

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إحداث الذهان الحاد نتيجة إساءة إستعمال مادة الدكستروميثورفان

عابد أبو مغصيب، طارق خماس، شيخة المظفري

Abstract

A case of Dextromethorphane abuse has been described. Three years abuse with excessive overdose resulted in confusion and pysychotic behavior (incoherent speech, hallucination and disturbed behavior). The condition resolved rapidly with antipsychotic drugs. A review of the literature regarding the abuse of DM, is mentioned and discussed.

Introduction:

Dextromethorphan is the D-isomer of codeine, analog of levorphanol is used for its antitussive activity by acting on cough center in the medulla oblongata and causes suppression of coughing by raising cough threshold. It is the active component in a variety of cough and cold preparations and can be obtained in several countries without prescription. This over the counter availability is probably responsible for most cases reported of it's abuse. Preparation containing dextromethorphan are not available in the U.A.E. and the case we report here is Saudi Arabian patient. As far as we could ascertain, this is the first case of dextromethorphan abuse to be described in this area.

Case:

Mr. B (35) years old male, Saudi national, widower with 6 children. He came to UAE to visit his sister, one week back. On his arrival, relatives notice that he was nervous, irritable and agitated and standing most of the time facing the wall and uttering religious phrases in rapid pattern and talking to non existent persons, and when questioned by them he said every inanimate object here talks to me. His sleep became disturbed, refused food and his speech became incoherent, irrelevant and exhibited aggression and abusive verbal behaviour. On other occasion he regressed in child like behaviour towards his sister, e.g talks like a child. The family tried to persuade him to come to hospital, but they fail and he became out of contact and violent. He was brought to psychiatric emergency clinic restrained by police. He was speaking nonsense, disorientated to time and place but could identify his family members with difficulty. He was admitted to the hospital and given Haloperidol 5 mg three times daily, Procyclidine 5mg twice/daily, Chlorpromazine 100 mg at night. After 48 hours on this regimen he improved dramatically and could not remember what happened to him and how

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المنزل ومع الأصدقاء وتهاونوا في أداء الصلاة وخسروا معظم أموالهم وسلكوا طرق غير شرعية من أجل الحصول على تلك العقاقير ولم يستغلوا أوقاتهم على الوجه المطلوب. ولقد واجه هؤلاء المرضى العديد من المشكلات التي جعلتهم يبحثون عن العلاج في المستشفيات المتخصصة في علاج الإدمان مع أن أكثرهم كانوا ينتكسون على الرغم من المحاولات الجادة في علاجهم.

الاستنتاج: وجد الباحثون نموذجا ديموغرفيا وإكلينيكيا عند متعاطي العقاقير، كما أن هناك العديد من المشكلات والصعوبات العلاجية التي يجب أخذها في الحسبان عند علاج أولئك المرضى حتى يتم علاجهم بكفاءة وتقل عندهم نسبة الانتكاسة. كما يجب أن تتكاتف الجهات المسؤولة من أجل بناء استراتيجية علاجية تسعى الى الوقاية والعلاج وإعادة التأهيل لهذا المرض المزمن.

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abuse status and the comorbid condition.
In conclusion, the authors attested to the fact that the drug use, abuse, addiction and associated problems are present in this culturally conservative Arab country. The sociodemography of drug abuse across other regions of Saudi Arabia is more or less similar except for the finding that most of the drug abusers of modern cities like Jeddah and Dammam were better educated. The trends in drug abuse are also comparable, with heroin and alcohol, in contrast to alcohol and amphetamines as revealed in our study, being the most frequently abused drugs in these cities. Across international boundaries cannabis, heroin, alcohol and amphetamines were the most frequently abused drugs. The authors suggest that further controlled multicenter cooperative studies on different aspects of drug abuse should be conducted throughout the Arabian Gulf states. Such a study should include a strategy for the prevention of drug abuse. A plan should also be drawn for integrating the efforts of different concerned authorities, not only for the prevention of drug abuse but also for studying the feasibility as to how to strictly control the flow of drugs to these countries. Finally, it is needless to share the recommendation that the prevention of drug abuse and its related devastating problems should be the motto of national and international campaigns.

الملخـــــــص

على الرغم من أن إساءة استخدام العقاقير يعد مشكلة صحية كبيرة فإن هناك نقصا في الأبحـــاث الإكلينيكيـــة والديموغرافية في البلدان النامية وتهدف هذه الدراسة الى بحث حجم هذه المشكلة وأسبابها وآثارهـــا الســـلبية وارتباطها بالأمراض النفسية ووسائل علاجها والوقاية منها. ولذلك فلقد راجع الباحثان العديد من الدراســـات ودرسا الجوانب الإكلينيكية والديموغرافية لـــ ٤٢٣ مريضا بإساءة استخدام العقاقير في مركزين للعلاج النفسي في منطقة القصيم.

النتائج: كان معظم المرضى غير متزوجين، وفي مرحلة الشباب ومدخنين وقد حصلوا على الشهادة الابتدائية فقط ولا يمارسون أية وظيفة. ولقد كان الكحول أكثر المواد استخداما عند حديثي السن من الشباب يلي ذلـــك استخدام الامفيتامينات. وبشكل عام فإن تعاطي عدة أنواع من العقاقير هو الأكثر استخداما لكن يظل تعـــاطي الكحول هو الأكثر انتشارا. ويعد تأثير صديق السوء هو العامل الأساسي في ابتداء واستمرار إساءة استخدام العقاقير، يلي ذلك البحث عن المتعة.

ولقد وجد أن أكثر من ٢٥% من المرضى يعانون من اضطرابات القلق والاكتئاب. إضافة الى ذلك فلقد أثر إساءة استخدام العقاقير وإدمانها سلبا على حياة أولئك المرضى حيث ظهر لدى أكثرهم السلوك العدواني فـــي

drugs. It is possible to attribute this inconsistent finding across studies to the fast urbanization, modernization, and possibly some effects on patients brought about by frequent pleasure visits to foreign countries. This is compounded by pressure from peers and friends as reported in most earlier studies[5,9]. Our findings relating to the first abused substances that is amphetamine, cannabis and solvents are similar to data reported from other developing countries[9,10,11].

Drug abuse and addiction as revealed in this research and other studies[5, 6,13] do have adverse effects on the drug abusers themselves and the society. Domestic and societal violence, educational difficulties, erosion of religious beliefs, chronic economic constraints, unemployment, committing crimes, are but only some of the problems of drug abusers revealed in this study. However, caution should be observed when interpreting these findings because some of these reported circumstances and difficulties might have preceded the problems of drug abuse. For instance, religiosity may be one of the extremely important familial/ environmental factors that affect the risk for substance use and dependence. Furthermore, religious devotion may play a role in coping up with stress[14]. Despite facing several difficulties, most of the patients in this study were able to find money for buying drugs, especially from parents. Hence, parents can play a prime role in the prevention of drug abuse by controlling the supply of money to their children.

