Their doctor knew that their symptoms were similar

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

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

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

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

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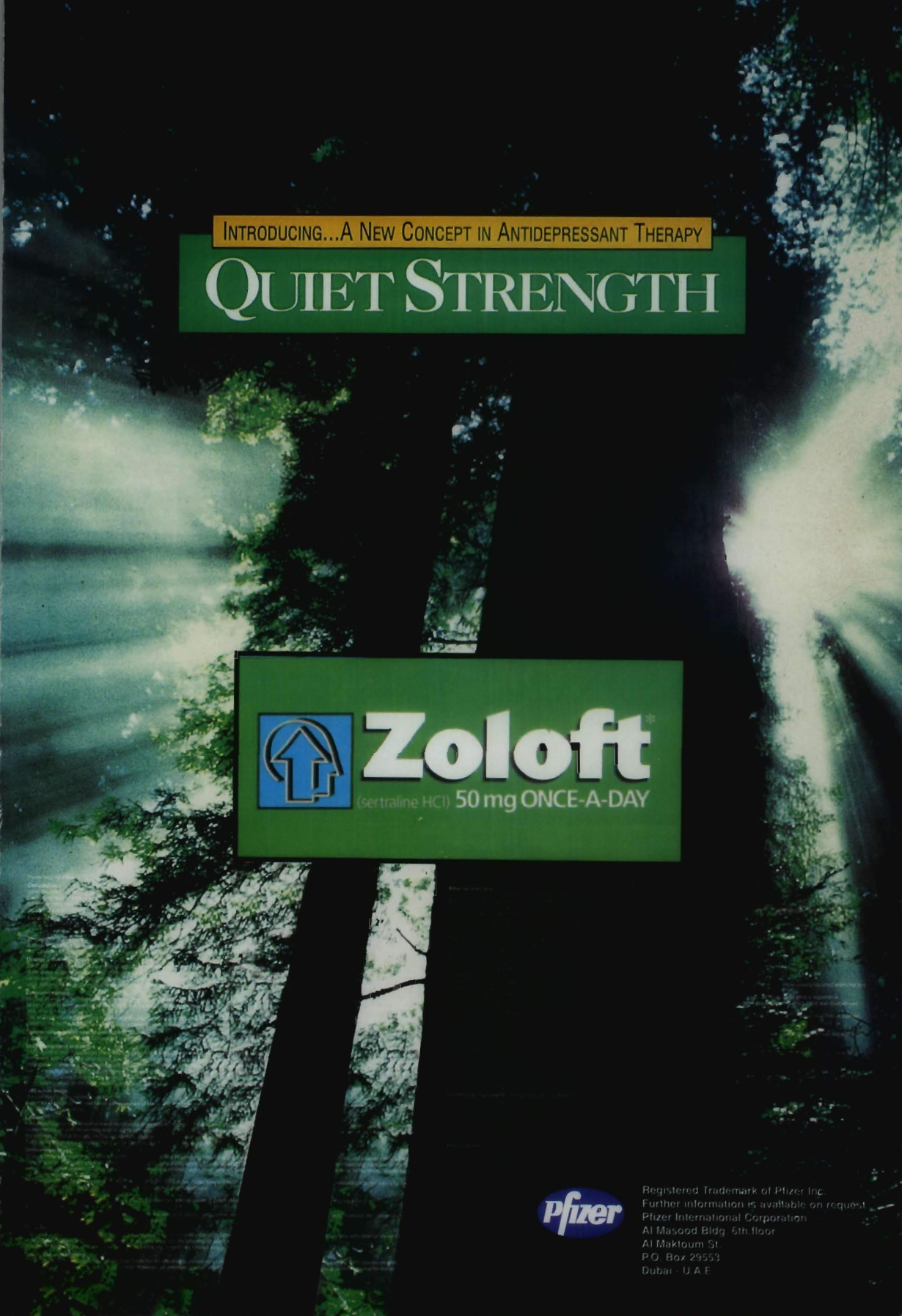
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: ١ - الطب النفسي - دوريات أ - اتحـاد الأطباء النفسانيين العرب

(تمت الفهرسة بمعرفة دائرة المكتبات والوثائق الوطنية)

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بسم الله الرحمن الرحيم

رسالة المحرر

يسعدني أن أتقدم بالشكر البالغ لجميع الباحثين من الأخوة العرب والاجانب الذين جعلوا دوام المجلة ممكناً والذين ساهموا بجهدهم على رفد المجلة بالأبحاث القيمة والتي رفعت المستوى العلمي والفني للمجلة.

ها قد أنهت المجلة السنة العاشرة من عمرها وهي تحث الخطى لبلوغ مستويات أعلى وما زال الأمل معقوداً على اعتماد المجلة في الفهارس العالمية وكذلك زيادة الأعداد الصادرة منها.

ان دعمكم للمجلة من حيث الأبحاث والاشتراكات والتواصل المستمر سيكون مثلاً يحتذى بين جميع الاختصاصات الطبية.

باسمي واسم الاتحاد أشكركم جميعاً وأتمنى لكم دوام التقدم والازدهار في سبيل خدمة أهدافنا العلمية والله المستعان.

أخوكم

عدنان يحي التكريتي

رئيس التحرير

معلومات هامة للناشرين

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

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

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

الصفحة الثالثة: تحتوى على أسماء المشاركين وعناوينهم وعناوين المراسلة.

يمكن أن تخصص صفحة للشكر للأفراد والمؤسسات التي دعمت البحث.

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

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

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

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

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

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٣. الخطيب، جمال الحديدي، منى السرطاوي، عبد العزيز (١٩٩٢). إرشاد أسر الأطفال ذوي الحاجات الخاصة. دار حنين، عمان ، الأردن.

ملاحظة: على الكاتب إرسال النسخة النهائية من الورقة أو المخطوطة على قرص قياس ٥ر٣ متوافق مع IBM-Microsoft Word.

المجلة العربية للطب النفسي

المحتويات

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Self Mutilation

Hussein Hassan

تشويـــــه الـــذات

حسين سرمك حسن

ملخـــــص

تم إجراء هذه الدراسة على مرضى (التشويه الذاتي) من خلال (٣٣) مريضاً نفسياً ممن يقومون بـــهذه العملية بصورة منتظمة ودرست خصائصهم الديموغرافية و المتغيرات النفسية التي ترتبط بـــهذه العمليـــة فظهر أن (٥٤%) من العزاب الذين عاشوا طفولة بائسة و عانوا من الحرمان من الأبوين في وقت مبكـــر و تركوا الدراسة في المرحلة الابتدائية و يتعاطون الكحول و العقاقير و للمتزوجين منهم علاقات جنســـية خارج العلاقة الزوجية و بعضهم علاقات جنسية مثلية . و قد بدءوا بتشويه الذات في عمر مبكر و تحـــت تأثير ظروف مختلفة تؤدي كلها الى توتر شديد متصاعد مؤلم ينتهي بتوجيه العدوان نحو الذات و بتشـــويه الجسد المصحوب بالارتياح لرؤية الدم و هو يسيل من الجروح التي تكون عادة سطحية متعددة و غـــــير مصحوبة بنية الانتحار و لا يصاحبها شعور بالألم.

و الأمر الذي يستحق الانتباه و البحث الواسع هو أن الغالبية من أفراد العينة (٩١%) شخصوا باضطراب الشخصية (السيكوباتية) في حين تشير المراجع التشخيصية الى أن تشويه الـــــذات هـــو مـــن مظـــاهر الشخصية الحدية

المقدمـــــة

عرف سلوك إيذاء أو تشويه الذات بتســـميات مختلفـــة (Self-Harm) أو Self Mutilation أو جرح الجسد Self-Injury أو سميت محـــاولات انتحار، وقد عرف إيذاء الـــذات Parasuicide بأنه سلوك متعمد يهدف الى الإيذاء الجســـدي ويقوم به الفرد بناء على معرفة مسبقة لنتائجـــه التي يتوقع أن تؤدي الى إيذاء بسيط أو كبـــير للجسم وفي العادة لا يقصد مـــن يقـــوم بـــهذا السلوك قتل نفسه[1] .

ظاهرة إيذاء الـــذات قديمـــة عرفتـــها أمـــم ذات حضارات قديمة كالصينية والهنديـــة والمصريـــة والعربية وقد كانت تمارس كجزء من طقوس دينية وهذه الظاهرة منتشـــرة فـــي الأوســـاط المدنيـــة والعسكرية[2،3]، وقد استحوذت على اهتمام البـــاحثين من علماء النفس والأطباء النفســـيين للحـــد مـــن انتشارها وتفادي نتائجها الوخيمة.

ويعتبر (دور كهايم) أول من لفت الانتباه الى هذا الموضوع[4] الذي أصبح أكثر تحديداً على يد (مننجر) الذي استخدم مصطلح الانتحار الجزئي) لوصف هذه الحالة واعتبرها نوعاً من أنواع (سلوك تدمير الذات الغير مباشر – Behavior Indirect Self Destructive) الذي يتضمن أي سلوك مهدد للحياة من دون نية مسبقة بالموت ويشمل الإدمان الكحولي، التمارض، الهوايات الخطرة، الهدوء والتنسك والاستشهاد وغيرها وفسرها مننجر على أساس التوازن المتغير بين غرائز الموت وغرائز الحياة[5] . وقد اختلفت الدراسات في تحديد نسبة انتشار هذه الحالة حيث حددتها إحدى الدراسات بـ (٣ر٤%) بين المرضى النفسيين (النساء تفوق الرجال بنسبة ١/٣)[6] في حيث حددتها دراسة أخرى أجريت لتحديد درجة انتشار كل حالات أذى النفس (ويتضمنها الانتحار) بـ (٧٣٠ حالة لكل (٠٠٠ر١٠٠) نسمة من السكان في السنة الواحدة). وقد وجد أن النسبة أعلى من هذه الحالات تحصل بين الأطفال الفصاميين وضعاف القول وبين السجناء ومن الجدول التشخيص الأمريكي الثالث المراجع[7] (DSM II -R) يعتبر تشويه الذات المتعمد واحد من القواعد التشخيصية لاضطراب الشخصية الحدية.

(Personality Disorder Borderline) فقط مع الرسغ وغيره من الممارسات يتكرر بين هؤلاء المرضى للحصول على العون من الآخرين أو للتعبير عن الغضب أو لتخدر الذات المؤثرات المؤلمة. وقد حصلت حالات تشويه بين الجنود في الحرب العالمية الثانية للتملص من واجباتهم في المعركة وقد ظهر أن نسبة عالية من هؤلاء الجنود مصابة بالفصام[8] .

من الصعب إحصاء مدى انتشار ظاهرة إيذاء الذات بدقة خاصة في الأوساط العسكرية هذا وقد أظهرت دراسة غير منشورة (تيسير أحمد ١٩٩٣ درس فيها ٦٠ فرداً من نزلاء أحد السجون العسكرية حيث أشارت النتائج بوجود علاقة بين اضطراب الشخصية السيكوباتية وسلوك إيذاء الذات.

إن الكثير من التساؤلات تثار وتتعلق بالخصائص المشتركة التي تقف خلف هذه الممارسات والانفعالات المرافقة لها والأدوات المستخدمة والمناطق المفضلة من أجسادهم.

هدف الدراسة

هدفت الدراسة الى التعرف على أن تشويه الذات المتعمد لدى عينة من المرضى النفسيين من العسكريين العراقيين وتحديد الخصائص النفسية المشتركة بينهم من جهة والتي تميز هذه الممارسة من جهة أخرى.

عينة الدراسة والإجراءات

تم اختيار عينة مقصودة من المرضى النفسيين بلغت (٣٣) فرد من الذكور الذين يحالون من

وحداتهم الى مستشفى كركوك العام بسبب قيامهم بتشويه ذاتهم والذين تم إعطاؤهم تشخيصات نفسية المركزي في بغداد ولديهم ملفات في هذه المستشفى المركزية وقد حصل بعضهم على قرارات لجان طبية نفسية متخصصة أثبتت تشخيص حالاتهم المرضية. ولأن التشخيص السائد كان (اضطراب الشخصية من النوع السيكوباثي). (٣٠) من أفراد العينة البالغ (٣٣) فرداً فقد تمت إعادة تشخيص هذه الحالات اعتماداً على الجدول التشخيصي الأمريكي الثالث المراجع والذي أكدت نفس التشخيص لهذه الحالات.

تم وضع استبيان خاص بهذه الدراسة يتضمن مجموعة من الأسئلة تهدف الى تحديد مختلف الجوانب النفسية المرتبطة بعملية تشويه الذات من جهة وتحديد الخصائص النفسية المشتركة بين من يقومون بها (انظر الملحق). كما اعتمدت استمارة البحث الاجتماعي المعتمدة مركزياً في وحدات الطب النفسي في تحديد التاريخ الشخصي والاجتماعي لأفراد العينة. وقد تم الفحص النفسي وإعادة التشخيص وملئ الاستبيان واستمارات البحث الاجتماعي خلال فترة مكوث هؤلاء المرضى في شعبة الأمراض النفسية في المستشفى لغرض العلاج بسبب تشويه الذات وبإشراف اختصاصي الأمراض النفسية مجموعة من الباحثين النفسيين في المستشفى.

مرضية من وحدة الطب النفسي في المستشفى

النتائج

أشارت نتائج الدراسة الى ما يلي:-

الحالة الاجتماعية : توزيع أفراد العينة بحسب حالتهم الاجتماعية الى:

(١٤) متزوجاً أي (٤٢ر٤%)

(١٨) أعزباً أي (٥٤%)

ومطلق واحد أي (٣%)

وقد أشار المتزوجون الى أن علاقاتهم الزوجية سيئة وغير مستقرة وتتخللها حالات كثيرة من الانفصال والابتعاد بين الزوجين بسبب المعاملة السيئة والعنيفة التي تلقاها الزوجة وكانت حالة الطلاق الوحيدة بسبب السلوك العدواني للزوج.

العمر: متوسط العمر هو (٢٥) سنة لأفراد العينة. وبلغ عمر أصغر أفراد العينة (١٨) سنة بينما بلغ عمر أكبر أفراد العينة (٤٣) سنة وهو من المتطوعين.

الوالدان: ظهر أن (١٧) من أفراد العينة أي (٥ر٥١%) أيتاماً من ناحية الأبوين

وكان (١٣) من أفراد العينة أي (٤٠%) أيتاماً من ناحية الأب

وكان (٣) من أفراد العينة أي (٩%) أيتاماً من ناحية الأم

وقد أشار جمع أفراد العينة الى أنهم عاشوا أجواء عائلية سيئة شاعت فيها الخلافات العائلية والانفصال بين الأبوين وكانت علاقاتهم سيئة مع

آبائهم وتسودها القسوة في حين كانت الأمهات (سلبيات) وتابعات للأب. وقد عانى بعضهم من فجوة عاطفية مؤلمة بينهم وبين آبائهم وأمهاتهم على حد سواء.

الطفولة ومركز الفرد بين الأخوة: أشارت النتائج الى أن ترتيب أفراد العينة بين إخوانهم على الشكل التالي:

(١٣) فرداً (٤٠%) كان تسلسلهم الثاني في العائلة
(٩) أفراد (٢٧%) كان تسلسلهم الأول في العائلة
(٦) أفراد (١٨%) كان تسلسلهم الثالث في العائلة
(٢) اثنان (٦%) كان تسلسلهم الرابع في العائلة
(٢) اثنان (٦%) كان تسلسلهم الخامس في العائلة
(١) واحد (٣%) كان تسلسله السادس في العائلة

وقد أشار جميع أفراد العينة الى أنهم عاشوا طفولة بائسة محطمة تميزت بقسوة معاملة آبائهم بشكل خاص لهم وتخللتها تصرفات غير سوية كالسرقة والكذب والهروب من البيت.

التحصيل الدراسي : (٣٠) فرداً (٩١%) تركوا الدراسة في المرحلة الابتدائية
(٢) فقط (٦%) أكملوا الدراسة المتوسطة
(١)فقط (٣%) خريج أحد المعاهد الإسلامية

وقد أشار أغلب أفراد العينة الى أن سجلهم الدراسي كان سيئاً وكثرت فيه العقوبات الانضباطية بسبب الهروب المتكرر من المدرسة أو الغياب غير المبرر أو المشاجرات والسرقة والكذب وتكسير الأثاث.

السلوك الجنسي: أشار المتزوجون من أفراد العينة الى وجود علاقات جنسية لديهم خارج العلاقة الزوجية وأشار (٩) منهم (٢٧%) الى أنهم يمارسون الجنسية المثلية (النوع الفاعل Active Homosexual) كلما توفرت الفرصة لذلك.

السجل العدلي: ذكر (٣٢) فرداً من أفراد العينة (٩٧%) أنهم أدخلوا السجن عدة مرات بلغت أحياناً عشر مرات لأسباب مختلفة تراوحت بين السرقة والمشاجرات والهروب من الجيش الى الاغتصاب والقتل العمد.

تعاطي الكحول والعقاقير: أشار (٢١) فرداً أي (٦٩%) الى أنهم يتعاطون الكحول والعقاقير بصورة منظمة. وقد كانت العقاقير المفضلة هي: الارتين – الفاليوم – السومادريل – رغم أنهم كانوا يفضلوا عقار (الاتيفان والموجادون) اللذين أصبح الحصول عليها صعباً. وقد أشار بعضهم الى أنهم بدأو بتعاطي العقاقير في مرحلة المراهقة.

العمر الذي بدأ فيه تشويه ذاته: كان متوسط العمر هو (٢٠) سنة حيث أن هناك حالات بدأت فيها العملية في عمر مبكر كان إحداها (١١) سنة كما أن هناك حالات بدأت فيها العملية في الثلاثين من العمر بعد التعرض لإصابة الرأس المغلقة (Closed Head Injury).

العوامل المرسبة والظروف المصاحبة: أشار أغلب أفراد العينة (٣٠) فرداً (٩١%) الى أن العوامل التي سبقت المرة الأولى تمثلت في حوادث سببت للشخص توتراً شديداً ولم يستطيع

الرد فيها على مصدر التوتر (مصدر العدوان) مثل فقدان أحد الوالدين أو شخص مهم في حياة الشخص، شجار مع أحد الوالدين – بشكل خلص الأم– أو مع رئيس، انفصال عن الزوجة،٠٠٠الخ أما عن العوامل التي تقف وراء تكرار العملية فقد أشار جميع أفراد العينة الى أنها لا تتعدى الحوادث اليومية البسيطة أحياناً (كخلاف بسيط مع أحد الزملاء أو رفض طلب بسيط مثلاً) وقد أشار بعضهم الى أن العملية تحصل بسبب (ضغط داخلي) كما يقولون ومن دون سبب ظاهر٠

أما عن تسلسل الحوادث في العملية ذاتها فهو كما يلي:-

حادث مثير للتوتر يعقبه شعور بالتوتر الشديد وعدم الاستقرار وسرعة الاستثارة وفقدان الرغبة بالمحيط والأشخاص٠٠٠٠والاحساس (بالاختناق وضيق الصدر) ثم تصاعد شديد في مستوى التوتر و(فقدان التركيز) يعقبه اتجاه الشخص (بصورة آلية) نحو الأداة الجارحة مع شعور مرافق ولحظي بكره شديد للذات يعقبه غرز الأداة الجارحة في الجسد وتكرار الفعل لحين الحصول على الارتياح و(التنفيس) وقد ذكرنا تسلسل الحوادث هذا بعبارات المرضى أنفسهم وكأن عبئاً ثقيلاً قد انزاح عن صدورهم وأنهم (يستطيعون التنفس بعد ذلك) على حد تعبيرهم فيجلسون مسترخين هادئين مع قدر كبير من الشعور بالارتياح وبعضهم يغط في نوم عميق هادئ بعد العملية٠

الدم: ذكر أغلب أفراد العينة بأنهم لا يستطيعون التوقف إلا بعد رؤية الدم وهو يسيل من جرحهم حيث يشعرون عندئذ براحة شديدة وهبوط في مستوى التوتر الى حد كبير٠

الألم: أكد أفراد العينة أنهم لا يشعرون بأي ألم لحظة القيام بفعل التشويه أو خلاله٠ وأكد بعضهم بأنه يشعر بالألم بدرجة بسيطة بعد ساعات من نهاية العملية٠ وأغلبهم يطلبون العلاج تحت ضغط أصدقائهم وذويهم أو رؤسائهم ويستدل على ذلك من خلال كون أغلب ندب الجروح قد شفت والتأمت بصورة مشوهة وبدون تدخل طبي رغم أن بعض الجروح عميقة٠

وكما أشاروا الى أنهم يراجعون الطبيب للحصول على العقاقير المهدئة ليس لتخفيف الألم بل للاستفادة منها في النوم ليلاً٠

الموقف من الآخرين: بين (٢٤) فرداً (٧٨%) أنهم يقومون بالعملية أمام أنظار الآخرين في حين أشار (٩) منهم (٢٧) الى أنهم لا يقومون بذلك أمام الآخرين، ولكن الجميع أشاروا الى أن لا أحد يساعدهم في إنجاز العملية ولم يقوموا بها بصورة مشتركة مع أشخاص آخرين٠

الحاجة الى العقاقير أو الكحول للقيام بالعملية: أشار الجميع الى أنهم لا يحتاجون لهذه المواد للقيام بالعملية ولكنهم يمكن أن يقوموا بتشويه أجسادهم إذا منعت عنهم أم لم يحصلوا عليها وقت حاجتهم الشديدة لها في حالات التوتر المؤلم٠

الأدوات المستخدمة: أكد جميع أفراد العينة على أنهم يستخدمون أي أداة تتوفر في محيطهم ولكنهم

يفضلوا وحسب التسلسل:

- شفرات الحلاقة
- شظايا الزجاج والقناني المكسورة
- السكاكين
- أعقاب السجائر
- ضرب الرأس بالجدار لحين حصول نزف من فروة الرأس

الطريقة التقليدية تتمثل بعمل جروح طويلة سطحية على الجلد بشفرة الحلاقة أو جروح عميقة تصل الى العضلات والأنسجة العميقة.

