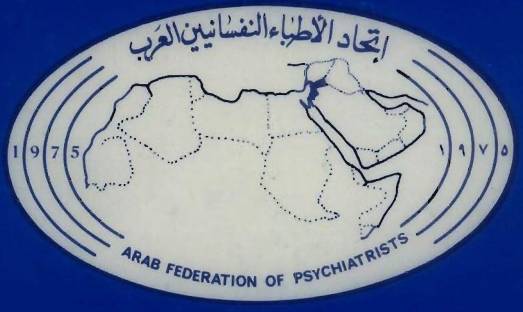
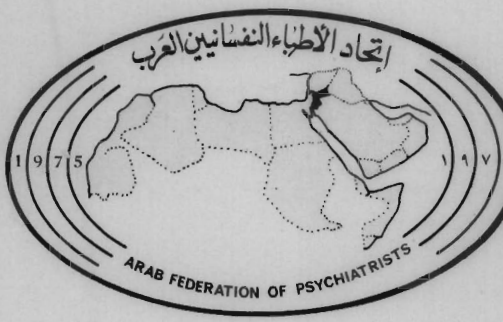


المجلة العربية للطب النفسي

المجلد الثاني . العدد ٢ . تشرين٢ (نوفمبر) ١٩٩١

تصدر عن
إتحاد الاطبّاء النفسانيين العرب



المجلة العربية للطب النفسي

المجلد الثاني ، العدد ٢ ، تشرين٢ (نوفمبر) ١٩٩١

تصدر عن
إتحاد الأطبّاء النفسانيين العرب

شعبة إتحاد الأطباء العرب

٦١٦,٨٠٥
مجل المجلة العربيـة للطب النفسي / اتحاد الأطباء النفسيين العرب. ـ عمان، ع١، تشرين ثاني، ١٩٨٩
٩٠ ص
ر٠١٠ (١٩٨٩/٦/٣٤٥)
١ ـ الطب النفسي ـ دوريـات أ ـ اتحاد الأطباء النفسانيين العرب

(تمت الفهرسة بمعرفة دائـرة المكتبات والوثـائق الوطنية)

Design, Artistic Layout, and Follow up:
Siham Al-Wahoush, Center for Educational Development for Health Personnel, University of Jordan

طبـع في شركة الشرق الأوسط للطباعة ـ تلفون ٨٩٤٩٤٠ ـ ٨٩٤٩٤١ ـ ص.ب ١٥٢٨٦ ـ عمّان ـ الأردن ـ ماركا الشمالية

﴿بسم الله الرحمن الرحيم﴾

رسالة المحرر

زميلي العزيز ،

تتقدَّم هيئة التحرير ببالغ الشُّكر والعرفان لهؤلاء الزُّملاء الَّذين بذلوا جهوداً جمَّة للمحافظة على استمرار نشر هذه المجلة والمحافظة على نوعيّتها، وإذ نشعر أن العمل العربي المشترك وتكريس الجهود لرفع مستوى الطب النفسي العربي هو من النِّقاط الَّتي تُساهم في ازدهار المجلة وتبقىٰ على تقدُّمها.

كما نشعر أن مجلَّتكم هي إحدى الملامح الهامَّة كرمز للوحدة، واننا إذ ندعوكم إلى هذه الوحدة ونعمل معاً لهذا الهدف النبيل.

وأخيراً فإننا ندعوكم للمشاركة بهذا العمل المشترك الذي يهمُّنا جميعاً.

مع التحية

المحرر

معلومات هامة للناشرين

يصدر اتحاد الاطباء النفسانيين العرب المجلة العربية للطب النفسي مرتين في السنة.

وتستقبل المجلة من الزملاء البحوث العلمية والمقالات العلمية ودراسة الحالة في جميع حقول الطب النفسي على أن لا تكون قد قدمت للنشر في أي مجلة أخرى وتقبل النصوص في اللغات العربية والانجليزية والفرنسية ويرفق بالبحث ملخص لا يتجاوز (١٥٠) كلمة على ان يضم ترجمات له في اللغتين الاخريتين.

ملاحظات هامة لمقدمي الأبحاث:

تهتم هيئة التحرير بوضوح التعبير والصياغة الجيدة ويجب ان تكون مطبوعة بمسافات مزدوجة بين الاسطر وبوجه واحد من الورقة وبهوامش واسعة ويفضل حجم الورقة ان يكون ٢١ × ٢٨ سم، ويجب ترقيم الصفحات ابتداء من صفحة عنوان المقال بشكل متسلسل، ويجب ان يكون العنوان قصيرا وذو دلالة لمحتويات البحث ويكتب في الصفحة الاولى اسم الكتاب، اسماءهم ودرجاتهم العلمية وعنوانهم الكامل ويرسل الباحث ثلاث نسخ من المقال الى محرر المجلة.

المراجع:

يعمل قائمة بالمراجع في نهاية البحث مرقمة حسب اولوية ورودها في النص الاصلي. وتشمل اسم العائلة للكاتب والحروف الأولى من اسماءه الاخرى. سنة. البحث وعنوان البحث بالاضافة الى اسم المجلة او الكتاب ورقم المجلد ورقم الصفحة.

(١) **مثال: م، س، عبد الجواد وعرفة، م. (١٩٨٠) دراسة عبر ثقافية لاغراض الكآبة المجلة المصرية للطب النفسي، ٣:٣٢ ـ ٣٧.**

أما الصور والجداول والاشكال فيجب ان تقدم بأوراق منفصلة مع تفاصيل عن ماهيتها وبيان موضعها من البحث ويجب الرجوع الى المرجع المتعلق بالابحاث المقدمة للمجلات الطبية Br. Med. J. 1988; 296:401-405 للتقيد بشروط تقديم الصور والجداول والاشكال. آخر موعد لتقديم الاوراق ٣٠/٩ و ٣٠/٣.

★ **يرسل للباحث عشر نسخ من المقال بدون مقابل.**

★ الاشتراكات: ان الاشتراك في اتحاد الاطباء النفسانيين العرب يهيىء للمشترك استلام المجلة مجانا.

★ الاشتراك السنوي (٢٥) دولاراً أمريكيا / (٤٠) دولارا أمريكيا لغير الأطباء النفسانيين العرب

★ ثمن العدد الواحد (٢٠) دولارا أمريكيا

★ يرسل الاشتراك للبنك الاهلي الاردني/ جبل عمان ـ عمان ـ الاردن.
رقم الحساب ١٢٠ **يُرسل الاشتراك بحوالة بنكية فقط**

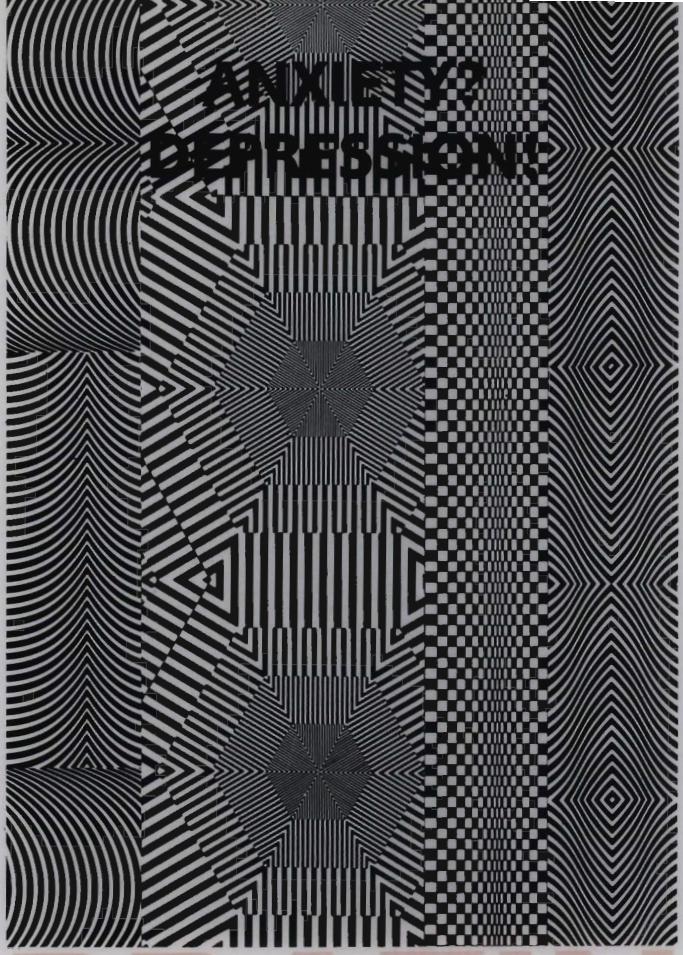
★ عنوان المجلة المحرر المسؤول ـ الدكتور عدنان التكريتي ص ب (٥٣٧٠) عمان، الاردن.

THE ARAB JOURNAL OF PSYCHIATRY

المجلة العربية للطب النفسي

هيئة التحرير

هيئة المستشارين



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المحتويات

المجلة العربية للطب النفسي العدد ٢ ، المجلد ٢ ، ص 184 - 170

دراسة عن الطب الشعبي في مستشفى الصحة النفسية بالرياض

فرج محمد حسين

A STUDY OF THE ROLE OF UNORTHODOX TREATMENTS OF PSYCHIATRIC ILNESSES

Faraj M. Hussien

ملخص:

تمّت هذه الدراسة على عيّنة عشوائية عددها (١٥٠) من مراجعي العيادات الخارجية لمستشفى الرياض للصحة النفسية. أظهره النتائج أن نسبة ٧٩٪ تقريبا من هذه العينة قد راجعوا المعالجين الشعبيين قبل أو بعد مراجعة هذه العيادات النفسية. وبالواقع فإن ٥٣٪ تقريبا قد راجعوا المعالجين الشعبيين قبل مراجعة العيادات النفسية. في هذه الورقة العلمية تم بحث انواع العلاجات الشعبية والتسميات التي تعطى للحالات النفسية المختلفة.

ان دوافع الناس الذين يراجعون المعالجين الشعبيين ما تزال في حاجة للدراسة للتحقّق منها.

ABSTRACT

This study was done on a random sample of the outpatient population of Riyadh Hospital for Mental Health in Saudi Arabia. (No. 150).

The results showed that approximately 79% of the sample have consulted a popular therapist before or after they came to the psychiatric

clinic. In fact about 53% have consulted the popular therapists at first.

The types of treatments given by those therapists and their nosology of mental illnesses are discussed in detail. The motivation of people seeking unorthodox treatments for mental illness is yet to be determined.

Résumé

Une étude sur le Rôle des traitements populaires dans les maladies psychiatriques

Cette étude effectuée sur un échantillon de 150 malades en soin externe dans un Hôpital psychiatrique à Ryad. Arabie Saoudite.

Les Résultats ont demontré qu'approximativement 79% des malades ont consulté les "guérisseurs" avant ou aprés être venus à la clinique psychiatrique.

En réalité 53% ont consulté les "guérisseurs" an début Les différents types de ces traitements et la nosologie des maladies mentales ont été étudiés en détail. La motivation des malades recherchant les "guérisseurs" reste à déterminer.

المقـدمـة:

ان التمييز بين ما هو طبيعي وغير طبيعي في سلوك فرد ما أو في طريقة تفكيره متعلق لدرجة كبيرة بثقافة المجموعة البشرية التي ينتمي إليها هذا الفرد أو بتعبير آخر بالمعتقدات والقيم والتقاليد التي تؤمن بها هذه المجموعة من الناس.

في هذه الحـالة يعتبر الفحص التقليدي للحالة النفسية غير كاف للوصول الى التشخيص. من هنا تبرز اهمية تفهّم العوامل والقوى الثقافية والبيئة المختلفة التي تحكم حالة المريض وان الدعوة تبدو هنا ملحة لتدريب كوادر من المعالجين النفسيين على نماذج الفحص بالمفهوم البيئي للمريض.

وتبعاً لما سبق فإننا نرى ان الكثيرين لا زالوا يولون ثقة كبيرة للطبيب الشعبي لأنـه يتنـاول العلة بمعنـاهـا الشامل للفرد والبيئة. وقد اجمع

الباحثون في حقل الدراسات الثقافية انه لا بد من صيغ للتعاون بين الطب النفسي من جهة والطب الشعبي من جهة أخرى. كما انه لا بد من خلق الوعي الصحي النفسي عن طبيعة المعالجات الشعبية واستطباباتها.

نبذة تاريخية:

لقد اتصفت فترة ما قبل الاسلام ببعدها عن الروح العلمية، والمعلومات المستقاة عن تلك الفترة في مجال العلوم الطبية والاجتماعية هي من الشعر والادب الشعبي.

وكان لهم معتقداتهم الخرافية وعاداتهم الاجتماعية ويؤمنون بتعدد الآلهة كما يؤمنون بالقوى الخارقة. وكان لهذا اثر على معتقداتهم عن الامراض ومعالجتها، وكان يعتقد ان اسباب الامراض النفسية هي الارواح الشريرة والجان. وقد استعملت الرقي والحجب كما استعملت بعض الاعشاب وأساليب كالحجامة والكي في علاج الامراض بشكل عام.

الطب العربي التقليدي في الجاهلية لم ينتقل بالكامل الى صدر الاسلام كما هو.. بل ادخلت عليه تحسينات مهمة اغلبها يعتمد على العقل والمنطق قبل ان يعتمد على الخبرة والتجربة، وكان التداوي بالجراحة يشمل عمليات الكي والخزم والحجامة، وكانت انواع الكي والخزم اما اسعافية عاجلة واما شفائية واما وقائية، وانواع آلة الكي والخزم اما معدنية واما نباتية واما حيوانية، واصول الكي لم تكن عشوائية ولم تكن غير مقبولة الا في حالات اضطرارية.. لا ينسون حديث رسول الله صلى الله عليه وسلم وهو يقول: «الشفاء في ثلاثة.. شربة عسل وشرطة محجم وكية نار.. وانهى امتي عن الكي.» وكانت مهارة الممارسين تعتمد على حكمة المداوي وعمق فهمه كما تعتمد على الخبرة والفراسة والمقارنة بين الحالات، ليس هذا فقط بل لها مواقع محددة وضمادات معينة ولها زيارات ومتابعة(٢)

يقول الامام العلامة ابن القيم الجوزية: المرض نوعان: مرض القلوب، ومرض الابدان، وهما مذكوران في القرآن ـ ومرض القلوب ـ نوعان: مرض شبهة ومرض شهوة وغي وكلاهما في القرآن(٣).

ومن الاطباء الشعبيين العرب من قسم الامراض النفسية الى:

١ـ الوشرة: تتميز بالهذيان.. وتكون اجابات المريض غير مرتبطة بالاسئلة الموجهة اليه.

٢ـ الجنون: وينقسم الى:
أ ـ جنون الرأس
ب ـ جنون القلب

وبعض الاطباء الشعبيين لا يفرقون بين الوشرة والجنون.

١ـ الوشرة: سببها هو سوء التئام عظام الجمجمة عند ملتقاها.. ويحتاج الى تحسس الرأس لاكتشافها في صورة مرتفعات أو منخفضات دقيقة في رأس المريض والتي تعنى في تقديرهم وجود الوشرة.. وقد قسم بعضهم الوشرة الى ذكر وانثى وهذا يتوقف على وجود مرتفع أو منخفض، ويلجأ بعضهم الى حلق رأس المريض تماما وطلائها بصفار البيض او الحناء لاكتشاف موقع الوشرة.. وبعضهم يقسمها الى وشرة قديمة او حديثة تبعا لحرارتها او برودتها وتعالج الوشرة بالكي في مكانها او اضافة كي في مناطق اخرى...

٢ـ الجنون: وتكون بالنظرة الفاحصة الى عيون المريض والفراسة وهما الطريقتان الى الوصول الى تشخيص الجنون.. وعلاجه.. قراءة القرآن، وضع كمادات ساخنة لرأس المريض، وضع لبخة من الحناء او ماء الورد وحبة البركة، استنشاق زعفران ايراني..

٣ـ الحسد والجن والعين والنفس:ـ

تعتبر اسباب المرض اكثر منها امراض في حد ذاتها واعراضها:

ضيقة الصدر، الحزن، اختلال التفكير، الاعراض الجسمية (مثل الشعور بالضعف والتنميل).. وعلاجه الشعبي: قراءة القرآن اما مباشرة او على زيت وماء او شراب او فكس. ثم يخلط الشراب بالماء فيشربه المريض أو يغتسل به أو يدهن بالزيت او بالفكس، ويحدث كثيرا ان تكون المياه مخلوطة بالزعفران، ثم يكتب بها على ورق (عزيمة) تعطى للمريض الذي بدوره يضعها في الماء، ثم يشربه ويغتسل به[٤].

هدف البحث:

دراسة دور الطب الشعبي وآثاره وطرقه العلاجية ودرجة اقبال المرضى النفسيين عليه في مستشفى الصحة النفسية بالرياض.

المواد والطرق المستخدمة في البحث:

ـ مائة وخمسون من المترددين على مستشفى الصحة النفسية بالرياض والذين يعانون من اضطرابات نفسية.

ـ تعرض المائة وخمسون مريض الى مجموعة من الاسئلة شملت التالي:

١ ـ اسم المريض/ ..... ٢ ـ الجنس ذكر ☐ انثى ☐

٣ ـ عمر المريض/ ..... ٤ ـ المدة الزمنية للمريض/ .....

٥ ـ تاريخ أول زيارة للمستشفى/ ..... ٦ ـ المستوى التعليمي للمريض:

اطفال دون سن الدراسة ☐ امي ☐ يقرأ ويكتب ☐

انهى الدراسة الابتدائية ☐ متوسطة ☐ ثانوي ☐ مستوى جامعي ☐

٧ ـ من زار اولا: الطب الشعبي ☐ الطب النفسي ☐

٨ ـ أسباب اختيار المريض للطب الشعبي:

١ ـ لعدم معرفته بوجود خدمات نفسية ☐

٢ ـ لاعتقاده في الطب الشعبي ☐

٣ ـ لبعد الخدمات النفسية عن منطقته ☐

٤ ـ يأسه من العلاج بالطب النفسي ☐

٩ ـ عدد مرات زيارة المريض للطبيب الشعبي / .....

١٠ـ هل نصح الطبيب الشعبي بالتوجه للطبيب النفسي نعم ☐ لا ☐

١١ـ نتيجة زيارة الطبيب الشعبي: ناجحة ☐ فاشلة ☐ ازدادت سوءا ☐ حول الى مستشفى ☐

١٢ـ نوع العلاج المقدم (طريقة العلاج)

* ـ كي ☐ هل سبقه الحلق نعم ☐ لا ☐ مساحته ☐ / عدد الكيات ☐ اماكن الكي على الرأس ☐

* ـ علاج بالقرآن ☐ * ـ علاج بالاعشاب ☐ * ـ الحمية (امتناع عن الطعام) ☐ نوع الممنوع ( )

* ـ اكثر من طريقة ☐

١٣ـ النصائح التي قدمها الطبيب الشعبي:

١ ـ

٢ ـ

٣ ـ

١٤ـ تشخيص الطبيب الشعبي : جن ☐ عين ☐ حسد ☐ نفس ☐ وشره ☐ جنون ☐

١٥ـ التشخيص الاكلينيكي:

طرق العلاج الشعبي:

١ـ الاعشاب المستخدمة في الطب الشعبي

مضادات التنشنج: اليوسين.