The results of the present study revealed further that some of the aforementioned problems were the driving forces for many of those drug abusers to seek treatment. The concerned physicians, therefore, should not miss these opportunities and be prepared to offer the maximum help possible to treat these drug abusers. However, patients faced several difficulties during their treatment, including protracted poor motivation, friends' manipulation, discomforting abstinence and psychiatric symptoms, and craving that led to multiple relapses. Notably relapses of addiction are the rule rather than the exceptions[15]. Therefore following successful detoxification, the prevention of relapses should be the major goal of long-term treatment of patients. From this perspective too, physicians should be prepared to offer appropriate drug treatment, proper psychosocial therapies, and rehabilitation.

In many studies[5,16,17,18,19] addictive patients were found to have comorbid psychiatric disorders including anxiety, affective, conduct and personality, attention-deficit hyperactivity, eating, schizophrenia and impulse control disorders. Although we have not determined in the present study, these psychiatric disorders may have reciprocal causal, or one-way relationship with the different types of drug abuse. Hence, we will explore this informative issue and so the Axis-II disorders in particular personality disorders in drug abusers in a separate communication. The comorbid psychiatric disorders cause diagnostic as well as therapeutic dilemmas in patients with drug abuse and vice versa is also true. Therefore, clinicians should assess the patients with drug abuse comprehensively in order to provide the optimum management of both the drug

of the patients [n=4] had schizophrenic psychosis. Despite not having full psychiatric syndromes, almost all patients [n=414] showed high scores on the BPRScale [Mean±Sd=10.82±4.15, range=19]. When several sociodemographic parameters of patients with psychiatric disorders were compared with those patients who were drug abusers, no significant statistical differences were observed. Similarly, patients recruited from two sources did not show any significant statistical differences as regards their socioclinical profiles. However, there was a trend towards patients from mental hospital who had notably more psychotic manifestations.

Discussion

In this study most of the drug abusers were young adults who were unmarried, unemployed, and had only the minimum of basic education. Almost all of them were cigarette smokers, less than 50% did not earn any money by themselves. Also a great proportion of these patients had at least two friends or relatives who were drug abusers themselves. These findings were slightly different from those reported by others[6]. The differences can be attributed to the setting of the study. Unlike this study, Hafeiz[6] found that most drug abusers had a junior high school education. We have reported earlier that most of the abusers of any drugs-licit or illicit tend to smoke cigarettes[7,8]. However, the revealed sociodemographic data are consistent with other researches carried out in local population[5] as well as in other developing countries[9,10]. The study conducted in Nepal[9] revealed that drug abusers had a mean age of 23.8 years, the majority were males, unemployed or students; only 30% of them were married, and a great proportion of them had relatives or friends who were also abusing drugs. In a study from Cameron, the drug consumers were both males and females from all age groups[10]. Overall, these findings support the notion that the prevention as well as intervention programs should target the young population that are sociodemographically vulnerable to the development of drug use, abuse, and addiction.

The trends in drug abuse as revealed in this study were partly consistent with earlier local studies. Unlike alcohol as the first drug of abuse in this study, other researches found that amphetamines[5,11] and opioids[2,6] were the most commonly abused drugs. Recently, amphetamine has been reported to cause greater human fatal deaths that may be natural, accidental, suicidal, homicidal and uncertain causes[11]. It is of greater concern that about 10% of patients began abusing drugs especially volatile substances during childhood. In a high school (secondary) student population, about 5% were abusing solvent substances. Taken together, the implication of early onset drug use as found in this and other studies is predictive of subsequent development of drug abuse including alcohol dependence[12], in both genders. Although some preliminary reports[2,6] showed heroin to be the first and most commonly abused substance, our study not in agreement with these researches indicates that alcohol is consistently abused first, and merely in combination with other

Table 4. Treatment related parameters

Variables	N	%
Motives for treatment*		
Drug problems	209	49.4
Family advice	189	44.7
Get rid from drugs	175	41.4
Police enforcement	123	29.1
Financial loss	33	7.8
Reasons for relapses		
Poor will power	169	40.0
Friend's influence	157	37.1
No improvement	72	17.0
Mixed	35	8.3
Identified areas for help during and after treatment*		
Strengthening of religious beliefs	246	58.2
Strengthening of will power	270	63.8
Change in social conditions	105	24.8
Interpersonal relations	58	13.7
Rehabilitation	51	12.1
Comorbid disorders	112	26.3

* more than one response by each patient

Treatment related data

There were several motives for seeking and initiating treatment including drug problems related to the abused substance itself [49.4%], family advice [44.7%], getting rid of drugs [41.4%], and imprisonment [29.1%]. Ninety percent of patients reported that only specialized hospitals are suitable for treatment. Less than half of the patients [47.3%] reported many difficulties regarding treatment, among which were poor motivation, peer influence, discomfortable withdrawal symptoms, craving and impending relapses. Most of the patients [58.2%] reported having had more than three relapses, which were attributed to a variety of reasons including poor motivation [40%], friends pressure [37%], and loss of hope for improvement [17%].

During the assessment and treatment of the abusers, favorable areas were uncovered and used for helping the patients during and after the active therapy. Those favorable responses included: the subject's religious attitudes and beliefs, volition, previous social status, interpersonal relationship, family and friends and a new job. It is noteworthy that 26.3% [n=112] of our patients had psychiatric syndromes, mainly anxiety [n=56, 50%] and depressive disorders [n=52, 46.4%]. The rest

Possible effects of drug abuse

The majority of patients [74.2%] performed prayers irregularly and 6.4% were not praying at all (Table 3). Many problems were associated with drug abuse, and these included verbal arguments and fights with family members and friends, followed by imprisonment, overwhelming financial as well as health problems. The majority of patients spent all their time as leisure time [n=231, 54%] or had very few hours per day as leisure time [n=129, 30.5%] and only 10.6% [n=45] did not have any leisure time. The ways of spending the time included hanging around in 56.7%, leaving out in 84.2%, or watching the T.V/radio in 56.76%. Regarding finance, about 60% of patients spent about 100 or less than 100 SR every day on drugs, while only 6% did not buy drugs at all but instead they shared them with their friends. About 50.4% of patients almost always had money at hand for buying drugs but those without financial resources adopted other ways of overcoming this problem, such as: borrowing money [40.9%], stop taking drugs temporarily [35.9%], seek treatment [22.5%] and almost 17% had to cheat people.

Table 3. Possible effects of drug abuse

Variables	N	%
Major problems*		
Violence	420	99.3
Imprisonment	225	50.9
Financial problems	129	30.5
Health problems	137	32.4
Loss of job	57	13.5
Drug overdose	40	9.5
Divorce	29	6.9
Prayers		
Regular	82	19.4
Irregular	314	74.2
No prayers	27	6.4
Daily Drug expenditure		
<100 Saudi riyals	256	60.6
100-200 "	28	6.5
>200 "	115	27.2
Nil	24	5.7

* more than one response by each patient

concurrently abusing multiple drugs at the index interview, alcohol abuse remained the most common drug of abuse [50.4%].

