

sadness
crying

difficulty
to sleep

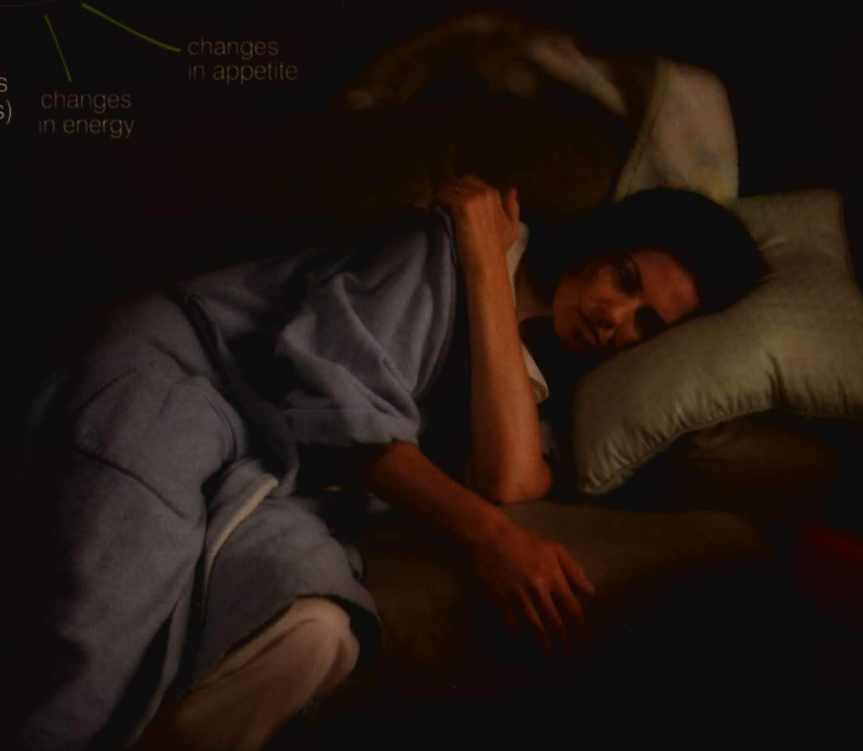
stressed
nervousness

changes
in appetite

changes
in energy

vague aches and pains
(headache, back, limbs)

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THE ARAB JOURNAL OF PSYCHIATRY



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1. اسماعيل، عزت (1984). جنوح الأحداث، وكالة المطبوعات: الكويت.

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الرازي طبيب العرب الأول

وليد سرحان

الملخص:

ينتمي أبو بكر الرازي إلى القرن الثالث الهجري و يعد طبيب العرب الأول ، فقد ذاع صيته و انتشرت كتبه في الطب و الكيمياء و الفيزياء و الفلسفة ، و ترك ما يزيد عن المائتين و عشرين مخطوط ضاع معظمها ، و كان للرازي إهتماماً بالطب النفسي و له كتاب الطب الروحاني.

حياته و نشأته

لقد سجل مؤرخوا الطب و العلوم في العصور الوسطى آراء مختلفة ومتضاربة عن حياة أبي بكر محمد بن زكريا الرازي، ذلك الطبيب الفيلسوف الذي تمتاز مؤلفاته وكلها باللغة العربية ، بأصالة البحث وسلامة التفكير . وكان مولده في بلدة الري ، بالقرب من مدينة طهران الحديثة. وعلى الأرجح أنه ولد في سنة (2 هـ/ 865 م). وكان من رأي الرازي أن يتعلم الطلاب صناعة الطب في المدن الكبيرة المزدهمة بالسكان ، حيث يكثر المرضى ويزاول المهرة من الأطباء مهنتهم . ولذلك أمضى ريعان شبابه في مدينة السلام، فدرس الطب في بیمارستان بغداد . وقد أخطأ المؤرخون في ظنهم أن الرازي تعلم الطب بعد أن كبر في السن . وتوصل ألبير إسكندر إلى معرفة هذه الحقيقة من نص في مخطوط بخزانة بودليانا بأكسفورد ، وعنوانه " تجارب بیمارستان " مما كتبه محمد بن ببغداد في

حداثته " ، وفيها يشهد أسلوبه بالإعتداد برأيه الخاص . وبعد إتمام دراساته الطبية في بغداد، عاد الرازي إلى مدينة الري بدعوة من حاكمها، منصور بن إسحاق، ليتولى إدارة بیمارستان الري. وقد ألف الرازي لهذا الحاكم كتابه "المنصوري في الطب" ثم "الطب الروحاني" وكلاهما متمم للآخر، فيختص الأول بأمراض الجسم، والثاني بأمراض النفس. واشتهر الرازي في مدينة الري، ثم انتقل منها ثانيه إلى بغداد ليتولى رئاسة بیمارستان المعتضدي الجديد ، الذي أنشأه الخليفة المعتضد بالله (279- 289 م / 892- 902 م). وعلى ذلك فقد أخطأ ابن أبي أصيبعة في قوله أن الرازي كان ساعوراً للبيمارستان العضدي الذي أنشأه عضد الدولة (توفي في 372 هـ/ 973 م)، ثم صحح ابن أبي أصيبعة خطأه بقوله "والذي صح عندي أن الرازي كان أقدم زماناً من عضد الدولة، ولم يذكر ابن أبي أصيبعة البيمارستان المعتضدي إطلاقاً في مقاله المطول في الرازي^{1,2}.