مضادات الهستيريا: مورنجا اوليفرا.

المنـومـات: السكـران المصري، ابو النوم والخشخاش والافيون

المهـدئـات: الوطواط، كونـايـزا، داتـورة، حلبـلات، امبرطه، التبغ الاخضر، شقائق النعمان، سعتر معروف، يم الفأر، شبكة.

المثـيرات: العـدنـة، الخـولنجـان الكبـير، البابونج، عيفجان، قرع مسكر، حب العزيز، سمسم، عرفـج، جرجـير، بيلسان، قرض، انيسـون، بطم، القـرنفـل، شمـر، لبلاب متسلق، رشـاد،زقـوم، جديبـة، نعنـاع لافانديولس، حبق (نعنع بري)، حبق (نعنع مغربي)، حبق عطسان، شقائق النعمان، كبـابـه، اراك (مسـواك)، سلين بيركـلي، شليات، زنجبيل، حلبة.

لأمراض الجنون: كوفولفيوس أوكسى

داتوره

تفاف مارتمس

للذهان: بكرس سيانوكاربا(٥)

٢ـ الكي: وهـو سر من أسرار الحـرفـة يتعاملون بأسرارها كما يتعاملون مع أسرار قيـافـة الاثـر والفـراسـة، اذ لهـا حدود ومواصفات ولها اوضاع من الجسم محددة..

أ) ومنهـا ما يكون بالنار نفسها لذعة واحـدة او عدة لذعات تبعا لاختيار اهل الخبرة والمتطببين.

ب) وعندهم قاعدة (الوقت المناسب من اليـوم والفصـل من السنة) اما ليلا واما نهارا، (وحسب الاسرار التي يحتفظون بها لأنفسهم.. فهـو مورد رزقهم وشهـرتهم)، والآلات اما حلقية او على شكل خاتم او على شكل ميسم مستطيل متقاطع او متوازي، واحيـانا يدخلون معها (الرماد النباتي او المعـدني الحار، والرمل الحار، والحمامات الحارة، والتدليك)(٢).

اما لتخدير مكان الكي فيعتمد على:

أ) القـوة المعنـوية عند المصاب ومدى قدرته على الصبر واستعداده لتحمل الالم، مما يساعد جدا على اختفاء الالم.

ب) عملية الكي نفسها هي عملية تخدير موضعيـة (لفقـد الاحسـاس بالنار) وهي نفسها عملية تطهير بفعل الحرارة، وتعتمد على خبرة الطبيب الشعبي المعالج ومهارته وبراعته في تنفيذ العملية بسرعة خاطفة.. امـا الاوضـاع المرضية التي يدخل فيها الكي فشيء لا نعـرفـه علميـا على الوجه الصحيح حتى الآن، ويعدّ سرا من اسرار الحرفة(٢).

٣ ـ الحجامة:

نوعـان ـ الجاف ـ والرطب.. واخبارها جاءت من حكماء اليونان، وفوائدها محدودة ـ وهي عملية فصد الدم.

٤ ـ الحمية:

وهي الامتناع عن بعض أنواع الاطعمة(٢)..٥ ـ قراءة القرآن والرقية:

والقرآن شفاء للصدور لا شك في ذلك اذا اخلص صاحبة النية لله.

والميراث الثقافي الاسلامي العظيم والتميز الخاص بالشخصية الاسلامية في المجتمع السعودي يكرر وبالحاح ضرورة اعادة النظر في التعامل مع المرضى النفسيين وبصورة مختلفة وبنموذج معين(٢).

وقد اشار كلينمان ورفاقه (١٩٧٨) بتقديمهم للعمل المتميز لفبرجا (١٩٧٤) بضرورة عمل ذلك النموذج والتنبيه اليه للمريض النفسي حسب بيئته الثقافية، وقدم ذلك للممارسين النفسيين، ويشير ذلك الى ان اهتمام المعالجين النفسيين بالمرض وليس العلة يعطى الاثر السلبي من عدم الرضا وعدم الطاعة من قبل المريض او اهله نتيجة العناية الاكلينيكية الغير كافية(١).

ومن هذا المنطلق ـ لا بد ان يكون المعالج النفسي منتبها الى ضرورة المقارنة بين نموذجه الاكلينيكي مع نموذج المريض.. وان التعارض بين الاثنين يدعو الى ضرورة تعليم المرضى، والشرح المستفيض للأعراض الاكلينيكية وبمعنى ادق عملية التفاوض مع المريض، وعلى الرغم من ان بعض الاعراض والشكاوى النفسية وعلى حسب التأثيرات الثقافية يمكن اعتبارها شبه ذهانية وليست فصامية، لذا يجب التأكد من ان المريض قد ادخلها ضمن العملية التفكيرية اولا.. اي لا بد من وضع الخلفية الثقافية في حوارنا مع المرض(١)...

النتائج

هذه الدراسة شملت ١٥٠ مريضا من المترددين على مستشفى الصحة النفسية بالرياض والذين يعانون من الاضطرابات النفسية في الفترة من ربيع اول عام ١٤٠٩هـ وحتى نهاية جماد أول عام ١٤٠٩هـ.

جدول (١)

توزيع الاعمار: اعمار المرض تراوحت بين ٤ سنوات، ٦٥ سنة بمتوسط ٣٣,٥ عاما..

العمر بالسنوات	عدد المرضى	النسبة المئوية
ـــ ـ ١٠	٥	٣,٣
١١ ـ ٢٠	١٣	٨,٧
٢١ ـ ٣٠	٥٠	٣٣,٣
٣١ ـ ٤٠	٤٦	٣٠,٧
٤١ ـ ٥٠	٢١	١٤
٥١ ـ ٦٠	١٣	٨,٧
فوق ٦٠	٢	١,٣
	١٥٠	١٠٠

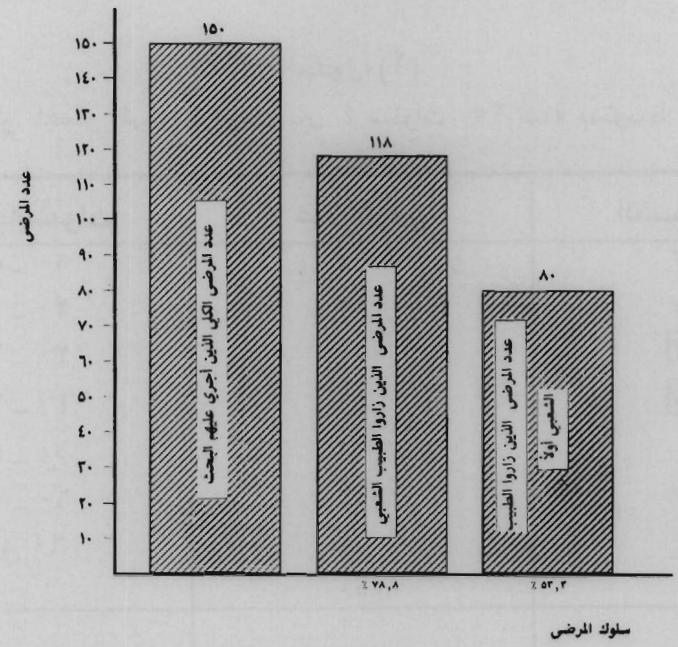
توزيع الجنس: جدول (٢)

الجـنـس	عدد المرضى	النسبة المئوية
ذكـــور	٩٢	٦١,٣
إنـــاث	٥٨	٣٨,٧

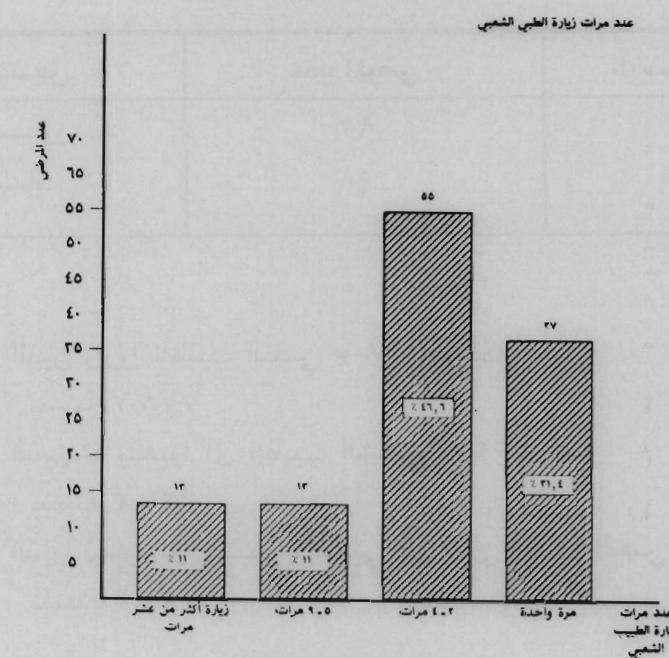
ـ عدد المرضى الذين زاروا الطبيب النفسي = ١١٨ مريضا
بنسبة ٧٨,٧٪

ـ عدد المرضى الذين لم يذهبوا الى الطبيب الشعبي = ٣٢ مريضا
بنسبة ٢١,٣٪

ـ عدد المرضى الذين ذهبوا الى الطبيب الشعبي اول قبل الطبيب النفسي ٨٠ مريضا
بنسبة ٥٣,٣٪

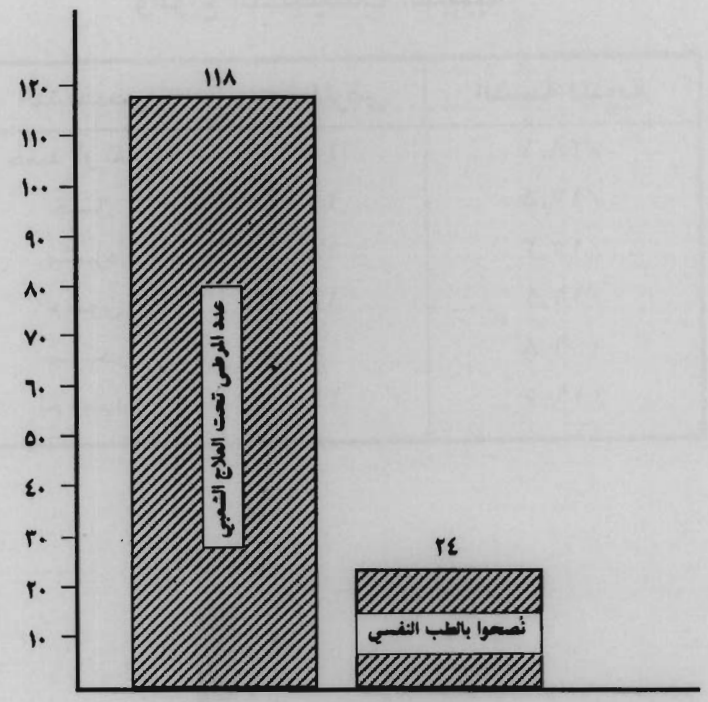


شكل (١) يبين نسبة وعدد المرضى الذين زاروا الطبيب الشعبي وأيضاً عدد المرضى الذين زاروا الطبيب الشعبي قبل الطبيب النفسي



شكل (٢) يوضح عدد زيارات المرضى للأطباء الشعبيين

- عدد المرضى الذين نصحهم الطبيب الشعبي بالتوجه إلى الطبيب النفسي = ٢٤ = ٢٠,٣ ٪
- عدد المرضى الذين نصحهم الطبيب الشعبي المعالج بالقرآن = ٢١ = ٢١ ٪



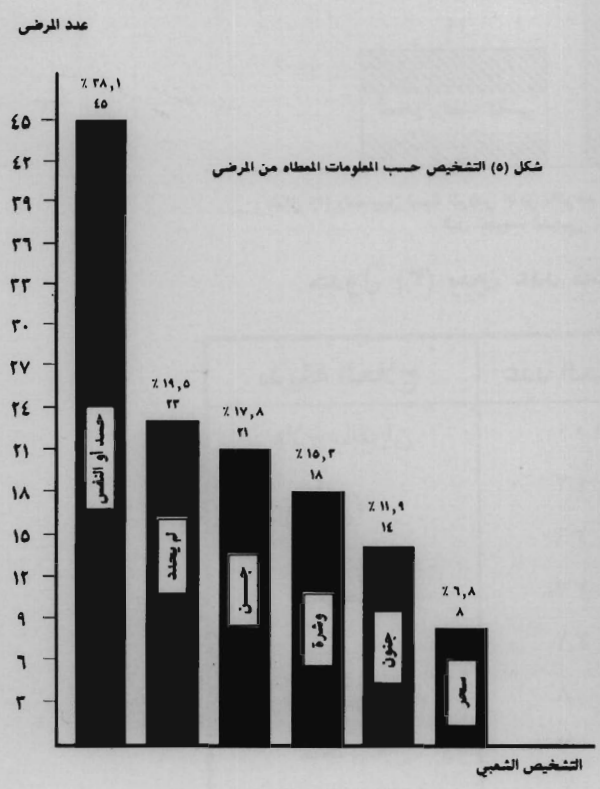
شكل (٣) رسم يبين نسبة المرضى الذين بالتوجه إلى الطبيب النفسي من قبل الطبيب الشعبي

جدول (٣) يبين عدد نسبة الطرق العلاجية

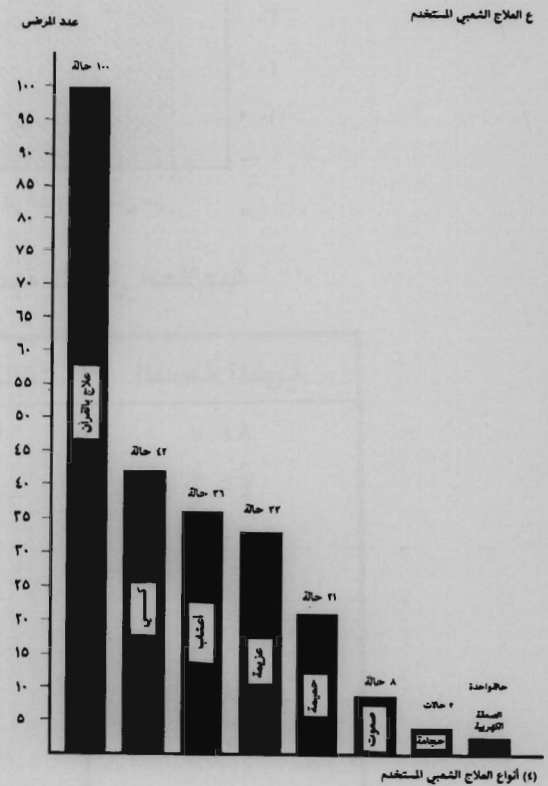
طريقة العلاج	عدد الحالات	النسبة المئوية
علاج بالقرآن	١٠٠	٨٤,٧
كـــي	٤٢	٣٥,٦
أعشاب	٣٦	٣٠,٥
عزيمة	٣٣	٣٨
حميـة	٢١	١٧,٨
صعـوت	٨	٨,٥
حجامـة	٣	٢,٥
صعقة كهربائية	١	,٨

جدول (٤) يبين عدد ونسب وأنواع التشخيصات الشعبية

التشخيص	عدد المرضى	النسبة المئوية
حسد أو نفس	٤٥	٪٣٨,١
جـــن	٢١	٪١٧,٨
وشـــره	١٨	٪١٥,٣
جنـون	١٤	٪١١,٩
ســـحر	٨	٪ ٦,٨
لم يحدد	٢٣	٪١٩,٥



شكل (٥) التشخيص حسب المعلومات المعطاه من المرضى



جدول (٥) يبين التشخيصات الاكلينيكية وعدد المرضى والنسب المئوية

التشخيص الاكلينيكي	عدد المرضى	النسبة المئوية
فصـــــام	٦٦	٥٥,٩
اضطراب انفعالي	٢٠	١٦,٩
قلق نفسي	١٣	١١
تخلف عقلي	٤	٣,٤
ذهان عقاقيري	٢	١,٧
توهم المرض	٢	١,٧
صرع ذهاني	١	,٨
وسواس قهري	١	,٨
اضطراب زوراني	١	,٨
نفسجي نية	٢	٢,٥
لم يحدد	٣	٢,٥
	١١٨	١٠٠

جدول (٦) العلاج الشعبي المستخدم مع حالات الفصام

عدد المرضى الفصاميين	العلاج الشعبي المستخدم			
	كـــي	النسبة المئوية	أكثر من طريقة	النسبة المئوية
٦٦	٢٥	٣٨٪	٤١	٦٢٪

جدول (٧) يبين التشخيصات الشعبية في مرض الفصام

عدد المرضى	التشخيص الشعبي				
	جنون/وشره	لم يحدد	حسد	جن	سحر
الفصاميين ٦٦	٢١ ٪٣١,٨	١٨ ٪٢٧	٢٠ ٪٣٠,٤	٥ ٪٧,٨	٢ ٪٣

المناقشة

تبين من النتائج ما يلي:

* ان ١١٨ مريضاً من عدد المرضى الكُلى والذين أجرى عليهم البحث وهم ١٥٠ مريضا بنسبة ٧٨,٧٪ وهذه النسبة تعتبر مؤشرا عاليا لمدى اهمية دراسة دور الطب الشعبي المؤثر في مجال العلاج النفسي ومحاولة اعادة التقييم لذلك الدور ومدى الاستفادة التي يمكن من ترشيد الطب الشعبي ومحاولة احتوائه وتوظيفه.
* كذا تشير النتائج الى ان ٨٠ مريضا بنسبة ٥٣,٣٪ من العدد الكلي ١٥٠ توجهوا اولا الى الطبيب الشعبي وبنسبة ٦٧,٨٪ من الذين توجهوا الى الطب الشعبي.. مما يدل على: مدى التأثير الكبير للطب الشعبي والاقتناع به.. كذلك يدل على اهمية الاعلام والتوعية بالطب النفسي والضرورة الملحة الى ذلك.. راجع شكل (١).
* وتشير النتائج ايضا الى عدد مرات زيارة الطبيب الشعبي والتي كانت ما يمثل ١٪ من الحالات لأكثر من عشر مرات كانت معظمها للاقتناع بالطب الشعبي او اليأس من العلاج النفسي كذلك لعدم وجود التوعية الصحية النفسية ويشير الى نفس المعنى نسبة ١١٪ لمن تراوحت زياراتهم ما بين ٥ ـ ٩ مرات والى ٤٦,٦٪ لمن زاروا بين ٢ ـ ٤ مرات، ٣١,٤٪ لمن زاروا لمرّة واحدة وهذا ما يوضحه شكل (٢).
* وعلى الجانب الآخر وجدت ان عدد المرضى الذين نصحهم الطبيب الشعبي بالتوجه للطب النفسي ما يمثل ٢٤ مريضا من مجموع ١١٨ مريضا بنسبة ٢٠,٣٪ وهي نسبة نرى انه يمكن

زيادتها بزيادة الوعي فيما يبين الاطباء الشعبيين واذا تحقق الوفاق المرجو من خلال التوصيات التي ستتلى.. انظر شكل (٣).