العدد: لقد تراوح عدد الجروح من (٨) ثمانية جروح سطحية على الساعدين لدى أحد المرضى الى أكثر من (٣٠٠) ثلاثمائة جرح لدى مريض آخر على شكل شبكة تمتد على الصدر والبطن والساعدين والرقبة وبعضها ملتئم بتشوه شديد.

المناطق المفضلة من الجسم والتي يتكرر جدعها: كانت حسب التسلسل الآتي:

الساعدين – الصدر – البطن – فروة الرأس – الرقبة.

النية الانتحارية: أشار جميع أفراد العينة الى أنهم لم يختاروا مناطق حيوية من أجسامهم يعلمون أنها تؤدي بهم الى الموت.

أشار (٣) أفراد الى وجود حالة مماثلة في العائلة (من إخوانهم الأكبر سناً) في حين أشار (٣) ثلاثة آخرون الى أنهم لهم أصدقاء يقومون بنفس العملية.

البنية الجسمية: كان (٢٩ فقط من ذوي البنية الجسمية الرياضية ويمارسان الملاكمة أما البلقون (٣١) فرداً فكانت بنيتهم متوسطة أو محيفة.

الوشم: لقد ظهر أن (٢٩) فرداً (٩٣%) يقومون بالوشم بأشكال مختلفة وفي مناطق متعددة من الجسم (سيتم تناول هذا الموضوع في بحث مستقل).

التشخيص: كانت تشخيصات اضطرابات النفسية على الشكل الآتي:

(٣٠) فرداً أي (٩١%) شخصوا باضطراب الشخصية – شخصية سيكوباتية

(٢) فقط (٩%) كابة عقابيل كألم الرأس المصحوب بفترات مختلفة من فقدان الوعي بسبب إصابات الرأس المغلقة.

المناقشة

على الرغم من قلة عدد أفراد عينة الدراسة إلا أن النتائج جاءت معززة للدراسات السابقة في ظهور علاقة بين الشخصية السيكوباثية وسلوك إيذاء الذات[١،٢،٣].

أشارت نتائج الدراسة الى أن العملية تبدأ في عمر مبكر مما يمكن أن يفسر تفسيرات مختلفة ولكنها متكاملة فهي تشير من جهة الى أنها جزء من اضطراب مبكر يتفق مع اضطراب شخصيات معظم أفراد العينة وأن العوامل التربوية والبيئية ومجموعات الأقران تلعب دوراً مهماً في هذا المجال. كما أن هذا العمر المبكر يدعو الى بحث العوامل المرتبطة بالاستعدادات الوراثية.

من الواضح أن العلاقات العائلية للمصابين سيئة وتلعب دوراً بارزاً. فقد أشار المتزوجون منهم الى أن صلاتهم بزوجاتهم سيئة ومتقلبة (قام أحد المرضى ببتر كف زوجته في نوبة هياج وعنف شديدة) كما أنهم يعاملون أولادهم بشكل قاسي (بعضهم يعاقب أولاده بكي أجسادهم بالسجائر) وقد تكون هذه المعاملة من الأب أو مزاحة عنه Displaced نحو الأولاد حيث أشار جميع أفراد العينة الى الدور التسلطي القاسي للأب والى الدور السلبي للأم، كما تبين أن لموت الأب المبكر تأثيراً سلبياً عليهم يثير مركز أفراد العينة بين إخوانهم أشكالاً يستحق البحث حيث أظهرت النتائج أن الولد الثاني هو الأكثر تعرضاً للإصابة بهذا الاضطراب بخلاف ما هو متوقع ومتفق عليه في أغلب البحوث وفيما يتعلق بالتحصيل الدراسي لم يحصل أي من أفراد العينة على مؤهل علمي عال وقد يكون ترك الدراسة بصورة مبكرة مظهر من مظاهر اضطراب شخصياتهم حيث يعود هذا العامل من انحرافهم واضطرابهم، ومن الملفت للانتباه أن أحد المصابين الذي تخرج من أحد المعاهد الإسلامية هو ابن لرجل دين وقد ينطوي اختياره لهذا المعهد على عدوان موجه نحو الأب وأن الأمل الديني لم يضعف من اضطرابه.

إن أغلب الأسباب المباشرة التي ترتبط ببداية عملية تشويه الذات هي من حوادث الحياة اليومية التي يمكن أن تحصل لأي فرد ولكن المصاب يوجه العدوان فيها نحو نفسه، ويمكن اعتبار رد الفعل المرضي هذا وسيلة لتفريغ التوتر المؤلم الناتج عن العدوان المكبوت الذي قد يعود الى الطفولة المبكرة حيث يمنع الطفل من التعبير عن مشاعر العدوان الطبيعية لديه في أوقات التوتر فيوجهها نحو ذاته ويترسخ هذا الأمر بتكرار الظروف والاستجاباب، كما أن قدراً كبيراً من (المازوخية) Masochism يتضح من خلال إشارة المرضى الواضحة الى مشاعر الارتياح التي ترافق العملية والى تلذلذهم برؤية الدم وهو يسيل من جروحهم وعدم شعورهم بالألم، ولم يشير أي من المرضى الى مشاعر الذنب التي قد تعقب تشويه الذات.

إن قيام أغلبية المصابين بتشويه ذاتهم أمام أنظار الآخرين يشير الى أن العملية تتضمن جانباً من تأكيد بدائي للذات وكوسيلة لإخضاع الآخرين والسيطرة عليهم من جهة أخرى إن انخفاض المستوى الثقافي لأفراد العينة قد يجعل عملية تشويه الذات تمثل (لغة) للتواصل مع الآخرين في جانب منها وللتعبير عن مشاعرهم وحاجاتهم لا سيما وأنها ترافقت مع (لغة) أخرى إذا جاز التعبير تمثلت بالوشم الذي وجدناه لدى (٩٣%) من أفراد العينة وهذه العلاقة بين الوشم واضطراب الشخصية أكدته دراسة سابقة[٢] .

إن قيام المصابين بتشويه ذاتهم من دون الحاجة لأي عقار مهدئ أو مسكن يشير الى الطبيعة الأصلية للعملية كوسيلة للخلاص من موقف غير محتمل ويحاول توزيع التوتر وهذا ما أكدته

الدراسات السابقة[1] ٠

إن قلة أو عدم وجود حالات مماثلة في عوائل أفراد العينة أو بين أصدقائهم يثير تساؤلا حول الكيفية التي بدأت بها هذه الحالة لديهم وكيف (تعلموا) هذا السلوك ومن أي (نموذج)؟ إن الاحتمال الأكبر هو أنه هذه الممارسات هي امتداد لممارسات مبكرة في الطفولة كما أسلفنا ويتطلب البحث والتحري بصورة أكثر شمولاً في الطفولة هؤلاء الأفراد وتطورهم النفسي والاجتماعي٠

ومن الملاحظات المهمة هو أن الجدول التشخيصي الأمريكي الثالث المراجع والجدول التشخيصي العاشر المراجع لمنظمة الصحة العالمية يعتبر أن تشويه الذات من مظاهر اضطراب الشخصية (الشخصية الحدية) وليس الشخصية السايكوباثية أي خلاف النتيجة التي وصلنا في بحثنا هنا، فهل يثير هذا الأمر الشك في وجود اختلافات (محلية) في طبيعة مظاهر الشخصية السيكوباثية؟ وهل يرتبط حصول تشويه الذات بين المصابين بالاكتئاب الذي يعقب كألم الرأس (رغم قلة الحالات) بحالة الاكتئاب ذاتها أم بالضرر الدماغي نتج عن الإصابة؟ إن هذه الأمور تتطلب المزيد من البحث والتقصي وإجراء الفحوصات مثل مخطط الدماغ الكهربائي Electroencephalography٠

استمارة رقم (١)

العمر

الحالة الزوجية : متزوج ( )، أعزب ( )، مطلق ( )

هل والدك على قيد الحياة؟ صف طبيعة علاقتك بهما؟ صف طبيعة العلاقة بينهما؟

ما هو تسلسلك في العائلة؟ كيف تصف مرحلة الطفولة التي عشتها

ما هو تحصيلك الدراسي؟ كيف كان سجلك المدرسي

ما هي طبيعة علاقتك بزوجتك وأطفالك؟

هل لديك علاقات جنسية خارج العلاقة الزوجية؟

هل لديك علاقات جنسية مثلية؟

هل تعرضت لمشكلات قانونية؟ وهل أدخلت السجن؟ كم مرة؟ وما هي الأسباب لكل مرة؟ ومتى أدخلت السجن لأول مرة

هل تتعاطى العقاقير أو/و المواد الكحولية بصورة منتظمة؟ ما هو العقار أو العقاقير المفضلة؟ ومتى بدأت بتعاطيها أول مرة

متى بدأت بتشويه الذات أول مرة؟ -حدد العمر بالضبط – وما هي الأسباب التي أدت الى ذلك؟

ما هي الأسباب التي تؤدي الى تكرار تشويه الذات عادة؟

ما هي طبيعة المشاعر والانفعالات التي تسبق وترافق وتعقب نوبة تشويه الذات؟ صفها بالتفصيل

هل تشعر بالألم بسبب تشويه الذات – أثناء أو بعد النوبة؟

صف مشاعرك عند رؤية الدم يسيل من جروحك؟

هل تطلب العلاج لجروحك بعد تشويه الذات؟

هل تتناول عقاقير مهدئة أو مواد كحولية تهيؤك لتشويه الذات وبشكل خاص لتخفيف الألم

ما هي الأدوات التي تستخدمها عادة في تشويه الذات؟

ما هي المناطق التي يتكرر تعرضها للتشويه من جسمك؟

هل اخترت مناطق حيوية من جسمك للتشويه وأنت تعلم أنها قد تؤدي الى الموت؟

هل تقوم تشويه الذات أمام أشخاص آخرين عادة أم بمفردك (منعزلاً عنهم)؟

هل هناك فرد من عائلتك يقوم بنفس العملية؟ هل لك صديق يقوم بنفس العملية؟

بالنسبة للفاحص: أ- ما هو انطباعه عن البنية الجسمية للمريض؟

ب- إذا كان جسم المريض فيه (وشم) فعليه وصفة تفصيلياً-المنطقة، العبارات، الصور

تثبيت عدد الجروح، نوع ندب الشفاء وهل الجروح سطحية أم عميق

Abstract

Thirty-three psychiatric patients who committed self-mutilation regularly were examined an interview and special questionnaire were used to identify demographic & psychological variables related to this process.

Results showed that majority of them were single, had miserable child hood due to death or emotional separation and they lift school early & had imprisoned many times most of them were alcoholic and drug abusers.

Self-mutilation started early in life, usually after stressful life events that cause severe painful tension leading the patients to, direct the aggression toward them. The following blood gives great satisfaction and they feel no pain through out the process. While the main diagnostic references (DSM-III-R), put self mutilation in the diagnostic criteria of borderline personality disorder, 91% of patients were diagnosed as having antisocial personality disorder this results needs further study.

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الدكتور حسين سرمك حسن

اختصاصي الأمراض النفسية والعصبية

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الملخـــــــص

من المعروف أن عوامل الثقافة الاجتماعية تؤثر في انتشار متلازمات الاضطرابات النفسية المختلفة. ان الهدف من هذه الورقة هو تحليل المظاهر الاجتماعية والاكلينيكية للاضطرابات المفتعلـــة علـــى ضـــوء المجتمع السعودي.

هذه الدراسة تحتوي على متابعة حالات ٥ مرضى (٣ ذكور، ٢ إناث) تبين أنهم يعانون من الاضطرابات المفتعلة بعد متابعة حالاتهم عقد من الزمان ومن خلال عدة مقابلات وبالتحديد في الفترة ما بيـــن كـــانون ثاني (نوفمبر) ١٩٨٣ وكانون أول (ديسمبر) ١٩٩٣.

على مستوى المعايير الديموغرافية فإن معظم هؤلاء المرضى اتصفوا بضعف التحصيل التعليمي وعـــدم استقرار الحياة الزوجية وكثرة عدد أفراد العائلة مع وجود مشاكل بينهم.

على مستوى العوامل المسببة وجد أن هناك عدة عوامل اجتماعية نفسية متناغمة مع الأبحـــاث العالميـــة أمكن تتبعها في كل المرضى من ناحية الأعراض فإن كثرة الاسفار والكذب والسلوك العدواني وجدت أقل حدة بين الاناث بالمقارنة مع الذكور وهذا يعزى الى الاختلافات الاجتماعية الســـادة. وهنـــاك أربعـــة مرضى بصورة خاصة استشاروا المعالجين الشعبيين.

باختصار فإن العوامل الثقافية الاجتماعية للمملكة العربية السعودية لها تـــأثير واضـــح علـــى متلازمـــة مونخاوزن. على الاختلافات النفسية والاجتماعية والثقافية للاضطرابات المفتعلـــة ممـــا يتيـــح وضـــع استراتيجيات علاجية على ضوء هذه الاختلافات.

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pitfalls, were also in line with reports from industrialized cultures. On clinical level, like our patients, abdominal pain, giddiness, loss of consciousness[44], renal colic, haematuria[45,46] and rectal/colonic bleeding[47], deaf-mutism[48], dermatitis artefacta[24], sleep disorders[49], asthma[50], cancer[51], and seizures[52] have been reported across other cultures. Interestingly, all patients but one [case 5] consulted traditional healers. Recently, we have reported the traditional practices in particular cautery by faith healers in Saudi psychiatric patients[53]. For brevity, these healers as well as their clients have strong religious background and beliefs. Overall, they believe in unorthodox concepts regarding the aetiologies and treatment of medical diseases. Likewise, they have their own classification, for example, wushra for schizophrenia and junoon for psychosis. They also believe that the mental illnesses are just caused by bad jinn, evil eye, magic, jealousy and sins. Therefore, they read special verses from Holy Quran and also use relevant Hadith for the treatment of their clients. Additionally, herbal medicines, venesection, cautery, special diets, Azeema and Saoot are included in their therapeutic armamentarium. Based on these beliefs and practices our patients' illnesses were attributed to the evil eye, magic, and jinn who were treated mainly by reading from Holy Quran and Hadith, cautery, sorcery and herbal extracts. However, none of these patients showed improvement. Lately there is an alarming resurgence of beliefs in magic, astrology, angels, and faith healers in other cultures[54]. It is emphasized that factitious patients seeking help from faith healers is a unique finding of this study. We have also summarized briefly other important sociocultural factors underlying factitious disorders[55].

Conclusions

Despite certain weaknesses of this pilot socioclinical analysis, it is concluded that some of the revealed sociodemographic and clinical characteristics of patients with factitious disorders such as inadequate education, marital failures and disturbed interpersonal family relationships, modest peregrination, less aggressive behaviors, and so fabrications especially in females may be attributed to sociocultural dynamics in Saudi Arabia. The most important tentative implication of this research is that cultural mechanisms like emphasis on not falsifying and lying might be used to remedy the maladaptive patterns of behaviours of such patients. Further transcultural researches should be conducted in order to understand the sociocultural mechanisms of factitious disorders which may lead to the development of novel culturally sensitive treatment modalities.

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aggression in two female patients might be explained by culture. Traditionally, a female needs mohrem [a person who can not marry her legally] who is not always available[19] for accompanying her for visiting hospitals. Hence. the travelling of females becomes relatively restricted. This is not the feature of wandering and/or prototypical type of MS[41]. The non-prototypical type[42] of MS in females is characterized by less severe psychopathology, higher level of functioning and infrequent factitious behaviors. Though recently this classification has been criticized[26], this analysis partly appears to justify this nomenclature. The one tentative implication is that the concept of truthfulness could be used to remediate the maladaptive patterns of false behaviors, a core clinical issue in factitious disorders.

The main aetiological variables in Case 3 were hospital milieu familiarity, physical abuse and neglect and masochistic traits. However, in Case 4 sexual failures, lowered self-esteem, guilt and derogatory remarks by his spouse may have led to Munchausen-like behavior. The importation of sex education is partly determined by culture. Unlike conservative societies, in Western cultures sexuality is often discussed freely which has its own advantages and disadvantages. The normally declining sexual potency might be viewed as a symbol of disgrace and insult in closed cultures as shown by this patient which are devoid of vital sexual knowledge. This patient maladaptively masqueraded egodystonic erectile dysfunctions in the form of factitious behaviour. The ultimate early disclosure of this disguisement to the therapist [NAQ] helped by supportive therapy was the cornerstone of treatment and good outcome in this patient. It is known that early appropriate intervention is more often than not is associated with good outcome not only in medical diseases but also in psychiatric disorders including factitious disorders.

In case 5, familiarity with hospital procedures, drug dependency, parental deprivation, and deficient social supports were the main contributing factors. Evidently, this patient developed different Munchausenian behaviors probably both before and after drug abuse. The complex relationship between drug abuse and MS has been discussed by researcehrs[19,43]. However besides reflecting a craving for attention and hospital contact, a second line of defence and a better therapeutic alliance, drug abuse also opens an easy gate for such patients to the hospitals[19]. Interestingly, some of these patients deceptively utilize their false symptoms for receiving drugs for abuse. This might give a mistaken and/or true impression as if they are acute malingerers. It would be prudent to comment that factitious patients sometimes might have other associated diagnoses such as substance use disorder and malingering. The issue of multiple diagnoses in the context with factitious disorder is yet to be explored.

The clinical features of prototypical MS[42] reported in males across Western cultures are not at much variance with our male cases. It is hypothesized that cultural factors are not enough to uniquely define the variations if existing among males with factitious disorders. Similarly, the sociodemographic variables, except illiteracy, marital issues and extended family dynamics with great promises and

for psychiatric evaluation. He was admitted to the prison ward as he was caught stealing drugs from hospital pharmacy. Although he was kept off antiepileptic drugs, no abnormality was found which was consistent with psychiatric evaluations and nursing observations. The repeat EEG was also negative. After his discharge to Buraidah Central Jail, he simulated acute fits, stomach cancer, and impostor. The diagnosis of factitious disorder was confirmed when during supportive therapy he disclosed to the therapist [NAQ] about his feigned illnesses. Moreover, it was made quite clear that with the exception to aggressiveness, stealing drugs and homicidal threats, other Munchausen-like behaviors such as fits and cancer were not related to drug seeking. However, craving for hospitalization and abdominal pain were governed by motivations associated both with MS and drug abuse. In addition to psychoeducation focusing on different issues, detoxification from all drugs was carried out which resulted in good improvement.

Discussion

All the five patients met the diagnostic criteria of factitious disorders as laid down in international classifications[30,33]. In case 1, the key presentation was dermatitis artefacta induced by auto-cauterization. The cautery, practiced over centuries in Islamic medicine and culture, is a traditional therapy for a variety of maladies and usually used by healers when all other treatments are failed[6,34,35]. This patient's past exposure to cautery might have acted as a guide for auto-cauterization. There are some other contributing factors including husband's crippling arthritis, sexual frustrations, economic strains and dependency traits. By self-inducing skin lesions and sheltering in hospitals, she might be trying to escape from imminent responsibilities of male gender. The females in most conservative cultures like Saudia are prohibited to take up male gender role and, hence, tend to express their aforesaid psychological stresses through disguised and maladaptive patterns of illness behavior[10].

Unlike this patient, case 2 developed multiple feigned somatic symptoms, pseudosuicidal attempts and trihexyphenidyl dependence which could be attributed to familiarity with hospital milieu and procedures, parental deprivation, dependent personality, multiple bereavements, physical abuse and divorce. Similar psychological factors have been reported previously in relation to factitious disorders[9]. It is not surprising that factitious patients sometimes might die due to suicide[26]. In recent times, Muslim societies are possibly loosening their cultural roots and cultural change as evident in rising cases of drug abuse[36], physical abuse and neglect[37,38] and poisoning[39]. The influence of other cultures on conservative societies and vice versa is obvious and attributed to economic boom, rapid and improved means of communications and transportation facilities[40] and finally political alliances. Indeed, such cultural transformations may have influenced the psychopathology of factitious disorders.

In contrast to their male counterparts, females in such societies are usually submissive and mostly look after the household chores. The relative lack of extensive peregrination, lying and

physical abuse and neglect and fragile relationships were also reported in the family. At best, he has scanty social support. Although his personality was characterized by masochistic traits, overall mental state examination demonstrated no major psychopathology. Based on direct evidence of self-production of illnesses, he was diagnosed having factitious disorder. A variety of biological medications and visits to traditional healers plus attempts to engage him in psychotherapy did not succeed.

Case 4

Mr. A was referred for psychiatric consultation when physicians after conducting both a battery of investigations and systemic assessments found no evidence of physical illnesses. Meanwhile he also sought help from healers but of no benefits. Over the last four years, he simulated abdominal pain, dyspnoea, giddiness, chest pain and loss of consciousness. In the past, he had a genuine episode of acute gastritis after taking high doses of effervescent tablets for dyspepsia. But he had complete recovery both from gastritis and dyspepsia. Psychological exploration revealed falsifications not only about aforesaid symptoms but also of nightmares, multiple fears, insomia, and ant-like sensations developed consecutively. Of particular relevance was the most dramatic simulation of altered consciousness while travelling to Riyadh which caused a terrifying scene in the plane. On clinical ground, both somatization and panic disorders were excluded. The diagnosis of MS was confirmed when he revealed to the therapist [NAQ] about the simulation of symptoms. During therapy, he further disclosed that sexual dysfunctions was the leading cause for simulations. His wife was also worried about it. Both of them joined family therapy in which the issues of sexuality, self-defeating behaviours, and reality orientation were discussed which finally led to his successful discharge.

Case 5

Mr. A's longitudinal history revealed that during early developmental phases he had in-patient treatment for traumatic eye, fissure-in-ano, squint and morbid obesity. Notably, later he simulated acute abdominal colics supported by fabricated medical stories as suspected by clinicians but confirmed by a key relative. For instance, he never visited foreign country for ophthalmic surgery as he falsified. Subsequently at 26, he received mild head injury due to motor car accident. He was admitted in intensive care unit just for observation where he developed no complications, like seizures. All the necessary investigations including EEG and brain CT were negative. According to him, antiepileptics including clonazepam were prescribed. He developed clonazepam dependence which was followed by alcohol, narcotics, stimulants and other benzodiazepines abuse. He consulted specialized centers for drug abusers but of no help.