Peer pressure [59%] was the most prominent reason to initiate abuse of drugs and only 6.6 % of patients gave no motives for starting such abuse. When they were asked about their motives for current persistent drug abuse, friends [86.5%], pleasure [59.6%] and curiosity [47.3%] emerged as the first three motives. Seventy two percent of patients abused drugs on daily basis. Almost 84.2% [n=356] of addictive patients had friends who themselves also abused drugs and 8.3 % [n=35] had family members with a positive history of drug abuse. At initiation, however, mainly friends introduced drugs to most of the patients [81%, n=343] while traffickers were involved in 7.6% of the cases [n=32].

Table 2. Drug-related parameters

Variables	N	%
Age*		
10-14	45	10.6
15-19	142	33.6
20-24	120	28.3
25-29	53	12.5
30-34	29	6.9
35 or above	34	8.1
First drug abused		
Alcohol	221	51.8
Amphetamine	107	25.3
Solvent	34	7.9
Opioid	29	6.7
Cannabis	18	4.1
Others	14	3.2
Multiple Drug abuse		
Yes	144	34
No	279	66
Frequency of drug abuse		
Daily	301	71.2
Weekly	108	25.5
Monthly	14	3.3
Reasons		
Peer pressure	249	58.9
Pleasure	90	21.3
Curiosity	38	8.9
Multiple problems	18	4.3
No reasons	28	6.6

* Age at initiation of drug use

single [60.3%] with primary education [56.5%], unemployed [60%] and current smokers [96.2%] (Table 1). About 54.6 % of patients did not have any source of income and they depended on their parents or other family members for their day-to-day expenses. 45.3% [n=192] were earning from 800 to 12000 riyals per month [Mean± Sd= 3967.79 ± 2394.65, range=11200].

Table 1. Sociodemographic parameters of drug abusers [n=423].

Variables	N	%
Age*		
< than 20 years	27	6.4
21-30	150	35.5
31-40	173	40.9
41-50	49	11.6
>50	24	5.7
Educational Level		
Illiterate	37	8.7
Primary	239	56.5
Preparatory	91	21.5
Secondary and above	56	13.2
Occupation		
Unemployed	259	61.2
Skilled	146	34.5
Unskilled	18	4.3
Marital Status		
Married	157	37.1
Single	255	60.3
Divorced	11	2.6
Smoking status		
Smokers	407	96.2
Nonsmokers	16	3.8

*Age at index interview

Drug related parameters

More than 60% of patients began to abuse various drugs between the age of 15 and 24 years (Table 2). Strikingly, 10.6 % of patients began abusing drugs at pediatric age. Alcoholic beverages were the first drugs abused by most [52%] of the patients, followed by amphetamines [25.3%], volatile substances [7.9%], opioids [6.7%] and cannabis [4.1%]. Other drugs included synthetic drugs like benzodiazepines. Although many patients [34%] were

motives put forward by the abusers to explain the initiation and/ or continuation of their pattern of abuse included curiosity, sense of belonging, independence and hostility, pleasure or dangerous experience, improved "understanding" or "creativity", sense of ease or relaxation, escape, peer pressure, and psychiatric disorders.

Drug abuse or addiction is associated with many problems including occupational difficulties, economic losses, dysfunctional families, crimes, violence, excessive demands on costly social and medical services. There is also a danger of the spread of infectious diseases that usually have direct impact on the society. By and large, there is a vast literature on drug abuse and addiction in western countries. In contrast in Gulf countries, there is scanty data on drug abuse. Therefore, we designed this study with the following goals; 1) to assess the magnitude of problems in drug abusers, 2) to look for possible etiological factors, 3) to consider the influence of drug abuse on work, 4) family and society, and also to determine the relationship between substance abuse and psychiatric disorders, and finally 5) to offer specific recommendations regarding prevention, treatment and rehabilitation of drug abusers.

Method

The sample of this descriptive study [n=423] was drawn from two hospitals in Al-Qassim Region, the central province of Saudi Arabia: 1) all adult in-patients admitted to Al-Qassim Psychiatric Rehabilitation Center [n=388] that provides comprehensive services exclusively to drug abusers, and 2) in-patients [n=35] diagnosed having drug abuse and admitted to the Buraidah Mental Health Hospital. This hospital provides in- and out-patients services to general psychiatric patients including drug abusers with psychiatric manifestations. The duration of the study was two years, commencing January 1996. A special interviewing form was designed to collect data from all drug abusers. A feasibility study of 20 randomly selected patients with drug abuse was carried out during a period of one month. The difficulties anticipated by the researchers were explored and identified and this initial assessment helped us in modifying the interviewing form for collecting the relevant data.

The data obtained from the medical records included general characteristics of clients namely age, sex, education, occupation, income and habits, detailed history of drug abuse, reasons for addiction, social and economic aspects, use of leisure time, other problems if any and lastly the treatment offered to them. The investigators also interviewed each patient in order to determine the presence of psychiatric disorders. The Brief Psychiatric Rating Scale [BPRS] was used to assess the psychopathology of all clients. DSM-111R and ICD-10 criteria were also used for the purpose of diagnosing drug abuse, addiction and psychiatric disorders.

Results

Sociodemographic parameters

All studied patients [n=423] were Saudi males, aged between 21 and 40 years, mostly

establishing comprehensive strategies on the preventive, therapeutic and rehabilitation aspects of drug addiction now considered a chronic, relapsing brain disease.
Keywords: Drug abuse, addiction, clinicoepidemiology, pattern, psychiatric syndrome.

Introduction

Since ancient times, man has long used psychoactive drugs not only to enhance pleasure or relieve discomfort but also to facilitate the achievement of social, religious and ritualistic goals. As a corollary in some societies alcoholic beverages became a traditional choice while in others opium, cannabis, or coca preparations retained such status[1].

In the Arabian Gulf countries, drugs that are now commonly abused include opium and its derivatives, cannabis, alcohol beverages, stimulants, volatile substances, khat, and a variety of synthetic drugs such as benzodiazepines and anticholinergics. Unlike Western countries, cocaine and hallucinogens are rarely abused in this region. There is a general impression that the abuse of those drugs has increased tremendously in Arab countries over the past few decades. Additionally, caffeine and tobacco are most widely abused not only in the developing countries but also in developed nations.