* ويبين شكل (٤) أنواع العلاج المختلفة حيث شكل العلاج بالقرآن ١٠٠ حالة بنسبة ٨٤,٧٪ والذي يمكن ان يوضح انـه بزيادة التوعية الصحية النفسية فيما بين المعالجين بالقرآن والرقية يمكن تحقيق التنسيق بينهم وبـين الطبيب النفسي ومثـل العـلاج بالكي التـرتيب الثاني في وسائل العلاج بنسبة ٣٥,٦٪ وبعـدد ٤٢ حالة.. والذي يدعـو الى الدراسة العلمية لفائدة هذا النوع من العـلاج ومحـاولة الحـد منهـا حيث استخدمت بصورة عشوائية.. كذلك بين الشكل: ٣٣ حالة عولجت بالعزيمة او الرقية والتي تحتاج في كثير من الاحوال الى اخلاص النية لله مع ضرورة التوجه للطبيب النفسي، ومثلت الحمية ١٧,٨٪ وكـان بعض المـرضى يتحفظون بصور مكتوبة لأنواع الاطعمة الممنوعة والتي بعدت في جانبها العلمي عن الموضوعية والدليـل. ومثلت الحجـامة ٢,٥٪ من الحالات بينما مثلت الصعقة الكهربائية ٨,٪ وهنـا نقدم الدعوة لإعادة النظر ودراسـة الطرق السابقة بشكل علمي موضوعي لتوجيهه وارشاده.

* ويـعـرض البحث التشخيص الشعبي وأنواعه ومثل الحسد والنفس ٤٥ حالة بنسبة ٣٨,١٪ والجن ٢١ حالة بنسبة ١٧,٨٪ بينما شخصت الوشرة في ١٨ حالة بنسبة ١٥,٣٪ والجنون ١٤ حالة بنسبة ١١,٩٪ والسحر ٨ حالات بنسبة ٦,٨٪ ولم يحدد التشخيص في ١٩,٥٪ وبمقارنة التشخيص الشعبي في المملكة مع التشخيص الشعبي في اماكن اخرى وجدانه، يقارب الاسماء والانواع مثل التـشـخـيص الشـعـبـي المـكسيكي الامـريكي.. (ارجـع للمقدمة) وتنافرت التـشـخـيـصـات مع التـشـخـيص الاكـلـينيكي في حالات الذهـان والذي يوضحه جدول (٥) كذلك في جدول (٦) والذي شمل مرض الفصام بين ان الكي استخدم في ٣٨٪ من الحالات الفصامية..

* كذلك بين جدول (٦) ان الجنـون او الوشرة شخصت في ٣١,٨٪ من الحالات ممـا يدل على البعـد والتنافر النسبي للتـشـخيص الشعبي عن التشخيص الاكلينيكي للفصام.

* كذلك من جدول (٥) وجـدول (٤)، حالات الذهـان سجـلت في ٩٠ حالة بنسبة ٧٦,٣٪ من الحالات بينما سجل الجنون والوشرة في ٣٢ حالة بنسبة ٢٧,١٪.

التوصيات

١ ـ من دراسة نسبة عدد الحالات التي تتردد على الطبيب الشعبي يتبين ضرورة اعادة النظر في دور الطب الشعبي كعامل مؤثر في الحالات النفسية والعملية العلاجية.

٢ ـ اقتراح بضرورة تنظيم دورات تدريبية للأطباء في مجال الطب النفسي البيئي والذي يعني بالجانب الثقافي للبيئة السعودية.

٣ ـ ضرورة تغيير نظام الفحص الاكلينيكي النفسي بما يتناسب مع ثقافة البيئة السعودية والبحث في امكانية عمل ما يمكن تسميته بالفحص الاكلينيكي النفسي البيئي.

٤ ـ ادخال المناقشة المتعلقة بثقافة البيئة والطب الشعبي كأحد محاور الاتصال بين الطبيب النفسي والمريض النفسي ومناقشتها وعدم التهكم او السخرية منها.

٥ ـ اقتراح بادخال الاطباء الشعبيين كطرف في الرعاية الصحية الأولية مع التوعية والرعاية والارشاد كطريقة لاحتوائها او تحسين مسارها كما هو معمول به في رعاية القابلات والمولدات في النساء والولادة والذي اوصت به منظمة الصحة العالمية.

٦ ـ الدعوة الى عمل لقاء او ندوة يدعى فيها الاطباء الشعبيين للمناقشة والتوعية..

دكتور/ فرج محمد حسين
اخصائي الأمراض النفسية

المراجع

(١) مرجع الطب النفسي.
كابالان ـ فريدمان ـ ساد وك ـ ١٩٨٠.

(٢) موجز تاريخ الطب العربي.
د. يوسف الحميدان ـ ١٩٨٦ ـ المكتبة السعودية ـ سلسلة الجمعية العربية السعودية للثقافة والفنون.

(٣) زاد السعاد في هدى خير العباد لابن القيم الجوزية ـ مؤسسة الرسالة ـ ١٩٨٢ (الجزء الرابع).

(٤) استقصاء اكلينيكي عن الاطباء الشعبيين وطرق علاجهم د. عبدالكريم الاصقه. كلية الطب ـ جامعة الملك سعود ١٩٨٧.

(٥) كتاب الطب الشعبي ونباتاته التي تستخدم في المملكة العربية السعودية للدكتور/ عبدالرحمن العقيل، الدكتور/ محمد طارق، الدكتور/ محمد اليحيى والدكتور/ منصور السيد ـ كلية الصيدلة ـ جامعة الملك سعود ـ ١٩٨٤.

مكتبة المجلة

القلق ـ قيود من الوهم

د. عبدالستار ابراهيم

كتاب الهلال ـ دار الهلال القاهرة مايو ١٩٩١

يقع الكتاب في ١٥٠ صفحة حجم الجيب ويتكوّن من ستة فصول. يعرّف الكاتب في الفصل الأول القرّاء بطبيعة القلق بأسلوب سلس، ويفرّق بين القلق الطبيعي والقلق العصابي الذي يجعل المرء يعاني من أعراض نفسية وجسمية وفكرية تجعله غير قادر على التكيف النفسي.

اما الفصل الثاني فيبحث في القلق من منظور مجتمعي وثقافي، ويعرّج قليلاً ليتكلم عن القلق من الناحية التاريخية. ويعطي الكاتب نماذج مجتمعية يزيد فيها القلق أو يقل تبعاً لمقاييس معينة، ثم يتكلم عن أمثلة مما يعانيه الفرد في البلاد العربية من أعراض متباينة للقلق من خلال بحوث أُجريت في بعض هذه البلدان والنتائج التي ظهرت نتيجة هذه الدراسات والفرق بين مظاهر القلق بين المجتمعات الغربية والمجتمع العربي، كما يفسر اسباب هذا التباين.

أما في الفصل الثالث فيتحدث الكاتب عن أسباب القلق من الناحية الوراثية، واثر التعلّم الاجتماعي على تطوير القلق واخيرا الضغوط النفسية التي يعاني منها الفرد، والتي تعمل على ترسيب القلق. وقد نجح الكاتب في تبسيط البحث على القارىء عندما سرد النظريات المعاصرة في تفسير القلق سواء من ناحية البيئة النفسية. أو أثر البيئة والتعليم الاجتماعي وبحث في مختلف أنماط التربية وعلاقتها بالقلق.

يتطرق الكاتب في الفصل الرابع الى طرق العلاج سواء كانت بالعقاقير أو المعالجات النفسية، التي تستند على نظريات علاجية تبعاً لمدارس علم النفس المعروفة. ويذكر المحاور الاربعة التي تبنى عليها المعالجة كالمحور الموقفي والمحور الانفعالي ومحور التفكير وتدريب النفس على حرية التعبير وتدعيم الذات.

يبحث موضوع القلق النفسي عند الاطفال بأُسلوب شيّق وفيه من المعلومات القيّمة التي نتحدث عن طرق الوقاية بتطوير سلوكات بناءة عند الأُسرة، حتى ينشأ جيل سوي وغير عصابي. ينهي الكاتب هذا الموضوع الهام بالتحدّث عن ملامح الصحة والوفاق النفسي يبحث

الكاتب في الفصل الاخير أسس الصحة النفسية من منطلق معرفي سلوكي، وفيه يلخص نظرة الانسان لنفسه وتقبله لنظرة الناس اليه كما يحثه على تقبل المعطيات والخصائص التي يمتلكها ويعيش حياتها يعمل بها في خدمة نفسه وخدمة الغير دون ان يؤثر عليه اجترارات الماضي وهموم المستقبل.

اعتقد ان هذا الكتاب يستحق اضافته الى مكتبتك كمرجع جيد عن هذا الموضوع باللغة العربية.

الأستاذ الدكتور عبدالستار ابراهيم يعمل في قسم الأمراض النفسية ـ كلية الطب مستشفى الملك فيصل الدمام ـ السعودية.

مشكلات الأطفال والمراهقين وأساليب المساعدة فيها

شارلز شيفر وهوارد ميلمان

صدر هذا الكتاب عام ١٩٨٩ ـ الطبعة الأولى منشورات الجامعة الأردنية ترجمة الدكتورة نسيمة داود والدكتور نزيه حمدي من قسم علم النفس في الجامعة الأردنية.

الكتاب يزيد عن ستماية صفحة ويقع في ستة فصول، يغطّي فيها الكاتبين عموم المشكلات السلوكية عند الاطفال، وهذه احدى المميزات التي يتمتع بها الكاتبان. فعموميته وأسلوبه السلس والحلول العلمية المحددة التي يطرحها الكتاب تجعله ملائماً للآباء، كمرشد لحل المشاكل النفسية التي يعاني منها الأبناء.

في الفصل الأول يتعرض الكاتبان لمشاكل اضطرابات النضج مثل النشاط الزائد والاعتمادية الزائدة واحلام اليقظة والانانية وغيرها. كما يتعرض في الفصل الثاني للعصاب عند الاطفال كالقلق والخوف والكآبة وغيرها. ويفرد فصلاً مستقلاً عن اضطراب العادات، كالعادات القهرية واضطرابات النوم والاكل والاخراج واضطرابات التكلم.

اما الفصل الرابع فيبحث في اضطراب العلاقات الشخصية سواء كان في نطاق العائلة أو خارجها كالسلوك العدواني والعزلة الاجتماعية وغيرها.

ويبحث الفصل الخامس في الاضطراب الأشد للشخصية التي تشمل السلوكيات اللاإجتماعية كالسرقة والكذب والتخريب والهرب من المدرسة والبيت. وأخيراً يبحث في الفصل

السادس مشكلة الإدمان والاضطرابات الجنسية ومشكلات الدراسة.

اعتقد ان هذا الكتاب يجب أن تقتنيه كل عائلة، فهو حافل بالمعلومات المفيدة والهامة لكل الآباء الذين يتطلعون قدماً لخلق جيل سوي وقادر على المضي قدماً في هذا العصر الذي يتصف بالتحديات.

وأخيراً فقد نجح المترجمان في نقل أفكار المؤلفين بأُسلوب سلس تجعل القارىء العربي يصل اليها بسهولة ويسر.

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Author:

Dr. N.A. Qureshi MD.

Specialist in Psychiatry
Mental Health Hospital, P.O.Box 2292
Buraidah, Al-Qassim,
Saudi Arabia

are the best studied drugs and, moreover, have shown promising results in lithium-resistant bipolar patients. The discontinuation of carbamazepine and poor drug compliance with other medications by this patient remind clinicians that such patients might require close clinical follow-up and drug monitoring.

In short, the author supports the view that antidepressant preparations can induce mania, hypomania, rapid cycling and deteriorating course and in such patients, the administration of these compounds involves risks.

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sion[17] which eventually this patient developed. The author tends to favour the diagnosis of recurrent depression but in the presence of psychosocial stressors, recovery following removal of the stress, symptoms not lasting more than six months, then working at a satisfactory level, a differential diagnosis of adjustment disorder[17] may be considered. However during the second episode of depression, the residual symptoms persisted despite the resolution of intrafamilial discord and treatment with antidepressant drugs which suggested the diagnosis of depression rather than adjustment disorder. Moreover, multiple psychosocial events have been reported frequently to precede the onset of depression. It is generally agreed that patients with recurrent depression are at a greater risk to develop bipolar depression. The antidepressant medication, in this case, has unequivocally accelerated the switch mechanism of manic induction, caused rapid cycling and deteriorating course, thus supporting the belief of other researchers[5-9]. The underlying mechanism of precipitation of mania in affective illness, according to some workers, is mediated by enhanced noradrenergic and serotonergic neurotransmission in the brain[6,7,9,18]. While others have reported lithium[19] and oxidation deficit[20] augmenting some effects of antidepressant drugs to induce mania. However it is expected that with the introduction of newer antidepressants, the other mechanisms of manic induction will appear in the literature.

The dilemma of rapid cycling and deteriorating course whether it is because of antidepressant medications or spontaneous recurrences remained unresolved. As demonstrated in this case by clinical trials and auto-medication with antidepressants, the use of later drugs either alone or in conjunction with lithium is associated with severe mania refractory to lithium but responsive to haloperidol which leads to depression. Therefore the use of these drugs ie antidepressants should be considered as a relative contraindication in such patients. It is, however, author's clinical impression that such patients respond better to relatively higher doses of lithium alone with a serum lithium level somewhere between 1.5-2.0mEq/l without toxic manifestations.

Finally as regards the treatment of rapid cyclers or lithium nonresponders, a large number of somatic therapies including carbamazepine, valproic acid, repeated ECT, sleep deprivation, benzodiazepines, l-tryptophan, l-hydroxytryptophan, rubidium, B-blockers l-thyroxine, haldol decanoate, MAOI-A with lithium, verapimil, and liothyronine have been advocated. Among them carbamazepine and valproic acid

and showed very good clinical improvement over a period of 2 months.

Subsequently the patient has been admitted five more times. The 3rd, 5th, 6th and 7th admissions were related to non-compliance with drugs. The 4th admission was related to imipramine, 75mg/day treatment which brought about hypomanic symptoms within 7 days. The imipramine was administered in combination with lithium (1325mg/d) when the patient developed depressive symptoms. As regards other hospitalizations, the patients ingeniously automedicated. The patient came to know that lithium would control his euphoric symptoms whereas amitriptyline will improve his depression. So he used lithium either irregularly or not at all when he was just euphoric or going to develop depression. But in later case he took amitriptyline in different dosages. In case of mixed state of euphoria and depression, the patient would use amitriptyline but lithium in low dosages or sometimes not. This strategy was identified when patient himself reported so and confirmed by serum lithium level done randomly and it was very low (0.46mEq/1). At this time the patient was advised to take 1600mg lithium per day and, therefore, the serum lithium was expected to be high.

The patient was told the adverse consequences of such maneuvers. At discharge the patient was given 1600mg lithium and 600mg thioridazine. The serum lithium was 1.52mEq/litre. At regular follow-up the patient was clinically improved and maintained. During his last visit, a month before he complained of sexual dysfunctions which necessitated the substitution of thioridazine by CPZ.

There were other noteworthy features about this patient who was having premorbid personality of passive aggressive type. The mean duration of stay during multiple admissions was 15.86 in days (range=7-31 days). During depressive manifestations or mixed state of depression and euphoria he took treatment on OPD basis while in manic or hypomanic phase he required admission. The attitude of family members contributed partly to his early discharge on many times. On one occasion the patient was advised to take carbamazepine, 600mg/day, to which he developed adverse abdominal symptoms and discontinued it by himself. Following manic induction by antidepressant therapy, the patient during a period of 16 month never achieved full remission lasting for 6 months. Finally he got voluntary retirement from his job as he showed inability to work.

Discussion:

Passive-aggressive persons are described to suffer from major depres-

for 5 years as a policeman. About 2 years ago, he was married and reportedly marital relations were good with his wife. However he reported family conflict involving his wife and mother. As a result of it, the patient again came to psychiatric clinic about 16 months ago. He complained of mixed features of depression and anxiety of 2 months duration. The depressive symptoms were more prominent during this episode. The patient was treated with 50mg Amitriptyline nocte initially which was increased to 100mg/day over a period of 4 weeks. Meanwhile the family problem was resolved. However, inspite of it, the patient continued to show the residual features of depression and on 38th day of antidepressant therapy, the patient was brought to the clinic in severe 5 days manic excitement. The patient was admitted to the hospital. Antidepressant treatment was stopped. He was treated with parenteral 30mg haloperidol and was switched over to oral haloperidol equivalent to 1200 CPZ within the next 2 days. He showed substantial improvement and within 7 days manic symptoms were completely disappeared and in the next 2 days the patient manifested depressive features. On 9th day, he was discharged as requested by the relatives. The patient was inadvertently prescribed amitriptyline 50mg nocte and 300mg thioridazine at discharge. With this treatment, he showed good response but developed hypomanic symptoms after 7 days. He was brought again to the clinic in hypomania. Amitriptyline was stopped and lithium carbonate 900mg/day and thioridazine 300mg were prescribed to him. It was noted that prelithium investigations were all negative. Over the next 3 weeks the lithium was increased to 1325mg/day with a serum lithium level of 0.75mEq/litre and the patient showed considerable improvement but within the next few days he showed again depressive symptoms. In combination with lithium ie 1325mg/24hr a challenge dose of amitriptyline 50mg nocte was given along with 100mg of thioridazine. Within 10 days the hypomanic symptoms reemerged. Amitriptyline was stopped immediately and patient was advised to continue lithium 1325mg/ day and thioridazine 100mg nocte. Interestingly this time he did not show improvement but his condition worsened and admitted in full manic syndrome after 3 days of discontinuation of amitriptyline. In hospital he was treated with parenteral 40mg haloperidol, 20mg thioridazine and 1325mg lithium. Within 24hrs haloperidol was discontinued and patient was given only lithium and 7th day he was discharged. He took lithium 1800mg/day with serum lithium level of 1.56mEq/litre. The patient did not manifest any toxic effects of lithium therapy

mania, and recurrent nature of the sample. However these figures of manic precipitation rates are higher than expected without antidepressant drugs. In another review authors[8] concluded that TCA can induce mania, rapid cycling with worsening course in bipolar and, to a lesser extent, in unipolar depressed patients.