As noted, his multiple addictions led to strained relationships with his family and peers. The death of his father further added fuel to the fire. He was left alone with no social support. Besides simulation both of abdominal pain and episodes of unconsciousness, he compulsively used drugs and was referred by police officials

faith healer who cauterized her on the abdomen. All relevant investigations were negative. The consultant dermatologist suspected these lesions as dermatitis artefacta.

Although her premorbid personality was characterized by dependency traits, multiple psychiatric examinations added nothing except preoccupation's with her husband's disabling arthritis and erectile dysfunctions plus daughter's marriage. During her stay in the ward, she was self-inducing lesions as observed by psychiatric nurses. When confronted directly, she denied it. Later on, neither she protested nor demanded discharge. Despite psychosocial support, planned discharge and an advanced appointment, she was lost for follow-up.

Case 2

Ms. A's history revealed that during early developmental period, she was exposed to multiple psychosocial stresses including parental death, economic hardships and adverse family relationships. Marital life was also associated with conflicts, physical abuse and neglect, bereavements and divorce. Additionally, she had many admissions and surgeries for genuine benign thyroid goiter, chronic cholecystitis, appendicitis and three abortions. At 37, she showed features of MS reported elsewhere[19]. Briefly, over the past eight years she sought help from different health personnel including healers for simulating acute abdominal and chest pains, breath-holding spells, labile hypertension, dyspnea, headache and exaggerated deliberated self-harm. There were no gynaecological, cardiovascular, skeletal and urological symptoms. She has a remarkable record of visits to emergency services [n = 204] and admissions [n = 30] and discharges against medical advice [n = 18] from different hospitals. The clinical assessment aided by DSM-IIIR found mixed histrionic and dependency traits and trihexphenidyl [THP] abuse but no somatization, panic, and borderline personality disorders.

The diagnosis of MS was based on recurrent intentional simulations of physical symptoms, their changing patterns contingent on recognition of their false nature and other associated features. Besides family therapy, she was given treatment for THP abuse, i.e, its gradual withdrawal and controlled prescription, 5mg/day. The patient showed substantial improvement in all clinical domains.

Case 3

Over the past twelve years, this patient visited emergency services and admitted more than 40 times in hospitals' different departments for simulating and self-producing a variety of acute diseases including abdominal pain, asthma, renal colic, haematuria, urinary retention, rectal pain, blood-tinged stool, constipation and deaf-mutism. He also showed violent behaviors, protests and left hospitals against medical advice whenever directly confronted regarding the false diseases. Although he fabricated voluminous stories about many surgical operations, physical examination revealed only single abdominal scar. All the relevant investigations which he took with equanimity were negative.

There was a history of parental physical disorders including asthma, appendicitis, and cholecystitis with cholelithiasis. The

vignettes of five patients who are analyzed and discussed both in the light of various Saudi sociocultural factors and international data related to factitious disorders.

Table 1: Some Sociodemographic and Clinical Features of Patients with Factitious Disorders [n=5]

Variables	1	2	3	4	5
Age	45	45	39	45	32
Sex	F	F	M	M	M
Education	illiterate	illiterate	illiterate	illiterate	literate
Marriage	yes	divorced	no	yes	no
Occupation	h/wl	h/wl	nil	yes	yes
Social class	middle	poor	middle	poor	middle
Residence	urban	urban	urban	urban	urban
Family type	nuclear	joint	joint	joint	joint
Ppt factors 2	spouse illness	multiple	sister illness	sex prob.	multiple
Illness duration	10m	8 yrs	12 yrs	2 yrs	6 yrs
F. Medical illness 3	yes	yes	yes	nil	Yes
F. Drug abuse 3	nil	nil	nil	nil	nil
Causative factors	social stresses	multiple	neglect	sexual	multiple
Key symptoms	skin lesions	multiple	multiple	multiple	multiple
Admissions	< 5	> 5	> 5	> 5	> 5
P Medical illness 4	nil	yes	nil	yes	yes
P. Mental illness 4	nil	yes	yes	yes	yes
Treatments	psych.	psych.+d5	psych.+d	psych.+d	psych.+d
Traditional tt.6	yes	yes	yes	yes	no
Outcome	equivocal	good	poor	good	equivocal

1 = house wife, 2 = precipitating, 3 = family, 4 = personal, 5 = drugs, 6 = treatment

Case 1

Ms. A was referred for psychiatric consultation for a 10-months history of skin lesions distributed on the abdomen and both thighs. But no such lesions were observed on the back or other inaccessible areas of the body. These lesions, neither associated with aggravating/relieving factors, itching, fever nor inflammatory signs, looked as if self-induced. Most of it were healed but few were fresh. In the past, for vague abdominal pain she consulted a

disorders. Moreover, a variety of specific culture-bound syndromes with several theoretical models have been exclusively described in certain Eastern and Western cultures[8].

Evidently, there is a vast literature which highlighted the cross-cultural differences and complex relationships between culture and psychiatry. Nonetheless, cultural psychiatry needs further researches worldwide for the sake of international comparisons regarding, interalia, behavioral and transitional developments which are constantly undergoing modifications and changes.

Notably, in contrast to huge data from developed countries, there is a dearth of literature on factitious disorders in developing countries[18,24]. Clinically, patients with factitious disorders either intentionally simulate, induce or exaggerate almost any known physical or psychological signs or symptoms for no apparent external motives. The manifestations may commensurate with any known physical or psychological disorders[25]. These individuals are usually characterized by poor prognosis and treatment pessimism[26]. Several studies have highlighted various psychosocial factors which explained the psychopathology of factitious disorders[9]. On the other hand, only few reports explored their biological underpinnings[27,28]. Therefore, it was hypothesized that factitious disorders are probably determined by nonbiological factors, in particular social and cultural. Moreover, there is no study which carried out such a detailed assessment of patients with factitious disorders in terms of sociocultural dynamics. From this perspective, we attempted a tentative analysis of five patients who predominantly presented with chronic physical symptoms and signs, commonly referred to as Munchausen's syndrome[29].

Method and Observations

Through January 1983 to December 1995, five patients with factitious disorders were identified. Over this period, the approximate incidence rate roughly calculated for admitted patients with this disorder was 0.13%. This rate is certainly lower than what is reported from Toronto General Hospital [0.8%] where patients were referred for psychiatric consultation on out-patient basis[26].

The data were abstracted from files in which relevant information was noted after multiple interviews conducted both with patients and relatives. At the time of writing this report, each patient and a key relative were also interviewed. Additionally, we also have an access to the medical files of these patients who consulted other hospitals of Saudi Arabia. In case 5, however, only a telephone interview could be arranged with one of his brothers who provided fair information. DSM-IIIR criteria[30] were used for reaching a consensus diagnosis. Finally, all the five patients and their key relatives were informed about the nature of the study and each one of them gave verbal consent.

It is acknowledged that in order to find out the cross-cultural variations in psychiatric disorders, there should be a quite large sample and also a longitudinal tracing of data[31]. These limitations could be overcome by detailed case studies[31]. Therefore, besides socioclinical features (Table 1), this pilot study describes the case

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Factitious Disorders: Sociocultural and Clinical Factors Among Saudi Patients

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الاضطرابات المفتعلة: العوامل الاجتماعية الثقافية والسريرية لدى المرضى السعوديين

نسيم قرشي، طارق الحبيب، مزامل عبد القادر، ياسر الغامدي

Abstract

Cultural factors are known to influence the epidemiology of various psychopathological syndromes. The goal of this article is to analyse the sociocultural and clinical features of factitious disorders in the light of Saudi culture. This case study comprised of five patients [male = 3, female = 2] with factitious disorders who were identified through multiple interviews over a period of decade, i.e., from January 1983 to December 1995. At a sociodemographic level, most of these patients were characterized by lack of adequate education, dysfunctional marriages and problematic large families. At an aetiological level, multiple psychosocial factors fairly consistent with the international literature were traced in all patients. Clinically extensive travelling, i.e, peregrination, pseudopathological lying, and aggressive behaviors were less intense in females as compared to their male counterparts which could be attributed to cultural differences. Furthermore, four patients uniquely consulted traditional healers whose responses were varied. It is tentatively summarized that some components of Munchausen's syndrome [MS] are influenced pathoplastically by sociocultural dynamics of Saudi Arabia. Further researches across cultures are needed for unentangling psychological, social and cultural perspectives of factitious disorders which may finally lead to the development of novel culturally sensitive treatment strategies.

Keywords: Factitious disorders, Munchausen's syndrome, sociocultural analysis, Saudi Culture, traditional healers.

Introduction

It has been reported that cultural factors are incorporated in the psychopathology of various psychiatric disorders[1,3]. They also influence the sociodemography[4], medical help-seeking pathways[5,7], aetiological constructs[8,10], psychopharmacotherapeutic models[1,11,13], counselling orientation[14], prognosis and outcome[3], psychological measurements[15], perception, attitudes and knowledge[16] and finally psychosocial rehabilitation[17] of patients with mental

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الخلاصة: هذه النتائج تشير بأن معلومات واتجاهات الأطفال نحو الدين تتـــأثر فـــي عمليـــات المقارنة الجارية بين المجموعة الواحدة كما افترضته نظرية الهوية الاجتماعية.

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Table 2: Evaluations of Muslims and Christians

Summary of finding	Significant result (where applicable)
Muslims thought of as: clean; nice; kind; polite; clever; good; goodlooking BY MUSLIMS	
Muslims thought of as: not nice; impolite; naughty BY CHRISTIANS	
Christians thought of as: nice kind, polite, clever, clean, good, goodlooking BY BOTH MUSLIMS & CHRISTIANS	
Muslims liked a lot BY MUSLIMS	$F(1,136) = 83.04, p < 0.001$
Christians liked a lot BY CHRISTIANS	$F(1,136) = 83.31, p < 0.001$
Christians evaluated Muslims as not nice	$X^2(3) = 47.43, p < 0.001$
Muslims evaluated Christians as nice sometimes	$X^2(3) = 71.93, p < 0.0001$

الملخـــــــص

هدف الدراسة: هدفت الدراسة الى التعرف على الهوية الدينية للأطفال المصريين، اتجاهاتـــهم واستجاباتهم العاطفية نحو دينهم ونحو المجموعة الدينية الأخرى.

العينة وأفراد الدراسة: اشتملت عينة الدراسة على ١٣٧ طفلاً مصرياً يتيماً تراوحت أعمـــارهم بين ٦ الى ١٣ سنة وتمت دراستهم من خلال استخدام مقابلة شبه مقننة ذات أغراض متعددة.

النتائج: أشارت النتائج بوجود دليل أن الدين يمثل مظهر (صامت) في هوية الطفل وهناك دليـل بأن بعض هؤلاء الأطفال أظهروا تحيزاً داخل مجموعتهم وتشويهاً للسمعة لمن خارج مجموعتـهم الدينية. هذا ما سبق وافترضته نظرية الهوية الاجتماعية وهـــذا مـــا لوحـــظ لـــدى الأطفـــال المسيحين.

أظهر الأطفال المسلمون تحيزاً لمجموعتهم الدينية مقارنة مع المجموعات الدينية الأخرى ولكنـــهم لم يظهروا تشويهاً للمجموعة الدينية الأخرى.

religion does appear to be a salient aspect of identity for children.

The children in this study did appear to engage in intergoup comparison, as predicted by Social Identity Theory. This was particularly evident in the evaluation task where each group were more likely to choose the positive adjectives when describing their ingroup than when describing the outgroup.

The social group difference obtained here is consistent with the postulates of Social Identity Theory. Coptic Christians (orthodox) make up approximately 15% of the Egyptian population, with the remainder being Muslim, and there are no evident differences in social status or power. As such, Christians are a minority group in Egypt, and as such may be more likely to use their religious group membership to achieve and maintain positive self-esteem. Muslim children, however, as members of a majority group, may not need to engage in social comparisons involving their religious group to the same extent. This finding highlights the importance of viewing social identities within specific social contexts, as although an aspect of identity may be salient, it does not automatically follow that the identity will be used as a basis for intergroup comparison.

Conclusion

In summary, the findings of this study suggest that religion was a highly salient aspect of identity for the Christian and Muslim children who took part in this study. Finally, the asymmetries observed in the children's evaluations of their own and the other religious group suggest that the minority/majority status of the social groups to which the children belong may have an impact upon their evaluations of religious groups as predicted by Social Identity Theory. These findings imply that both Social Identity Theory may well provide fertile theoretical frameworks for the future exploration of the development of children's religious identity.

Table 1: Table showing significant differences relating to the importance of religious identity

	Group of children	Significant results	Meaning
Religious identity Compared with age and gender identities	Christian Younger Christian Older Muslim Younger Muslim Older	$X^2(20)=307.60$, $p < 0.0001$ $X^2(20)=454.53$, $p < 0.001$ $X^2(20)=426.14$, $p < 0.0001$ $X^2(20)=429.12$, $p < 0.0001$	For all children religious identity was more important than either age or gender identities
How important is religion?	Younger Muslims Compared with Younger Christians	$U = 419.5$, $p < 0.05$	Religion is more important to young Muslims than to young Christians

- There was a difference associated with religious group in the younger age group, with young Muslims rating religion higher than young Christians ($U = 419.5$, $p<0.05$).

Responses relating to Muslims

- Overall, 50% or more of the Muslim children evaluated Muslims as clean, nice, kind, polite, clever, good, and good looking.
- 50% or more of the Christian children evaluated Muslims as not nice, impolite, and naughty.
- Christian children were more likely to evaluate Muslims as not nice (X^2 (3) = 47.43, $p<0.001$).
- The children's affective response towards Muslims was further assessed by asking "Do you like to dislike Muslims?". This question was then immediately followed up by "Do you like/dislike them a little or a lot?" This allowed the responses to be classified along a five point Likert scale (like a lot = 5, like a little = 4, neither like nor dislike = 3, dislike a little = 2, dislike a lot = 1). A 2 (age) x 2 (religion) ANOVA was used to analyse the children's responses. A significant main effect of religion was obtained, with more Muslims than Christians liking Muslims a lot, 92% and 26% respectively ($F(1,136)=83.04$, $p<0.001$). No further main or interaction effects were obtained.

Responses relating to Christians

- Overall 50% or more of both Muslim and Christian children tended to evaluate Christians positively, viewing them as being nice, kind, polite, clever, clean good and good looking.
- Despite the pattern above, more Christian than Muslim children evaluated Christians as nice. Muslim children were more likely to give qualified responses such as 'sometimes' or 'some of them are nice and some of them are not nice' (X^2 (3)= 71.93, $p < 0.0001$).
- As with questions relating to Muslims, the children's affective response towards Christians was further assessed by asking "Do you like or dislike Christians?" This question was then immediately followed by "Do you like/dislike them a little or a lot?" A 2 (age) x (religion) ANOVA, was used to analyse the children's responses. A significant main effect or religion was obtained, with more Christians than Muslims liking Christians a lot, 94% and 28% respectively ($F(1,136)=83.31$, $p<0.001$). No further main or interaction effects were obtained.

Discussion

One of the aims of this study was to investigate the importance or religious identity to these children, particularly in comparison to their other social identities. The use of the Relative Subjective Importance Task (RSI) showed that religion was the most important social identity for both religious groups at both ages. It must be noted that the children completed the sorting RSI part way through the interviewing procedure when it was already clear that the focus of the interview was religion. However, further research using a version of RSI task with Christian, Muslim, and Hindu children in London has found religion to be a highly salient aspect of children's identities even when no such cues are given[17]. So, despite this limitation,

skill; if the child had difficulty with this, help with reading was given.

In the interview, the children were first asked about their own religious beliefs, in both a free expression format and a more structured way, asking whether they thought God exists.

A sorting task was then used (question4). In the sorting task 9 bipolar adjective pairs (e.g.: dirty/clean; nice/not nice) and 5 social identity terms (Christian; Muslim; Boy; Girl; Egyptian) were presented to the child. Each adjective or term was written on its own card, and the cards were randomly ordered. The children were asked to choose the cards which they thought could be used to describe themselves. Immediately following this task, the children were given a Relative Subjective Importance Task, in which the cards the child had chosen in the sorting task were represented to them and they were asked to choose the one card which they felt described them best of all. This card was then removed and the child was then asked to choose the card which described them best from those remaining. This process was repeated until all the cards had been chosen, allowing a rank ordering of the relative subjective importance of the various attributes and identities to the child. The children were then asked whether they thought their own religious group (either Christian or Muslim) and one other specified religious group (either Muslim or Christian respectively) were nice or not nice. The order of questioning about the ingroup and the outgroup was counterbalanced across the children. The children were then given the 9 bipolar adjective pairs again and asked to choose those adjectives which they felt described the members of the group. Exactly the same procedure was then used to question the children about the other religious group. Finally, the children's feelings towards Christians and Muslims were assessed in the following way. Two inter-connecting questions were asked: 'Do you like Christians/Muslims?' This was immediately followed by 'Do you like/dislike them a lot or little?' (Question 13 and 14). These two questions were asked about each of the two religious groups in turn; again, the order of questioning about the two groups was counterbalanced across the children.

Results

Responses relating to the self

- No significant differences with respect to age or religion were obtained in response to whether the children believed in the existence of God, with all children answering 'yes' to these questions.
- All children correctly classified themselves according to their own religious group membership.
- In the Relative Subjective Importance Task, religion was the highest ranked social identity card by all four sub-groups of children (Younger Christians X^2 (20)=307.60, $p<0.0001$; Older Christians X^2 (20) = 454.53, $p<0.0001$; Younger Muslims X^2 (20) = 426.14, $p<0.0001$; and Older Muslims X^2 (20) = 429.12, $p<0.0001$).
- Mann-Whitney U tests were used to look for differences in the rating of religion between the groups. No difference associated with age group was found.

knowledge, and religious attitudes in Christian and Muslim Egyptian children. The second was to explore the possibilities for applying a socio-psychological theory to this developmental domain, Social Identity Theory.

Social Identity Theory[15,16] postulates that individuals can identify strongly with some of the categories to which they belong, for example, gender, nationality, religion, ethnic group, social class, etc. Furthermore, when a particular identity becomes salient, various psychological effect relating to that category are predicted to occur. For example, the theory suggests that a fundamental human need is to have positive self-esteem. Therefore, in constructing representations of a salient ingroup and its associated outgroups dimensions of comparison are chosen which produce more favourable representations of the ingroup and less favourable representations of the outgroups. This process results in ingroup favouritism, outgroup denigration, and positive self-esteem.

With Social Identity Theory as a background, this study was designed to investigate a number of issues within this domain. Firstly, it aimed to investigate whether religious identity is important to these children, and to assess the relative importance of religion in comparison with their other social identities. Secondly, Social Identity Theory predicts that if a group membership is salient and used as a basis for intergroup comparison then the phenomena of ingroup favouritism and outgroup denigration should occur. Consequently, the children's evaluation of, and affective responses to, the religious ingroup and one other specified religious outgroup was also investigated.

Method

Participants and Design

137 children aged between 6 and 13 years participated in the study. Seventy-one boys and sixty-six girls were interviewed. All of the children lived in Cairo, were born in Egypt and held Egyptian nationality. The children were all orphans and lived in single-religion institutions in Cairo. Seventy-two of the children were Coptic Christian and 65 were Muslim.

For the purposes of analysis, the children were split into 2 age groups, with the first age group ranging from 6 to 9 years, and the second age group ranging from 10 to 13 years. Thus, the children could be divided into two religious groups (Muslim and Christian) and two age groups (younger and older). There were, therefore 2 (religion) x 2 (age) independent groups. Within these constraints, the children were selected randomly from orphanage registers.

Materials and Procedure

Each child was interviewed independently in a quiet room which was made available in their orphanage. The interviews were conducted in Arabic by an Egyptian interviewer. The interviewer did not give any cues as to his or her own religion.

For the interview, a semi-structured interview schedule was used. This was identical across all subjects. The questions were asked as scheduled, but children were free to discuss side issues of they wished. Explanations were given if required. In some instances within the interview, sorting tasks were used, which required reading

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Religious Identity in Egyptian Muslim and Christian Children Aged 6- 13 Years

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الهوية الدينية لدى مجموعة من أطفال مصر المسلمين والمسيحين للأعمار من ٦-١٣ سنة

راشل رويال، مارتن باريت، يحي تكريتي

Abstract

Objectives: This study investigated Egyptian children's religious identity, their attitudes towards and affective responses to their own and one other religious group.

Method: 137 Muslim and Christian Egyptian orphaned children aged between 3 and 13 years were questioned using a semi-structured interview which incorporated various tasks.

Results: Evidence was found to suggest that religion was a salient aspect of the children's identity. There was evidence that some of the children were engaging in intergoup comparison, ingroup favouritism and outgroup denigration as predicted by Social Identity Theory; this was especially true for the Christian children. The Muslim children did demonstrate ingroup favouristism but did not appear to engage in intergroup comparison and outgroup denigration to the same extent.

Conclusion: These finding suggest that children's knowledge and attitudes in the religious domain may be influenced by the process of intergroup comparison as proposed by Social Identity Theory.

Keywords: Children, religious identity.

Introduction

The study of children's social identity is currently an active area of research[1,2,3,4,5]. The field of children's understanding of religion has also been a focus of much research[6,7,8,9,10,11]. However, research into the development of children's religious identity has been declining in recent years. The majority of the work in this area has focussed on the acquisition of specific beliefs of understanding of religious practices. As a consequence a number of stage-based accounts linking with the cognitive-constructivist account of development have been proposed[6,7,8,9,12,13,14], which attribute little role to any social factors associated with belonging to a religious group. Furthermore, previous work in this area has focussed mainly on Christian and Jewish children, with little work on any other religious groups.

The aims of the current study were twofold. The first aim was to investigate the development of religious identity, religious

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الملخـــــــص

هدف الدراسة: هدفت الدراسة الى التعرف على مدى انتشار الاعتمادية على النيكوتين وعلاقته في ظهور أعراض الاكتئاب والقلق لدى الطلبة السعوديين في الجامعة.

العينة وأفراد الدراسة: اشتملت عينة الدراسة على طلاب جامعة اختيروا بشكل تتساوى فيه الاناث والذكور. وقد تعيّن على الطلبة الاجابة على استبانة منظمة الصحة العالمية للتدخين وكذلك مقياس هوسبيتل للاكتئاب والقلق.