It is roughly estimated that more than 50 million people abuse various drugs worldwide. The epidemiology of drug abuse varies across countries, and this has been attributed to biological, social, and cultural factors. Reliable data on the nature and extent of drug abuse in the kingdom of Saudi Arabia are lacking, only anecdotal reports have described drug abuse at local levels. In 1992 a retrospective one year study, carried out in Jeddah, Saudi Arabia, identified 485 patients in whom heroin and alcohol were the most commonly abused substances[2]. In another study of drug-dependent patients from Jeddah, the prevalence of hepatitis B surface antigen was 16.3%, the majority of these patients were intravenous drug users. Further 14.4% of HBsAg positive patients were identified as chronic carrier with either chronic liver disease or primary liver cancer[3]. A study conducted in three urban areas in Eastern region, Saudi Arabia, showed a prevalence rate of 5.3% of volatile solvent substance abuse among high school (secondary) male students[4]. A preliminary study carried out in Al-Qassim Region recruited 120 male patients who satisfied the criteria of third revised edition of Diagnostic and Statistical Manual of Classification (DSM-111R) for substance abuse/dependence disorders. The abstracted data showed that the abuse of amphetamines was the most frequent pattern, followed by beverages/alcohol abuse while heroin was the least frequently abused substance[5]. Another preliminary study carried out in Dammam City, Eastern province, Saudi Arabia revealed the following pattern of drug abuse: 84% abused heroin alone or in combination with other drugs; 31% used alcohol; 26% used cannabis; and 10% used stimulants[6].

In the studies mentioned previously, no single reason for abusing drugs has been found. However, some of the most important

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Sociodemographic Parameters and Clinical Pattern of Drug Abuse in Al-Qassim Region-Saudi Arabia

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المقاييس الإجتماعية السكانية والنمط السريري لإساءة استعمال العقاقير في منطقة القصيم – المملكة العربية السعودية

نسيم قرشي وطارق الحبيب

Abstract

Background: Although drug abuse is a major public health problem worldwide, there is a dearth of epidemiological and clinical data in rapidly developing countries of the Arabian Gulf. This research aims to describe sociodemography, epidemiology and pattern of drug abuse in psychiatric population.

Method: The basic clinicoepidemiological information on 423 patients with drug abuse drawn from two mental health facilities in Al-Qassim region, Central Saudi Arabia.

Results: Most of the studied patients were unmarried, unemployed, young adult smokers with low level of education who at very young age abused alcohol first, followed by amphetamines. A proportion of patients were abusing multiple drugs while, on long term basis, alcohol was the most consistently abused drug. Peer influence followed by pleasure and curiosity were the most important factors in introducing, initiating and maintaining the drug abuse by the patients themselves. More than a quarter of patients had mood and anxiety disorders. Drug addiction affected adversely the life style of these patients as most of them showed episodes of violent behavior, neglected prayers, spent lots of money and adopted criminal ways for obtaining drugs and did not use leisure time positively. Patients also presented with multiple associated biopsychosocial problems and treatment difficulties including relapses, which were the major driving forces for seeking treatment in specialized hospitals.

Conclusions: It is concluded that the drug-abusers have certain epidemiological, clinical and drug patterns. There are several drug-associated problems that should be appreciated and addressed by the assessing clinicians. Likewise, it is also recommended that concerned authorities and planners must integrate their efforts for

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وزيادة القدرة على التفاعل الاجتماعي. كما ينجم عنه مشاكل جسدية ونفسية متعددة. وقد ارتبط تعاطي القات بفقدان الشهية والامساك والأرق والصداع ومشاكل في التنفس. بالنسبة للكآبة والقلق فهي تظـــهر بشكل أقل رغم أن أشكال مختلفة من الذهان وجدت في المهاجرين من الصوماليين. وقد وجد أن انتشار التدخين هو أعلى في ماضغي القات في دراسة لندنية. وقد وجد أن استعمال العقاقير الممنوعة غير شائع لدى ماضغي القات إلا أن استعمال الحشيش من قبلهم يتم بصورة أكبر. وقد وجد أنه لا يوجد أعـراض انسحاب للقات كما في الأمفيتامين. ورغم أن القات منتشر بشكل كبير إلا أن قليلاً من الأشـخاص هـم بحاجة الى التدبير الطبي. وأخيراً لا شك أن النمط والنظرة لاستعمال القات بين متعاطيـــه آخـذة فـي التغيير.

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Conclusion

Despite the widespread of Khat use, few individuals appear to request help with their Khat use. Severe medical problems were rarely reported among Khat users although the literature indicates that a few cases of psychotic episodes have been identified. Most studies have focused on that a few cases of psychotic episodes have been identified. Most studies have focused on those who admitted to taking this psychoactive substances and this may be an underestimate of the prevalence of the use of Khat and other psychoactive substances such as alcohol or cannabis due to socio-cultural (refugees status) and religious factors. It is clear that the pattern and perceptions of Khat use are changing among the community of Khat chewers. This social deviation from the "norms" of use of the substance in the country of origin is a cause for concern, especially among young Somalis. Due to the socio-economic and psychological problems faced by Somalis in the UK, this may have implications in the changing pattern of Khat use and the initiation in the use of alcohol and/or illicit substances. Although Khat chewing is perceived by the Somali community to serve in cementing social relationships and the maintenance of cultural identity in an alien land, the use of Khat outside the country of origin is transgressing its traditional social functions. Further research studies is therefore required to map out the incidence and prevalence of Khat use among the wider Somali or other ethnic minorities, the changing pattern of use and their socio-economic and health effects associated with Khat use and other psychoactive substances. Kennedy et al (1980)[25] postulated that a "more complex theory is needed and that social and cultural perspectives must be added to the concepts of the physiological and psychological effects of drugs if progress is to be made toward understanding institutional drug use as is found in Khat".

Health care needs assessment should be taken with the various groups located in different parts of the country to enable the implementation of health intervention strategies. Assessment of the individual should be taken within the socio-cultural context of Khat use and the particular circumstances the patient is presenting to health care professionals. The taking of a drug and alcohol history (including Khat use) in-patients should be performed with cultural and religious awareness and sensitivity. Anxiety states, depression or other psychotic reactions may be due to social dislocation and exclusion from the dominant community rather than the chronic use of Khat. However, brief interventions, advice and counselling may provide an effective tool in the promotion of "health conscious" among the ethnic minorities who consume Khat.

الملخـــــــص

لقد اقتصرت عادة مضغ القات في المملكة المتحدة على مجموعات عرقية محددة كالصوماليين واليمنيين. وفي أوروبا انتشرت هذه العادة بين الصوماليين في روما. ومضغ القات هو الطريقة الشائعة للاستعمال إلا أنه يمكن أن يدخن أو يغلى كالشاي. وينجم عن تعاطي القات حالة من الزهو وزيادة الانتباه والهيجان

relatively weak, of profound lassitude, anergia, difficulty in initiating their normal activities and a slight trembling several days after ceasing to chew". It is argued that tolerance may be developed to the sympathetic effects of Khat[32]. This is in contrast to some authors[13] that there are no physical withdrawal symptoms associated with the cessation of Khat use. Alem et al, (1997)[2] reported that only 0.6% continue to chew Khat because of withdrawal symptoms. On stopping the use of Khat, general health showed improvement in sleep and appetite, fewer problems due to constipation and a decrease in alcohol consumption[28].