On the other hand, in two larger retrospective studies the author[12] inferred that majority of switches seemed to occur as a spontaneous course of bipolar illness and were not significantly influenced by introduction of antidepressant drug treatment. In a recent study researchers[13] suggested that clinicians should be prepared for depressed bipolar patients to switch to mania regardless of treatment status. Furthermore, in one study[15] it was found that 20% of depressed adolescents developed manic episodes within the next 4 years. In a very interesting development, the author[16] reported the successful treatment of mania on three occasions rather than inducement with doxepin. Though most of the studies are anecdotal, evaluating the evidence for and against the manic precipitation by antidepressant drugs, it is viewed that larger placebo-controlled studies are needed to clarify this issue. The objective of this case report is to demonstrate. 1). TCA can induce mania, hypomania, rapid cycling, and worsening course. 2). rapid cyclers pose treatment dilemma. 3). the use of antidepressants in conjunction with lithium involves risks.

Case history

Mr. A,a 23-year-old man came for psychiatric treatment about 6 years ago. He came from a large family comprising of 17 siblings. He is 3rd among them. He was unmarried and employed as a guard. He never liked this job and always felt a need to change it. He was distressed and related his symptoms to job problem. He reported overlapping symptoms of somatization, anxiety, and depression of 5 months duration. The symptoms were not severe and so he continued to work. At the same time he was looking for another job. At physical examination no medical illness was found. The patient did not report any abuse of drugs and alcohol. Similarly there was no family history of affective disorders or other psychiatric diseases. The patient visited religious faith healer earlier but without any benefit. He was prescribed lorazepam 6mg/day for 20 days and advised to return for psychotherapy.

The patient did not maintain any contact with the hospital for 5 years. However he informed that he got a better job within one month following his earlier visit to the clinic. His symptoms were improved and he worked satisfactorily

Résumé

Manie provoqueé par des Antidépressifs tricycliques cycle rapide et aggravation

L'anteur décrit le cas d'un patient souffrant de dépession unipolaire récurrente, qui a développé une manie induite par les anti dépressifs, cycle rapide et aggravation, ce qui a posé un problème de conduite thérapeutique.

A la lumiére de ce cas, les différents possibilités ont été discutées compris le modèls thérapeutiques concernant les malades souffrant de desorde affectif à cycle rapide.

Introduction:

The disturbance in the dynamic equilibrium of various neurotransmitters in the central nervous system due to mutiple biopsychosocial factors is the basic underlying etiological hypothesis of major mood disorders. The psychophrmacology of major depressions primarily involves the reorganization of those neurochemicals in the brain. The antidepressant drugs bring about this disequilibrium back to normal by either blocking the reuptake of neurotransmitters in the synaptic clefts or stopping their degradation in the presynaptic terminal of neurons. The whole mechanism is extremely complex because it also involves many other structural neurosynaptic changes. However, the most important clinical counterpart of disturbed neurotransmitters' homeostasis sometimes engendered by both old and new generations of antidepressants[1-6] is the induced mania or hypomania, rapid cycling and worsening course not only in predisposed bipolar but also in unipolar depressed patients[7-10]. Some researchers are convinced about manic precipitation by antidepressant medication while others are skeptical [11-13] . In an extensive review on switch mechanisms in affective illness the author[6] reported 6.8% manic induction rate by TCA drugs; the time from institution of drug therapy to the onset of mania ranges from few days to 8 weeks; and discontinuation of offending drugs results in clearing the manic symptoms within few days to weeks. In other studies[10,14] the researchers reported 3.4% and 6.5% manic induction rate. The low incidence was attributed to stringent diagnostic criteria, systematic assessment of

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CASE REPORT
TCA-Induced Mania, Rapid Cycling, and Worsening Course

N.A. Qureshi, M.D.

الهوس الناتج عن مضادات الاكتئاب ثلاثية الحلقات الدورة السريعة وتدهور حالات الهوس

نسيم قرشي

ملخص:

يعرض الباحث حالة اكتئاب أحادي القطب متكرر، تطوّرت الى حالة هوس نتيجة استعمال مضادات الاكتئاب ثلاثي الحلقات وأدى هذا الى سرعة دورة الاكتئاب والهوس وتدهور الحالة مما ادى الى مشكلة في العلاج. وعلى ضوء هذه الحالة تم بحث الجوانب المختلفة لعلاج مرضى الاضطراب الوجداني سريعي الدورة.

Abstract

The author describes a case of recurrent unipolar depression who developed antidepressant-induced mania, rapid cycling, worsening course, and posed a management dilemma. In view of this case, relevant issues including the treatment modalities for rapid cyclers are discussed.

C+D	03.55	15.38	3.162*
A+B+D	13.02	-----	-----

* Significant, ** Not significant.

A mainly included Thioridazine, Chlorpromazine, Butyrophenones, Trifluperazine, Fluphenazine.

B mainly Trihexyphenidyl HCl.

C mainly Amitriptyline and Imipramine.

D mainly Diazepam, Chlordiazepoxide.

Authors:

1. **Dr. Naseem Akhtar Qureshi,** MD**
   Psychiatric Specialist,
   Buraidah Mental Health Hospital
   Buraidah, Saudi Arabia.

2. **Dr. Nabil Yasin Al Quraishi,** KFUF
   Director, King Fahad Specialist Hospital
   Buraidah, Saudi Arabia

3. **Dr. Ibrahim Soliman Hegazy,** MD
   (Comm. Med.)
   Director, Medical Education Center
   for Primary Health care,
   Al-Qassim Region, Central Hospital
   Buraidah,
   Saudi Arabia.

**

Correspondence:
P.O.Box 2292
Buraidah Mental Health Hospital,
Saudi Arabia.

TABLE 3

PATTERN OF DOSAGES AMONG STUDIED CASES.

DRUGS	DIAGNOSIS					
	Major psychoses N=169		**Neurotic disorders N=26**		**Total=195**	
CPZ						
<400mg	36	21.30	22	84.62	58	29.74
>400mg	127	75.15	--	-----	127	65.13
ANTIDEPS						
<50mg	23	13.61	14	53.85	37	18.97
>50mg	19	11.24	01	03.85	20	10.26
BDZ						
<10mg	12	07.10	01	03.85	13	06.678
>10mg	16	09.47	03	11.54	19	09.74
ANTIPARK						
<6mg	139	82.25	15	57.69	154	78.97
>6mg	015	08.88	01	03.85	016	08.21

TABLE 4

PSYCHOTROPICS AND THEIR COMBINATIONS USED IN THE TREATMENT OF PSYCHOTIC AND NEUROTIC PATIENTS

DRUGS	MAJOR PSYCHOSES N=169%	NEUROTIC ILLINESSES N=26%	Z VALUES
Neuroleptic(A)	96.45	84.62	2.547*
Antiparkinson(B)	91.12	61.54	4.201*
Antidep(C)	24.85	57.69	3.427*
Anxiolytics(D)	16.57	15.38	0.152**
A+B	62.13	42.31	1.917**
A+B+C	15.98	19.23	0.417**
A+C	05.33	23.08	3.162*

TABLE 2
DISTRIBUTION OF THE CASES IN RELATION TO DEMOGRAPHIC PARAMETERS

DEMOGRAPHIC VARIABLES	DIAGNOSES				
	Affective psychoses N=33	Schizophrenic psychoses N=111	other* psychoses N=25	Neurotic** disorders N=26	P values
Male	26 (78.79)	61 (54.95)	12 (48.00)	16 (61.54)	>0.05##
Female	07 (21.21)	50 (45.05)	13 (52.00)	10 (38.46)	
Nuclear	04 (12.12)	16 (14.41)	10 (40.00)	08 (30.77)	>0.01#
Joint	29 (87.88)	95 (85.59)	15 (60.00)	18 (69.23)	
Illiterate	20 (60.61)	68 (61.62)	18 (72.00)	15 (57.69)	>0.05#
Literate	13 (39.39)	43 (38.74)	07 (28.00)	11 (42.31)	
Rural	12 (36.36)	46 (41.44)	10 (40.00)	08 (69.23)	>0.05##
Urban	21 (63.64)	65 (58.56)	15 (60.00)	18 (30.77)	
Married	19 (57.58)	64 (57.66)	19 (76.00)	17 (65.38)	>0.05##
Unmarried	14 (42.42)	47 (42.34)	06 (24.00)	09 (34.62)	
Unemployed	27 (81.82)	87 (78.38)	22 (88.00)	12 (46.15)	>0.01#
Employed	06 (18.18)	24 (21.62)	03 (12.00)	14 (53.85)	

significant, ## nonsignificant.

a, Depression = 25, manic = 8,

* Organic conditions-OBS=10, MR with psychosis=4, Epileptic psychosis=2 Unspecified psychosis (postpartum)=9.

** Drug dependence=8, Conversion state=6, Neurotic depression=5, Adjustment reaction=4, Anxiety neurosis=3.

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TABLE 1

BASIC CHARACTERISTICS OF THE STUDIED CASES

		N = 195	%
AGE (in years)	30.49±10.85		
Sex			
Male		115	58.97
Female		80	41.23
FAMILY CONSTELLATION			
Nuclear		38	19.49
Joint		157	80.51
EDUCATION			
Illiterate		121	62.05
Elementary		038	19.49
Intermediate		017	08.72
Seconday		013	06.67
College		006	03.08
RESIDENTIAL STATUS			
Rural		76	38.97
Urban		119	61.03
MARITAL STATUS			
Single		76	38.97
Married		92	47.18
Divorced		24	12.31
Widow		03	01.54
OCCUPATION			
Unemployed		148	75.90
Unskilled		004	22.56
Skilled		003	01.54

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use of antiparkinson drugs has been criticized by researchers[22-26]. Similarly the regular use of benzodiazepines which has a potential for abuse[27] was discouraged, though BDZ as an adjunctive to antipsychotics, as found in our study, could be used to control the initial excitement of psychotics[28]. The limited role of other modalities[29-31] and other clinical variables like high rates of polyadmissions and relapses, family history of mental disorders, poor drug compliance and stressors as found in our study, need future research work. Finally the occurrence of physical diseases among our mental patients corroborated the results of other workers[32-33], could be attributed to long stay, poor personal care, oversmoking, nutritional deficiencies, infections and unsocialized habits.

In conclusion, we found, 1). female subjects underutilized the indoor services, 2). joint families and unemplyment were significantly associated with mental diseases, 3). Schizophrenic psychosis was the commonest diagnosis, 4). Polypsychopharmacy was the commonest mode of treatment, 5). antiparkinsons agents were used routinely, 6). physical diseases were common in admitted patients. Keeping in view the limitations of retrospective evaluation, we felt that larger prospective investigations were warranted to study further the different aspects of hospitalized mental patients.

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ric diseases. Considering the significance of other psychosociocultural factors[15] we felt that mental disorders might be the end results of complex faulty interaction between many socioenvironmental variables and biological unseen vulnerabilities of patients.

With few exceptions like unsocialized behavioral disorders, the female gender has shown increased susceptibility to develop mental illnesses due to multiple reasons[16]. However, we, like others[8] found that female patients underutilized the indoor services. Which could be attributed to cultural constraints, excessive somatization, religous beliefs in mental illnesses, social stigma, and finally fear of rejection by spouse. The same factors might also explain the low diagnostic rating, in general, of all mental disorders but especially of affective diseases (16.92%) as contrast to UK hospital diagnosis (31.00%)[17] and others (27%)[8]. Notably the US hospital diagnosis of affective psychoses was comparatively very low (05.25%). As contrast to diagnostic rating of schizophrenia (22%) by previous researchers[8], our diagnosis of schizophrenia (56.92%) was midway between US (61.50%) and UK (33.90%, 46.60%) hospital diagnosis of this disorder (17-18). However, the overrating of schizophrenia in US hospital has been confirmed by IPSS[19]. According to Odegaard[20] each schizophrenic patient would need admission once and, as in our study, in addition to characteristics of sample and catchment area, the nonavailability of alternative custodial and community services as contrast to others (0) might explain the overrepresentation by schizophrenic patients.

The relative lack of personality disorders and low drug related diagnoses in our study, unlike others[17-18], could be due to cultural factors and restricted availability of abusive drugs. However the distribution of hysteria (03.08%) in our sample as compared to other researchers[18] was higher, which could be due to poor concept of the illness, "forced admission phenomenon" reflected both in the behavior of patients and relatives. At variance with other workers[8] the diagnosis of organic conditions was high (08.21%) in our sample which might be attributed to lack of alternative geriatric indoor services and generous hospital policies. The diagnosis of other unspecified psychoses especially postpartum (04.62%) psychosis according to these authors, need prospective exploratory study for clarifying this syndrome.

The polypsychopharmacy, which could be due to multiple factors[21], as contrast to monopharmacy or judicious use of polypharmacy[21], and the routine

(no=81.03% vs yes=18.97%), relapsing rates (no=63.59% vs yes= 36.41%), reasons for relapses (poor drug compliance= 94.37% vs others= 05.63%), precipitating factors (no=71.30% vs yes= 28.70%), and follow-up visits (no=35.90% vs yes=64.10%) were analysed in relation to various diseases, it was found that statistically significant number of patients maintained follow-up treatment ($p<0.02$), poor drug compliance was the single important factor ($p<0.0002$) responsible for relapses, and precipitating factors were significantly associated with most mental disorders ($p<0.0001$).

Table-3&4 demonstrated those common drugs used in the management of psychotic and, to a lesser proportion, in neurotic patients. The drugs mainly were psychotropics and their various combinations in different dosages. In addition, 12 patients (06.15%) recieved modified ECT, lithium was administered in 5 patients (02.56%), carbamazepine was used in 4 patients (02.05%), fluphenazine decanoate was administered in 14 patients (07.18%) and rehabilitation efforts were attempted in 15 patients (07.69%) and finally psychotherapy in the form of counselling, education, suggestion and support was used mainly in neurotic patients (23.08%) as compared to psychotic patients (13.02%). Despite almost prophylactic use of antiparkinson drugs, 21 patients (12 schizophrenics, 5 affective and 4 neurotics 10.80%) developed extrapyramidal manifestations.

In an attempt to find out the physical morbidity among psychiatric patients, the extensive review of records showed that 16 patients (08.21%) developed mild physical symptoms treated in the hospital, and 74 patients (37.95%) were referred to specialists' clinics due to a variety of diseases which were medical (45.95%), dental (35.14%), ophthalmic (32.43%), skin (16.22%), ENT (12.16%) and others (12.16%).

Discussion:

Our study explored demographic and various clinical parameters of patients who were admitted to a mental hospital. There was an accumulating evidence from different studies (11-12) that a large number of psychosocial variables were significantly associated with psychiatric illnesses. However our study found that only joint family constellation[13] and unemployment[14] were the two important variables associated with mental diseases among adults. This strong relationship however did not reflect any cause and effect phenomenon.

Further relatively predominance of extended family systems in Saudi culture might cast doubt about the determinant role of joint families in psychiat-

Patients and Methods:

The Buraidah Mental Health Hospital comprises of 100 in-patient beds, 50 each for male and female. It provides the admission facilities for the entire Al-Qassim region and, therefore, receives referrals from different sources. As regards the OPD services, this hospital is assisted by 3 other OPD clinics attached to Ar-Rass, Uniaza General and King Fahad Specialist Hospitals.

The record files of patients admitted during a period of 5 year through 1986 to 1990 were randomly selected and this process 202 files were retrieved. These files were extensively reviewed and 7 files were dropped for different reasons which were incomplete data and diagnostic issues. Therefore only 195 patients were considered for final analysis. The OPD files of the same 195 patients were also retrieved. Following detailed examination of each OPD and indoor case notes, the data regarding demography, clinical, and treatment parameters were recorded on a semis-tructured proforma. In addition, the psychiatric referrals to other departments were also recorded. For diagnostic purpose ICD-1X[9] definitions were applied in each case. The dosages of different neuroleptics dispensed at the time of discharge were noted and converted to equivalent doses of chlorpromazine[10]. The dosages of other psychotropic drugs and antiparkison agents were also noted. The data were analysed by computer and various tests including chi square, Z, and F were used for statistical purpose.

Results:

The table-1 summarized the demographic parameters of 195 Saudi admitted mental patients who were referred from different sources; 81 (41.54%) brought by the relatives, 58 (29.74%) from different hospitals and primary health centres, 37(18.97%) by police, and 12 patients came by other ways (06.15%). When demographic parameters were analysed in relation to diagnostic groups, as shown in table-2, only family type and occupation achieved statistical significance ($p<0.01$).

As regards other clinical variables, the duration of mental illnesses and patients' stay in the hospital did not reveal significant results when analysed against different diagnoses by F test. ($p>0.05$). It was further observed that 151 patients (77.44%) were admitted once while 44 patients (22.56%) were admitted repeatedly, again without achieving any statistical significance in relation to various diagnoses. However it was noticed that schizophrenic (n=28,25.23%) and affective (n= 9,27.27%) patients were commonly having multiple admissions. When the family history of psychiatric disorders

Il a été trouvé que l'âge moyer des patients était 30±10.85 et les sujets mâles 58.97%, préfèrent les services de soins internes comparé à 41.23% femelles.

Le milieu familial et le travail prsentaient un lien direct avec les diffrents maladies psychiatrioqes parmi les quelles le diagnostic le plus commun était la schizophrénie 56.92%.

L'Admission à répétition, le taux èlévé des récurences, maladies psychiatriques familiales, l'irrégularité, des prises médicamenteuses et la présence des facteurs favorisants.

En plus les anteurs ont trouvé que 74 malades souffrant des madadies organiques (37.95%) ont été transférés dans d'autres specialités ils ont réléve d'autre part la multitude des médicaments psychotropes et l'utilisation des medicaments anti-parkinsoniens d'une façon prédominante, dans le traitement.

Différents aspects de cette étude ont été discutés et des recommandations ont été suggerées en conséquence.

Introduction:

It is generally agreed that psychiatric illnesses are found in all cultures[1-3]. The hospital and community-based studies, though both have their advantages and disadvantages, carried out across cultures have, however, revealed the variable mental morbidity attributable to a variety of psychosociocultural factors[4-8]. Notably tremendous significance has been given to such researches because they provide possible etiological associations between biopsychosocial variables and development of mental illnesses and also help in planning the comprehensive mental health services. Relatively there is a limited research work on the mental morbidity in Saudi Arabia. In one study[8] authors reported interesting dissimilarities regarding age, gender, referrals and diagnostic categories when they compared their results with western literature. Keeping in view the relative dearth of literature and reported striking inconsistencies by previous researchers, this study was carried out with the aims of, 1). to find out any significant associations between demographic parameters and mental disorders, 2). to study the patterns of mental disorders, 3). to study, besides diagnostic categories, other clinical parameters of these patients, 4). to explore the treatment modalities used, 5). and finally to study the physical diseases among these patients.