كما استخدمت في هذه الدراسة المقابلة شبه المقننة على عينة تجريبية من غير المرضى وذلك للتعرف على صدق المقياس. وأيضاً استخدمت الدراسة مقياس فيجرستروم للتحمل لغرض التعرف على الاعتياد وعلى النيكوتين.

النتائج: أشارت النتاج بأن نسبة انتشار الاعتمادية على النيكوتين هو ٣ر٣% من العينة الكلية ٧ر٢٠% من عينة التدخين. أشارت النتائج بأن أفراد الدراسة المعتمدين على النيكوتين لم يختلفوا عن غير المعتمدين على النيكوتين من حيث المعلومات الديموغرافية ولكنهم اختلفوا في المدة الزمنية للتدخين وكان لديهم صعوبة في التوقف عن التدخين حتى في الأماكن الممنوعة ويدخنوا وهم مرضى ويعمدوا الى استنشاق الدخان وقد أظهر المعتمدون على النيكوتين وبشكل ذو دلالة اكتئاب وقلق أكثر من غير المعتمدين على النيكوتين.

الخلاصة: أظهرت الدراسة بأن هناك ارتباط بين أعراض القلق الاكتئاب مع الاعتمادية على النيكوتين لدى طلبة الجامعة السعودية

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Table (3): Anxiety and Depression in Nicotine Dependents*

Mood	Non-Dependents N (%)	Dependents N (%)	P
Anxiety			
Not a case	46 (43.0)	4 (14.8)	
A probable case	25 (23.4)	4 (14.8)	
A definite case	36 (33.6)	19 (70.4)	0.002
Depression			
Not a case	68 (63.6)	11 (40.7)	
A probable case	27 (25.2)	14 (51.9)	
A definite case	12 (11.2)	2 (7.4)	0.027

* Missing cases are excluded

Table (4): Predictors of Nicotine Dependence Logistic Regression Model

Variable	B	S.E.	R	P
Difficulty refraining from smoking in non smoking places	3.9692	1.134	0.2815	0.0005
Smoking even when very ill	4.3413	1.1718	0.3013	0.002
Inhaling smoke into lungs	2.9018	0.9833	0.2279	0.0032
Number of cigarettes smoked per day	1.8181	0.6846	0.1978	0.0079
Being an anxiety case	1.0928	0.5122	0.1405	0.0329
Constant	-13.372	3.2993		0.0001

Table (2): Smoking behavior by Nicotine Dependence*

Behavior	Total	Dependents	Non-dependents	P
Age at start of smoking in years				
< 10	2 (1.5)	1 (3.6)	1 (0.9)	
10 –15	25 (18.7)	6 (21.4)	19 (17.9)	
16 – 20	86 (64.2)	17 (60.7)	69 (65.1)	
> 20	21 (15.6)	4 (14.3)	17 (16.1)	NS
Having difficulties refraining from smoking in no smoking area				
No	95 (70.9)	9 (32.1)	86 (81.1)	
Yes	39 (29.1)	19 (67.9)	20 (18.9)	0.000
Number of Cigarettes smoked per day	59 (45.4)	2 (7.4)	57 (55.3)	
< 16	46 (35.4)	13 (48.1)	33 (32.0)	
16 – 25	25 (19.2)	12 (44.4)	13 (12.6)	0.000
> 25				
Making an attempt to quit				
Yes	74 (54.8)	16 (57.1)	58 (54.2)	
No	61 (45.2)	12 (42.9)	49 (45.8)	NS
Smoking even when very ill				
Yes	43 (32.6)	22 (78.6)	21 (20.2)	
No	89 (67.4)	6 (75.0)	83 (79.8)	0.000
Inhaling smoke				
Never	18 (13.3)	1 (3.6)	17 (16.2)	
Sometimes	48 (36.1)	6 (31.4)	42 (40.0)	
Always	67 (50.4)	21 (75.0)	46 (43.8)	0.000
Reasons for smoking				
Experimentation	51 (38.3)	10 (35.7)	41 (39.0)	
Peer Pressure	26 (19.5)	8 (28.6)	18 (17.2)	
Modeling someone	11 (8.3)	2 (7.1)	9 (8.6)	
Lack of entertainment	13 (9.8)	1 (3.6)	12 (10.4)	
Psychological stress	27 (20.3)	7 (25.0)	20 (19.0)	
Others	5 (3.8)	0(0)	5 (4.8)	NS

* Missing data are excluded

Table (1): Demographic Data by Nicotine Dependence*

Data	Non-Dependents N(%)	Dependents N (%)	P
Age group (years)			
< 20	6 (5.7)	0 (0)	
20 – 25	91 (85.8)	26 (92.9)	NS
26 – 30	8 (7.5)	2 (7.1)	
> 30	1 (0.07)	0 (0)	
Sex			
Males	96 (89.7)	24 (85.7)	
Females	11 (10.3)	4 (14.3)	NS
Academic Level			
1 – 2	36 (35.3)	10 (37.0)	
3 – 4	44 (43.1)	9 (33.3)	NS
5 – 6	8 (7.8)	6 (22.2)	
> 6	14 (13.7)	2 (7.5)	
Nationality			
Saudi	98 (94.2)	25 (89.3)	
Non-Saudi	6 (5.8)	3 (10.7)	
Smoking Parent			
Yes	48 (46.2)	15 (53.6)	NS
No	56 (53.8)	13 (46.4)	

* Missing data were excluded from analysis

Independent variables, which were significantly associated with nicotine dependence at the level of bi-variate analysis, were entered in a logistic regression equation with nicotine dependence as a dependent variable (table 4). Being a case of depression was removed from the equation, while smoking a large number of cigarettes, inhaling smoke or having difficulty refraining from smoking when smoking is prohibited or when very ill were significant independent predictors of nicotine dependence.

Discussion

The low rate of nicotine dependence in this study (20.7%) compared to that of 55% reported by Breslau, Kilbey & Andreski[18] could be due to measurement differences, cultural differences, or different liabilities to addiction to nicotine. Also the age in our sample seem to be younger, with the median age 22 years compared to 26 years for Breslau's sample.

Understandably, Nicotine dependents had a longer duration of smoking than non-dependents and they had more difficulties in refraining from smoking where smoking is prohibited, smoked even when very ill, inhaled smoke into their lungs and smoked more cigarettes during the course of the day.

The high rate of anxiety among nicotine dependents in this study (70.4%) is supported by similar findings by other[18,19]. Although smokers regularly report that nicotine diminishes anxiety, this anti-anxiety effect has not been demonstrated in experimental settings[20]. It seems that anxiety have a stronger role on initiation of smoking than on smoking cessation as suggested by Glassman[21].

Also the higher rate of depression is in keeping with results of other studies reporting an association between depression and nicotine dependence[22,23]. Kendler et al[24] suggest that the association between smoking and depression is mediated largely or entirely through genetic factors which influence the liability for both conditions. Social pressures as suggested by Glassman[21], lead to diminishing community rate of smoking because individuals who can easily quit, leave only those with greater vulnerability. The same concepts can be generalized to the association of anxiety to smoking and nicotine dependence.

The results of this study lend support to the association between nicotine dependence and depressive and anxiety disorders. It does not, however, determine the direction of this relationship.

Thanks are due to Professor Sheik Edris for his statistical supervision and to Drs. M.K. Marwa and A. Gaffas for his help.

Results

In the 79 students sub-sample who underwent a semi-structured psychiatric interview, the sensitivity and specificity of the HADS against HDRS and HARS were respectively 72.3% and 97.7% for depression; and 74% and 75% for anxiety. These figures compare well with those of El-Rufaie and Absood[15], and indicate the validity of the HADS in detecting psychiatric morbidity in the studied students population.

One thousand questionnaires were distributed and the response rate was 91.1% (50.8% males and 49.2% females). The rate of smoking was 15.6% (150 students), but only 135 smoking students (15%) filled out the F.T.Q. All the F.T.Q items had a strong positive correlation with its total score ranging from 0.352 to 0.609. Item number 7 relating to the brand of the cigarette smoked and it nicotine concentration had no correlation with the F.T.Q total score. Cronbach's alpha reliability of the F.T.Q was 0.438.

Nicotine dependence defined as scoring 6 points or more on the F.T.Q accounted for 20.7% of the smoking group (3.3% of the total sample). The mean age and age of smoking initiation was 22.8 years (SD=1.8) and 17.1 years (SD=3.3) respectively for the dependents, and 22.6 years SD = 2.1 and 18.1 years (SD = 3.0) respectively for the non-dependents with no statistically significant difference between the two groups. The mean duration of smoking was significantly longer in the dependents (5.7 years, SD = 3.55 than in the non-dependents (4.4 years, SD=2.7) (t=0.206, DF=131, P=0.041).

As presented in table (1), there was no difference in demographic data between nicotine dependents and non-dependents.

In table (2), smoking behaviors are tabulated against nicotine dependence status. Nicotine dependents reported more difficulty refraining from smoking in no-smoking places, smoking even when very ill, smoking more cigarettes and inhaling smoke into their lungs. There was no difference between the two groups, however, with regard to making previous attempts to quit or reasons for smoking initiation.

Anxiety and depression caseness is shown in table (3) according to nicotine dependence status. Nicotine dependents had significantly more definite cases of anxiety (70.4%) than non-dependents (33.6%). When probable cases were included, the frequency of all likely cases was still significantly higher in dependents than non-dependents (85.2% and 57%) (X^2=12.4, DF = 2, P = 0.002). Nicotine dependents had a slightly lower frequency of definite cases of depression (7.4%) than non-dependents (11.2%). When probable cases were included, however, the frequency of all likely cases of depression increased significantly among dependents (59.3%) than non-dependents (36.4%) (X^2 = 7.19, DF = 2, P = 0.027).

Anxiety symptoms most clearly differentiating dependents from non-dependents were "feeling tense and uptight" (X^2 = 18.04, DF = 3, P = 0.000) and "sense of impending doom" (X^2 = 14.04, DF= 3, P = 0.003). For depression, the only differentiating symptom was "feeling physically slowed down" (X^2 = 9.68, DF = 3, P = 0.021).

by the American Psychiatric Association in its third edition of the Diagnostic and Statistical Manual of Mental Disorders in 1980[6].

Although nicotine appears to affect a variety of neuronal pathways involved in behavioral reward and arousal process, not all smokers become addicts. Nicotine dependence was found to be related to certain personality traits[7] and mood states[8].

As Reported by Cocores[9], nicotine dependence is the number one killer in the DSM-III diagnoses. Despite the fact that the World Health Organization described smoking as an epidemic in 1983, research on smoking in the developing countries remains descriptive and aims at providing baseline information. In Saudi Arabia, regular smoking was reported in 7.8% of schoolboys[5] and 37% of university students[10] smoking started before the age of 15 years in 26% - 41% of the subjects[4,11,12].

In a previous work we reported on the prevalence of smoking among Saudi University students and its relationship to depression and anxiety[13]. In this study using the same data set we further explore the relationship between nicotine dependence and depressive anxiety symptoms.

Methods

A sample of university students was selected by taking whole classes at random from the different colleges including equal number of males and females, but proportional to the number of registered students in each college. There were no exclusion criteria and the only inclusion criterion was being a university student. The World Health Organization (WHO) questionnaire on smoking was used as translated into Arabic by Jarallah & co-workers[11]. It contains items on demographic data, smoking history of students and parents as well as attitudes towards smoking, reasons for smoking in smokers and for not smoking in non-smokers. A current smoker was defined as anyone who smokes at least one cigarette per day at the time of the study.

The Fagerstrom tolerance Questionnaire (FTQ)[2] was translated into Arabic by the author and then independently back translated into English until the two versions became almost identical. This scale consists of 8 questions measuring the compulsive nicotine seeking for positive and negative reinforcement and the compulsive use to avoid withdrawal effects[2]. The scoring ranges from 0 to 11 with the most commonly used cut-off point defining nicotine dependents in unselected samples being 6 (SD=2). It is by far the most widely used and researched instrument for nicotine dependence with a demonstrated good validity[2]. The Hospital Anxiety and Depression Scale (HADS)[14] was used to screen for depression and anxiety. This instrument had been translated and validated in Arabic on a group of Saudi patients[15]. We also used a semi-structured psychiatric interview in a pilot sample consisting of 79 students, using the Hamilton Depression Rating (HDRS)[16] and the Hamilton Anxiety Rating Scale (HARS)[17]. The ratings on the Hospital Anxiety and Depression Scale were compared to those on the Hamilton Depression Rating Scale and the Hamilton Anxiety Rating Scale to test the validity of the former in non-clinical populations.

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Nicotine Dependence and Its Relationship to Depressive Anxiety Symptoms Among Saudi University Students

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الإعتمادية على النيكوتين وعلاقته مع أعراض القلق والكآبة لدى مجموعة من طلبة الجامعة السعوديين

عبدالله سلطان السبيعي

Abstract

Objectives: This study aims at examining the prevalence of nicotine dependence and its relationship to depression and anxiety among Saudi University students.

Design, Setting and Participants: A sample of University students were selected including equal number of males and females.

Main Outcome Measures: Students were asked to fill out the World Health Organization questionnaire on smoking and the Hospital Anxiety Depression Scale (HADS). A semi-structured interview was used on a pilot sample of students to ensure the validity of the HADS in the non-clinical population. The Fagerstrom Tolerance Questionnaire (FTQ) was used to identify nicotine dependents.

Result: The prevalence of nicotine dependence was 3.3% of the total sample and 20.7% of the smokers. Nicotine dependents were not different from non-dependent in demographic data but they smoked more cigarettes for a longer duration, had difficulty in refraining from smoking in prohibited places, smoked even when very ill and inhaled smoke into their lungs. Also, they had significantly more cases of depression and anxiety than non-dependent.

Conclusion: Nicotine dependence is associated with depression and anxiety among Saudi University students.

Keywords: Smoking, Nicotine, Depression, Anxiety, Saudi.

Introduction

Smoking of tobacco is a widespread and deeply ingrained pattern of learned behavior. There is an evidence that nicotine dependence is a major reinforcer for smoking and the current prevailing view is that nicotine seeking and nicotine dependence are the key elements in the maintenance of smoking and the inability to quit[1]. While nicotine is considered as the primary reinforcer in smoking, behavioral and sensory components are viewed as secondary reinforces gaining power through constant association with the effects of nicotine[2]. More teenagers are starting smoking and most are likely to become regular dependent smokers[3,4,5]. Nicotine is therefore, the most widely used addictive substance. Disorders resulting from tobacco use were included for the first time

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Table 5: Comparison of Symptomology with King Khalid University (KKUH) Study[19]

SR.No:	SYMPTOMS	KKUH STUDY		PRESENT STUDY	
		No.	%	No.	%
1.	Loss of consciousness	11	29	32	25.6
2.	Paralysis	10	26.4	25	20
3.	Fit-like movements	8	21.1	37	29.6
4.	Abnormal movements	7	18.4	7	5.6
5.	Weakness	5	13.2	5	4
6.	Decreased sensation	1	2.6	5	4
7.	Mutism (Aphonia)	8	21.1	39	31.2
8.	Amnesia	-	-	2	.4
9.	Blindness	-	-	2	1.6
10.	Fugue	-	-	1	0.8

Table 4: Comparison of Socio-demographic data with King Khalid University Hospital (KKUH) study [19]

	KKUH STUDY				PRESENT STUDY			
	Male	**Female**	**Total**	**P value**	**Male**	**Female**	**Total**	**P value***
	No %	**No %**	**No %**		**No %**	**No %**	**No %**	
Age (yrs):								
< 20	5	11	16	0.716	20	51	71	0.272
20 – 30	12.5	27.5	40		15.2	38.6	53.8	
> 30	3	13	16		12	32	44	
	7.5	32.5	40		9.1	24.2	33.3	
	2	6	8		8	9	17	
	5	15	20		6.1	6.8	12.9	
Nationality:								
Saudi	7	21	28	0.6625	33	82	115	0.4458
Non-Saudi	17.5	52.5	70		25	62.1	87.1	
	3	9	12		7	10	17	
	7.5	22.5	30		5.3	7.6	12.9	
Marital Status:								
Single	3	16	24	0.299	26	57	83	0.7768
Married	20	40	60		19.7	43.2	62.9	
Others	2	12	14		14	34	48	
	5	30	35		10.6	25.8	36.4	
	-	2	2		-	1	1	
		5	5			1.1	0.8	
Educational Level:								
Illiterate	2	7	9	0.985	3	22 16.7	25	0.0425
Primary	5	17.5	22.5		2.3		18.9	
Intermediate	4	10	14		17	21 15.9	38	
	10	2.5	35		12.9		28.8	
Secondary	1	3	4		-	- -	-	
	2.5	7.5	10		-		-	
Others	2	8	10		20	48	68	
	5	20	25		15.2	36.4	51.5	
	1	2	3		-	1 1.1	1	
	2.5	5	7.5		-		0.8	
Total	10	30	40		40	92	132	
	25	75	100		30.3	70	100	

N.B: A P-value of 0.05 or less was taken as significant

Table 2: Frequency of Symptoms

Symptoms	No.	%
Mutism	**39**	**31.2**
Fit like movements	37	29.6
Loss of consciousness	32	25.6
Paralysis	25	20
Abnormal movements	7	5.6
Weakness	5	4
Decreased sensation	5	4
Amnesia	3	2.4
Blindness	2	1.6
Fugue	1	0.8

Table 3: Duration of the Episode

Duration of Episode	No.	%
1 minute - 1 hour	30	22.7%
1 hour. - 1 day	64	48.5%
1 day - 1 week	30	22.7%
1 week - 1 month	8	6.1%
Total	132	100%

الملخـــــــص

تهدف هذه الدراسة الى تقديم المعايير الديموغرافية والسريرية لمرضى الهستيريا الذين يرتـــادون أقســام الطوارىء والإسعاف في مختلف مستشفيات المملكة العربية السعودية. كان عدد المرضى المشمولين في الدراسة ١٣٢ مريضاً تم تشخيصهم طبقاً للطبعة الرابعة من الدليل الاحصـــائي والتشـــخيص للأمـــراض العقلية. كان غالبية المرضى من النساء (٧٠%)، دون الثلاثين عاماً مـــن أعمـــارهم (٨٧%)، وغـــير متزوجين (٦٣%). كما كان الاضطراب الهستيري التحولي هو الأغلب (٩٨%) وغالباً ما يظهر علـــى هيئة عرض واحد، وكان عدم القدرة على الكلام هو أكثر هذه الأعـــراض انتشـــاراً (٢ر٣١%)، يليـــها الحركات الشبيهة بالتشنج (٦ر٢٩%) ثم فقدان الوعي (٦ر٢٥%). ولقد كان الاكتئاب هو أكثر الأمـــواض النفسية انتشاراً بين المرضى (٥ر٢٣%). تستنتج هذه الدراسة أن أعراض اضطراب الهستيريا آخذة في التغير بعض الشيء في المملكة العربية السعودية. وعلى الرغم من تشابه نتائج هذه الدراسة الـــى حـــد كبير مع نتائج الدراسات المماثلة في مختلف بلاد العالم إلا أن تبرير النتائج هنا ربما كان مختلفاً. ويـــوى الباحثون أهمية القيام بدراسة تدرس السير المرضي ومآل مثل هؤلاء المرضى.

Table 1: Sociodemographic characteristics of both genders

Variable	Male No. %	Female No. %	Total No. %	P – Value *
ars				
10 – 20	20 (15.2)	51 (38.6)	71 (53.8)	
21 – 30	12 (9.1)	32 (24.2)	44 (33.3)	0.272
31 – 45	8 (6.1)	9 (6.8)	17 (12.9)	
Nationality				
Saudi	33 (25.0)	82 (62.1)	115 (87.1)	0.4458
Non-Saudi	7 (5.3)	10 (7.6)	17 (12.9)	
Marital Status				
Single	26 (19.7)	57 (43.2)	83 (62.9)	
Married	14 (10.6)	34 (25.8)	48 (36.4)	0.7768
Others	0 (0.0)	1 (1.1)	1 (0.8)	
Educational Level				
Illiterate	3 (2.3)	22 (16.7)	25 (18.9)	
Primary	17 (12.9)	21 (15.9)	38 (28.8)	
Secondary	20 (15.2)	48 (36.4)	68 (51.5)	0.0425
Others	0 (0.0)	1 (1.1)	1 (0.8)	
Total	40 (30)	92 (70)	132 (100.0)	

* N.B. A P-value of 0.05 or less was taken as significant

previous study no sociodemographic parameter was significantly associated with either of the two sexes. However, females were significantly less educated, as observed in the present study [p=0.0425]. This variation might be attributed probably to greater literacy of Riyadh population. Table 5 shows the frequency distribution of comparative symptomatology observed in two studies. Some symptoms in particular abnormal movements, paralysis and sense of weakness were comparatively were frequent in the previous study. On the other hand, mutism and fit-like movements were more frequently seen in the present study. Other, symptoms like amnesia, blindness, and fugue were observed only in the present study.

Precipitating stressors in the current study were noted as expected in 95.5% of the patients as compared to 62.5% in Central Saudi Arabia[19] and 83% in Eastern Saudi Arabia[17]. The clinical implication of this finding is that clinicians should attempt to resolve these stresses in order to prevent the recurrence of hysterical episodes. In a unique fashion, about 40% of patients visited traditional healers before presentation. Notably, many of them went to such healers even after receiving modern therapies. This could reflect two things; firstly, People in Saudi Arabia and also of other Gulf countries have strong beliefs in supernatural forces as the cause of psychiatric disorders, and secondly, and as a consequence, they tend to visit faith healers who, according to them, are specialized experts to deal with such supernatural forces. Integrating these healers into main stream of psychiatry may modify their attitudes and beliefs in a healthy manner so as to utilize their services.

The typical histrionic personality was rare (4.5%) and this agrees with two earlier studies conducted in Saudi Arabia[17,19]. Social unacceptability and conservation of Saudi society may, to some extent, inhibit or grossly modify some histrionic behaviour and make proper personality assessment difficult[19]. Almost 23% of patients were admitted for further assessments in different wards, which emphasizes the need for enhancing the awareness among different clinicians, of the various hysterical presentations[19]. It was stated that "no branch of medicine is free from the puzzling manifestation of hysteria"[30].