Discussion

The literature on the prevalence, patterns of use and the sequelae of Khat use should be adopted with caution. The relationships of Khat use with health and socio-economic problems are often not supported by robust epidemiological studies. Nevertheless, there is strong indications of the adverse consequences caused by the social dislocation from the culture of origin, coupled with the socio-economic problems faced in the new country have had on the new refugees and immigrants. Studies reported in this paper have focused largely on limited sample, without a control group, and based on case studies. The studies have been based on a few developed and developing countries with the sample of the population coming from different ethnic minorities from East African countries. It is interesting to note that of the population sampled agree that "they would rather their children used Khat than either alcohol (agree 90%) or cigarettes (agree 77%)[17]. This raises the question that both alcohol and cigarette smoking are perceived as more dangerous than Khat due to cultural norms and religious affiliation. In East African countries and the Arabian Peninsula, Khat use is regulated by social and cultural norms of behaviour and boundaries.

Studies of Khat chewers have been based in Kenya[33] with 100 randomly selected outpatients, in Rome[32] with 20 members of the Somali community; Melbourne[38] with East African communities; in Yemen with 28 patients[10] and 65 heavy chewers of Khat[11] and 3064 patients undergoing upper gastrointestinal endoscopy[18]. A more recent study of a large rural community (10,468) in Butajira, Ethiopia[2]. Pantelis et al. (1989) is based on case studies with the presentation of three cases of psychotic reactions to Khat use in Somalian males in London. However, in Griffiths et al (1997)[17] study a sample of 207 people from the Somali community living in London were interviewed. The authors of the latter study did emphasised that caution should be used when generalising their findings to the wider Somali community based in different locations in London. They stated that their data are based on self-reports and not a random sample resulting from a sampling bias towards chronic users of Khat. In addition, the lack of a control group diminished the generalisation of the findings. The instrument used for measuring the severity of Khat "dependence" is the Severity of Dependence Scale (SDS Gossop et al 1995). This instrument has been validated with an English and Australian sample of heroin, cocaine and amphetamines users. This raised the question of the cultural bias and the reliability and validity of the instrument administered to a sample of the Somali communities in London.

cases of low birth weight and still birth among Khat chewing mothers than among non-users[12,1].

Depression and feelings of anxiety seemed to be less common response to Khat use[34,17]. It appears that Khat-chewing can induce at least two kinds of psychotic reaction: a paranoid psychosis with prominent persecutory delusions and a hypomanic illness with grandiose delusions[34]. Several studies[6,8,7,14,30], have reported the onset of psychosis after recent increases in Khat use with first rank symptoms of thought broadcast, passivity experience, manic illness with grandiose delusions, usually without auditory hallucinations. In addition, Khat chewers experience unpleasant dreams of a paranoid nature of being attacked, strangles or followed, lability of mood, increase in anxiety and tension, confusion, disorientation, and grandiose fantasies[25,19,15,29,17]. This episode has been interpreted as "rebound Phenomena" rather than a specific abstinence syndrome. However, despite heavy consumption of Khat in East African and Arabian countries, Khat psychosis is rarely present in Khat chewers[27,34]. In Europe, in recent years, various forms of psychosis have been associated with Khat among migrant populations such as the Somalis[34,39]. A case of violent behaviour following heavy Khat consumption has been reported by Alem (1997)[2].

Misuse of Psychoactive Substances

In order to counteract the psychoactive effects of the Khat, the misuse of alcohol and hypnosedatives is common[3]. The concomitant use of alcohol and other psychoactive substances as a form of self-medication has been reported elsewhere[33]. This pattern of poly-drug use reinforces the addictive potential of the psychoactive substances and raises the risk of health loss. However, only nine subjects (4%) in the London study report having used alcohol and few subjects admitted drinking alcohol in the Rome study[32]. In Alem's (1997)[2] study of an Ethiopian community, there seemed to be an overall difference in problem drinking between daily-chewers, and non-chewers, although not significant when stratified for sex, no relationship between daily Khat chewing and problem-drinking.

The prevalence of tobacco smoking is high among the Khat chewers in the London' study. One hundred and twenty two (72%) who smoked cigarettes had an average level of consumption to 17 cigarettes per day. There is evidence to suggest that there is a strong association of daily Khat chewing with tobacco smoking. It has also been reported of an increase in the prevalence of respiratory problems in men, resulting from associated heave (tobacco) smoking during Khat sessions[24]. Illegal drugs are relatively uncommon among Khat chewers, but six percent (6%) of the sample reported the use of cannabis[17].

Some Khat users in (Griffiths et al, 1997)[17] study reported moderate problems of dependence and only a minority reported severe level of dependence and problems. It is considered that there are no physical symptoms or withdrawal of Khat[28,13]. It seemed that Khat carries a moderate but often persistent psychological dependence, but no physical dependence or tolerance in contrast to the marked tolerance observed with amphetamine misuse[24,25]. Kennedy (1987)[25] considered that heavy chewers experienced withdrawal symptoms, "albeit

per session) whereas in Eastern Africa, it costs approximately £1. However, in countries where Khat is an illegal psychoactive substance, the drug costs between 1/5 and 1/9 more. In a study by Seyoum et al (1986)[37], Khat was found to be the primary source of income (76.8%) in Khat-growing community as compared to crops, mild and fire-wood (100%) for those non-Khat growing community.

Griffiths et al (1997)[17] study of pattern of Khat use among 207 Somalis living in London, found that 78% has used Khat and that the majority of the sample (76%) has used more Khat than in Somalia. The mean age of the respondents was 36 years with a range of 18-78 years. The London sample studied is from a younger and middle-aged group as compared to the country of origin, where elderly men tend to be majority that consumes Khat. Although the consumption of Khat remain largely with male population in the country of origin, women users reported of using over 2.5 days per week, compared with 3.6 days for men[17]. It has been stated that there is a trend of excessive Khat misuse and the drug being taken alone rather than to complement social relationship[34]. However, in Griffiths et al (1997)[17] study 77% of the sample were found to "always" or "often used" the drug in company with friends compared with only 12% who always or often used Khat in isolation. Khat chewing was predominantly an evening activity and largely social in nature. This supports the literature that Khat use is a group activity and enable the facilitation of social relationship, the elevation of mood and cultural integration in an alien country[38,2].