لعيادات الاختصاص الأخرى. لوحظ تعدد الأدوية النفسية واستعمال مضادات الباركنسون بشكل رئيسي في معالجة المرضى، نوقشت الجوانب المتعددة لهذه الدراسة واعطيت التوصيات المناسبة.

ABSTRACT

We retrospectively reviewed the randomly selected case files of 195 Saudi patients who were admitted to a mental health hospital and relevent data were recorded on a semistructured proforma and ICD-IX definitions were applied for diagnostic purpose. It was found that mean age of patients was 30±10.85 and male subjects (58.97%) as compared to female gender (41.23%) utilized more indoor services. Both family constellation and employment were significantly associated with a variety of mental diseases among which the commonest diagnosis was of schizophrenia (56.92). Multiple admissions, high rates of relapse family history of mental illnesses, poor drug compliance and presence of precipitating factors were other features of these patients. In addition, physical diseases were found in 74 patients (37.95%) who were referred to different specialists' clinics. The polypharmacy of psychotropic drugs and prophylactic use of antiparkinsonian agents were the mainstay of treatment. The different aspects of this study were discussed and relevent recommendations were suggested.

Résumé

Quelques caractéristiques des malades mentaux admis dans un Hôpital psychiatrique

Les auteurs ont choisi au hasard et d'une façon rétrospective les dossiérs de 195 malades Soudiens admis dans un hôpital psychiatrique. Les informations recueillies ont été inscrites sur un proforma modèle et les définitions de la neuvième classification mondiale des maladies ont été appliqueés à des fins de diagnostic.

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SOME CHARACTERISTICS OF MENTAL PATIENTS ADMITTED TO A PSYCHIATRIC HOSPITAL

Naseem Akhtar Qureshi
Nabil Yasin Al Quraishi
Ibrahim Soliman Hegazy

بعض خصائص المرضى النفسيين الذين أُدخلوا إلى مستشفى أمراض نفسية

نسيم قرشي ، نبيل القريشي ، ابراهيم حجازي

ملخص:

قام الباحثون باختيار عشوائي لملفات ١٩٥ مريض سعودي كانوا قد أُدخلوا إلى مستشفى للأمراض النفسية، جمعت المعلومات على نماذج شبه مقننة واستعملت تعاريف التصنيف العالمي التاسع للأمراض لأغراض التشخيص.

وجد ان معدل أعمار المرضى كان (٣٠ ± ١٠,٨٥)، وان الذكور كانوا أكثر استعمالاً للخدمات الداخلية (٥٨,٩٧٪) مقارنة بالاناث (٤١,٢٣٪). وقد كان للوضع العائلي والعمل ارتباط واضح بمختلف الأمراض النفسية والذي شكل منها الفصام العقلي النسبة الكبرى (٥٦,٩٢٪) وقد تميز هؤلاء المرضى بتكرار الدخول وارتفاع معدل الانتكاس ووجود مرض نفسي في العائلة بالاضافة الى عدم الانتظام في العلاج ووجود عوامل مرسبة للمرض. وجد الباحثون ان ٧٤ مريضاً (٣٧,٩٥٪) يعانوا من أمراض عضوية تم تحويلهم

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Authors:
Dr. Omer El-Farouk El-Rufaie
MBBS, DPM (Lond.), FRC Psych.
Associate Professor & Acting Chairman
Department pf Psychiatry
Faculty of Medicine UAE University
P.O.Box 17666 AL AIN
United Arab Emirates.

Dr. M.S. Abu Mediny
MBBS (K.F.U.)
Clinical Assistant
The Maudsley Hospital & Institute of Psychiatry
Denmark Hill London S.E.5.

the cause of hospital admission.

Schizophrenia constituted 22.8% of the total admissions, while depression alone was 35%. Among the primary care group, the commonest diagnosis was neurotic disorder (54%), while neurotic disorders formed only 6.8% of the studied in-patient group. In a similar recent study of psychiatric in-patients to a Saudi military hospital, affective disorders were also the commonest diagnosis, 27%.[6] This is different, for example from the United Kingdom, where the commonest diagnosis among in-patients was schizophrenia, 46.6.[7]

Why depressive disorders (35%), rather than schizophrenic disorders (22.8), constituted the majority of in-patients needs further investigation. However, this could perhaps be explained by the fact that religious and cultural background of Saudi society make it a moral obligation for people to tolerate and care for their chronically ill relatives, e.g. chronic schizophrenics, at home rather than in public institutions. This is substantiated by the fact that the policy of almost all in-patients facilities all over the country is to accept patients only for short stay. The majority of our patients with depressive disorders presented to hospital, mostly to the Emergency Department, with acute presentation needing immediate admission.

Hysteria constituted 3.9% of our in-patient group, compared to 1% of the primary care clinic group. The difference is not statistically significant (P=0.0578). In the Saudi military hospital group, hysteria was diagnosed in 5% of their patients, again, the difference is not statistically significant (P=0.459). This indicates that our ratio of hysteria is consistent with the findings of other workers in this country. However, the ratio of hysteria in Saudi Arabia are less than the figures from Egypt (10.9%)[8] and Sudan (10%).[9]

Acute psychosis, or acute psychotic attack or acute schizophrenic episode was recorded as the final diagnosis in 8.2% of the total admissions. This short-lived clinical phenomena was previously reported in this geographic area.[10] It was suggested to be a culture-related syndrome. The symptoms and course of this syndrome are more or less consistent with Acute Schizophrenic Episode, as described by I.C.D.[9] (WHO 1981). According to DSMIII, it is roughly consistent with Schizophreniform Disorder (295-40), when the illness lasts for more than 2 weeks but less than 6 months; or Brief Reactive Psychosis (298-80), when the psychotic symptoms lasted more than a few hours but less than 2 weeks.[11]

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MARITAL STATUS:				
Married	46	65	111	54%
Single	51	40	91	44%
Divorced	2	1	3	1.5%
Widowed	1	0	1	0.5%
TOTAL	100	106	206	

Discussion:

The male: female ratio of the studied group was 1:1,06 i.e. In a recent study of patients attending a psychiatric clinic in a primary care health centre, the male: female ratio was 2.3:1.[2] A similar preponderance of males in out-patient clinics had been reported by other workers in this country.[3] The remarkably high ratio of females in the in-patient unit, compared to the out-patient facility may suggest that females in this culture, perhaps refrain from seeking psychiatric help for minor needs. Many studies in the Western world demonstrated that female psychiatric morbidity exceeds that of males.[4] However, some studies in Africa, done in out-patient clinics, showed no difference between sexes.[5]

The vast majority (75.3%) of our in-patient group were young people, in the age group 15-34 years; almost equally distributed between the age groups 15-24 and 25-34 years. A similar finding was obtained from the previously mentioned primary care psychiatry clinic, where this age group constituted 73%. This is the reverse of the situation in Western world where the peak psychiatric morbidity is in the middle life. This may be attributed to a variety of reasons. One possibility is that, in this area young people constitute a high proportion of the total population. Another possibility is that young people were more enlightened and educated and so tended to seek psychiatric help more that older people who also have reservations towards the role of University-trained physicians in treating mental disorder. Alternatively, with the recent developments and change of life style within Saudi society, young people are subjected to more stresses, such as working responsibilities and competition, in addition to other marital, family and social problems.

Affective disorders were the commonest diagnosis encountered, 43.8%. This group consisted of depressive disorders 35%, mania or hypomania 4.9% and those whose diagnosis was recorded as manic-depressive illness were 3.9%. This shows that affective disorders exceeded other psychoses (35.8%) as

2. **AFFECTIVE DISORDERS:**		
a) Depression	72	35%
b) Mania/Hypomania	10	4.9 %
c) Manic - Depressive Disorder	8	3.9 %
TOTAL	90	43.8 %
3. **NEUROTIC DISORDERS:**		
a) Anxiety States	6	2.9 %
b) Hysteria	8	3.9 %
TOTAL	14	6.8 %
4. **OTHERS:**		
a) Attempted Suicide	19	9.2 %
b) Grief Reaction	2	0.97%
c) Epilepsy	2	0.97%
d) Mental retardation	1	0.49%
e) Anorexia Nervosa	1	0.49%
f) Personality disorder	3	1.5 %
TOTAL	28	13.6 %

Table 2

Demographic Characteristics of 206 Patients admitted to the University In-Patient Psychiatric Unit during the one year period

AGE:				
Less than 15	0	2	2	1%
15 - 24	38	40	78	37.9%
25 - 34	36	41	77	37.4%
35 - 44	17	20	37	18%
45 - 54	4	3	7	3.4%
55 - 64	1	0	1	0.5%
65+	4	0	4	2%
TOTAL	100	106	206	

All other diagnoses were put under the heading: Others, This grouping is somewhat arbitrary and is made to facilitate the process of comparisons, in spite of all pitfalls of psychiatric classification.

Results:

A total of 206 patients (100 males and 106 females) were admitted to the unit during the period under review. This gives a male-female ratio of 1:1.06. Of these patients, 185 were admitted once. 15 twice, 4 were admitted 3 times and 2 four times during the same years. Therefore, the initial total figure which appeared in our record was 235 admissions. The 6 patients who were admitted 3 or 4 times included a young male patient with recurrent manic attacks, a young single female usually presenting with an overdose and was diagnosed as personality disorder, all others were diagnosed as depressive disorders and their re-admissions usually followed stressful situations at home.

Saudi patients were 169 (82%) and non-Saudis were 37 (18%). Most non-Saudis were from Arab and Asian countries.

Out of all patients 43.8% were diagnosed as affective disorders, 35.8% as psychoses, 6.8% as neurotic disorders and 13.6 had "other" diagnoses. Details of diagnostic categories are shown in Table 1, while Table 2 shows characteristics in relation to age, sex and marital status.

Table 1

Diagnostic Categories of 206 Patients admitted to University In-Patient Psychiatric Unit within one year.

DIAGNOSTIC CATEGORY	NO. OF PATIENTS	PERCENTAGE
1. **PSYCHOSES:**		
a) Schizophrenia	47	22.8 %
b) Late Paraphrenia	2	0.97%
c) Schizo - Affective Psychosis	2	0.97%
d) Acute Psychosis/ Acute Psychotic Episode	17	8.2 %
e) Peurperal Psychosis	6	2.9 %
TOTAL	74	35.8 %

Introduction:

The psychiatric in-patient unit of King Fahd Hospital of the University, Al-Khobar, Eastern Province, Saudi Arabia, was opened to receive patients on 19.3.1988. It comprises 18 beds, 10 for males and 8 for females. The policy of the unit states that only short stay admissions were allowed. Patients who need long term care were referred to appropriate facilities in the area. Drug abuse patients needing admission were also sent to a specialised hospital.

This work aims at studying the sociodemographic characteristics and the diagnostic categories of all patients admitted to this unit within its first year. Comparison will be made between the in-patient group and a group of patients attending a primary care psychiatric clinic situated in a Health Centre. In addition, broad comparisons will be made with other relevant studies from inside and outside Saudi Arabia.

Method:

All admissions during the period 1.4.1988 to 1989 were assessed retrospectively by examining their case notes. Diagnostic categories and sociodemographic characteristics were documented. The latter included sex, age, marital status, nationality and re-admissions.

Only the final diagnosis as recorded by the consultants in charge of the patients were used. All consultants received similar British training; and the diagnoses were made in line with nomenclature of the I.C.D.9[1].

Diagnostic categories were grouped under 4 main headings: Psychoses, Affective Disorders, Neurotic Disorders and Others. Due to the known problems of the classification of mental disorders, it would be difficult to put clear lines of demarcation between the different groups. There is an overlap between Psychoses, Affective Disorders, at the same time reactive depression may be put under Affective Disorders or Neurotic Disorders. Therefore, inclusion criteria was put for this grouping. Affective disorders group included all cases diagnosed as depression, irrespective of whether the final diagnosis put by the responsible consultant was endogenous depression, reactive depression or just depression. However, cases who suffered from depressive symptoms as part of peurperal mental disorders were put under the heading peurperal psychoses, with the group of psychoses. The group of psychoses included all schizophrenias, irrelevant of the type; late paraphrenia; schizo-affective psychosis; acute psychoses and peurperal psychoses.

Neurotic disorders included all neuroses except reactive depression which is grouped with the affective disorders.

1989 were retrospectively assessed by examining their case notes. The assessment included diagnostic categories and sociodemographic characteristics.

The male: female ratio was 1:1,06. The majority of patients (75.3%) were young, aged 15 - 34 years. The commonest diagnosis was affective disorder (43.8%). Depressions accounted for 35% while schizophrenias accounted to 22.8%. Acute psychosis was recorded as a final diagnosis in 8.2% and hysteria in 3.9%. The possible sociocultural and medical implications of the findings were discussed.

Keywords:
Psychiatric In-patients, Psychiatric Morbidity, affective Discorders, Acute Psychosis, Cultural Factors, Saudi Arabia.

Résumé

Les malades psychiatriques hospitalisés dans un Hôpital universitaire Une Expérience d'Arabie Saoudite

Une étude rétrospective a été effectuée sur tous les malades hospitalisés à l'hôpital King Fahd de l'université de Al-Khobar pendant une période d'un an (Avril 1988 - Mars 1989.)

L'étude comporte le diagnostic par catégories et par carestéristiques socio démographiques des différents malades.

Le rapport Mâle: femelle 1:1.06 La majorité des malades était Jeune (75.3%) de (15-34a ns).

Le diagnostic le plus fréquent était les désordres affectifs 43.8%, Les dépressions représentaient 35% tandis que les schizophrénies atteignaient 22.8%. La psychose était le diagnostic final dans 8.2% et l'Hystérie dans 3.9%. Les implications médicales et socioculturelles possibles des différents données ont été discutées.

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PSYCHIATRIC IN-PATIENTS IN A GENERAL TEACHING HOSPITAL: AN EXPERIENCE FROM SAUDI ARABIA

O.E.F. El-Rufaie, M.S. Abu Mediny

المرضى النفسيين الداخليين في مستشفى تعليمي عام
خبرة من المملكة العربية السعودية

عمر الرفاعي ، م. أبو مدني

ملخص:

هذه دراسة رجعية لكل الحالات التي أُدخلت لوحدة الطب النفسي للادخال بمستشفى الملك فهد الجامعي بالخبر في المملكة العربية السعودية خلال عام واحد، من مارس ١٩٨٨م الى ابريل ١٩٨٩م. تمت دراسة التشخيص والخصائص الاجتماعية والسكانية لجميع الحالات.

نسبة الرجال للنساء كانت ١:١,٠٦ ووجد أن ٧٥,٣٪ من المرضى كانوا من صغار السن (١٥ ـ ٣٤ سنة). وكان التشخيص الغالب (٤٣,٨٪) هو الاضطرابات الوجدانية، حيث كانت نسبة الاكتئاب النفسي ٣٥٪ من المجموع بينما كانت نسبة إنفصام الشخصية ٢٢,٨٪, كانت حالات الذهان الحاد ٨,٢٪ بينما كانت نسبة الهستيريا ٣,٩٪.

قورنت النتائج بنتائج مقابلة من عيادة نفسية في مركز للرعاية الصحية الأولية بمدينة الخبر أيضاً ونوقشت النتائج من عدة جوانب.

ABSTRACT

All admissions to the psychiatry in-patient unit at King Fahd Hospital of the University, Al-Khobar, during one year period April 1988 - March

والمقابر، مع سوء قصد لمن يغاضبه ويكون بروز صاحبه ليلا واختفاؤه وتواريه نهارا، كل ذلك حبا للخلوة، وبعداً عن الناس، ومع ذلك فلا يسكن في موضع واحد أكثر من ساعة واحدة بل لا يزال يتردد ويمشي مشياً مختلفاً لا يدري اين يتوجه مع حذر من الناس، وربما لم يحذر بعضهم غفلة منه وقلة تفطن لما يرى ويشاهد ومع ذلك فانه يكون على غاية السكون، والعبوس والتأسف، والتحزن، اصفر اللون، جاف اللسان، عطشان، وعلى ساقه قروح لا تندمل.

6. (Ibid, 897)

7. المنجد في اللغة والاعلام (١٩٧٣) بيروت: دار الشروق ط٢٦

8. مجمع اللغة العربية (المعجم الوسيط) إخراج : ابراهيم انيس، عبدالحليم منتصر عطية العدالي ومحمد خلف الله احمد مجمع اللغة العربية (المعجم الوسيط) الجزء الأول . مصر . دار المعارف (١٩٧٢) ط٢.

Authors:

ELZUBEIR BESHIR TAHA: University of U.A.E.

ABDALLA MOHAMMED ABDALLA: Desert and Marine Environment Research Centre University of U.A.E.

AL AADLA SAEED ALQUBAISI: Dept. of Psychology University of U.A.E.

٩٨٠ ـ ١٠٣٧م) القـانـون في الطب تحقيق ادوارد القش ـ بيروت: مؤسسة عزالدين للطباعة والنشر (١٠٨٧).

26 ـ تذكرة أولى الالباب والجامع العجب العجاب = تذكرة داود ـ داود بن عمر البصري الانـطاكي ـ القـاهـرة مكتبـة الثقافة الدينية لسنة ١٣٥٦هـ. بهامشة النـزهـة المبهجـة في تشحيـذ الاذهان وتعديل الأمزجة. للمؤلف.

27 ـ الخـوري، ميشيل (١٩٨٣) مقدمة التحقيق في كتـاب التيسـير في المداواة والتـدبير لأبي مروان عبدالملك بن زهر ص ص (ز ـ ق) ـ دمشق: دار الفكر.

28 ـ القش، ادوارد (١٩٨٧) فهرس كتاب ابن سينـا «القـانون في الطب». بيروت مؤسـسـة عزالديـن للطبـاعـة والنشر (١٩٨٧)، جزء ٤.

29 ـ طـه، الزبير بشير (١٩٩٠) الفسلجة العصبيـة في كتاب القانون في الطب ـ المجلة العـربيـة للطب النفسي ٢ ، ١ ، ١٤٢ ـ ١٥٢.

30 ـ مراد، إبـراهيم (١٩٨٥) المصطلح الاعجمي في كتب الطب والصيدلة العربية ـ بحث نموذجي في اصوله ومنزلته العلماء منه ـ بيروت: دار العربي الاسلامي.

NOTES

والمستعد للمالنخوليا يصير اليها بسرعة اذ اصابه خوف او غمّ او سهر.

1. (Avicenna, 1087, P. 892)

ومن الأسباب القوية في توليد المالنخوليا افراط الغم او الخوف.

2. (Ibid, P. 892)

وقد رأى بعض الأطباء ان المالنخوليا قد يقع عن الجن، ونحن لا نبالي من حيث نتعلم الطب ان ذلك يقع عن الجن او لا يقع بعد ان نقول: انه ان كان يقع من الجـن، فيقـع بأن يحيـل المـزاج الى السوداء، فيكون سببه القريب السوداء، ثم ليكن سبب تلك السوداء جنا أو غير جن.