It was not unusual that depression was encountered more than any other psychiatric disorders (23.5%). Also patients with pseudoseizures suffer from severe affective imbalances and disturbed impulse control[31]. There are many implications of concomitant diagnosis such as etiological, diagnostic, therapeutic, and prognostic and, therefore, efforts should be made in diagnosing and treating disorders coexisting with hysteria.

Despite several inherent limitations of descriptive research, this study replicated, to a greater extent, the sociodemographic and clinical patterns of hysteria previously reported from developing and developed countries. The explanations which were offered for certain variations of these studies and the present one are different but are compatible with the sociocultural status of Saudi Arabia. In light of this study findings and other reviewed studies, it is recommended that a long-term follow-up research on hysteria should be carried out in order to identify its course and outcome.

contrast, Chodoff and Lyons held the view that conversion was seen mostly in males[4]. The predominance of females versus males was reported previously: 3:1[19], 2.4:1[20], 1.8:1[21] and 1.8:1[22]. Although our figures are comparable with those of Western societies, the explanation may be different. Men in Arab societies have more advantages and do not have to adopt the sick role[16] and abnormal illness behaviour[23]. Also, in a conservative society such as Saudi Arabia, hysterical symptoms are an acceptable way for females to express themselves. In addition, Saudi females nowadays feel more individualistic, less dependent on males and exposed to more stressors; this being the outcome of the conflicting opinions regarding the exact role of females in a society passing through a transition from closed to semi-open[19]. There is a general feeling that females in Saudi society should now assume well defined roles in the society.

Our observation that the educational level was low in most of the participants in this study, conforms with earlier reports[15,22]. This finding can not be considered significant in this study, because education in Saudi Arabia is still not well developed although it is progressing quickly[19].

Conversion symptoms were evident in 97.7% of the subjects and is comparable with 95% reported earlier by Al-Habeeb et al[19], 76% (Hafeiz)[16], 73% (Hafeiz et al)[17] and other studies conducted in 3rd World Countries[10,13,15]. Evidently, the increasing incidence of conversion symptoms in Saudi Arabia may be attributed to stresses contingent on rapid urbanization, industrialization, and diverse other advancements, shifting gender roles and responsibilities. In contrast Woodruff [24] reported conversion symptoms in only 25%. This could be explained by the observation that in less developed countries physical symptoms attract attention of both lay people and physicians, more than psychological symptoms.

The most common hysterical symptoms were mutism (aphonia) (31.2%), fit-like movements (29.6%) and loss of consciousness (25.6%). Aphonia is more common in this study (31.2%) than in Eastern Saudi Arabia study[17] (4%) but is not markedly different from the figures obtained previously from Central Saudi Arabia[19], Sudan[25] and Egypt[26]. Similarly, in Scandanavian countries, Carter[27] reported aphonia in 29% whereas Ljungberg reported these symptoms in only 1.3%[21]. Fits-like movements were reported differently in transcultural studies. In the present study, it was manifested in 29.6% of the patients, compared to 21.1% in Central Saudi Arabia[17], 47% in Eastern Saudi Arabia, 7.5% in Sudan[25], 34% in Egypt[26] and 20% in the Ljungberg series from the Scandinavian countries[21]. It seems that the changing face of hysterical symptoms varies not only among different cultures, but also within the same culture[28]. It was postulated that with cultural sophistication and development, gross hysterical symptoms decrease and are replaced by anxiety and depressive symptoms, as the comparison of the hysterical patients in the two world wars have shown[14]. Most of the studies in the developing countries, including this study, highlight gross symptoms and it may yet be some time before distinct change could be seen[19].

A comparison of sociodemographic variables distributed according to gender in previous study and the present one is shown in table 4. It is obvious that in the

hospitals and were familiar with the assessment procedures. The study was conducted in the period from October 1st 1996 till March 1st 1997, in the Emergency Department of five different hospitals, located in different regions of Saudi Arabia. Three of these hospitals were Ministry of Health hospitals, one was a military hospital and the other was a university hospital. Those hospitals provide services to large geographical regions because health services in Saudi Arabia are not restricted by catchment areas, and the population served are both urban and rural.

Detailed physical examination was conducted with particular attention to the nervous system; mental status examination and the appropriate laboratory investigations were requested to exclude possible physical illnesses including epilepsy. No intelligence test was carried out. Personality assessment was done in accordance with DSM IV.

The data were entered into a PC microcomputer and analyzed using a Gold Statistical package. Chi-square test were performed to test statistical significance. A P-value of 0.05 or less was taken significant.

Results

Demographic Characteristics

The majority of the study population were females (69.7%), young (< 30 years, 87%), single (62.9%) Saudis (87.1%). Overall, the level of education was low, especially in females; twenty five patients (18.9%) were illiterate, 38 (28.8%) did not go beyond the primary school level and 68 (51.5%) were secondary school graduates (Table 1).

Clinical Characteristics

The most frequent presentation was conversion disorder, (97.7% of the cases); 79.6% presented with a single conversion symptom, and 2.3% (3 patients) presented with single dissociative symptom. In contrast, 24 patients (18.6%) presented with variable combinations of symptoms. Fit-like movement was the most frequent single symptom (25%), followed by loss of consciousness (20.5%) and mutism (16.7%). The duration of the episode was less than one day in 80% of the cases (Table 3).

Fifty nine patients (44.7%) reported history of previous hysterical episodes; 29 of these patients were admitted previously with hysterical episodes (25 patients admitted once, 3 patients admitted twice and one patient admitted five times). In contrast 30 patients (22.9%) of the study subjects were admitted for further assessment. Precipitating stressors were reported by 126 patients (95.5%) and a family history of any psychiatric disorder was positive in eight patients (6.1%). Fifty three patients, (40.2%) visited traditional healers to the presentation.

While 11 patients (8.3%) had additional physical disorder, 48 patients (36.3%) had additional psychiatric disorder; the commonest psychiatric disorder was depression in 23.5% (31 patients).

Discussion

The sociodemographic characteristics of the study population bares many similarities with most of the previous studies conducted in different cultures. Hysteria tends to affect the younger, less mature and less sophisticated person[16], this is in line with the findings of the current study and most previous studies[15,22]. In

hysterical patients and their impact on the receiver[7]. Recently, dissociation theory mainly based on reactions to extremely traumatic events in the environment has been put forward to explain the psychopathology of various related disorders, including dissociative and conversion hysteria, pathological spirit possession, multiple personality disorder and/or dissociative identity disorder [8].

The concept of hysteria has undergone repeated changes and its validity as a psychiatric entity has been questioned[9]. At present, the term "hysteria" is dropped from the recognized classifications of psychiatric disorders (e.g., DSM IV, ICD 10) although it is commonly used in clinical practice. As a result of the opinion of those opposing the concept of hysteria and the increasing sophistication of the society, the use of hysteria as a diagnostic label has declined in western countries[10]. A review of the literature revealed a predominance of conversion symptoms in World War I and a relative decrease among World War II neuropsychiatric casualties[11]. In the Outpatient Department of Bethlem and Maudsley Hospitals, London, 223 out of 6229 cases (3.5%) were diagnosed as hysteria in 1955 – 57, whereas in 1967-69, the figure dropped to only 45 out of 8585 cases (0.5%)[12].

In developing countries, however, it is still early to have comparative figures, but the pattern does not seem to be different. In a report in 1968, conversion hysteria was found to be common in northern Sudan: "hysterical blindness, mono-ocular diplopia, paralysis, monoplegia, diplegia or hemiplegia, fits and coma are seen daily in the Clinic of Nervous Disorders. In general, the less educated or sophisticated the patient, the more gross are the clinical features."[13] In Cairo, Egypt, in the late 1960's, 11.2% of the attendants to the outpatient clinic were suffering from a hysterical illness, which represented 23.8% of all the neurotic cases[14]. A similar figure was reported in Lebanon in 1969, where conversion hysteria accounted for 22.4% of all neurotic disorders[15]. In a more recent study in Eastern Libya, hysteria was diagnosed in 8.3% of all first attendees at an outpatient clinic[10]. The psychiatric clinic in Khartoum General Hospital in Sudan reported that 10% of all patients over a three-year period were suffering from hysteria[16].

A study from Saudi Arabia estimated the incidence of hysteria in an outpatient clinic to be 5.1%. Out of these, 84.7% were less than 30 years of age; the female:male ratio was 1.8:1 and 61% were single. Conversion symptoms were the most common (73%) so are the stressful situations (83%) preceding the onset of symptoms. No great deviations in intelligence were noted in the patients and the typical hysterical personality was rare[17].

The objective of this study which is the first multicenter study on hysteria in Saudi Arabia, as far as we know, is to give baseline data on the clinical features and sociodemographic status of Saudi patients presenting to the Accident and Emergency Department with hysterical disorder.

Subjects and Methods

This is a cross-sectional descriptive study covered 132 cases of hysteria (both types, conversion and dissociative) as defined in the Fourth Edition of the Diagnostic and Statistical manual of mental disorders (DSM IV)[18]. The data collected from each patient were recorded on a special form by the authors who are working in those

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The Sociodemographic and Clinical Pattern of Hysteria in Saudi Arabia

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النمط الديموغرافي والسريري للهستيريا في المملكة العربية السعودية

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Abstract

The objective of this study is to describe prospectively the sociodemographic and clinical parameters of patients with hysteria presenting to Psychiatric Emergency Services of five regional hospitals in Saudi Arabia.

Method: This multicenter study recruited 132 patients with hysteria, diagnosed in accordance with the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorder criteria (DSM IV).

Results: The majority of patients were females (70%), young (<30 years, 87%) and single (63%). Most of them presented with conversion disorder (98%) and were chiefly characterized by a single symptom. The most frequent symptoms whether single or in combination with other symptoms were aphonia (31.2%), fit-like movements (29.6%) and loss of consciousness (25.6%). A proportion of patients (23.5%) was clinically depressed. **Conclusion**: the socioclinical pattern of hysteria in Saudi Arabia appears to be changing. It is mostly consistent with international data but the explanations are different. In light of this study and other reviewed researches, it is suggested that a long-term study should be pursued in order to identify the final course and outcome of such clients.

Keywords: Sociodemographic, clinical, hysteria, Psychiatric Emergency Services, conversion disorder, Saudi Arabia.

Introduction

Hysteria is a common disorder and has been extensively studied. However, the current lack of a clear understanding of its etiopathogenesis as well as the difficulties faced in its management necessitate further research. Hysteria has been described since antiquity. A French Neurologist dubbed it as "neurological nonsense" because its presentation was so complex and confusing[1]. Hysteria, is classically defined as a chronic polysymptomatic illness mainly affecting women[2]. Breuer and Freud viewed hysterical symptoms as arising from repressed sexuality[3] but this psychoanalytic view is less generally accepted nowadays. An alternative behavioral model has been suggested in which conversion symptoms are considered as a form of nonverbal communication[4,6]. A version of this model is seen in studies emphasizing the interpersonal behaviors of

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Table 2: Deliberate self-Harm in the Elderly
The DSH Act

DSH Act	Under 65 year of age	Over 65 year of age
Wanted to die	40%	63%
Intent score: High	2%	14%
Medium	36%	69%
Low	62%	27%
Acting to gain help	72%	50%
Timing: Intervention probable*	62%	33%
Precautions against discovery	26%	33%
People in vicinity	59%	41%
Suicide note*	14%	46%
Lethality of method*	16%	41%
Found accidentally	6%	22%
Method: Drug with alc	42%	21%
Drug without alc	50%	67%
Cutting	6%	0%
Exhaust fumes	0%	4%

* Significant at 5% level

الملخـــــــص

هدف الدراسة: دراسة حالات إيذاء الذات لدى المسنين في ميدستون ومقارنتها بـــــهذه الحـــالات مـــن ذوي الســـن الأصغر.

تصميم الدراسة : لقد تمت مقابلة كبار السن (فوق ٦٥) الذي أدخلوا الى مستشفى ميدستون خلال أربعة أعوام حسب استبيان أعد مسبقاً وقورن بعينة عشوائية ممن هم أصغر سناً في نفس الفترة.

النتائج: دلّت الأرقام على أنها في الحد الأدنى مقارنة بالدراسات السابقة إلا أن المسنين أظهروا ميلاً أكبر للانتحار.

الاستنتاجات: إن تواجد الأمراض العضوية بشكل أكبر لدى المسنين وقلة تحويلهم الى المختص في الوقت المناســـب يؤكد على أهمية وجود الفريق المختص في الرعاية الأولية.

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Table 1: Deliberate Self-Harm in the Elderly
***Risk Factors for DSH**

DSH Risk Factors		Under 65 year of age	Over 65 year of age
Sex -	Female	64%	71%
Marital	Single	32%	8%
	Married/Coh	48%	42%
	Sep/Div/Wid*	14%	50%
Loss		46%	71%
Health problems > 1 year*		12%	58%
Previous suicide attempts*		47%	4%
Help	GP	25%	37%
	Psychiatrist	9%	16%
	CPN	19%	0%
	SW	4%	8%
Emotions	Anger	20%	8%
	Depressed	34%	42%
	Frustrated	12%	4%
	Despair	16%	29%
Diagnosis	Schizophrenia	6%	0%
	Affective Dis	44%	33%
	Adjustment Dis	12%	25%
	No diagnosis	14%	4%
Reason	Relation probl*	35%	4%
	Physical probl	2%	17%
	Psychological	16%	25%

* Significant at 5% level

The comparison of the two groups revealed important differences. The differences in the demographic features and physical health status might be a reflection of the differences in the denominator[5]. However, it is clear from the comparison that the elderly groups carry a higher risk of completing suicide. The lack of statistical significance on some variables might be due to the small numbers in the elderly group.

One of the important targets of the Health of the Nation Report was to reduce the rates of suicide[11]. This target aim at reducing the suicide rate overall by at least 15% by the year 2000 and the suicide rate of severely mentally ill people by at least 33%. Studies have shown consistently that the risk of suicide following DSH is far larger than would be expected in the general population[6]. That is why targeting DSH in prevention of suicide is an important step in achieving the Health of the Nation targets. Kreitman and Foster (1998)[8] have recently reported the development of scales predicting DSH repetition in adult general psychiatry. Such a scale is an important step in the targeting of prevention of repetition but we do not know how applicable this scale is with the elderly.

The patients seen by the DSH team are likely to be only the tip of an iceberg of the DSH in the community. It is thought that only around 70% of DSH cases are referred to hospital[7]. The small number of the elderly on the register might represent only a small proportion of the actual prevalence of elderly DSH in the community. However, this might also mean that the elderly suicides are more likely to succeed and do not come to hospital.

The profile of the elderly DSH person is that, they are mostly female, divorced or widowed, who have experienced life events in term of bereavement and who have had chronic health problems for more than a year. These elderly are less likely than the younger DSH subjects to have had previous suicide attempts. This might reflect a higher success rate of these attempts in the elderly.

It is known that a significant number of those who complete suicide (particularly the elderly) consult their GPs before the suicide act[3,14]. It would seem that Maidstone elderly DSH cases behave similarly, they are less likely to self present to A&E and anecdotal information available to the DSH team suggest that their GPs are less likely to refer elderly DSH. This has important implications for suicide prevention and its targeting at primary care levels. This also has a bearing on the fact that the majority of the elderly DSH cases related their physical and psychological problems to the DSH act. This might necessitate treating late life depression more effectively and targeting specific counselling services at primary care level on the physical and psychological ills of the elderly.

The suicidal risk associated with elderly DSH is clearly high and any attempt to address prevention of suicide should address targeting resources at the assessment, management and follow-up of the elderly DSH. A Dedicated service that could work with elderly DSH cases is clearly needed. This service could incorporate prevention as an aim by targeting elderly patients at primary care level addressing chronic physical problems, depression and adjustment disorders[3].

significant because of the small numbers).

During the DSH act and subsequently the main emotion that the patient had in both groups, was depression (42% in the older group and 34% in the younger sample). The elderly experienced more despair (29% compared with 16% in the younger sample) while the younger group experienced more anger (20% compared with 8%) and frustration (12% compared with 4%). These differences did not react statistical significance levels.

The examining psychiatrist gave an ICD9/10 diagnosis to the patients. The differences in diagnosis did not reach statistically significant levels. As table 1demonstrates, the younger group had higher proportions of a diagnosis of schizophrenia and affective disorders, but the elderly had a higher prevalence of adjustment disorders.

The reason stated for the DSH act was also examined. Relationships problems were the significantly more prevalent reason behind DSH in the younger are group (P=0.006) while the elderly group attributed the reason to physical and psychological problems (P=0.06).

2. The DSH act and suicide risk:

Psychiatrist undertook detailed suicide risk assessments after each DSH act. Table 2 shows the aspect of risk associated with the DSH. In the DSH team assessment form, a visual analogue was filled by the assessor demonstrating the level of suicidal intent that is important in predicting repetition of DSH or completed suicide. The scores of this scale showed that the elderly group had significantly high and intermediate scores (P=0.006).

The elderly group showed more serious intention to die (63% compared with 40%, NS), and took more precautions against discovery and being found after an attempt (50% compared with 26%, NS). A significantly higher proportion of the elderly left a suicide note (46% compared with 14%, Chi-sqr=11.3 & P=0.0007) and used a more lethal method of DSH (41% compared with 16%, chi-squ=4.49, P=0.03). Furthermore, the elderly group were more likely to be discovered accidentally (22% compared with 6%, NS). The younger sample on the contrary was more likely to time their attempt so that they would be found (62% compared with 33%, chi-sqr=4.25 & P=0.04) and they were more likely to act to seek help (72% compared with 50%, NS).

The methods used in the DSH were mainly drug overdoses. The younger sample more often used the drugs with alcohol (42% compared with 21%, NS) and they used cutting as a method of DSH (6% compared with none of the elderly). One of the elderly used a very serious method of DSH (car exhaust fumes) while none of the younger sample has used this method.

Discussion

There are very few studies that have compared DSH in the elderly with that of the younger adults. This study has aimed at investigating the risk factors and suicidal risks involved in DSH in the elderly, and comparing it with those of younger adults with DSH presented to the same service and within the same period.

Depressive illness was the major diagnosis as it was present in 87% of the cases. On the other hand alcohol/substance abuse was present only in 32%; organic brain syndromes in 29%; and personality dysfunction in 26% of cases. Major functional disorders were found predominantly in females and were associated with higher levels of suicidal intent, psychosis, and fewer chronic physical illnesses. Nowers (1993)[10] studied the characteristics of 56 female and 32 male elderly people presenting with DSH to an A&E department in London where higher levels of depression and lower levels of physical illness were found to be predominant among the younger females and the older males. This same group had a high repetition rate of self-harm within 1 year. In 1 year's follow-up, 65 out of the whole sample had repeated.

There are also important differences between old and younger age groups in service utilisation immediately before the suicidal act. Younger suicides in particular are less likely to have had contact with their general practitioner[14], whereas, 68% of suicides over 65 years of age had seen their general practitioner in the four weeks prior to the suicide[14]. This might give more opportunity for preventive intervention at primary care level.

Method

Since 1989 a team has been established at Maidstone Priority Care NHS trust to undertake the assessment, management and follow-up of cases of DSH admitted to Maidstone District General Hospital. This multidisciplinary team has kept a computerised register of the assessments undertaken since 1990[18]. There were 500 cases seen between 1990 and 1995. Of these, 24 cases were of people who were over 65 years. This constituted the lower level of the proportion of the elderly amongst DSH cases in previous studies, which ranged from 5-10%[5]. The records of these 24 elderly people were compared with 50 randomly selected adults (18-64 years old) who presented to the service during the same period.

Results

The mean age of the elderly group was 75 years (Standard deviation = 5.7) and ranged from 65-85 years. The younger adult sample mean age was 35 years (S.D. = 11.75) and ranged from 18-64 years. The variables of the DSH patients were classified into two parts and were as follows:

1. Risk factors for DSH: In this section all the demographic and other variables that might contribute to DSH or suicide are discussed (see table 1). Females had a higher risk of DSH but less risk of committing suicide. The risk of suicide for female increased with age. There were higher numbers of females in the older people sample (71% compared with 46%)(NS).

   More of the elderly had experienced losses (particularly of their spouse) (71% compared with 46% of the younger adults)(NS). They were more worried about their physical health (58% compared with 12%, Chi-sq= 15.4 & P=0.0008) and had more contact with GPs (37% compared with 25%), psychiatrists (16% compared with 9%) and social workers (8% compared with 4%) but less contact with CPNs (0% compared with 19%) (These not

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Deliberate Self-Harm in the Elderly: A Comparison with Younger Adults

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إيذاء الذات القصدي في كبار السن: مقارنة مع البالغين ذوي السن الأصغر

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Abstract

Objectives: This study aimed to describe the elderly deliberate self-harm (DSH) cases in Maidstone and compare them with younger adult DSH cases.

Design and Setting: Structured information on all DSH cases admitted to Maidstone Hospital has been dept by the DSH team for 4 years. We analysed the records of all DSH cases who were over 65 years and compared them with a random sample of the younger adults DSH cases presented to the services during the same period.

Results: The number of the elderly DHS cases in Maidstone was in the lower levels of the prevalence suggested in previous studies. These elderly exhibited higher suicidal risks and has more serious suicidal attempts.

Conclusion: The association of the elderly DSH with physical health problems and the possible low referral rate of elderly DSH to A&E department suggest the need to move the DSH team work to primary care.

Introduction

Deliberate self-harm is defined as "a non-fatal act, whether physical injury, drug overdose or poisoning, carried out with the knowledge that it was potentially harmful"[9]. Research studies have demonstrated that there is a higher risk of suicide following DSH. This is 100 times greater than the expected rate in the general population in the year following DSH[6]. The highest risk of suicide appears to be in the first 3 years and particularly in the first 6 months following DSH[6]. These research findings demonstrate the importance of assessment and short and long term management of DSH in the prevention of suicide.