Health Behaviour & Effects

The perception of Khat users to the pleasurable effects of the drug is similar to those of amphetamine users. The effects include euphoria, increases alertness, excitement with and improved ability to communicate etc.[34,27,13,39]. A selected review of the literature on the effects of Khat on health-behaviour reveals that it has a wide range of physical effects on the cardiovascular, digestive, respiratory, endocrine and genito-urinary systems; and addictive behaviour problems. There are indications that the chronic use of Khat could affect the oral cavity, inflammation of the mouth, secondary infections and the loss of appetite[17]. However, no evidence was found that Khat chewing has particularly detrimental oral and dental effects[21]. In a study of Yemeni patients, El Guneid et al (1991)[10] found that there is a significant association between daily Khat use and the prevalence of duodenal ulcer, particularly in females. A strong association was also found between heavy smoking and ulcer, with most ulcer patients who chewed Khat daily being heavy smokers. There seems to be gender differences on the effects of Khat use. In a Yemeni study by (Kennedy et al, 1983)[24], strong associations were found between the use of Khat and histories of anorexia, constipation, insomnia, headaches and respiratory problems in men. In females, there were strong associations between Khat use and the diagnosis of acute gastritis and histories of jaundice, bronchitis and hepatic diseases. Other problems that have been reported include ear disease, liver problems, constipation, malnutrition cells[34,26]. There is evidence to suggest of the loss of libido in men and sperm defects[11]. It is also reported that

the criteria for control under the Convention of Psychotropic Substances[40,41]. However Khat is not internationally controlled, only chathinone and cathine are controlled under the United Nations Convention on Psychotropic Substances. In 1993, the United States upgraded the drug from Schedule 1, alongside heroin and crack. Other countries to have prohibited the use of Khat include Italy, Morocco, Switzerland, Canada, Norway, Sweden, Finland and Saudi Arabia. The United Kingdom is the only country with a sizeable Somali and Yemeni communities, which has not placed legal restrictions on Khat. In England, cathinone is controlled by the Misuse of Drugs Act (1971), although Khat itself is not a prohibited substance.

The Import of Khat is now reaching Europe and it is known that there is a market and distribution network for this psychoactive substance. In recent years, the use of Khat has not only been restricted in certain countries of the Arabian Peninsula and East Africa but widespread among some ethno-cultural groups in certain locations in the Untied Kingdom (UK) and in other European countries[22,27,5,32].

The aims of the paper are to present an overview of the prevalence, nature and pattern of the use and misuse of Khat with reference to Khat use in the United Kingdom.

Khat

Khat is a shrub that grows in high altitude extending from East to Southern Africa, as well as Afghanistan, Yemen and Madagascar[26,23]. It is also known by various names such as Bushman's tea, la salade and there is a wide range or variants even in the same country of produce[4]. There are two basic strains: the stronger, Miri, from Kenya, is prized above Hereri from the Ethiopian region of the same name. The Kenyan type is said to be stronger due to, perhaps, correlating with the cathinone content[27]. This plant with amphetamine-like effects (Cathinone) have been used for recreational purposes[23] as an aphrodisiac[26,29], as a medicine[24] and for maintaining cultural identity in a foreign land[38,17].

It is estimated that about seven tonnes of Khat pass through Heathrow airport daily, legally brought over from Somalia[20]. Khat-chewing, in the United Kingdom, has been largely confined to specific ethno-cultural groups such as the Somali in Liverpool[17] and London[7,34,17], and Sheffield; and the Yemeni community in South Wales[31]. In Europe, Khat-chewing has also spread among members of the Somali community in Rome[32]. There are also reports of the use of Khat by Whites in the UK[22,35]. It has been reported that there are at least 100 Khat houses or "peace room" or "Mar" in London and a "guess estimate" of about 10,000 Khat "addicts" in the UK[20]. However, epidemiological studies of the use and misuse of Khat among ethno-cultural minorities in the UK is limited.

Methods and Patterns of Use

The chewing of Khat is the most common method of use but it can also smoked and taken as tea[34]. Daily consumption of 250-400 grammes is common in the countries of origin, where Khat sessions may last for about four hours mostly after meal. The psychological effects of the psychoactive substances can last for up to 24 hours. This is similar to those resulting in taking a dose of 5 mg of amphetamine? In London, Khat costs £4 a bundle (one or two are needed

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The Flower of "Artificial Paradise": The Use and Misuse of Khat (Qat) – A Review of the Literature

G. Hussein Rassool, Mohammed Abou-Saleh

زهرة الجنة الصناعية: استعمال وإساءة استعمال القات

مراجعة للأدبيات

حسين رسول، محمد أبو صالح

Abstract

Khat chewing, in the United Kingdom, has been largely confined to specific ethno-cultural groups such as the Somali and the Yemeni community. In Europe, Khat-chewing has also spread among members of the Somali community in Rome. The chewing of Khat is the most common method of use but it can also be smoked and taken as tea. The effects include euphoria, increased alertness, excitement with an improved ability to communicate etc. Various physical and psychological problems have been reported among Khat users. Strong associations have been found between Khat use and histories of anorexia, constipation, insomnia, headaches and respiratory problems. Depression and feelings of anxiety seemed to be less common although various forms of psychosis have been associated with Khat among migrant populations such as the Somali population. The prevalence of tobacco smoking is high among the Khat chewers in the London's study. Although illegal drugs are relatively uncommon among Khat chewers, cannabis use has been reported. It is considered that there are no physical symptoms or withdrawal of Khat or tolerance in contrast to the marked tolerance observed with amphetamine misuse. Despite the widespread of Khat use, few individuals appear to request help with their Khat use. It is clear that the pattern and perceptions of Khat use are changing among the community of Khat chewers.

Key Words: Khat Somali community, Patterns of use, Effects-Medical and Psychological.

Introduction

The use of Khat (Catha Edulis, Forskal) was listed in an Islamic medical book[36] more than seven centuries ago. During the last decade, with improved cultivation of the Khat plant, together with migration of people to developed countries and with more rapid communication, it has been observed that Khat-chewing has reached epidemic level in some countries[4]. Several millions people are estimated to be frequent users of Khat[27] and its consumption is increasing.

The World Health Organisation Expert Committee on Drug Dependence included Khat type substances of Catha Edulis in their group of "dependence-producing drugs" and felt that the compounds meet