3. (Ibid, P. 892)

مادة في العروق صائرة اليها من موضع آخر.

4. (Ibid. P. 892)

علامة ابتداء المالنخوليا ظن رديء، وخوف بلا سبب، وسرعة غضب، وحب التخلي

5. (Avicenna (1987) p. 891)

هو نوع من المالنخوليا، أكثر ما يعرض في شهـر شبـاط ويجعل الانسان فرارا من النـاس الاحيـاء، محبـا لمجاورة الموتى

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22 ـ ابن البيطار عبدالله ابن احمد المالقي (توفي سنة ٦٤٦ هجرية/ ١٠٤٠م) ـ الجامع لمفردات الأدوية والاغذية ـ (اعادت طبعة بالاوفست مكتبة المثنى ببغداد لصاحبها قاسم محمد الرجب) (بدون تاريخ).

23 ـ ابن رسول، الملك المظفر يوسف بن عمر بن علي العشائي التركماني (ت ٦٩١ هجرية) المعتمد في الادوية المفردة صححه وفهرسه الاستاذ مصطفى السقا ـ بيروت: دار القلم (١٩٥١).

24 ـ ابن زهر، ابو مروان عبدالملك (٤٨٤ ـ ٥٤٢ هجرية) ـ كتاب التيسير في المداواة والتدبير ـ تحقيق ميشيل الخوري ـ دمشق دار الفكر (١٩٨٣).

25 ـ ابن سينا، الشيخ الرئيس ابو علي الحسين بن علي (٢٧٠ ـ ٤٢٨ هجرية /

recommends creamy and sweet food and prohibits lentils, preserved meat and Bagila. Sanitation also includes proper ventilation, working and bathing and the excessive use of perfumes and creams for grooming.

Psychotherapy for Melancholia involves the presence of co-patients who are favourite to the patients, keeping the patient busy with activities including listening to Music. (The Canon P. 894-

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Aloe is an anthraquinones laxative which is believed to cure or alleviate a host of unrelated conditions including depression. (Hecht. 1981) and hysteria[5].

Shabath (Anethum graveolens L.):

Often called dill or garden dill, this plant is widely known as a condiment. Per 100g dill seed contains 303 calories, 7.7g H20, 16.0g protein, 14.5g fat, 55.2g total carbohydrate, 21,1g fiber, 0.7g ash 1.516mg Ca, 277mg P, 16.3mg Fe, 256mg Mg, 20 Mg Na, 1.186 K, 5.2 Zn, 53 I.U. vit A equivalent, 0.42mg thiamine and 0.28 riboflavin[5]. Fatty acids contents of dill include 0.73g saturated, 9.4g monounsaturated and 1.0g polyunsaturated plus 124mg phytosterol.

Additionally there are 575mg Threonine, 767mg isoleucine, 925mg deleucine, 1.038mg lysine, 143mg methionine, 1.120mg valine and significantly 670mg phenylalanine. The central action of this plant is highlighted by this rich phenylalanine content. It has been shown that in vivo amination of dill oil can produce a series of three potent amphetamines[8]. The paradoxical folk use of dill sometimes as a narcotic sometimes as a stimulant (Duke 1981) is presumably explicable in terms of the paradoxical dose - related effects of amphetamine[19].

Analysis of Avicenna's Anti Melancholia Medication

The herbal medication of Melancholia indicated by Avicenna may, therefore, be said to constitute a comprehensive delivery program. This is obviously emphasized by four important facts.

Firstly: Avicenna takes care of both acute and chronic conditions of the disease.

Secondly: The anti melancholia herbal treatment in 'the Canon' is carefully assigned into two categories: the one manages the disorder as a primary ailment and the other manages the disorder as a seconday reaction.

Thirdly: There is reason to suggest that Avicenna was aware of the necessity of using both narcotic and stimulant and hypnotic drugs, presumably to manage the (now well documented) antihetical symptoms of psychosis which may range from indolence to violence. Chronic mild depression is also commonly held to be a common associated feature of schizophrenia'[1].

Fourthly: Avicenna uses herbal medication as one single component in a tripartite delivery program which involves the sanitary and psychotherapeutic modalities. His sanitation for Melancholia is associated with specific dieting prescriptions in which he

fiber, 7.1g ash, 530mg Ca, 240mg P per 100g, together with pyrrolidine alkaloids[5]. The Chrysanthmum parthenium flowers contain parthenolide, Cosmosiin (apigenin - 7 glucoside) and Santamarin (see Duke 1988); while dry seeds are rich in both protein 22.2% and fat 31.2%[5].

Khirbig Aswad (Helleborous niger L.):

With chronic patient of Melancholia Avicenna prefers to use Khirbig (see Avicenna 1987 P. 895). Here Avicenna must have counted on the wisdom of his predecessors as the plant (folklorically named Christmas rose) has been used as a purgative in mania since 1400 B C, Presumably because of its narcotic properties[7]. In homeopathy Helleborous niger is recommended for, among other things, psychosis, dementia Praecox and Melancholia [7,10].

Afsanthin (Artemisia absinthium):

This drug was well recognized by Etantaki, Ibn El-Bitar and Avicenna[18]. Avicenna recommended it for chronic Melacholia to be given as a boiling water extract with the dose of 3 ounces 0 gerat/ 3 uwag of water which is equivalent to 76.5g[28]. It was shown in preliminary phytochemical examination of the different organs of this plant that contains alkaloids, flavonoids in combined state, pyrogallol tannins, carbohydrates and glycoside absinthin, sterols and/or triterpenes. In addition the leaves, stem and flowers contain volatile oil and sesquiterpene[18]. Pharmachologically a graded, dose-dependent relaxant effect of the drug was demonstrated which was shown to be more marked than that of comparable adrenaline concentration[12]. Like Adrenaline, the action of Artemisia absinthium may be mediated by central mechanisms. In this respect it has been found that Thujone was the active principle of this plant. It was postulated that Thujone interacted with CNS receptors in much the same sites as did tetrahydrocannabinol (obtained from cannabis sativa)[2].

Avicenna may have used this drug as a sedative to ameliorate the anxiety often associated with chronicity of mental disease. Avicenna was particularly keen on the drug, when the Melancholia disorder is associated with or caused by gastrointestinal infections. The use of this drug against typhoid and paratyphoid infections is now well documented (Hermann, 1956; Bohnn 1959). Avicenna was also obviously judicious about the dosage of his Artemisia absinthium medication. It has been shown that an overdose of this drug causes restlessness, vomiting, vertigo, tremors and convulsions[20].

Sabar (Aloe vera)

In 'the Canon' tablets of Aloe vera were recommended for Melancholia..

In a way it is reminiscent the dose of dependent action of amphetamine. At low doses amphetamine is a perfect stimulant while at high dose it produces catalepsy[19].

Many studies seem to highlight the anti manic potentials of Matricaria chamomilla. In that it has been shown that it helps depotentiate a number of active behavioral symptoms associated with mania. In South Africa it is used for insomnia and hysteria, whereas in Costa Rica it is used for the management of insomnia and overeating[15]. Needless to say that insomnia, overeating and explosive hysterical responses might accompany or be mistaken for manic reactions. Since Avicenna classifies mala as a subtype of Melancholia, he might have found baboonij particularly helpful.

The hypnotic effect of matricaria was further substantiated by an experiment in which 12 myocardiac patients Matricaria Chamomilla were monitored after taking Matricaria Chamomilla tea. Approximately 10 minutes later, they all fell in deep sleep for a duration of 10 minutes[11]. It would be of interest to extend this experimental treatment to normal subjects with view of verifying whether Matricaria Chamomilla per se was critically responsible for this hypnotic effect.

As such the folkloric antimanic uses of Matricaria chamomilla is born out by evidence from a number of psychiatric and experimental paradigms.

Ughuwan (Chrysanthmum cinerariifolium "Trevir")

Ughuwan is closely related to the previous medicine Baboonij (Matricaria chamomilla) these two arabic terms are sometimes used interchangeably (see The Canon P. 389): Duke 1988 puts it "Homeopathy may use it like true camomile" P. 118 contents Avicenna uses both herbal medicines to induce a state of sleep in his melancholic patients. He puts it "the most appropriate treatment for melancholics is to put them to sleep" (Avicenna P. 894). This presumably is consistent with the neuroleptic induced Tranquilization very popular at the present time for the management of psychosis.

The Chrysanthmum genus includes Chrysanthmum cinerariifolium an overdose of which might cause unconsciousness[7] and Chrysanthmum partherium.)

Both are used in prophylactic treatment of migraine presumably because the plant contains sesquiterpene lactones, particularly parthenolide[13,20].

More specifically, Chrysanthmum parthenium is known to be utilized by Europeans as a sedative particularly in hysterical reaction[6]. On a zero-moisture condition, Chrysanthmum cinerariifolium shoots contain 13.0g protein, 0.5g fat, 79.4g total carbohydrate 23.6g

bal management includes mainly, Mufarihat, A. (Borago officinalis, L.) (Baboonij, A.) (Matricaria chamomilla L.) Ughuwan A. (Chrysanthmum parthemium) Khirbig Aswad A. (Helleborous niger, L.) Afsenteen, A. (Artimisia absinthium L.;) Sabar A. (Aloe vera L.) Sowsan al-Samangooni A., or Irsa (Iris germancia L.) Shahm al-Handhal, A., (Hordeum distichon, L.;) Sakbinj. A.; (Ferula assa-foetida, L.:) Shabath A., (Anethum graveo lens L.;) and Khashkhash Agran, A. (Glaucium flavum).

Mufarihat (Borago officinalis, L.)

This plant is rich in Ca and K. Furthermore their glucose, galactose, arbinoze pentoses, resin, bornesit, cyanogenic materials, acetic-, lactic-., and malic acids. They also contain 0.003% vitamine C, up to 3%. Tannins, 1.5 to 2.2%. Salicic acid[4,7].

It has been indicated that its leaves and flowers may help alleviate boredom Melancholy and Sadness[7]. It is worth noting here that the Arabic name Mufarihat stands for euphoric. It is highly probable that Avicenna used Borago officinalis for the management of the depression which shows in his Melancholia patients. But what precisely are the neural mechanisms that may mediate the action of this medicinal plant?

Personal experiences of some users indicate that eventhough the weak tea of Borogo Officinalis's flowers was supposed to calm the nerves, users feel hyperactive nonetheless. Such report compare it to amphetamine-like stimulant effects[7]. There is a general agreement that amphetamine induced stimulant effects are mediated by central catecholamine systems perhaps with specific emphasis on dopaminoceptive sites. Such amphetamine related mechanism might be suspected in the search for the neural substrates of Borago Officinalis's psychoactivity.

Baboonij: (Matricaria chamomilla, L.,)

This herb with numerous flowerheads and tiny leaves contains azulene bisabolol, cadinene, farnesene, furfural, paraffin, hydrocarbons, sequiterpene alcohols, triacontane methyl-ether and umbelliferone.

This a widely used herb, the flowerheads, leaves and oil extracts of which have extremely diverse applications including flavouring antiinflammatory and antimicrobal actions[13]. However, Matricaria Chamomilla is also equally known for its psychoactive effects. In that the hypnotic properties of camomile tea are well documented[13]. Antagonistic sadative and stimulant properties of Matricaria chamomilla have both been reported. This is presumably a dose related effect.

terized by fugue but perhaps a psychotic fugue and not the hystrical type.

Secondly: Avicenna appears to subscribe to an organismic approach with respect to the pathology of Melancholia. Here he ascribes the disease to 'al Sawdaa al-muhtariga' some kind of exhausted or depleted 'rooh' or transmitter in the brain. Needless to say he speaks here in general terms, but that is about as close an explanation as any of his contemporaries could get. However, without discounting the contribution of psychosocial factors to the generation (Taulid) of Melancholia, his organismic approach represents rather a safe path in which the organic/functional controversy is not likely to show up.

Thirdly:
The Canon's account of Melancholia and indeed other mental disorders must have enjoyed an outstanding heuristic value in that it organises information, about the disease in a very familiar form: clinical picture, features, age of onset predisposing factors and epidemiological variables including sex ratio and seasonal pattern, to be concluded by treatment (al Muaalajat).

Fourthly: Avicenna places undue emphasis on various infections as causes and correlates of Melancholia. He also takes this into account in his management of the disease. This a rather unfamiliar to contemporary thinking. Deterioration of hygiene is recognized nowadays not as an essential feature of certain psychoses so much as a secondary feature.

Fifthly: The highlight of Avicenna's account is this bizarre type of Melancholia which he calls al-Qutrub the equivalent of which one never encounters in current psychiatric nosology. Is this an obsolete disorder that has withered away in the course of one thousand years since **The-Canon** was first published? or has it escaped the detection of contemporary psychologist being essentially a run-away reaction?

The Psychopharmacology of Melancholia:

A cocktail of herbal medicines are prescribed in the Canon for the management of Melancholia. There appear to be close parallels between such management strategies in Arabic classics and their counterparts in current psychiatric practice. For one thing, The Canon anti-Melancholic medicines are almost invariably psychoactives falling mainly in the category of hypnotics and tranquilizers but including sometimes sedatives and narcotics and indeed stimulants. Furthermore some antiinflammatory and also nutritive medications were also prescribed. Finally judicious care is often taken to determine the appropriate dose to guard against adverse effects.

The Canon's Antimelancholic her-

directions 'as though' he doesn't know where to go while being cautioned not to confront people" (The Canon P.897.) The word Qutrub literally means a restless water animalcule or alternatively a randomly wandering wolf.

Ishq (pathological love): "This is an obsessive ailment similar to Melancholia which the affected inflicts on himself by focusing his thought on adoring some features or traits owned by him" ('him' probably refers to the object of love) (The Canon P. 898).

Here Avicenna emphasizes intensity and variability of emotions (ranging from happiness and laughter to distress) on hearing about romance. In connection Avicenna stresses another feature here namely, Irregular pulse. In fact he uses this as an index which he utilizes to detect the object of love which the patient may be reluctant to reveal. Avicenna might have borrowed this biofeedback technique from Galen, thought he developed it in his owm original manner.

In this comprehensive account of Melancholia. the Canon furthermore spends a few lines on predisposing factors, sex ratio, age of onset and seasonal pattern. "While it hardly affects the fair and fat, Melancholia is prevalent among the dark and thin..... of those predisposed to it are the lispers..... it is more frequent among males but more frank (promisicuous) among females. It occurs more frequently in Kuhula (30-50 years of age)[6] and Sheikhukha (starting at the age of fifty)[7] later stages of life. It is less frequent in winter but occurs more frequently in summer and autumn and probably also in spring". (The Cannon P.892). Here the age of onset is comparable to that specified for paranoid reactions in DSM III - R (see P. 200). However other types of schizophrenia as are known today do not seem to meet Avicenna's description in this respect. This particular anomaly awaits further investigation as Avicenna does not appear to be confined to paranoid conditions so much as he appears to include them among other psychoses in Melancholia.

The following analytic remarks may be made about the nosology, etiology and symptomatology of Melancholia in the Canon.

Firstly: The treatment of the subject is remarkably comprehensive Judging from the account of the Canon Melancholia designates nearly the same conditions that are classified under psychoses at least according to I C D - 9[21]. This includes organic psychotic conditions as well as schizophrenic, affective and paranoid psychoses. However, the Canon's list of Melancholia comprises yet another syndrome which is given the name al Qutrub. al Qutrub is charac-

of the DSM III nosology al Rakhway put it "The term functional has a weak rationale to prolong its life time"[16].

Melancholia: Symptomatology and Types

Under the subheading 'al-aalamat' which means features, Avicenna differentiates between two types of Melancholia of which may correspond to the present day functional and organic schizophrenia. He also speaks of a third type of Melancholia as yet unfamiliar to present psychiatric nosology which he calls al Qutrub. He also discusses a fourth related disease which he calls Daa al Ishq (pathological love).

The symptoms of endogenous Sawdaa: According to the Canon "this begins (in the acute stage) by bad beliefs and fears without reason, quick anger, love of seclusion (withdrawal)[4] When it stabilizes then (we get) panics, suspiciousness, distress, seclusion, incoherent speech, eroticism and types of fears mostly from things that are not usually feared. These types of fears are not limited. Some fear the sky might fall on them, some fear the earth might swallow them, some fear Djinn (the devils), some fear the ruler, some fear thieves, some make precautions (lest) they be attacked by beasts. Past experience may have an effect on all that. "(The Canon, P. 893). Avicenna did not forget to include delusions "some of them may imagine themselves to have become kings, beasts, devils, birds or industrial machines". Imagining being a king is an example of what we presently designate as grandiose, whereas imagining being such thing as industrial machines might involve what we presently refer to as loss of ego boundaries.

Symptoms of exogenous Sawdaa: Without excluding the previous symptoms this particular syndrome in the Canon involves a generalized impairment of health (bodily weakening and darkening) (see The Canon P. 893). Avicenna adds "diseases that are followed by Melancholia are like chronic and mixed (?) fevers". This type of Melancholia according to Avicenna is associated with strong eroticism.

al Qutrub: "This is a type of Melancholia that occurs mostly in Shabat (February). The affected person shuns living humans and loves the neighbourhood of the deceased and their graves. He harbours bad intentions to those who take them by surprise. He appears only during the night, and disappears by day. All this for the sake of seclusion and withdrawing away from people". (see The Canon P.897). Most importantly however this type of reaction according to Avicenna involves considerable mobility. The 'Qutrub patient "never dwells in one place more than one hour, rather he moves in different

brain roohs (P. 890-1). It has been explained elsewhere[29] that Avicenna uses the term mizage in the sense of the product of a metabolic process, and the term roohs in the sense of neurotranmitter. As such Avicenna's statement may, perhaps, be interpreted in modern terms as indicating that the etiology of Melancholia is due to conditions in which the chemical formula of certain brain transmitters are disturbed. In fact Avicenna speaks of no other cause. Avicenna admits that precipitating factors of same forms of Melancholia might include excessive emotional distress or fear (The Canon, P. 892)(1) Nonetheless he consistently insists that the direct cause of Melancholia is always this chemical imbalance in the brain which he calls al-Sawdaa or more specifically al-Sawdaa al-Muhtariga (exhausted or depleted Sawdaa). This position on his part is made all the more clear in his argument against the Djinn (devil) hypothesis. "Some men of medicine thought that Melancholia may be caused by Djinn (devil) . We as students of medicine do not bother whether or not it is caused by Djinn as long as we hold that even if it is caused by Djinn Melancholia does not occur until (and unless) the Djinn disturbs the mizage (chemical formula) so that it becomes Sawdaa 'Melancholia'. Thus the direct cause is Sawdaa. After that, let the cause of Sawdaa be Djinn or anything else"(2) (The Canon P.892).

Thus Avicenna speaks on the basis of etiology of two main types of Melancholia. The Sawdaa which results from conditions intrinisic to the brain or extrinsic to it.