In the over 75 years age group, the risk of completed suicide is still higher than in younger age groups in spite of the progressive fall in the rate of suicide in the elderly and the increased suicide rates of 15-24 years old[2]. The high rates in the elderly might be related to adverse episodes specific to old age such as, life events, bereavements and losses, alienation and social isolation from others. Physical illnesses which usually accompany old age such as neoplastic disease[13] epilepsy (which is associated with a 25 fold increase in suicide risk[1] are associated with an increased risk of suicide.

There is a dearth of information on DSH in elderly populations Draper (1996), Draper (1994)[4,5] investigated the psychiatric status of 69 Australian elderly, who were aged 65 yrs and older, after suicide attempts.

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events[23]. It is too hard to answer question such as, what is the best treatment plan for heroin abusers. But we can say at least there are many effective treatments. Those treatments should be tailored to the need of individual patients[5].

Treatment for addictive behaviours can progress most smoothly if both client and therapist are focusing on the same stage of change[23]. There are multiple interventions but little integration across theories. One promising approach to integration is to begin to match particular intervention to key client characteristics[31].

Most of the work in stages of change and drug addiction has been carried out in smoking. Bandura (1977), postulated that a cognitive mechanism underlies behaviour change and self-efficacy expectations are hypothesized to determine the initiation and maintenance of behaviours required altering maladaptive response patterns[12]. High self-efficacy is associated with making attempts to quit[27].

There are many ways to enhance the self-efficacy in treatment. For instance, the relationship between clients and therapist, can be designed to the sense of personal responsibility and the learning of new skills, instead of focusing on the distal end goal (maintaining lifelong abstinence) the client is encouraged to make the trip step by step, providing clients with feedback concerning their performance on any new task[21].

In relation to our finding in the present study it is suggested that treatment should focus in the patient's need by treating them in where they are. By another words, patients stages are important to help them progress forward or backward. It is recommend further research in self-esteem and stages of change by following each stage at least for six months with more subjects than that was observed in the present study.

In the present study we have noticed that a small number of individuals who did not concentrate on their response to the questionnaire scored the same for all the stages, which made it difficult to classify in a particular stage.

الملخـــــــص

إن هدف هذه الدراسة هو بحث العلاقة بين احترام الذات ومراحل التغيير لدى متعاطي الهيروين الذين يتناولون علاج الميثادون لدى مستشفى المودسلي.

وقد طبق استبيان احترام الذات ومراحل التغيير على ٣١ شخصاً (ذكوراً وإناثاً). وقد صنفت الى خمس مراحل:

١. لا يوجد محاولة للتغيير، وليس لديه بصيرة بأن هناك مشكلة.

٢. يوجد مشكلة والبدء بالتفكير بالتغلب عليها.

٣. الاستعداد للتحرك لحل المشكلة.

٤. أخذ الحيطة لمنع انتكاسات.

وقد دلت النتائج على أن هناك علاقة إحصائية بين احترام الذات ومراحل التغيير. إن هذه الدراسة تساعد على تقويم متعاطي الهيروين في أثناء المعالجة.

p = <.024), Preparation stage was (N = 6, r = .532, p = <.017).

Previous treatment (detox-time) and self-esteem, by using Spearman correlation coefficients, the result indicated a negative correlation (N = 32, r = -.4195, p = <.019).

Discussion

The main question in this study was to investigate whether there is any relationship between self-esteem and stages of change. The result indicated that there is a relationship between the two variables which encourages us to go further to understand the nature of this relationship in one hand and we should consider the limitation of the study (e.g. study design, sample, self-report) which will not allow us to generalise the results in the other hand. By another works, individual's self-esteem (sample) in this study associated with their movement through the stages of change.

Individuals-attractiveness, approval by others, self-regard and self-efficacy had a positive association with all the stages of change. Demographic variables did not greatly associate with the stages of change. Two subjects were classified in Precontemplation stage.

This is not surprising because precontemplators at this stage are not yet considering the possibility of change and seldom introduce them selves to treatment[24]. Individuals who were in the contemplation stage had a lower self-esteem than those who were in the action and maintenance stage.

This may reflect the conflict and ambivalence that they have about quitting or continuing to use drugs. Contemplators appear to struggle with their positive evaluations of the addictive behaviour and the amount of effort, energy, and loss it will cost to overcome the problem[31]. Individuals who were in the preparation stage also had a lower self-esteem than those in the action and maintenance stage.

Although they have made some reductions in their problem behaviours, individuals in the preparation stage have not yet reached a criterion for effective action, such as abstinence from heroin use[31]. Individuals who were in the action stage had more positive self-esteem. It may reflect what they believe negatively about their selves and the degree of confidence about their abilities to succeed by taking action (stop using heroin).

The transition for negative self-esteem at the preparation stage to positive self-esteem may mediate by other factors such as self-liberation and the process of consciously making the commitment to change[1]. Individuals who were in the maintenance stage had no relationship between their self-esteem and the stage where they were. This may be due to the fact that the maintenance stage could be a termination stage followed by abstinence or relapse. It might be the individuals (sample in this study) at this stage were mixed group including those who were likely to relapse.

The stage of change model may be in a sense theoretical, but it provides a heuristic framework on the basis of which differing client motivation can be conceptualised and taken into account in our interventions[14]. The motivation of drug users to change is distinctly socially oriented. By changing their behaviour, they expect to achieve social reinforcement.

This social reinforcement comes from other who play an important impact in the individual's behaviour as an external

For each stage, Precontemplation was (N = 2, r = -.323, p = <.001). Contemplation was (N = 9, r = -.7073, p = <.033). Preparation was (N = 6, r = -.8407, p = <.036). Action stage was (N = 5, r = -.646, p = <.000). Maintenance stage was not significant.

Table (1): The Correlation between Self-Esteem and Stages of Change

	Sample number (N)	Spearman's correlation	Significant level
All stages	32	.4723	.007
Precontemplation	2	-.323	.001
Contemplation	9	-.7073	.003
Preparation	6	-.8407	.036
Action	5	.646	.000

There was a negative correlation between self-esteem and Precontemplation, Contemplation and Preparation stages. The sub-scales of self-esteem measure were then examined with respect to the stages. Attractiveness and Approval by others was positively correlated with the stages of change (n = 32, r = .4153, p = <.020). Autonomous self-regard was significant positive correlation (N = 32, r = .3752, p <.038). Competence, self-efficacy were significant positive correlation (N = 32, r = .5473, p = <.001).

The interesting findings in the present study were found in the Contemplation and Preparation stage, the result indicated that self-esteem level decreased (contemplation, N = 9, r = -.7073, p = <.033), (preparation, N = 6, r = -.8407, p = <.036) and increase at the Action stage in the positive direction (N = 5, r = .646, p = <.000).

Table (2): The Relationship between Sub-Scale of Self-Esteem and Stages of Change

Self-esteem, sub-scale	Stages of change	Sample number (n)	Spearman's correlation	Significance level
Attractiveness, approval by others	All stages progression 1-5	32	.4153	.020
Autonomous self-regard	All stages	32	.3751	.038
Competence, self-efficacy	All stages	32	.5473	.001

Other variables

Crime number (in their lifetime) and stages of change, by using Spearman correlation the results indicated the, Precontemplation stage was (N = 2, r = .323, p = <.016), Contemplation stage was (N = 9, r = .735, p = <.024). Preparation, action, and maintenance stages were not significant.

Contemplation, Preparation were associated with crime number, by using Spearman correlation coefficients, Contemplation stage was (N = 9, r = .7350,

employed, 23 (71.9%) were unemployed. Eleven subjects (34.4%) had children, 21 (65.6%) had no children. The mean age for starting use heroin was 18.9 years (SD = 3.1). the mean time for using heroin (duration) was 14.2 years (SD = 6.08). Twenty-six subjects (81.3%) had injected heroin, 6 (18.8%) had smoked heroin.

The mean detox number (how many times have been detoxified) was 1.9 times (SD = 1.5). The mean duration spent in detoxification was 5 weeks (SD = 4.7). Twenty-two subjects (68.8%) have not been in rehabilitation, 8 (25%) have been once in rehabilitation, two subjects (6.3%) have been twice in rehabilitation.

The mean duration spent in rehabilitation was 1.5 months (SD = 2.59). Twenty subjects (62.5%) had committed crime in their lifetime, 12 (37.5%) had no history of crime. The mean number of crimes among those who committed crime was 1.5 times (SD = 1.4). Seven of twenty (21.9%) who committed crime were thefts, 2 (15.6%) were shoplifting, 8 (25%) were drug dealers. 16 (50%) were sentenced, 4 (12.5%) were fined. The mean sentence duration 6.5 months (SD = 9.7).

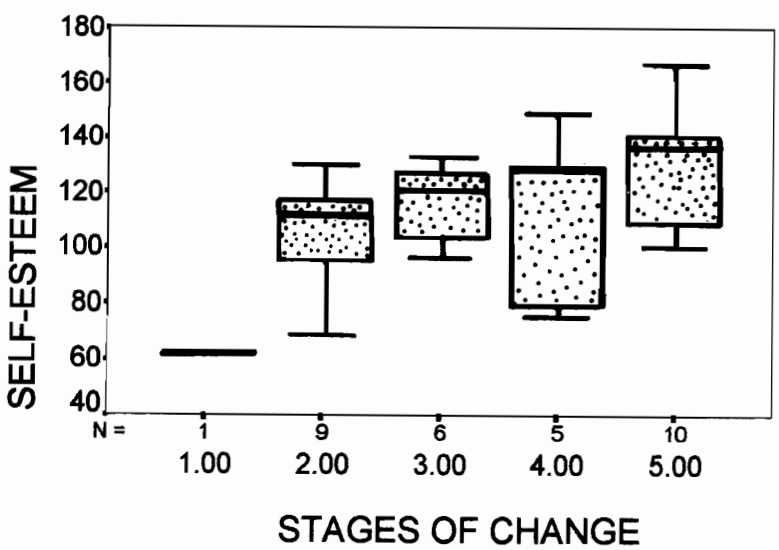
Result relating to the main hypotheses

The relationship between self-esteem level and stages of change:

The present study was trying to answer this question: is there any relationship between self-esteem and stages of change (Precontemplation, contemplation, preparation, action and maintenance)?

By using Spearman correlation coefficients, the results indicated a significant positive correlation between self-esteem scores and the stages of change (N = 32, r = .4723, p = <.007). (Graph 1).

Graph (1) the relationship between self-esteem and stages of change, key: (1) Precontemplation, (2) Contemplation, (3) Preparation, (4) Action. (5) Maintenance.



subsequent drinking behaviour were inspected, all group means of changes in level of consumption from initial assessment to follow-up were in the order predicted by the stages of change model, a finding which was highly unlikely to have occurred by chance[14].

Study Design

The present study is a cross-sectional study were the individuals are observed only once. The sample has been taken from opiate users population attending a methadone maintenance programme.

Dependent variables

Using drugs (heroin), trying to be abstinence, based on self report.

Independent variables

The level of self-esteem, based on self-esteem questionnaire.

The stages of change, based on stages of change questionnaire.

Demographic information

The subjects were given demographic questions about their sex, age, education and social economic situation.

Other variables

The sample were given questions about:

Drug use (heroin) over lifetime.

Previous treatment-history.

Crime over lifetime

Procedure

Subjects in the present study were 32 patients recruited as follows: 7 patients represent 1993, 10 patients represent 1994, 10 patients represent 1995, 5 patients represent 1996.

Subjects were interviewed and told that research aimed to find out whether self-esteem (how you feel about yourself) influence what you think about your current and future drug use. Also patients were told that their participation would not influence their treatment status. Informed consent was obtained.

Subject were given stages of change questionnaire, self-esteem questionnaire and questions on demographic information. Each individual took nearly 45 minutes to complete the questionnaire.

Data Analysis

In this study, all variables were analysed by multiple group comparison tests including ANOVA. The main hypotheses were tested statistically by the SPSS computerised analytical system using Spearman correlation coefficients.

Results

Sample response rate

The total sample was 30. Seven subjects were excluded because they did not fit the study criteria. The eligible subjects for this study were 32.

Sample characteristics

The total sample was (n=32), 18 of them were male (56.3%), 14 of them were female (43.8%). Mean age for the total sample (n=32) was 33.5 years (SD=6.106). Thirty subjects (93.8%) were UK ethnic, 1 (3.1%) was African, 1(3.1%) was Asian. Eleven subjects (34.4%) lived in private flat, 10 (31.3%) lived in council flat, 3(9.4%) lived in a friend's flat, 8 (25.0%) lived in parent's flat.

The mean age for leaving school was 15 years. Seven subjects (21.9%) had qualifications, 25 (78.1%) had no qualification. Nine subjects (28.1%) were

Self-esteem level in this study is the scores that the patient will get on the self-esteem scale, based on self-report.
Stages of change in this study are the scores that the patient will get on the stages of change questionnaire, based on self-report.

Method

Subjects

Subjects were a series of consecutively consenting patients attending methadone maintenance programme at the Muadsley Hospital (Institute of Psychiatry, London). This sample was chosen because the programme attended by people at differing stages of change. In order to test the hypotheses, we should find a suitable population, which represents the five stages of change. So the methadone maintenance is a useful population to find subjects with different stages and some of them continue using heroin during the methadone maintenance.
Methadone maintenance at the Muadsley Hospital started in 1993. The total number of patients who attended the program and continue in treatment form 1993 to 1996 is 151 patients including some people who have been coming to the clinic for a short time and some who have been coming for longer. We can classify them as follows: 16 patients during 1993, 54 patients during 1994, 55 patients during 1995, 25 patients during 1996. For the present study 32 patients have been recruited, which represent the four classification.

Instruments

Self-esteem questionnaire

This questionnaire has been constructed by Robson (1989)[32]. Self-esteem was defined as follows: The sense of contentment and self acceptance that result from a person's appraisal of his own worth, significance, attractiveness, competence, and ability to satisfy his aspiration.
The questionnaire was found to be acceptable to patients. The reliability data compare favourably with that reported from other self-esteem measures. Preliminary investigations of convergent and discriminant validity are also encouraging. Reliability coefficient alpha was .83. (Robson, 1989)[32]. The questionnaire has 30 items representing five factors, "attractiveness, approval by others", "contentment, worthiness, significance", "autonomous self-regard", "competence, self-efficacy", "the value of existence".

Readiness to change questionnaire (Drugs-version)

The questionnaire (drugs-version) is designed to identify how the individual personally feels about his or her drug taking right now. The questionnaire consists of 20 items to represent the five stages of change, Precontemplation, contemplation, preparation, action and maintenance, each stage represented by 5 items. This way enables individuals to allocate drug users to stage of change on the basis of their questionnaire responses. Reliability coefficient alpha was .81.
In previous studies the readiness to change questionnaire showed satisfactory psychometric properties. The stage of change variable continues to predict change in consumption, providing a good evidence of one form of predictive validity, the ability to predict changes in drinking behaviour overtime, of the readiness to change questionnaire. When relationships between allocated stages of change and

in the past year. Individuals in the preparation stage have not yet reached a criterion for effective action.

Action

It is the stage in which individuals modify their behaviour, experiences, or environment in order to overcome their problems. Action involves the most overt behavioural changes and requires considerable commitment of time and energy. The modification of addictive behaviour that made in the action stage tends to be most visible and receive the greatest external recognition. Individuals are classified in the action stage if they have successfully altered the addictive behaviour for a period of from one day to six months. Successfully altering the addictive behaviour means reaching a particular criterion, such as abstinence.

Maintenance

It is the stage in which people work to prevent relapse and consolidate the gains attained during action. Maintenance is a continuation, not an absence, of change. For addictive behaviours this stage extends from six months to an indeterminate period past the initial action. For some behaviours maintenance can be considered to last a lifetime. Being able to remain free of the addictive behaviour and being able to consistently engage in a new incompatible behaviour for more than six months are the criteria for considering someone to be in the maintenance stage[31].

The Aims of the Study

Opiate users often have practical, emotional and social problems. The vast majority of patients can be helped to improve their adjustment to such problems and events by individual counselling or supportive group therapy while they are in the process of short or long detoxification (methadone maintenance), or in rehabilitation phase of treatment[18].

The present study aims to know the nature of the relationship between the two variables, self esteem and the stages of change to stop heroin use which may help understanding the progress and regress of patient's movement during the course of treatment.

The Main Hypotheses

The Methadone maintenance program is one of the suitable place to find opiate users (especially heroin) who have different levels of motivation and different psychosocial situations. Most of them attend the program to gain abstinence as an ultimate goal. Also they are at different levels regarding to their own decision to give up drugs. Therefore, assessment is very important to identify their needs in treatment. It is of interest to investigate whether there is any change in self-esteem associated with the client's movement through the stages of change.

This study is concerned the question: Is there any correlation between the level of self-esteem and the stages of change to quit heroin among the patient who attend the methadone maintenance program as out patients at Maudsley Hospital?

Operational Definition

Heroin addicts in this study are out-patients attending the methadone maintenance program who have been using heroin for more than one year, self classified as heroin addict.

During residence in a rehabilitation centre for drug misuser, significant changes were seen in emotional state including self-esteem[2]. Norris (1983) demonstrated that self-esteem and the level of personal function greatly improved during the time spent within a therapeutic community, also therapists of many different persuasions feel that improvement in self esteem is an important element in the process of treatment[22].

Self-esteem is determined by the interaction between success and pretension and it seems logical to suppose that the person's concern about the consequences of his actions must depend to some extend on the value he attaches to himself and his existence. His opinion of him self is also likely to influence his expectancies and explanation of what happens to him[32].

Stages of Change

In a compendium of 43 theories of substance abuse, five theoretical stages have been delineated in the addiction cycle. The five stages are initiation, continuation or escalation, cessation and relapse. Variables that employed to explain addictive behaviour are seven major domains: euphoria/pleasure, drug knowledge, cognitive factors, tension-anxiety reduction, interpersonal variables, personological factors and social / environmental factors. One of the personological feature is low self-esteem or self concept[13].

The stages of change model which was articulated by Prochaska and Diclemente (1992)[31], Prochaska, and Diclemente, 1986)[30] provides a way of conceptualising and measuring readiness to change. The model could offer a means of identifying different levels of treatment motivation in different patients and a framework for effective treatment[1]. According to the model, individuals trying to modify a particular behaviour progress through five stages: Precontemplation, Contemplation, Preparation, Action, and Maintenance. Each stage represents a constellation of attitudes and behaviour[34].

The stages represent specific constellations of attitudes, intentions, and behaviours. Every stage represents a period of time as well as a set of tasks needed for movement to the next stage[20]. Following are brief descriptions of each of the five stages.

Precontemplation

It is the stage at which there is no intention to change behaviour in the foreseeable future. Many individuals in this stage are unaware or under aware of their problems. Families, friends, neighbors, or employees, however, are often well aware that the precontemplators have problems.

Contemplation

It is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action. People can remain stuck in the contemplation stage for long periods. Another important aspect of the contemplation stage is that weighing of the pros and cons of the problem and the solution to the problem.

Preparation

It is a stage that combines intention and behavioural criteria. Individuals in this stage are intending to take action in the next month and have unsuccessfully taken action

appetitive behaviour on one hand, and other they need to be a bread-winner, to be a family person, to enjoy life, to have a clear conscience, to have friends, to have self-respect[27].

Heroin addiction has proved very difficult to treat because it not only is a pharmacologic addiction but it also involves an addiction to particular life style. In the process of pharmacological addiction, conditioning occurs that serves to make other heroin addicts and dealers the most salient social group for the user[26].

Treatment goals must fit with the client's stage of change. Since treatment goals are different stages of change require different interventions that are consistent with client's stage of change. Treatment services must adapt to changing characteristics of the population, which they seek to serve, different people will require different types of help[3].

Methadone maintenance is the most effective widely available treatment for opiate. Some studies about group therapy in the methadone clinic showed that the clients learn to communicate feelings and conflicts with each other, gain insight and improve their self-esteem[39].

However, treatment failures are typically ascribed to insufficient motivation of the addicts to change[1]. Personality factors precipitate involvement in drug and alcohol use either directly or indirectly[28]. Ghodse (1995)[9] noted that personality characteristics of drug addicts may be manifested by resistance to social structure. Such characteristics do need more investigation to suit the needs of opiate addicts (heroin), and research to address the link between the issues. Two factors emerged strongly from the literature review. These are self-esteem and stages of change.

Self-Esteem

William James (1890) discriminated the self as known from the self as knower, and divided the former into three components: material (body, family, home); social ("a man has as many social selves as there are individuals who recognise him"): and spiritual (states of consciousness, psychic faculties, disposition).

The self-concept was seen as being acquired through interaction with others people rather than being inborn, and it was recognised that the self as experienced may differ from the self as presented. James stressed the vital role of personal values in determining the affective response to self-evaluation, and argues that self-esteem is determined by the interaction between success and pretensions[33].

The involvement in substance abuse and the relationship between self-esteem and drug use has been found in number of studies. Some studies showed a significant negative correlation between self-esteem and drug use[38,35].

A comparison study between heroin and cocaine addicts suggested that personality psychopathology in drug addicts is associated with lower self-esteem[1]. Low self-esteem also has been associated with a large number of undesirable traits, and some investigators have argued that it may in some circumstances have a causal or maintaining role[32].

Some studies in relation to drug involvement and offenders program found that participants had experienced significant enhancements in psychological well being including self-esteem[29].

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Stages of Change and Self-Esteem among Opiate Users

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مراحل التغيير واحترام الذات لدى متعاطي مشتقات الأفيون

عبدالله العتيبي

Abstract

The aim of this study was to investigate the relationship between self-esteem and stages of change among heroin users on methadone maintenance at the Maudsley Hospital. The sample was 31 male and female subjects. Subjects were given a self-esteem questionnaire and stages of change questionnaire. They have been classified to five stages, Precontemplation, Contemplation, Preparation, Action, Maintenance. Data was analysed by using Spearman correlation coefficient. Results showed that there was a correlation between self-esteem and stages of change ($N = 32$, $r = .4723$, $p = < .007$). This study suggested that this result would help us to assess heroin users at treatment.

Introduction

Treatment for opiate problems showed that opiate users do change over time, Stimson and Openheimer followed up 128 English heroin addicts over decade and found that 48 percent were still using opiates and 12 percent had died, but 31 percent were abstinent[18]. There is good evidence for believing that some treatment can have an impact.