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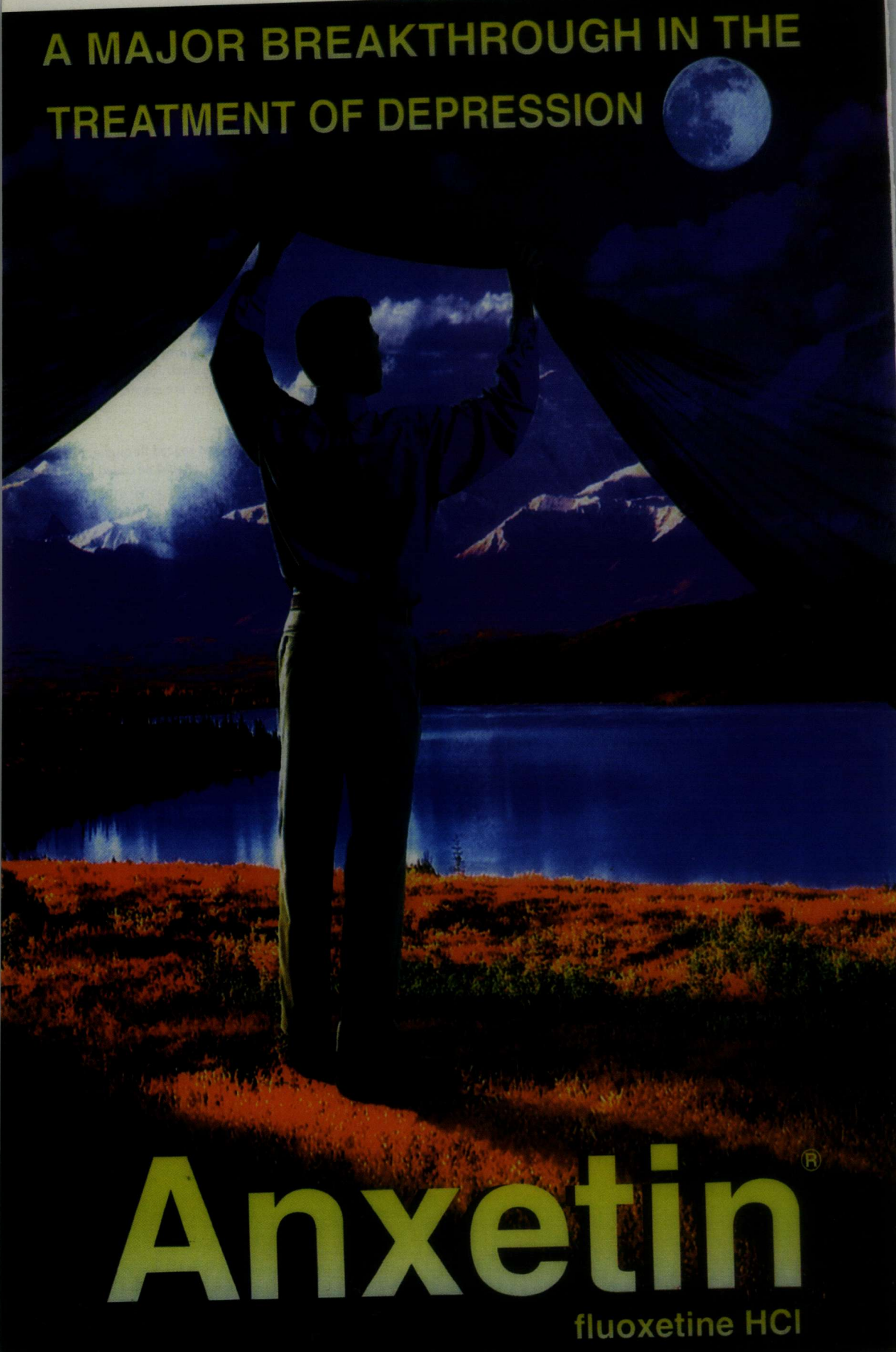
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Manuscripts must be submitted as an original with two copies and must be typewritten, double-spaced throughout in ISO A4 pages with a margin of 3 cm. Sub-heading in the text should be limited to three grades and should be coded in the left margin.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

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

Page1: Title, running head (Max: 40 letters), title or 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.

Acknowledgment of financial support and persons who have had major contribution to the study can be included on a separate page.

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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1. Zeigler FJ, Imboden, JB, Meyer E. Contemporary conversion reactions: a clinical study. Am. J. Psychiatry 1960; 116:901-10.
2. Mosey AC. Occupational therapy. Configuration of a profession. New York: Raven Press, 1981.
3. Gotesman KG. Behavioural aspects of physical illness. In: Ohman R, Freeman H, Holmkvist AF, Nielzen S, editors. Interaction between mental and physical illness. Needed areas for research. Berlin: Springer Verlag, 1989: 120-34.

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st day, 25 or 50 mg on the se-
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p to 300–450 mg p.o. (in some
300 mg) per day in divided do-
mum oral dose: 900 mg/day. For
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dications
nsitivity to the drug; history of
uced granulocytopenia/agranu-
; impaired bone marrow function;
lled epilepsy; alcoholic and other
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ion; severe hepatic, renal, or car-
ease.

tions
can cause agranulocytosis. Its
uld be limited to treatment-resist-
izophrenic patients who have nor-
cocyte findings, and in whom the
tory white blood cell counts (week-
ng the first 18 weeks, at least
y thereafter) can be performed.
nitant use of drugs with a substan-
ential to depress bone marrow func-
d of long-acting depot antipsycho-
ould be avoided. For instructions on
proceed in the event of infection
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ation.
n when patients drive a vehicle or
te machinery; with patients with a
y of seizures; in the presence of car-
icular, renal or hepatic disorders,
tic enlargement, narrow-angle glau-
; in children and in elderly patients;
g pregnancy and lactation.

actions
ol, MAO inhibitors, CNS depres-
, narcotics, antihistamines, benzo-
pines, anticholinergic drugs, antihy-
nsive agents, adrenaline, drugs with
ratory depressant effects, warfarin
other highly protein-bound drugs, ci-
dine, phenytoin, carbamazepine, fluo-
ne, fluvoxamine, lithium. See full pro-
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effects
nulocytopenia, agranulocytosis, throm-
ytopenia, eosinophilia, leucocytosis,
siness, fatigue, sedation, dizziness,
dache, confusion, restlessness, agita-
, delirium, EEG changes, myoclonic
s, seizures, rigidity, tremor, akathisia,
y rarely neuroleptic malignant syndro-
; dry mouth or hypersalivation, blurred
on, disturbances in sweating and tem-
ature regulation; tachycardia, postural
otension, hypertension, in rare cases
culatory collapse, respiratory depres-
n or arrest, ECG changes, isolated
ses of cardiac arrhythmias, pericarditis,
ocarditis, rare cases of thromboembo-
m; dysphagia, aspiration, nausea, vom-
ng, constipation, ileus, weight gain, he-
tic dysfunction, rarely cholestasis or
ute pancreatitis; urinary incontinence
retention, in a few cases priapism, iso-
ted cases of acute interstitial nephritis;
enign hyperthermia, hyperglycaemia,
PK elevation, skin reactions; isolated re-
orts of unexplained sudden death; isola-
d cases of leukaemia and tardive dyski-
esia have been reported.