The intrinsic causes in the Canon either include spontaneous adulteration in the psychological roohs or some harmful substance that reaches the brain via the bloodstream(3). It might also ensue from epilepsy.

The extrinsic causes of Sawdaa include conditions of inflicted swollen spleen, liver or intestines. (The Canon P.891).

One can hardly miss the parallels between this classification and the current endogenous and exogenous nomenclature in DSM III, where endogenous factors include structural brain disease or metabolic disturbance while exogenous factors refers to physical factors that affect the central nervous system such as infections and trauma).(1)

The only difference however is that Avicenna does not speak, as we do today, terms of functional and organic conditions. He assumes that Melancholia is always caused by organic causes: some may be tangible like infections others are as yet invisible and can only be assumed. In this way Avicenna was fortunate enough not to encounter the controversial organic/functional dichotomy which bedevils contemporary psychiatric thinking. In his critique

What Avicenna precisely meant by Melancholia proved to be a real stumbling block. The Lag of one thousand years between his age and ours is partly to blame. However there is more to this problem than just the sheer passage of time. Culture, needless to say, determines the nosology of mental disease. The values, behavioral norms idiomatic expressions of distress and indeed language of Avicenna's age are not quite the same as those prevalent among even his people today. Hence the problem of disease in the Canon, including Melancholia.

To start with what Avicenna meant by Melancholia is not what is presently referred to as Melancholy which usually refers to depressed mood[1]. This Avicenna calls Malicholia and attributes to it pretty nearly the same symptom as those of depression. Indeed Avicenna stresses the temporal relationship between the onset of Malicholia and the winter season in a way reminiscent of the seasonal pattern criteria of depressive episodes according to DSM III - R (1) (see Avicenna (1987) p. 117) But if the Cannon's Melancholia is not Melancholy what else is it? The closest rendering of the exact words of Avicenna is presumably as follows "The (name) Melancholia is given (for a disease) when there is a change in belief and thought from normal processes to disintegration..... but when Melancholia is left with irritability and restless jumping from one place to another it is called Mania" p. 890-1.

When the symptomatology and pathology of Melancholia is discussed at length it will probably become all the more clear that the Canon's Melancholia stands (arguably with some modifications) for the generic term psychoses. In the Ninth edition of the International Classification of Disease (ICD-9) 'Psychoses' is defined as "Mental disorders in which impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality. **It is not an exact or well defined term.** Mental retardation is excluded" (WHO, 1978, 290-299). Even ICD - 10 and DSM II characterize psychoses similarly in terms of personality organization and the mode of relating to reality[17].

Ibn Sina adopts rather an intricate system of classification in which he uses etiological (pp. 890-2) as well as symptomatological (pp.897-8) criteria in the nosology of Melancholia; much to the pleasure of the advocates of the multiaxial DSM III.

Melancholia: etiology and types. Ibn Sina puts it. 'Melancholia is due to a change of mizage which disturbs the

ABSTRACT

In its comprehensive account of Melancholia, the Canon of Medicine examines its essential features, epidemiological properties nosology and etiology in a way that exhibits close parallels between the concept of Melancholia and that of the psychoses in modern psychiatry. Of special interest is a type of Melancholia which is given the name al-Qutrub. The Canon subscribes to an organismic approach regarding the etiology of Melancholia, and expectedly it leaned heavily on phytochemical prescriptions for the management of the disease, including hypnotic narcotic sedative and antidepressant medicinal plants. This research examines, in addition, the psychopharmacological properties of the plants prescribed by Avicenna compared to those currently used in psychiatric practices.

Résumé

Nosologie Etiologie symptomatologie et psychopharmacologie de la melancolie dans le "canon de médecine"

Le "canon de Médecine" examine les aspects essentiels, les proprietés épidemiologiques la nosologie de la mélancolie de telle façon qu'il démontre un parallelisme étroit entre le concept de la melancolie et la psychose dans le psychiatrie moderne, on a accordé, un intéret special au type de melancolie appelé Al-Qutrub.

Etant donné que le "canon" adopte une approche organique concernant (l'etiologiè) la mélancolie, il ná pas été étonnant qu'on insiste sur les prescriptions phytochimiques compris les hypnotiques, les narcotiques, les sedatifs et le plantes médicinales antidepressives.

En outre, cette recherche examine les proprietés psycharmacologiques des plantes prescrites par Avicenne compareés à celles utilisées couramment dans les pratiques psychiatriques modernes.

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NOSOLOGY, ETIOLOGY, SYMPTOMATOLOGY & PSYCHOPHARMACOLOGY OF MELANCHOLIA IN THE CANON OF MEDICINE

ELZUBEIR BESHIR TAHA, ABDALLA MOHAMMED ABDALLA, AL AADLA SAEED ALQUBAISI

مرض المالنخوليا في كتاب القانون في الطب
تصنيفه ، مسبّباته ، اعراضه ، وعلاجاته

الزبير بشير طه ، عبدالله أحمد عبدالله ، العدلة سعيد القبيسي

ملخص:

يتناول كتاب القانون مرض المالنخوليا موضحاً أعراضه الأساسية وخصائصه الوبائية وأسبابه العضوية والنفسية على نحو يبين المتوازيات اللصيقة بين مفهوم المالنخوليا والمفهوم المعاصر لاضطرابات الذهان. ومن بين أنواع المالنخوليا المثيرة للاهتمام والتي عالجها كتاب القانون مرض اطلق عليه اسم داء القطرب.

وحيثما ان كتاب القانون يتبنّى منهجا عضويا في تفسير منشأ المالنخوليا فلم يكن أمراً مفاجئاً انه ركز في وصفاته العلاجية بصفة أساسية على المعالجة بكيمياء النبات مستخدما في ذلك المنوّمات منها المهدّئات والمفرحات والمغذيات.

وقد عنى البحث بمعالجة الخصائص السايكوفارماكولوجية لوصفة القانون الطبية في تدبير المالنخوليا مقارناً إياها بالعقاقير النفسية المعاصرة.

promising younger clinicians or scientists. They may be held within Australia, or for 2 to 3 years in a centre of excellence overseas, but paid from Australia. Such Fellowships have proved to be an excellent national investment because they have helped to generate a cohort of well-trained, able research across Australia. After advanced training and experience, these individuals tend in turn to have a major influence on the next generation. The result is that Australia now has a vigorous research community and a satisfactory output of scientifically sound research. This is a markedly different situation to that 20 or 25 years ago.

A.S. Henderson MD, FRACP, FRCP, FRCPsych., FRANZCP
Professor and Director
NHB & MRC Social Psychiatry Research unit
The Australian National University
Canberra Act 2601 - Australia

der non-medical behavioural or biological scientists. The Society meets annually for 3 days, when individuals present work being planned or work completed. Their work is constructively criticized by the other members. Preference is given to younger members in allocation of time. Help is given in how to apply for a research grant, and how to behave at the interview. Regional research meetings are frequently held in the major cities. The scientific standing of the Society has gradually been established over a decade, and it has become a highly effective organization in its advocacy to the Federal Government for increased funding for research on mental disorders.

The anatomy of success in one setting is likely to need some modification to become culturally portable. On the other hand, this writer believes that some general principles exist that can be widely applied with a desirable outcome. Psychiatry in Arab countries already has a considerable wealth of intellectual resources. The opportunities for truly useful research are abundant. By expanding its research activities, achieve major advances in the care of the mentally ill and in the promotion of public health Arab psychiatry could be far-reaching.

In what follows, some features of psychiatric research as it has been experienced in Australia are described, with the full knowledge that conditions there and in Arab countries are appreciably different. In Australia, psychiatric research has been greatly helped in recent decades by initiatives from the National Health and Medical Research Council, which is the principal source of funding for medical research. In addition to making funds available for psychiatric research projects on a competitive system, based on national and international peer review, the Council has made further contributions. First has been the setting up of two Research Units, one in social psychiatry and psychiatric epidemiology in Canberra, the other being the Schizophrenia Research Unit in Melbourne. These Units each consist of a group of committed staff, including psychiatrists, engaged in full-time research. Such Units provide ideal conditions for intensive research, and they have become invaluable resources for other psychiatrists and mental health workers throughout the country and elsewhere. The second initiative by the Council has been to establish Research Fellowships in psychiatry. These are provided on a competitive basis for

derives from major centres elsewhere, imported more or less accurately, and applied more or less appropriately to the mentally ill of a host community. Idiosyncratic beliefs and practices inevitably emerge, but are likely to go unchecked or without adequate evaluation, and to be further propagated within the profession. But a better situation is not too difficult to achieve. In what follows, an attempt is made to set out some of the general principles that might be applied where it is considered that they are needed, and where there is a will to promote scientific advancement in the practice of psychiatry.

1. *Research experience benefits clinical practice.* It should be one component of postgraduate training.

   Although it may be only an optional component in some settings, the value of some personal experience of research is that instils a spirit of healthy enquiry and scepticism. Closely linked to this is the ability objectively to criticize any aspect of clinical practice or the knowledge on which it purports to be based. The young clinician comes to recognize that a questioning outlook, in which the daily practice of medicine and psychiatry becomes a continuing exploration, generates real fulfillment in professional life.

2. *Research experience, with publications in national and international journals, is a major asset in career appointments.*

   When individuals come to seek appointments in hospitals, health centres, medical schools and administrative posts, having publications is evidence of at least three attributes: such a candidate has had the ability and drive to embark on a study, to see it through to completion, and to express it more or less clearly in written word. It has also been laid before a wider readership for objective evaluation.

3. *The existence of an informal research community brings scientific benefits to the speciality.*

   What is envisaged here is a network of individuals sharing a common interest in promoting the scientific basis of psychiatry and psychological medicine. Such a network already exists through the Arab Federation of Psychiatrists, which provides an effective means for further development.

4. *A Forum for Psychiatric Research.*

   One further developemnt in Australia seems to have proved extremely useful. This is the Australian Society for Psychiatric Research. It has over 150 members, about half being psychiatrists and the remain-

General principles were offered to enhance such programmes. The Australian model was presented for discussion, and possible application in the Arab world.

Résumé

La Promotion de la recherche psychiatrique dans le monde Arabe

L'auteur relève que la psychiatrie reste pauvre dans un pays sauf si elle est sontenue par la recherche développée localement. Cette recherche doit prendre en considération les croyances et les coutumes locales.

Les principes généraux ont été offerts pour encourager des tels programmes.

Le modèle Australien a été présenté pour duscussion et son application possible pour le monde Arabe.

Research deserves to be promoted in Arab psychiatry. The context in which this proposition is made requires some explanation. This writer has been kindly invited by the Editor to contribute a paper on social psychiatry. In responding, he has chosen to focus not on specific themes, but to examine matters that are arguably fundamental to the fabric of Arab psychiatry and what can be offered to the communities it serves.

In presuming to offer comment on research development, the writer is fully aware that he is at some disadvantage in neither being an Arab himself nor having any personal experience of psychiatry in the Arab world. What is offered here is predicated on three assumptions: that a vigorous commitment to research brings major benefits to the discipline of psychiatry and to the services it provides within any country; that there are remarkably simple ways to have research recognized as a desirable professional activity; and that most of these simple ways have universal applicability, albeit with tailoring to fit local conditions.

Psychiatry that is practiced and taught without at least some research component is in poor shape. It is likely to be based on information that is largely

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THE PROMOTION OF PSYCHIATRIC RESEARCH IN THE ARAB WORLD

A.S. HENDERSON

تشجيع البحث العلمي في الطب النفسي في العالم العربي

أ.س. هندرسون

ملخص:

لا بدّ من إعطاء البحث العلمي في الوطن العربي الاهتمام الكافي، فمهما كان الطب المستورد من الخارج أميناً، ومهما كان تطبيقه بالمعايير الخارجية دقيقاً، إلا أنه يبقى ضعيفاً وعرضة لأن يصطدم بالمعتقدات والعادات المحلية السارية.

ان فوائد البحث العلمي أكيدة وتنعكس آثارها على الطب النفسي، والطبيب الممارس والمرضى، ويؤكد الكاتب ان هناك طرقاً بسيطة للبحث تحظى بقبول عالمي، ومن الممكن تطبيقها في كل البلاد مع قليل من التعديل بما يلائم الظروف المحلية المختلفة.

يقترح الكاتب مبادىء عامة لتشجيع التقدم في البحث العلمي، مثل ربط البحوث بالتدريب الطبي بعد التخرج، وربطها بالتعيين والترفيع في المؤسسات ونشرها بعد الاشراف عليها وتمويلها، ويعطي المثل الاسترالي كنموذج يمكن الاقتداء به.

ABSTRACT

The writer makes the point, that psychiatry in any country is poor, unless it is backed by research developed locally. This research should take into account the local beliefs and norms.

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AUTHORS

* **Ahmed Okasha: Professor and Chairman of Department of Psychiatry.**
AIN SHAMS UNIVERSITY. CAIRO - EGYPT

** **Mona Raafat: Assistant Professor of Neurology**
AIN SHAMS UNIVERSITY. CAIRO - EGYPT

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these drugs is probably related to the physiology of serotonin.

The role of serotonin, in human behavior is not well understood, but there is evidence that it is important in suicide, appetite, aggression, depression among other functions. All these drugs are characterized by being potent reuptake inhibitors of serotonin i.e. increasing its turnover. No one has shown any abnormality of serotonin either in the blood or spinal fluid in OCD patients and the precise mode of actions of these drugs remains to be elucidated.

To formulate a hypothesis about the possible biological basis of OCD, it seems possible that latent behavioral patterns stored in the basal ganglia are somehow triggered by abnormally functioning inferior frontal lobes. The initiating impulse is conveyed to the basal ganglia by pathways mediated by serotonin. Successful drug treatment might alter the role of serotonin in those pathways, thereby damping the spark from the frontal lobes[32].

We have to differentiate between impulse control disorders e.g. Trichotillomania, Kliptomania, pathological gambling where the act produces gratification as compared with obsessions where no gratification is established. But whether these disorders will respond to those antiobsessional drugs will be the subject of future trials and reaserch.

Some authors according to the biological substrate of OCD divide it into many subtypes which will underline the method of therapy.

We have: 1) OCD and Tourette syndrome responding to serotonin drugs and neuroleptics; 2) Schizo-obsessives responding to neuroleptics; 3) OCD and depression, they are hard to treat, 50% may respond to serotonin drugs and further 20% with the addition of lithium. Adjuvant therapy with Fenfluramine, Clonidine, and sometimes psychostimulants; 4) OCD and anxiety symptoms or panic attacks may respond to benzodiazepines and serotonin drugs. There is probably a serotonergic OCD, may be a dopamine OCD, a peptide OCD and OCD that is mainly related to environmental factors.

OCD patients have a risk avoidance, are meticulous, have multuple rituals and they have high 5HIAA in the CSF. In the impulse suicidal or homicidal patients, you have the reverse, with very low 5HIAA. It may be that serotonin system may have something to do with a dimension that at one end may be impulsivity and the other end, harm avoidance, or obsessions and compulsions.

that they are hard wired into the brain circuitry. Many of the behaviors shown by OCD patients seem to resemble the fixed action patterns described by Lorenz. It is obvious that cultural and physical stimuli account to some degree for a particular patient symptom, but the ritualized aspect of the behavior and its starting uniformity along with the fact that children and adults show identical symptoms suggest biological programming.

The disease is more prevalent in relatives suggesting a genetic cause. About 20% of OCD patients display motor tics: involuntary movements that are usually blinks of the eyes or facial grimaces. It has been shown repeatedly that OCD occurs in association with several types of neurological disorders: Sydenham's chorea, epilepsy, Parkinson's disease, Tourette syndrome and toxic lesions of the basal ganglia. The basal ganglia are known to be way stations between sensory inputs and the resulting motor and cognitive outputs. It is possible that in OCD disturbances in these way stations have somewhat short circuited the loop that normally connects sensory input and behavioral outputs, thereby releasing hard wired behavioral packages.

A study by Rapoport (1989) showed with CAT scans of the brain of OCD smaller caudate volumes. Another study showed that 20% of rheumatic fever with chorea displayed OCD which may suggest dysfunction in the basal ganglia.

Positron emission tomography (PET) showed OCD patients had higher level of glucose metabolism in an area of the frontal lobe and in the cingulate gyrus which connects the frontal lobe with the basal ganglia.

Two different types of treatment of OCD may be effective: behavior therapy mainly exposure-prevention and antiobsessional drugs. Behavior therapy does not contradict the biological basis. Ethnologists have shown that many fixed action patterns in animals can be extinguished by repeated training. Moreover, since the brain is both a biological organ and the recipient of sensory and psychological inputs, it is only to be expected that strictly psychological causes can have biological effects. Behavior therapy seems to be more effective in treating compulsions than obsessions.

On the other hand, new drug treatments seem to be effective in reducing both obsessions and compulsions. Three drugs have been shown to have anti-OCD effects: Clomipramine, Fluvoxamine and Fluoxetine. Their effects are not mediated through their antidepressive properties as most antidepressants are not helpful in OCD, the effectiveness of

previous study of the brain mapping in affective disorder[29] we found that most of the depressed patients had right hemispheric dysfunction, this finding could be interpreted as a psychobiological link between OCD and affective illness, even in those obsessionals who do not manifest depressive symptoms. However, the nature of a link between OCD and affective illness is not clear. Neither DST nor the sleep EEG abnormalities predict response to antidepressants in OCD[19]. One explanation for the apparent psychobiological link between the two disorders is that patients with chronic OCD develop episodic depressions rather than displaying the affect common in major depressive disorder. These episodes are manifested as exacerbations of obsessions and rituals. Many patients with OCD are ill for years before they seek treatment, some apply for help when they become overtly depressed, some when their obsessive compulsive symptoms are more severe. In both cases, the acute episodes superimposed on chronic disorder may be a form of affective illness.

Two of our patients showed right hemispheric hyperarousal, a finding which could not be supported by other authors, although it may suggest the presence of high cortical arousal as an evidence for anxiety associated with OCD, the septo-hippocampal system model of Gray (1982) can explain some physiological basis of OCD. It was observed that increased emotional arousal preceeds the onset of OCD. This may lead to oversensitivity of the hippocampal system which may mediate signals labelling previously mental stimuli as aversive. Similar studies in other anxiety disorders have generally found no abnormal results[9].

13.3% of our patients (4 cases) showed non-specific generalized cerebral dysfunction and 6.7% (2 cases) had borderline records, similar to the finding of Insel et al. (1983).

The data reported here and the studies cited previously, point to the prevalence of left hemisphere dysfunction and abnormal cognitive processing. It is of interest to note that similar findings were also reported in psychotic disorders[8,13,34,37,35,10,28] which may suggest the existence of a link between OCD and psychosis.

CONCLUSION

The overall prevalence of OCD ranged from 1.9-3.3% in five communities in USA, a rate greater than previous estimates.