وتنقل الرازي عدة مرات بين الري وبغداد- تارة لأسباب سياسية- وأخرى ليشغل مناصب مرموقة لكل من هذين البلدين. ولكنه أمضى الشطر الأخير من حياته بمدينة الري، وكان قد أصابه الماء الأزرق في عينيه، ثم فقد بصره وتوفي في مسقط رأسه إمامي سنة (313 هـ/ 925 م)، وإما في سنة (320 هـ/ 932 م)!

كتابه "المنصوري في الطب" ما هذا نصه: "هذه صناعة لا تمكن الإنسان الواحد إذا لم يحتذ فيها على مثال من تقدمه أن يلحق فيها كثير شيء ولو أفنى جميع عمره فيها لأن مقدارها أطول من مقدار عمر الإنسان بكثير. وليست هذه الصناعة فقط بل جل الصناعات كذلك. وإنما أدرك من أدرك من هذه الصناعة إلى هذه الغاية في الوف. من السنين الوف، من الرجال. فإذا اقتدى المقتدي أثرهم صار أدركهم كلهم له في زمان قصير. وصار كمن عمر تلك السنين وعنى بتلك العناية. وإن هو لم ينظر في إدراكهم، فكم عساه يمكنه أن يشاهد في عمره. وكم مقدار ما تبلغ تجربته واستخراجه ولو كان أذكى الناس وأشدهم عناية بهذا الباب. على أن من لم ينظر في الكتب ولم يفهم صورة العلل في نفسه قبل مشاهدتها، فهو وإن شاهدها مرات كثيرة، أغفلها ومر بها صفحاً ولم يعرفها البتة" ويقول في كتابه "في محنة الطبيب وتعيينه"، نقلاً عن جالينوس "وليس يمنع من عني في أي زمان كان أن يصير أفضل من أبوقراط".

كتب الرازي الطبية

يذكر كل من ابن النديم والقفطي أن الرازي كان قد دون أسماء مؤلفاته في "فهرست" وضعه لذلك الغرض. ومن المعروف أن النسخ المخطوطة لهذه المقالة قد ضاعت مع مؤلفات الرازي المفقودة. ويزيد عدد كتب الرازي على المائتين و عشرين كتاب، في الطب والفلسفة والكيمياء وفروع المعرفة الأخرى. ويتراوح حجمها بين الموسوعات الضخمة والمقالات القصيرة ويجدر بنا أن نوضح

ويتضح لنا تواضع الرازي وتقشفه في مجرى حياته من كلماته في كتاب "السيرة الفلسفية" حيث يقول: "ولا ظهر مني على شره في جمع المال وسرف فيه ولا على منازعات الناس ومخاصماتهم وظلمهم، بل المعلوم مني ضد ذلك كله والتجافي عن كثير من حقوقي. وأما حالتي في مطعمي ومشربي ولهوي فقد يعلم من يكثر مشاهدة ذلك مني أنني لم أتعد إلى طرف الإفراط وكذلك في سائر أحوالي مما يشاهده هذا من ملابس أو مركوب أو خادم أو جارية، وفي الفصل الأول من كتابه "الطب الروحاني"، "في فضل العقل ومدحه"، يؤكد الرازي أن العقل هو المرجع الأعلى الذي نرجع إليه، "ولا نجعله، وهو الحاكم، محكوماً عليه، ولا هو الزمام، مزموماً ولا، وهو المتبوع، تابعاً، بل نرجع في الأمور إليه ونعتبرها به ونعتمد فيها عليه".

كان الطبيب في عصر الرازي فيلسوفاً، وكانت الفلسفة ميزاناً توزن به الأمور والنظريات العلمية التي سجلها الأطباء في المخطوطات القديمة عبر السنين، وكان الرازي مؤمناً بفلسفة سقراط الحكيم (469 ق.م - 399 ق.م)، فيقول، أن الفارق بينهما في الكم وليس في کیف. ويدافع عن سيرة سقراط الفلسفية، فيقول: أن العلماء إنما يذكرون الفترة الأولى من حياة سقراط، حينما كان زاهداً وسلك طريق النساك. ثم يضيف أنه كان قد وهب نفسه للعلم في بدء حياته لأنه أحب الفلسفة حباً صادقاً، ولكنه عاش بعد ذلك معيشة طبيعية.

كان الرازي مؤمناً باستمرار التقدم في البحوث الطبية، ولا يتم ذلك، على حد قوله، إلا بدراسة كتب الأوائل، فيذكر في

الطب" ، وكتاب "الجدي والحصبة" ، وكتاب "الأدوية المفردة" ، وقد وجدت أصولها جميعاً في مذكرات "الحاوي في الطب".