Also there are no good criteria for prognostic indicators for drug treatment. Patients with good psychosocial adjustment before treatment and with good social support are more likely to benefit, but those with poorer psychosocial adjustment are important, from a public health and social order perspectives, for methadone treatment and HIV infection and hepatitis prevention[7].

There are many factors, which influence drug treatment such as the patient's physical, psychological, social, cultural situation. Treatment is understood as physical, psychological and psychosocial intervention, which has the aim of reducing harm or producing change[18].

Factors that determine outcome may be divided into treatment factors and patient factors. Treatment factors relate to the choice of treatment, and sometimes patients may make their own choice. Patient factors that have been assumed to predict treatment outcome include patient characteristics such as gender, age, motivation, degree of dependence and personality[5].

The motivation of clients seeking help for problems of addiction is frequently assumed to influence the course and outcome of treatment interventions for people[25]. The motivation for change derives from an accumulation of "losses" "costs" or harm resulting from behaviour, and that have accumulated to the point at which they exceed "gains", benefits, or pleasurable outcomes of appetitive behaviour to such a degree that the conflict between the desire to continue with the

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hospitals allow more flexibility, they are less restrictive and less expensive than inpatient hospitalisation.

2. There is a need to have a clear definition of day hospitals in order to specify their roles and the range of services they can provide. It is essential to be aware that duplication of other services can adversely affect the justification of having day hospitals as separate or complementary care to the other existing psychiatric services.
3. There should be a proper and efficient communication between day hospitals and the treating multidisciplinary teams. It is necessary to ensure strong linkage with those who provide continuous care and to become an integral part of the process of an ongoing system of care.
4. Skill mix of day hospital staff is advantageous to provide patients with a variety and often more suitable options to achieve the same desired goal.

الملخـــــــص

"المستشفيات" النهارية" تهيء جو ملائم لعلاج عديد من الأمراض النفسية، ويمكن خلالهن مساعدة المرضى لاستعادة وتطوير إمكانياتهم للمعالجة ومواجهة الضغوط النفسية بشـــكل عام.

تلك المستشفيات أقل كلفة من الناحية المادية مقارنة بالأساليب الأخـــرى للعـــلاج. مـــن الممكن استعمال كفاءات عديدة في المستشفيات النهارية لعلاج المرضى النفســـية بشـــكل فعال.

ان هذا البحث يفسر دور المستشفيات النهارية في ممارسة الطب النفسي بأسلوب حديـــث. هذا البحث يحتوي مراجعة الدراسات والمصادر التي تخص هذا المجال ويشمل أيضاً آراء الأطباء الاستشاريين الذين كانوا مسؤلون عن عدد من المستشفيات النهاريـــة التـــي قمنـــا بزيارتها في "سوليهل وبرمنجهام" في المملكة المتحدة.

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unspecific programs which are not time limited.

Evidence Based Knowledge

A study of day patients in Birmingham in the late 1960's showed Patients who attend day hospitals as a part of a larger hospital were mainly older and the majority were diagnosed with schizophrenia. They were found to have a greater morbidity according to the frequency and duration of their previous psychiatric care compared to those patients who were attending smaller and relatively modern day hospitals.

The location of day hospitals is an important factor for its success. Day hospitals are usually preferred to be in the community and easily accessible. The physical building of a day hospital is more appropriate to be purpose built rather than a converted house. Purpose built premises give the opportunity to have larger rooms for various groups and activities. Observations and assessments could be easily carried out in such buildings. Day hospitals, whether on inpatient units or elsewhere in a hospital, may be helpful for the inpatients to attend groups and perhaps prepare themselves for a smoother transition from inpatient to a day hospital after discharge.

The psychiatric consultants in Solihull Hospital, in West Midlands, U.K. assist with input into how to run day hospitals. Their role also included reviewing the progress of their patients, either themselves or indirectly through their junior doctors or clinical assistants. However, the staff at the day hospitals are independently running the groups and determining the suitability of patients to various group activities. The consultants view day hospital as a place where a wide range of psychiatric illnesses can be treated. They agree that the skill mix of day hospitals is important. They do not see any specific role for day hospitals in running lithium, depot and Clozaril clinics or delivering ECT. They find the psychological intervention is a significant component of the treatment which all the day hospital attendants receive. The consultants are divided in regards to whether day hospitals are complimentary or an alternative service to inpatient hospitalisation. They foresee day hospitals struggling for its existence. However, they are convinced that there is definitely a role for the day hospital in practicing modern psychiatry.

Future of Day Hospital

At present, when every penny is accounted for in delivering health services, day hospitals should come up with a more clear definition of their role and mandate in order to justify their existence and growth. They may be replaced either by intensive multidisciplinary out-patient modalities, which can assume the role of existing day hospitals or by less intensive modalities such as psychosocial and vocational rehabilitation programs. The latter is increasingly supported, especially the private sector and third party payers for health services.

Conclusion

1. There is a need for day hospitals to serve a patient population who need more than intensive out-patient programs and they can use day hospitals in lieu of inpatient hospitalisation. In such cases day

attending a day hospital. For example, a physiotherapist in a day hospital can use physically-focused relaxation techniques for patients who may have difficulties with more mentally-focused relaxation techniques. Also having physiotherapists in a day hospital can benefit those patients who may have a co-existing physical problem in addition to their mental problems, as these patients may find it difficult to attend a regular physiotherapy department for various reasons, psychiatric or otherwise. Another benefit from having a physiotherapist in a day hospital may be for patients who have conversion disorders to address their physical symptoms and encourage them to realise that there may be some psychological component to their illness and put them in a more psychological frame of mind. Occupational therapists in a day hospital can help patients to develop some skills to perform activities of daily living according to their level of disability. They can also help the patients to achieve their goals and objectives, using activity as a therapeutic tool. Art therapists in a day hospital can assist patients to address some of their difficulties and psychological conflicts through artistic expression. Social workers can help the day hospital attendants with their social problems and assist them to improve or develop social skills. Nurses can play a role in facilitating the understanding of patients with their mental illnesses and the various treatment strategies used to treat them including medications. Another important role of nurses is to monitor mental state of the patients while attending day hospitals.

Programs of Day Hospitals

Depending on the ratio and the level of expertise of day hospital staff, almost any psychiatric patient can be treated in a day hospital from anxiety disorders, affective disorders, psychosis and related illnesses to dementia and other organic illnesses. However, day hospitals traditionally have been more often associated with a place where a wide range of group therapies are provided.

Programs of day hospitals can be highly specialised, such as dynamic group psychotherapy programs, or family therapy programs, etc. As it was mentioned earlier depending on the staffing level of a day hospital and the degree of disturbed behaviour day hospitals can be used for treatment of acutely ill psychiatric patients. However, to serve that purpose there should be crisis teams operating outside the regular times of opening or on the weekends as well as overnight beds available for crisis admission.

Working of Day Hospitals

The American Psychiatric Association Psychotherapy Research Report 1982 suggests there is a need for precise descriptions for patient selection, treatment modalities, staff orientation and outcome for specific patient groups. Ideally referrals should be made by a psychiatrist to ensure a proper selection of patients, proper utilisation and reviewing the program of attendance. Assessments can be carried out by the day hospital staff after a referral by a psychiatrist to allocate patients to appropriate programs. Prescribing "Treatment Packages" with flexibility and ongoing re-evaluation are more focused and may have better outcomes compared to

of psychiatric day hospital experiences upon subsequent utilisation of medical, surgical and psychiatric services at the Eastern Reference Administration Medical Centre in USA[5]. They concluded that:

1. There was a net decrease in medical and psychiatric care costs for the patients from two years before to two years after day hospital treatment.
2. The beneficial impact of day hospital treatment was particularly greater in the change of medical and surgical out-patient visits compared to other measures of service utilisation.

Positive outcome of day hospital treatment appeared to lead to a significant decrease or less increase in medical and surgical visits, psychiatric admissions, and the number of psychiatric hospital days when the variance associated with other parameters was removed. They also concluded that the duration of day hospital treatment showed the predicted inverse relation to past treatment, medical and surgical care events.

A study on patients satisfaction with partial hospitalisation as a community based program in patients attending partial hospitalisation program in Chicago has shown that patients were satisfied with their care in partial hospitalisation. Satisfaction was measured according to satisfaction items generated from a factor analysis of Satisfaction Instruments for Inpatient Programs, but there was no comparison with a control group[7].

It has been reported that despite the variability of programs, the diagnosis of patients, the treatment modalities, the goal of treatment, and administrative affiliation of day hospitals there is a 60% to 90% improvement in clinical condition and role functioning after discharge[5,17,19,21]. Significant improvement on MMPI[21], WAIS full scale of IQ[19], and on an anxiety scale and the Semantic Differential as a Measure of Self-Concept[6] have been reported for attendants of day hospitals.

What is Psychiatric Service?

The psychiatric system of care usually comprises the acute residential "Inpatient", longer term resident "Rehabilitation", partial hospitalisation as well as ambulatory care which normally includes out-patients and community care. This system serves to promote mental health well-being, to provide vocational training, rehabilitation, and relapse prevention strategies, in addition to more intensive interventions during the acute phases of mental illnesses. It is clear that day hospitals can play an important role in this psychiatric system of care.

Staffing of Day Hospital

To fulfil the definition of a hospital, the patients in a day hospital should have a named "designated" nurse, they should be under the care of a consultant psychiatrist and they must have medical examination on admission. Attendants of a day hospital should not help in running the service. In practice, there is some apprehension associated with having a named nurse especially when the staffing of day hospital constitutes a skill mixture of professionals such as social workers, occupational therapists, physiotherapists, and psychologists in addition to nurses. However, the skill mixture of day hospital staff can be quite enriching and it benefits the patients. Staff who are coming from different professional backgrounds bring multiple skills to assist patient who are

Hospital setting is a crucial point in determining whether a day hospital can treat acute mentally ill patients because it can determine the level of disturbed behaviour that can be tolerated in that setting according to the staff versus patients ratio. At present, the only commonality of various day hospitals is their similarities in length of daily programs which usually ranges from three to eight hours during weekdays.

In addition to being used as a supportive environment for Psychoeducation or relapse prevention, day hospital may serve the important but non-specific purpose of developing and improving social skills of the patients.

Literature Suggestions

Majority of the studies which compare the effectiveness of day hospitals services to inpatient hospital admissions agree that day hospitalisation, when utilised properly, is at least as effective as inpatient hospitalisation for a substantial number of acutely ill patients. Although some critics view that the average patient may use more of in-hospital stay in a day hospital compared to an intense inpatient treatment, day hospitals continue to prove that they are still more cost-effective alternatives to inpatient hospitalisation[3,10].

Investigators agree that there is a need for precise descriptions of patient selection, treatment modalities, staff orientation and outcome for specific groups. Since the vast majority of studies had evaluated comparisons between inpatient hospitalisation and day hospitalisation only, there is a need for comparison between intensive out-patient intervention and short-term day hospitalisation.

In the latter half of 1980's day hospitals started to close at a surprising rate in the United States of America. The Department of Mental Health in many states started to withdraw both commitment and financial support to the day hospitals. There are several factors identified for the challenges that the day hospitals are facing such as: 1. The private sector sees the intensive community intervention and treatment to be more effective and humane for patients; 2. The difficulty of day hospitals to maintain a full census, either due to poor attendance or increased numbers of the drop-outs; 3. Day hospitals are often viewed as creating a new inter-unit boundaries. It is seen as another dimension added to the traditional inpatient and out-patient systems, which can make communication and flow of information more difficult; 4. The lack of strong linkage between day hospitals and out-patient care providers which is essential to ensure the continuous process of the ongoing system of care.

Proponents of Day hospitals recognise them as a place where patients can get adequate support while a comprehensive discharge planning can be put together. They also acknowledge their role to facilitate a smoother transitional period and a gradual detachment from inpatient services.

Another factor in favour of day hospitals is that day hospital attendants will have considerably less somatic morbidity which frequently accompanies or follows psychiatric disorders. Therefore there is a reduction in utilisation of medical services for patients who attend day hospitals. This finding had been attributed to that perhaps day hospitals permit patients to develop more adaptive mechanisms for dealing with stress. Comstock et al had studied the effect

The American Association for Partial Hospitalisation (AAPH), has given a comprehensive definition to partial hospitalisation which includes day hospitalisation[1]. They define partial hospitalisation as: "an ambulatory treatment program that includes the major diagnostic, medical, psychiatric, psychosocial and prevocational treatment modalities designed for patients with serious mental disorders who require co-ordinated intensive, comprehensive, and multidisciplinary treatment not provided in an out patient clinic setting. It allows for more flexible and less restrictive treatment program by offering an alternative to inpatient treatment[4].

Many authors divide partial hospitalisation into three broad categories, using somewhat different terms at times. Rosie (1987) in his review article on "Partial Hospitalisation" thinks that the terms "day hospitals", "day treatment programs", and "day care centres" adequately describe these categories[18]. He describes "day hospitals" as providing diagnostic and treatment services for acutely ill patients who will otherwise be treated on a traditional inpatient psychiatric units.

Rosie views 1. "day treatment programs" to be more diverse in functioning which they often treat patients who are in some degree of remission from an acute illness. They may also treat those who are in transition from inpatient to outpatient care, they are considered as an alternative to the standard out-patient care. All day treatment programs aim for improvement of functioning of patients as well as some reduction in their symptoms. 2. "Day care centres" have the maintenance of chronic psychiatric patients as their primary task. They may also work on habilitation or rehabilitation aspects. 3. "Day care centres" are often divided into those catering to the general psychiatric population and those catering to the old age psychiatrically ill patients.

In this report, we try to emphasise on day hospitals separately from the other two categories (day treatment programs and day care centres). In our opinion, "day hospitals" require a less exhaustive, more clear and succinct definition. We suggest "day hospitals" be defined as ambulatory programs which provide diagnostic and "multidisciplinary" treatment services for acute psychiatric patients which can not be provided in out-patient clinics and are more suitable, flexible and less restrictive alternatives to inpatient programs.

Types and Purposes of Day Hospitals

At present, day hospitals are providing a wide range of services from being quite non-specific to being highly specific. There are some day hospitals that offer group therapy only while others run specific treatment programs, such as depot clinics, lithium and Clozapine monitoring clinics. There are also suggestions that ECT treatments be provided in day hospitals. Such specific treatment, although can be satisfactorily delivered in day hospitals, they do not specifically required a day hospital service.

Day hospital's mandate and utilisation are more efficient when they have after hours support such as The Inn Model, which was developed in Massachusetts[12]. In that case they are able to efficiently treat a broad range of acute and disturbed mentally ill patients. The level of staffing of the Day

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Review Article:

The Role of Day Hospitals in Modern Psychiatry

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دور المستشفيات النهارية في الطب النفسي الحديث

مروان حسني، جواد شيخ، نرمين كويي، جون هاكرتي

Abstract

Day hospitals for mentally ill patients provide a setting where patients can be actively treated and assisted to develop proper skills for better coping with their illnesses and stress in general. They provide a unique setting in which diversified skills in the management of the mentally ill patients are used effectively. Day hospitals are cost effective in the spectrum of care for psychiatric patients.

This paper discusses the role of day hospitals in the current practice of psychiatry. The discussion is based on review of the recent literature, visits to a number of day hospitals in Solihull and Birmingham in west midlands, U.K. as well as interviews with the consultant psychiatrists in charge of them.

Keywords: Day Hospital, Partial Hospitalisation.

Background

Day Hospitals were born out of necessity due to shortage of inpatient beds. The first day hospital was opened in Moscow in 1933. In the 1940's day hospitals became increasingly popular in the western world, particularly in Britain and North America. Following The Second World War day hospitals became even more popular and they started to grow very quickly. However, over the past two decades their popularity has been declining in the public and the private sectors. The research on day hospitals has also been decreasing, and it is almost in a standstill point at present.

We will discuss the factors that have led to this change in the role of the day hospitals in psychiatric practice.

What is a Day Hospital?

There is lack of a clear definition of the concept of a day hospital. It is often confused with other terms such as partial hospitalisation, day treatment, day unit, day drop-in or day clinic. In addition, day hospitals are often called or referred to differently by different authorities. For example, the health authorities may call them day hospitals, while Social Services may call them day centres.

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ملخـــــــص

إن سوء استعمال العقاقير هي مشكلة عالمية كبرى ذات أبعاد وعواقب طبية ونفسية وشرعية. وأساليب العلاج يجب أن تخاطب النواحي المعقدة بمداخلات تشمل العقاقير والعلاج النفسي والعلاج الاجتماعي والتي تلعب دوراً هاماً بشكل منفرد أو جمعي. إن هذه الورقة ستركز على المعالجات النفسية وستعرض المعالجات بشكل موجز مع الخلفية النظرية مع بحث الجانب النظري كمرجع لكفائتها. وفي نهاية البحث سيركز الباحث على المعالجة المعرفية السلوكية بجوانبها النظرية والعملية بالنسبة لعلاج سوء استعمال العقاقير.

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According to the model there are several points of intervention "exits" from the circle. Diary keeping, imagery are helpful to identify stimuli which sometimes are not so obvious and in identifying automatic thoughts, drug beliefs and permissive beliefs. Advantages/disadvantages analysis, downward arrow exercise, flash cards can help the individual to challenge the identified thoughts and lead to cognitive restructuring. Activity scheduling, education on the nature of craving, relaxation training, behavioural experiments can help the individual to tolerate the craving and gain control over the decision making process. Evaluation of past experience, cognitive restructuring, can help in challenging permissive beliefs. Behavioural analysis, coping skills, planing of specific strategies to delay the process or postpone action can help in making the time required for the individual to gain control[24].

Although according to the writers, the model has been developed for cocaine users (and the examples given in the book are for cocaine clients), the only randomised controlled trial has been done with opiate users.

Two types of treatment has been compared: SE therapy and CT which were added to methadone maintenance programme and compared against the control treatment (methadone with drug counselling). The assessment of outcome incorporated medical, social, psychiatric consequences, severity of use and urine screening. The results suggested that clients receiving the experimental treatments improved significantly compared with the control group with best results for the individuals with higher psychiatric comorbidity. There was no difference between CT and IPT[3,4,5].

Comment

Several psychological interventions were developed over the years to address the problem of substance misuse. The interventions are used as sole treatment but usually in combination as parts of a treatment package. The evidence for their efficacy is derived from open studies, case studies and accumulated clinical experience with few randomised clinical trials.

What is required is research with sound methodological designs to evaluate these interventions; The field is prompt with difficulties related to the complexity of the substance misuse problems and the nature of the psychological interventions themselves.

There is no place for therapeutic pessimism. There is now good evidence from recent research that shows, that even people with severe dependence on alcohol and drugs can recover from their addictions.

Treatment for substance abuse has to be seen as a long journey similar to that of Ulysses; with many achievements, as well as relapses and complications.

Short term harm reduction strategies as well as long term controlled use or abstinence strategies have a very important role to play depending on the individual needs. At the end of the journey Ithaca is the destination, the goal to achieve, whatever that can represent.

managing thoughts, problem solving, drink refusal skills, planning for emergencies, coping with seemingly irrelevant decisions and termination session. After the first seven sessions, 4 elective sessions can be added. These are, job seeking skills, family and couple sessions and anger management[9]. The model has been also used with cocaine misusers with promising results[21].

Network Therapy (NT)

Network Therapy was developed by Galanter. The aim is to augment individual therapy by involving the patient's family/friends in therapy initially once a week and later less often. The people are charged with reporting on the patient's drug use, recovery activities, setting up structured activities between the patient and themselves, identifying triggers of craving, confronting denial, and offering support.

There is also a cognitive-behaviour component in the treatment based on RP techniques[22].

There is only one outcome study of NT. This study though was very limited (open study, small sample, one outpatient setting) to generalise any results[23].

Cognitive Therapy (CT):

Cognitive Therapy for substance misuse has been developed by Beck and his colleagues in 1993, although an earlier version of the model has been used for a series of randomised controlled trials with opiate users in 1980's[3,4,5].

It is an adaptation of the depression model and has been developed for individuals with cocaine use. Collaborative approach, Socratic questioning, graded task assignment, cognitive formulation, structured sessions, remain crucial elements of the intervention.

According to the model, the individual faces drug stimuli which can be external (meeting other drug users, being in a party etc.) or internal ones (withdrawal symptoms, emotional states etc.).

These stimuli activate drug beliefs (which can develop from anticipatory, to predictive of gratification or escape beliefs, further to relief orientated beliefs e.g. "I need the drug") and automatic thoughts which in turn activate cravings and urges. Drug beliefs are built on top of core beliefs (about personal survival, achievement, freedom, autonomy or bonding with others or a group). The model emphasises that drug taking is a decision making process although this process is happening so fast that the individual thinks it is an automatic behaviour on which he/she has no control. Therefore it is crucial to support the individual to become aware of this process and to be able to tolerate the unpleasant state linked with the craving.

Craving has physiological, emotional and cognitive components. During the craving state the individual may have conflicting thoughts and is ambivalent about what action to take (to use or not use drugs).

There are also facilitating or permissive beliefs which give permission to the individual to proceed with drug use and exit the uncomfortable state he was in. These permissive beliefs are excuses: "it will be only once", "nobody will find out", "I have nothing to lose" etc.

This is followed by the action stage when the individual concentrates on planning and implementing action to obtain drugs. That leads to initial use which itself is a stimulus and the circle is completed[24].

chronic and acute psychosis. Over the last two decades, CBT has attracted enormous research interest, with several very well designed studies supporting its efficacy, and therapeutic manuals have been developed. In addition to outcome studies, process studies were conducted to identify elements of the therapeutic models that are important for therapeutic success. The development of CBT is very closely linked with advantages in Cognitive Psychology theory and research.

This paper will present four models which have been mostly researched or used in the field.

Relapse Prevention (RP)

This model was initially developed by Marlatt and Gordon in 1985, for individuals with alcohol problems, where most of the research work was conducted. RP incorporated Bandura's concept of self-control and self-efficacy (social learning theory)[18].

According to the model when an individual faces a High Risk Situation (HRS) he/she applies methods to cope successfully with this situation. HRS is a subjective situation directly or non-directly linked with substance misuse.