The work in ethology by Konrad Lorenz who described nest building, grooming, courtship and defensive behavior patterns that appeared without learning models led him to hypothesize

their finding on the basis that in vivo exposure, cerebral blood flow represent a hypofunction of some parts of the brain, predominantly in the posterior left hemisphere.

None of our patients showed specific frontal lobe dysfunction as found in the work of Flor-Henry et al. (1979) who described left frontal lobe dysfunction in 11 subjects with OCD showing EEG abnormalities and neuropsychological test impairment. Baxter et al. (1987) studied 14 subjects with OCD by PET and found an increase in the left orbital gyrus and bilaterally in caudate. Paunovic (1984) reported a patient who developed OCD after anterior dominant cerebral infarction. O'Callaghan et al. (1982) found that lesions of the cingulate gyrus and lower quadrant of the frontal lobe have been found useful in OCD. Changes in some of the early latency evoked potentials[38] have been interrupted differently to implicate left hemisphere responsiveness, left frontal dysfunction and increased cerebral arousal. However, such abnormalities in the EEG and similar neuropsychological tests were not found by Insel et al. (1984) in 8 cases of OCD.

Two cases of our patients had diffuse left hemispheric dysfunction, similar to the finding of Flor-Henry et al. (1979) who found dominant hemisphere dysfunction by computerized EEG.

Two of our patients had left mid-temporal hyperactive foci (sharp waves). Insel et al. (1983) found intermittent left temporal sharp waves in 2 of 18 cases with OCD. Epstein & Balline (1971) found temporal lobe spikes and theta waves in the sleep EEG during stage 1 and REM of three subjects with OCD.

Links between OCD and epilepsy have been noted in few case reports. Stereotyped thoughts or forced thinking have been demonstrated as part of an epileptic aura[31,23] reported two cases in which typical OCD developed in teenage patients shortly after the onset of epilepsy, one patient had GME, and the other TLE. Both patients were free of obsessive compulsive symptoms before the onset of epilepsy.

20% of our patients (6 cases) showed right hemispheric changes. Four cases had right hemispheric dysfunction. This finding was not supported by many authors who studied subjects with OCD. Although Khanna et al. (1987) found decreased power in the non-dominant fronto-medial and temporal regions. Hassler (1980) reported that right sided disruption of thalamofrontal pathway was in some cases sufficient to produce clinical recovery. Some patients required subsequent operation in the dominant hemisphere. We suggest that since depression is the most common complication of OCD[14] and that in our

implications have been more for the neurotransmitter involved-serotonin- than for the site of dysfunction[4]. Luria (1966) beleived in the localization of function of specific areas of the brain. In contrast with the generalists who believed that the whole cortex is implicated in all such phenomena. The evidence for localization of dysfunction in OCD has recently gained support from cerebral glucose studies[1] CT scans[4], electrophysiological considerations[2-4] and psychosurgical evidence[27],7,16.

AN EVIDENCE FROM TOPOGRAPHIC EEG

Thirty patients (19 males, 11 females) diagnosed as primary obsessional disorder according to DSM–111 R were studied. They fall into two major symptoms: rituals and ruminations and all have experienced symptoms for at least one year. Their age ranged between 16–45 years, with a mean age of 32.1 years. Those with suspected organic lesions or secondary to another psychiatric disorders were excluded. All the patients were subjected to a semi-structured psychiatric interview (Ain Shams psychiatric sheet), physical and neurological examination and topographic EEG mapping using 16 channels Dantec-Siegen Machine.

90% of our cases (27 cases) showed TEEG abnormalities and 10% (3 cases) had normal records. 70% of our patients (21 cases) showed evidence of hemispheric lateralization, where 15 cases (50%) showed left hemispheric dysfunction predominantly posterior quadrant and two had temporal hyperactive foci. Six cases (20%) showed evidence of right hemispheric involvement where two had right hemispheric hyperarousal and 4 showed hemispheric dysfunction. No hyperactive foci were detected in the right hemisphere. Four cases (13.3%) had generalized cerebral dysfunction and 2 cases (6.7%) showed borderline records.

DISCUSSION AND REVIEW OF THE BIOLOGY OF OCD

In this study we found that 50% (15 cases) of our patients showed left hemispheric changes. 11 out of 15 had focal hemispheric dysfunction: 4 in the temporal region and 7 in the posterior quadrant. Bingley & Persson (1978) found increased fronto-temporal theta activity in 5 of 35 subjects with OCD. Jenike & Brotman (1984) found disturbances predominantly in the temporal and fronto-temporal regions. Zohar et al. (1988) found increased total cerebral blood flow markedly during imaginal flooding, but decreased, even below relaxation levels, during in vivo exposure. These changes were found mostly in the left temporal region. The greatest decrease during in vivo exposure was in the left parieto-occipital region. They explained

associated with a religion; by work, which is a bit reminiscent of Janet's idea of moral therapy; and to some extent by obsessions and compulsions that arise particularly in the absence of collective rituals (e.g., religion, the distraction of work).

Problems develop when obsessions or compulsions are associated with either avoidant behavior or an increase rather than a decrease in anxiety or depression. Both anxiety and depression may interact with obsessive compulsive symptoms, as well as act on the existing struggle for control, to initiate a positive feedback loop. Either religion or work might decrease the intensity of this loop by providing alternate channels for the guilt or worry. Implicit in this model is that the disability resulting from obsessions and compulsions (and thus the diagnosis of OCD) reflects not only the symptoms per se but also the predisposition to anxiety, avoidance, and depression on the one hand and the absence of more adaptive channels for guilt and worry on the other hand.

The model is clearly oversimplified. It fails to explain entirely why some individuals develop successful careers while others are too disabled to work. It also does not explain why some individuals have a heightened sense of responsibility or predilection to worry in the first place. It may, however, prove useful as a first step toward understanding obsessive compulsive phenomena within the broader context of "normal" mental life[20].

Obsessional disorders have received considerable attention from the psychologists over the last 10-20 years, although most of the effort has been directed towards techniques, while attempts to understand the mechanisms of the disorder have been less evident[3].

Current behavioral theories centre on the notion that an obsession is a learned behavior which become established through its anxiety relieving properties. However, this simple explanation fails to deal with many puzzling features of the disorder, such as why the performance of rituals often increase rather than decrease anxiety, or how altered mood, rather than environmental experience, serves to activate pathological behavior. An alternative approach to explaining the phenomena of obsessional disorder has involved the search for signs of physical abnormalities. A number of workers have suggested the possibility of neurological basis for OCD[36].

Recently, OCD has been found to be associated with various biochemical markers; this has revived interest in its biological basis. The evidence for a biological substrate for OCD has been gradually mounting[39]. However, the

psychasthenia[5]. All of those describe a collection of obsessive compulsive phenomena that are often grouped with other phobias, tics and what are now called anxiety disorders.

Although the french clinician did not agree on a single explanation for this mysterious disorder, the original view of Esquirol, later embraced mostly by Ribot (1904), Janet (1903), and others, stressed the loss of will, or volition, in patients with obsessions. The inability to make a decision or to trust a perception was considered a form of abulia or lack of will. The treatment, now usually ascribed to Janet, was "moral therapy", which combined the distraction of work and the pride of being productive to move people away from a low mental energy state where they also buffeted about by instrusive thoughts or ideas[21].

German clinicians, in contrast to the French and English theorists, took a more intellectual perspective. Westphal, a German psychiatrist and neurologist, wrote a brilliant paper (1878) on what he called Vostellungen, a syndrome that was really the same as that now defined as obsessive compulsive disorder. However, for him, the central feature of the disorder was not the anxiety or the affective elements, but the cognitive aspect.

Westphal was convinced that the basic pathology was the emergence of irrational thoughts. He perceived irrational thoughts as mental tics, neurologic events that had a cognitive representation. He used the term abortive insanity to describe the phenomenon and to distinguish these thoughts, which were associated with recognition of senselessness, from more psychotic thoughts, or true insanity. He also noted that unlike patients with true insanity, patients with abortive insanity, now called OCD, would get worse rather than better when they were put into an asylum.

All of us have intrusive, senseless thoughts and urges. All of us engage in rituals. However, most of us are not disabled by these thoughts or behaviours.

How do these "normal" obsessions and compulsions relate to the symptoms of OCD? Or, more to the point how can we understand pathologic obsessions and compulsions in the context of "normal" mental life?

A hypothesized model begins with a predilection to guilt, which is due to a heightened sense of responsibility, and a related predilection to worry, which is a consequence of uncertainty and the expectation of negative consequences.[20]

The distressful feelings of guilt and worry can be coped with in a number of ways: by religious endeavors, replete with all the guilt-reducing rituals

Résumé
La Biologie de Désordre Compulsif obssessionel

Les auteurs rappellent l'histoire du désorde compulsif. obssessionel au cours des six derniers siècles et insistent sur l'aspect biologique. L'étude de 30 malades présentant des désordres obssessionels primaires démontre un E.E.G anormal chez 90% des malades...

Les résultats de cette étude ont été discutés à la lumière d'autres études faites sur la biologie de ce désordre.

Les auteurs suggérent que les bases biologiques possibles de D.C.O. sont le fait que des modèles du comportement latent stockés dans le ganglion basal, sont d'une façon quelconque provoqués par le fonctionement anormal des lobes frontaux.

Obsessive compulsive disorder is a syndrome characterized by recurrent, intrusive thoughts (obsessions), usually accompanied by washing or checking. OCD patients generally recognize their symptoms as senseless and ego-dystonic, and in most cases, struggle against performing their compulsive rituals.

Although obsessive compulsive disorder has received considerable attention, recently, it is not in any sense a new disorder. Indeed, a syndrome identical to what we now call obsessive compulsive disorder (OCD), has been recognized for nearly 300 years.[17] Early descriptions of the syndrome stressed various aspects of what we now define as the core disorder, and a brief historical review of these different perspectives provides a useful introduction to the nature of the syndrome.

The first English descriptions of the syndrome, or a syndrome similar to OCD, stressed a relationship to melancholy or depression.[26] They also stressed the preoccupation with religious themes. The terms scruples and religious melancholy were used to describe this affliction when guilt was the prominent symptom.

The French nineteenth-century clinical descriptions of obsessions focus less on guilt and superstition and more on the uncertainty inherent in the syndrome. Esquirol (1837) may have been the first, although there were many subsequent clinicians, who related the disorder to doubt or to what was called insanity with insight. Several names have been applied to essentially the same phenomena: folie du doute, délire du toucher, folie raisonnante, and later

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THE BIOLOGY OF OBSESSIVE COMPULSIVE DISORDER
"AN EVIDENCE FROM TOPOGRAPHIC EEG"

AHMED OKASHA & MONA RAAFAT

بيولوجية اضطراب الوسواس القهري
(دليل من تخطيط الدماغ الكهربائي)

أحمد عكاشه ومنى رأفت

ملخص:

يستعرض الباحثان تاريخ مرض الوسواس القهري عبر القرون الستة الماضية، ويركّز على الجوانب البيولوجية منه. أُجريت دراسة على ثلاثين من المرضى بالوسواس القهري، أظهرت أن هناك اضطراب في تخطيط الدماغ الكهربائي عند حوالي ٩٠٪ من المجموعة. نوقشت نتائج هذه الدراسة في ضوء الدراسات المشابهة عن بيولوجية هذا المرض، ووصل الباحثان الى افتراض ان هذا الاضطراب نتج عن نماذج سلوكية كامنة مخزونة في العقدة القاعدية، وبطريقة ما تثار من قبل الفص الجبهي الأسفل المضطرب في وظيفته.

ABSTRACT

The authors review the history of obsessive compulsive disorder, over the last 6 centuries with emphasis on the biological aspects. The study on thirty patients with primary obsessional disorder, showed abnormal E.E.G. in 90% of the cases, the results of this study are discussed in the light of other studies about the biology of this disorder, the authors hypothesized that the possible biological basis of OCD, is that latent behavioural patterns stored in the basal ganglia are somehow triggered by abnormally Functioning inferior frontal lobes.

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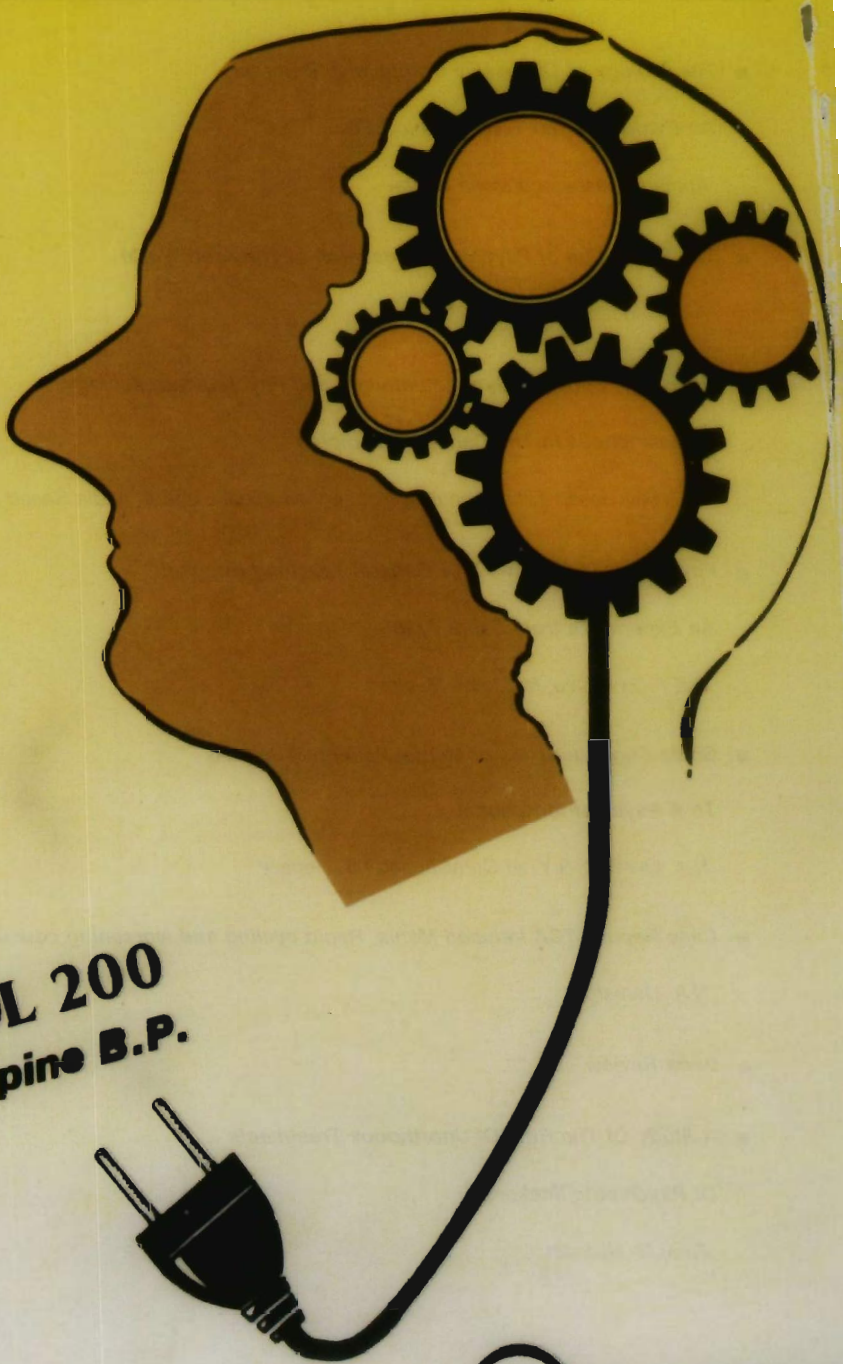

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The editorial board is very grateful to those colleagues who paid lot of efforts to maintain the production and quality of the Journal. We feel that it is the joint pan arab work and dedication to the cause of promoting Arab psychiatry, that the Journal can flourish and keep progressing.

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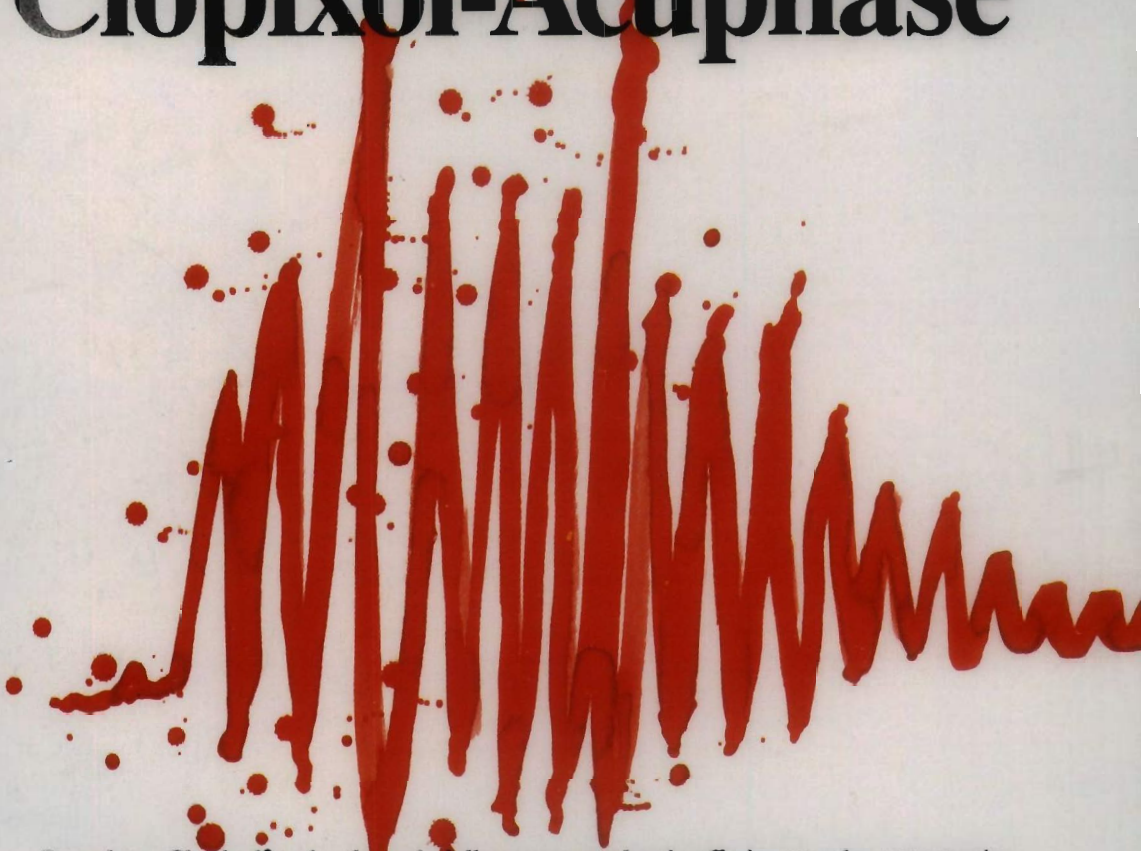

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