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ountry specific

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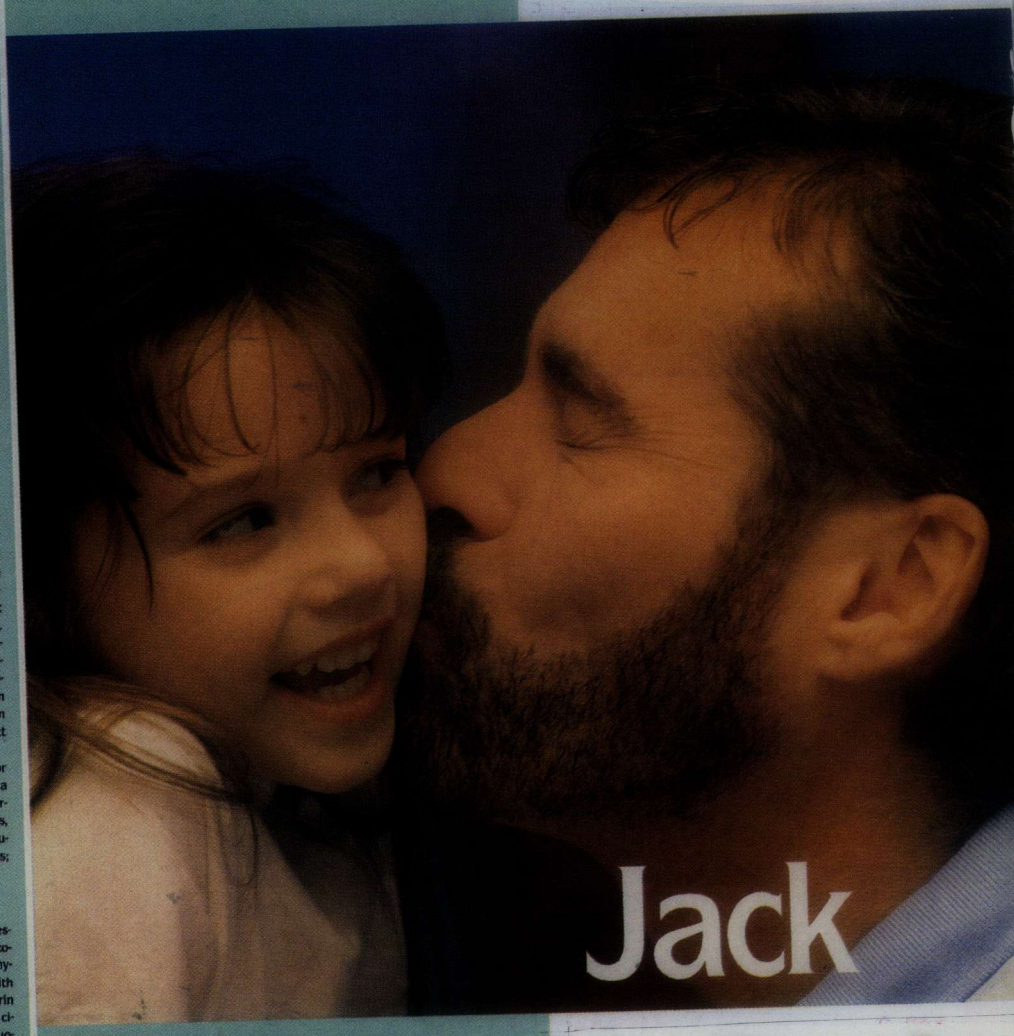

Jack, a treatment-resistant schizophrenic, was once considered hopeless.

- Onset of symptoms at age 25
- Diagnosis: Chronic disorganised schizophrenia
- Therapy history:
  Inadequate response to standard antipsychotic agents:
  chlorpromazine, thiothixene, haloperidol
- Lifestyle:
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  Isolated, alone
  Increasingly frequent hospitalisation from age 27

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Vol. 11, No. 1 May 2000

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Published by

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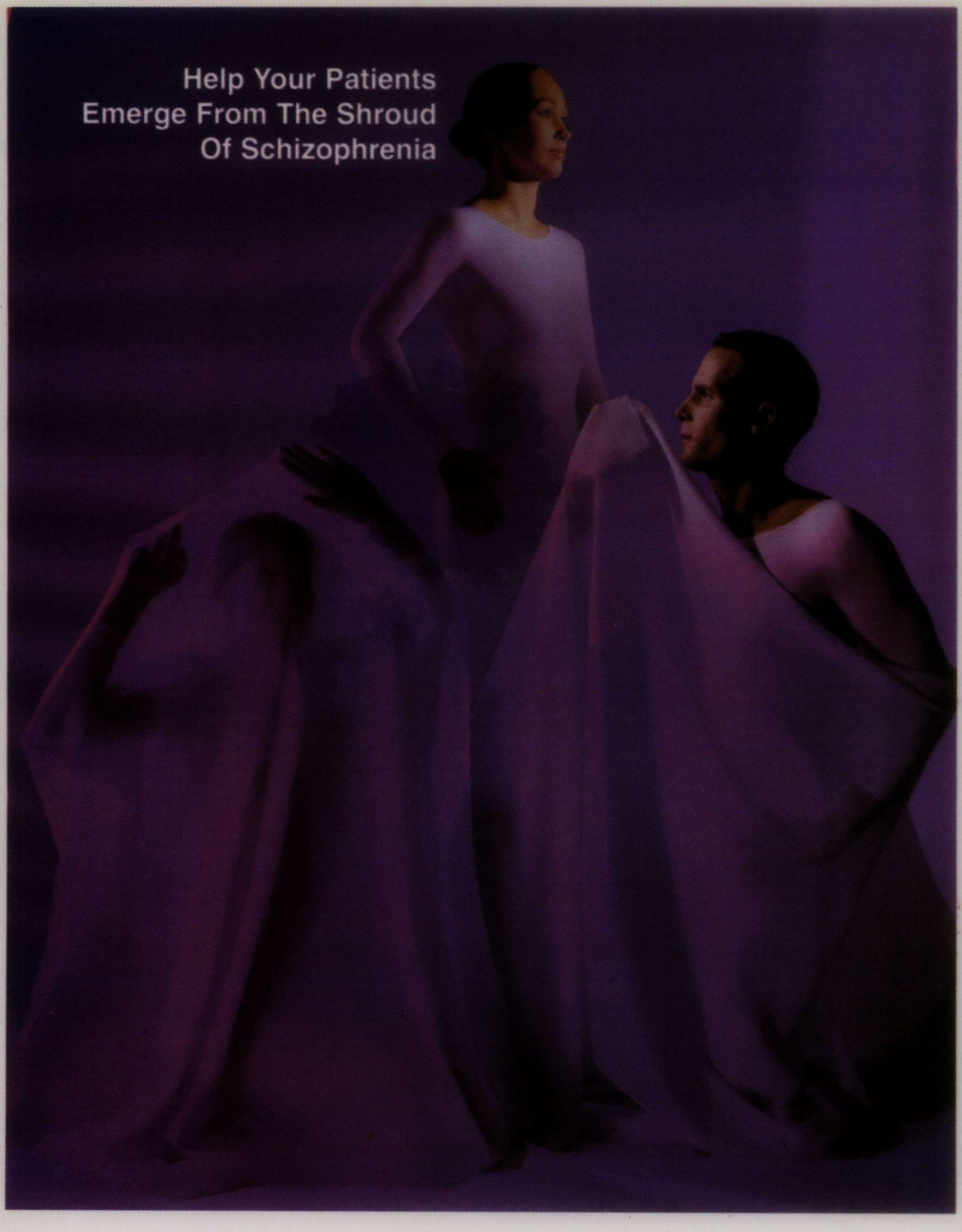

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