The model predicts that if an individual develops coping skills which are successfully applied to cope with this situation, that increases self-efficacy and reduces the probability of relapse. The lack of coping skills leads to a reduction in self efficacy and positive outcome expectancies for the substance leads to initial use of the substance. This in turn leads to the Abstinence Violation Effect (AVE), a process during which the individual attempts to conceptualise the reason and the meaning of the lapse, with an emotional component and the cognitive concept of the locus of control (self-attribution associated with guilt and perceived loss of control). Following this process there is increased probability of relapse[18].

Specific strategies of RP include addressing ambivalence, identification of HRS, reducing exposure to drug cues and modifying the response to these cues by taking a "stop, look, think" approach to forestall drug consumption, by reviewing coping strategies (determining what has worked to curtail drug use and planning ahead for HRS), distraction, exploring the decision-making process leading to drug use (e.g. rationalisation, minimisation, cognitive distortions), making lifestyle modifications, and learning from slips to prevent full relapse e.g. discussing a brief lapse to learn what precipitated it and what strategies might prevent future escalation to full relapse.

In one study of cocaine users, RP was found superior to IPT with higher retention and abstinence rates for severe users[19]. For cocaine users with a secondary alcohol misuse, Carroll emphasised the importance of combining psychotherapy (RP) and pharmacotherapy (disulfiram) in the treatment of drug use disorders[20].

Cognitive Coping Skills Training

This model was developed by Monti et al[9],originally for the treatment of alcohol misuse. The aim of the treatment is to train clients to develop practical coping skills. According to the therapeutic manual that was developed for the Alcohol Project Match Study there is a core of 8 sessions which include introduction to coping skills training, coping with cravings and urges,

research done on either TC or GP, which partly reflects the difficulties in using sound research protocols with these treatment interventions.

Family therapy (FT)

Family interventions are a crucial part of any treatment approach in the substance misuse field. This is reflected by the fact that almost all different theoretical schools have developed family interventions offering support (e.g. AL-ANON), education (e.g. Network Therapy)or more specific approach where the substance misuse problem is seen as part of the family's malfunctioning. Structural Therapy, Strategic Therapy and Systemic Therapy have been used as the only treatment or as part of a treatment package. There is very little research done with FT interventions. One of the most important findings so far is the beneficial use of Systemic Therapy with teenagers with a substance misuse problems[12].

Behaviour Therapy (BT)

Although in recent years, behaviour interventions have incorporated cognitive elements and in general BT has been merged with Cognitive Therapy to form Cognitive Behaviour Therapy, there are still some interventions which only focus on the behaviour as the problem without working with the cognitions linked with the problem.

Cue exposure (CE)

CE has been mostly used in the alcohol field, where most of the research has been done. In CE, individuals are gradually exposed to alcohol/drug cues, either in vivo or in vitro, which provoke craving , and individuals are supported to stay within the situation until habituation is achieved. The aim is to break down the stimulus-response relationship that has developed to the drug and to various conditioned stimuli, by exposing the patient to the stimuli in sessions when these are not associated with reinforcement through drug-taking[13]. The principals of CE has been incorporated in the Relapse Prevention model and the Beck's CBT model.

Very little research was done within the drug misuse field. One study with methadone-maintained opiate clients demonstrated habituation of subjective craving , and the clinical status of addicts who received CE was improved at follow-up. One study of opiate users reported that CE intervention was not superior to the control treatment condition[14].Research has also been carried out on cocaine misusers[15].

Community reinforcement

This is an adaptation of the "Token Economy" model used in mental health institutions in 1970's, with some research evidence suggesting its efficacy in addressing institutionalised behaviour. In this model, which was mostly used with alcohol misusers, clients are offered access to various privileges, including assistance with job finding and leisure rewards, contingent on abstinence[16,17].

Contingency Contracting is an adjunctive behavioural treatment based on negative reinforcement[2].

Cognitive Behaviour Treatments

CBT has established efficacy in the treatment of depression, anxiety states, panic disorder, bulimia nervosa, OCD,

Motivational Interviewing (MI)

MI has been developed by Miller and Rollnick in 1991 and its roots can be found in Rogerian client-centred therapy and cognitive behavioural methods. It is also based on the theory of the stages of change developed by Prochaska and DiClemente[8].

This treatment approach introduces the revolutionary concept within the field of Substance Misuse, that motivation is something that the therapist has to work with the client to achieve and is not a requirement before entering into treatment. Ambivalence is seen as part of the substance misuse problem, which the therapist has to encourage the client to explore.

The five principals of MI are:

The therapist 1)should express empathy, 2)help the patient to recognise discrepancies between his goals and current problem behaviour, 3)avoid argumentation, 4)roll with the patient's resistance rather than oppose it directly and 5)support self-efficacy by emphasising personal responsibility and the hope of change[8].

Most of the research evidence for MI comes from the alcohol field where therapeutic manuals have been developed for very short interventions of one or two sessions usually before other therapeutic interventions. The term Motivational Enhancement Therapy has been used for these intervention.

MET has been used in the Alcohol Project Match Study. The results suggest that two sessions of MET are superior to six sessions of either 12-step based individual therapy or Cognitive Coping Skills Therapy[9]. An earlier review of short MI interventions in the alcohol field was also in favour of MI[10].

Therapeutic Community (TC)/ Group Psychotherapy (GP)

Rehabilitation units based on the therapeutic community principals have been developed and were a most influential approach in 1960's, 1970's and 1980's. Rapoport identified four concepts central to therapeutic communities: democratisation, permissiveness, communalism, and reality confrontation[11].

Group psychotherapy of psychoanalytic orientation was the major treatment offered in these units. In recent years attempts have been made to incorporate other interventions of a different theoretical background such as Cognitive, Behavioural, Cognitive Analytic Groups or individual interventions, or elements of the above such as anxiety management, anger management, problem solving, drama therapy and others.

There are major differences between groups of different theoretical background but it seems that they all share the same beneficial factors which are the result of the group setting rather than the specific approach. These factors are: acceptance, altruism, universality, installation of hope, vicarious learning, guidance, self-understanding, learning from interpersonal actions, self-disclosure, and catharsis[11].

Group psychotherapy is also a prominent intervention in day hospital/day centre programmes as well as in the community. Relapse prevention groups have been widely developed across UK for alcohol or non opiates clients. These groups usually incorporate elements of different schools. Some of them though are based on the Relapse Prevention model (RP), which will be presented in the CBT section of this paper. Unfortunately there is very little

12- step approach

Narcotics Anonymous, the adaptation of the Alcoholics Anonymous philosophy of treatment remains the most widespread network of treatment worldwide, offering open meetings to the individuals in concern and their families. The Minnesota Model is a 12-step program for inpatient rehabilitation treatment and it has been implemented. Despite the criticism and the lack of strong research evidence, it remains a valuable therapeutic approach.

Dynamic Psychotherapy

Freud conceived substance misuse problem as the outcome of an underlying neurosis and treatment of this neurosis will eventually lead to improvement of the substance misuse. There is no research evidence for the efficacy of this type of approach.

However in recent years there has been a move towards brief focused psychodynamic interventions for substance misuse. Although several models has been developed, three of them have been proven to be useful. These will be presented in this paper.

Supportive-Expressive Therapy (SE)

Based on work by Malan, Sifneos and Luborsky, the supportive component involves creating a safe alliance with the therapist, which allows the expressive component to be conducted. It also emphasises transference-counter-transference, resistance, attention to the patient's anxiety during the session and focus on the patient's responsibility for himself[2].

SE therapy has been one of the two psychological interventions used in a series of randomised controlled trials done in USA in 1980's[3,4,5]. In these trials SE therapy and cognitive behaviour therapy (CBT) was added to methadone maintenance treatment and was compared with Drug Counselling (DC). The results of these trials suggest that SE and CBT psychotherapy are superior to DC especially for clients with psychiatric comorbidity.

Interpersonal Therapy (IPT)

This is a focused treatment that lasts 9-12 months and addresses one or two problem areas in the patient's interpersonal functioning. IPT emphasises the patients interactions with other people, with particular attention to areas such as interpersonal disputes, role transitions, and interpersonal deficits.

Its techniques include exploration methods, encouragement of affect expression, clarification and communication analysis. Behaviour-change techniques, such as limit setting, advice and suggestions, education, modelling, and decision analysis are also used[6].

Although there is evidence for the efficacy of IPT in the treatment of depression, there is limited evidence suggesting its efficacy in substance misuse.

IPT was one of the two models used (along with Relapse Prevention) in a study with Cocaine users and was found effective[7].

In a study of patients receiving methadone maintenance, IPT was not found superior to "low-contact" control treatment. The study had several limitations (small sample, not random allocation) which may limit the generalisation of the results[6].

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Review Article:

Psychological Treatment of Substance Misuse: A Review

C. Kouimtsidis, M. T. Abou-Saleh

المعالجات النفسية لسوء إستعمال العقاقير

د. كومتسيدس ، محمد أبو صالح

Abstract:

Substance Misuse is a universal major problem with medical, psychological and forensic dimensions and consequences. Treatment approaches to substance misuse should address its complexity, with pharmacological, psychological and social interventions having an important role to play, either separately or in combination. This article will focus on the psychological approaches. There will be brief presentation of the models and the theory behind them as well as reference to research evidence supporting their efficacy.

At the end there will be more detailed presentation of the theory and practice of cognitive behaviour therapy in substance misuse.

Introduction

Substance Misuse is one the greatest public health problems that international community with opiate misuse being the most challenging. The epidemic of HIV, Hepatitis B and C, accidental deaths, association with crime, violence, reduction of the age of introduction and association with psychiatric disorders (dual diagnosis) are few problems or consequences.

Methadone prescribing for either detoxification or maintenance has been introduced in USA by Dole and Nyswander in 1964 and overall has been proven successful in minimising crime and medical complications[1].

The introduction of the 'Harm Minimisation' philosophy was required to address the epidemic explosion of HIV and AIDS in the population of intravenous users. This approach has been found successful in engaging individuals in treatment and help them to achieve stability in their lives.

Cocaine and crack misuse is a major problem at the other side of the Atlantic while Great Britain has been a 'speed society', with amphetamines being the drug of choice for young people.

Other so called recreational drugs e.g. LSD, Ecstasy are usually linked with other social trends and cannabis is also widely used.

In this paper the term substance misuse will not include alcohol or nicotine misuse.

Most of the research into psychological approaches to the substance misuse has been conducted in USA with Vietnam veterans. Studies have mainly involved non-opiates users, where psychological interventions has been developed or expanded from the alcohol field as the main treatment available. In the field of opiates, psychological approaches are used in conjunction with methadone or rehabilitation programmes.

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on incident disability was nonspecific as to type of baseline chronic physical illness[15].

Conclusions

The review of these studies, in particular the ECA study, has highlighted that the relationships between psychosocial stressors, physical and mental illness are not simple. In order to understand these relationships one has to use more complex models of etiology. As we could study within the ECA study population, psychopathology could be a determinant of, as well as it could be caused by physical illness. If we consider the role of social and demographic characteristics, in addition to factors affecting access and utilization of health services within the framework of these relationships, the need for a more integrative approach to etiologic research has to be underscored.

As an area of epidemiologic concern, psychopathology has received increasing attention over the past two decades. Early efforts in psychiatric epidemiology have focused primarily on issues of measurement. More recently, more analytic an etiological studies are being conducted using epidemiologic techniques.

In this region of the world, we have witnessed over the past decade the development of a few large scale studies in psychiatric epidemiology, i.e. studies conducted within the framework of the Lebanese civil war. However, a lot needs to be done in this field and we need to start with the training of psychiatric epidemiologists from this region.

الملخـــــص

تبحث هذه المقالة العلاقة بين أنماط الأوضاع الحياتية الغير عادية وأثرها على الصحة النفســـية والجسدية وتأثير هذه الأوضاع مما تحدثه من مؤثرات نفسية اجتماعية ذات طابع سلبي. كمـــا أنها تبحث وبائيات تلك الاضطرابات وطريقة التعامل معها. ويوصي الكاتب بـــالعمل بأســلوب متكامل يأخذ باعتباره مختلف الجوانب لدراسة هذه الأوضاع المعقده.

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interviewed using a special psychiatric questionnaire over a period of one year. Within two years following the earthquake, about 60 percent of this adult population had symptoms that could fulfill the diagnosis of either PTSD and/or depression. The risk of PTSD and depression was related to the amount of loss in the individual's family. Thus, the intensity of the ensuing loss from the disaster was related to the intensity of the psychiatric morbidity in this population (H. Armenian et al. Manuscript in preparation).

Physical Illness and Stressors

The role of psychosocial stressors in physical illness has been highlighted in a number of studies. The ongoing war in Lebanon, provided an opportunity to assess the impact of war stressors on coronary artery disease (CAD) within a case-control study as the American University of Beirut. A total of 127 patients who underwent coronary angiography were individually matched with visitor controls free from any evidence of clinical CAD. Arteriographic cases were compared with two control groups: arteriographic controls with entirely normal coronaries, and visitor controls. Cases reported significantly higher number of exposures to acute war events compared to both control groups. Crossing the "green line". Separating the two fighting factions in Beirut, considered as an attribute of war related chronic stress, which was more frequent in cases compared to both control groups. Adjusting for the effect of well established CAD risk factors did not alter the above reported findings[12].

Psychopathology and Physical Illness

Although there is a wealth of clinical reports in the literature about psychopathology following physical illness, most of these are based on cross sectional studies and very few of these are population based. The role of psychopathology itself as a determinant of physical illness has been difficult to study. A major problem for such studies is the difficulty in establishing antecedence of diagnostic specific psychopathology to physical illness.

The Baltimore Epidemiologic Catchment Area (ECA) Follow-up project is a population based study of assessment of diagnostic specific psychopathology and other comorbidity in 1981, 1982 and 1993. From an original population-based cohort of 3481 persons who were interviewed in 1981 for psychopathology, chronic physical illness and disability, 1920 were alive and reinterviewed in 1993. In this study we were able to investigate psychiatric antecedents of a number of physical illnesses including arthritis, diabetes, migraine and coronary heart disease. For example, persons with major depressive disorder had a 2.2 fold increase in risk for incident type II diabetes mellitus[13]. Also, the risk for new myocardial infarction was increased 2.1 fold in persons with dysphoria and 4.5 times for those with a history of major depressive disorder[14].

In a recent analysis, the interaction between antecedent psychiatric illness and chronic illness as determinants of incident disability was studied. There was a significant independent effect of antecedent major depression on activities of daily living disability. The effect of psychopathology

Follow-up Study in Baltimore provides us an opportunity to test these relationships using a more systematic approach.

At the conclusion of this presentation we will highlight the need for an integrated approach in epidemiologic research in such complex situations and some issues related to the future of psychiatric epidemiology in this region.

Psychopathology in Disaster Situations

There is a rich literature of studies that have looked at the relationship of disasters to psychopathology. Whether it is following a hurricane, an earthquake or war, it is well established that as a result of a major disaster there is a high level of psychopathology in the exposed population[3].

Psychopathology in Wartime

A number of studies have reported increased psychiatric illness in persons exposed to war stress. These reports include high rates of psychiatric disorders among concentration camp survivors following the Second World War[4,5], in East European refugees[6], and in Vietnamese evacuees[7]. Many of these studies have a clinical focus and few are population based.

While the protracted war in Lebanon was in progress, we have conducted a number of investigations that have assessed the role of stressors on illness in the population. During the siege of Beirut, in the summer of 1982, we conducted an Emergency Health Surveillance Project that was designed to provide ongoing information on the health status of Beirut residents and to quickly identify health problems requiring assistance and intervention[8]. As part of this project we conducted a population based household survey of about 1,345 families in Beirut and its suburbs. The analysis of data from this population survey revealed, that parallel to high rates of common infections, this population also reported high rates of psychological distress symptoms[9]. The frequency of these symptoms in this population was related to worsening physical health and loss of home and income.

In a separate study of children in schools and orphanages in Beirut, and using various psychological tests, it was observed that being disadvantaged in wartime, like in an orphanage, increased the probability of the child having psychological problems[10].

Psychopathology Following an Earthquake

Psychiatric morbidity, particularly post-traumatic stress disorders (PTSD) following disasters are a major public health problem. Estimates of PTSD following disasters vary between 2 and 60 percent[11]. Although measurement issues may explain some of the differences in these estimates, it is more probable that these could result from differences in the nature of the disaster and the sociocultural environment within which these disasters occur.

Following the earthquake of December 7, 1988, in Armenia, we embarked on a number of population based epidemiological studies of the determinants of death and injury during the earthquake as well as of the long term effects of the earthquake in a cohort of 33,000 survivors of the disaster. Within this population, a geographically stratified sample of 1,785 persons between the ages of 16 and 70 were

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Leading Article:

Psychopathology and Physical Illness in Disasters and within the Inner City

Haroutune K. Armenian

دراسة للاضطرابات النفسية والجسدية في الكارثة

هاروتون أرمنيان

Introduction

The information gained from investigations of unexpected patterns of disease, like epidemics, has allowed us to prevent the future occurrence of such disease patterns. However, the primary concern of most epidemiologic research nowadays is not with the unusual patterns of disease but with the most common endemic priority problems. One approach for investigating such common problems is to focus on unusual situations in human populations where one may be able to learn from associations observed under a set of circumstances that are different from those where a majority of the cases occur. Epidemics may occur as a result to unusual exposure patterns but these may also happen in a subgroup of the population that is susceptible for the disease even under regular exposure patterns. An unusual exposure pattern may also provide an opportunity to study diseases that are endemic and highly prevalent. Unusual situations in human population sometimes provide the possibility of studying the effect of massive doses of exposure in these groups like in the population exposed to the atomic bomb in Hiroshima and Nagasaki. These unusual situations may also be associated with unusual frequencies or patterns of outcomes.

This presentation will provide examples of research that were conducted in populations that were exposed to unusual situations and/or lived in an unusual environment. These examples will focus primarily on the relationship of psychosocial stressors and mental and physical illness.

The effect of various psychosocial stressors on mental and physical illness is well documented by a number of clinical investigations and few population based epidemiological studies. There are a number of issues that epidemiologists have to deal with within the context of some of the complex relationships that exist between psychosocial stressors and mental and physical illness. Some of these issues are definitional and involve classification of outcomes, others deal with measurement. However, some of the most critical problems in conducting epidemiological research in this arena relate to the logistic and other difficulties of implementing such research in the field[1,2].

Our presentation of epidemiologic research done during the civil war in Lebanon and investigations following the 1988 earthquake in Armenia, illustrate the potential for learning about the role of massive environmental stressors on both physical and mental health from such research. Our current investigations from within the Epidemiologic Catchment Area

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Manuscripts

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

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

Page1: Title, running head (Max: 40 letters), title or article in English and names of authors, without titles or addresses.

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

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

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

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

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

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EDITORIAL LETTER

On behalf of the Arab federation of Psychiatrists and the editorial board of the Journal, may I thank all the authors who contributed to the journal and made it a reality.

As we are celebrating the tenth anniversary of the journal, the active role of all Arab psychiatrists is tremendously required to get the accreditation of the journal by international indices, and promoting it is cause.

Your contributions in articles, papers at one hand and subscription to the journal on the other hand is highly appreciated.

God Bless you all.

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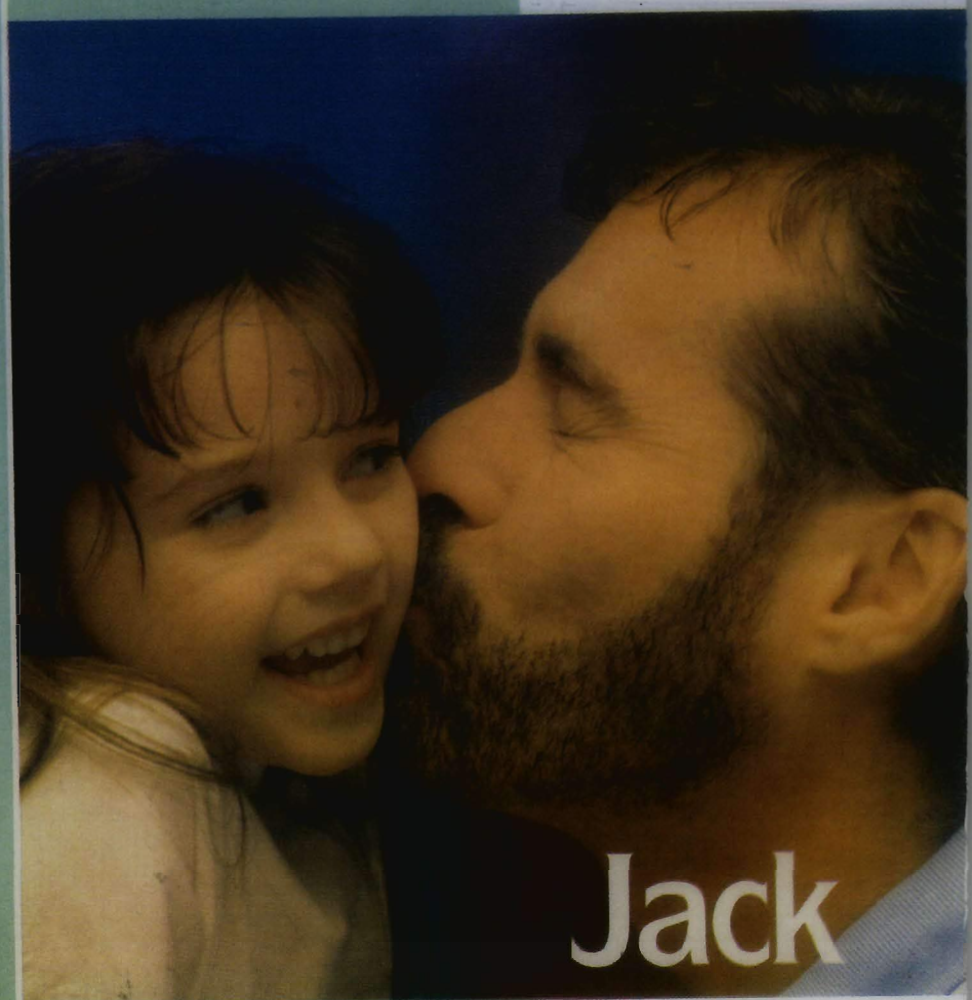

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