ومما يدل على أن "الحاوي في الطب" لم يكن إلا مجموعة من المذكرات الخاصة، أن القارئ يجد ملاحظات إكلينيكية عن أمراض ووعكات إصابات الرازي نفسه كما دون الرازي فيها بيانات مفصلة عن حالات مرضاه. ومن المعروف أنه كان يؤمن بسرية المهنة، كما ذكر ذلك في كتابه "في محنة الطبيب وتعيينه" فليس من المعقول إذن أن يثبت هذه الأسرار في كتاب يعده للنشر ويضمنه أسماء مرضاه من ذكور وإناث، وفيه وصف دقيق لما يشكوه كل مريض، مع بيانات اجتماع مميزة كالمهنة ومكان السكن وسن المريض.²

الجامع الكبير:

وأما الرازي يذكر عنوان كتابه "الجامع الكبير" عدة مرات، بل يحدد السنين الطويلة التي قضاها في تأليف هذه الموسوعة الضخمة. فيقول في كتابه "السيرة الفلسفية": وأنه بلغ من صبري وإجتهادي أنني كتبت بمثل خط التعاويذ في عام واحد أكثر من عشرين ألف ورقة وبقيت في عمل "الجامع الكبير" خمس عشرة سنة أعمله الليل والنهار حتى في ضعف بصري وحدث على فسخ في عضل يدي يمناني في وقتي هذا عن القراءة والكتابة. وأنا على حالي لا أدعها بمقدار جهدي وأستعين دائماً بمن يقرأ ويكتب لي وفي موضع آخر من كتاب "السيرة الفلسفية" يذكر الرازي عناوين

هنا الإبهام الشديد الذي يشوب كلا من "الحاوي في الطب" و "الجامع الكبير". وقد أخطأ مؤرخو الطب القدامى والمحدثون في إعتبار العنوانين كأنهما لكتاب واحد فقط، وذلك لترادف معنى كلمتي الحاوي والجامع¹.

التعريف بمادة "الحاوي في الطب" :

يتوفر الدليل في مادة "الحاوي في الطب" على أنها لمذكرات شخصية سجل الرازي فيها آراءه الخاصة، وقصص مرضاه، كما دون فيها مقتطفات من كتب الطب التي قرأها، من مؤلفات أبوقراط إلى كتب معاصريه من الأطباء. وبذلك فقد حفظ لنا الرازي من الضياع مادة بعض الكتب التي فقدت أصولها اليونانية منذ قرون عديدة . ويوحى ترتيب المادة العلمية في هذه المذكرات بأن الرازي كان يدون ملاحظاته في كراسات يضعها في حافظات. وكانت كل حافظة من حافظات الأوراق مخصصة لموضوع من الموضوعات الطبية، وترتيبها جميعاً على نظام خاص، من القرب إلى القدم وكان الرازي يدون كل ما يقرأ - حتى تلك الآراء التي حكم بطلانها . فكان يسجل هذه مشفوعة بنقد يكتبه بوضوح تام لا لبس فيه، بعد كلمته الماثورة: "لي". وكثيراً ما نقح الرازي المادة التي نقلها من المراجع، مسجلاً تلك العبارات المنقحة عقب قوله "لي مصلح". وبذلك فقد ضرب لنا المثل الأعلى في الأمانة العلمية ذاكرة ماله وما لغيره من الأطباء والفلاسفة. واستعان الرازي بمذكراته الخاصة في تأليف كتبه الطبية التي تمتاز بجمال الأسلوب وأصالة المادة، مثل كتاب "القولنج" ، وكتاب "المنصوري في

كتاب "في الفصد والحجامة" :

ألف جالينوس (130 م تقريباً - 200 م تقريباً) كتاباً (في الفصد في ثلاثة مقالات، وخصص المقالين الأولى والثانية من هذا الكتاب لمناقضة أرسطوطاليس من مدرسة الإسكندرية القديمة، القرن الرابع ق. م - القرن الثالث ق. م)، ثم تلاميذ أرسطوطاليس وكانوا جميعاً يمنعون من الفصد، ظناً منهم بأنه يجلب المرض .

وكان الرازي يؤمن بأن الفصد مفيد لعلاج بعض الأمراض. كتاب " في الفصد والحجامة" أربع عشرة مقالة - بحثاً عن تجربة المقارنة التي دونها في مذكراته الخاصة "الحاوي في الطب" ².

كتاب "في الشكوك على جالينوس"

هذا كتاب غزير المادة، ولم يطبع حتى الآن. وينقد الرازي في هذا الكتاب ثمانية وعشرين كتاباً من كتب جالينوس، أولها كتاب "البرهان" ، وآخرها كتاب "النبض الكبير" وأن مقتطفات الرازي من كتاب "البرهان" لجديرة بالدراسة المتعمقة، فقد كان الجزء الأكبر من هذا الكتاب الفلسفي مفقوداً في زمان حنين بن إسحاق (192-260 هـ 808 — 873 م) الذي ترجم ما عثر عليه من النصوص اليونانية لبعض مقالات هذا الكتاب. ويقول حنين ابن إسحاق أنه سافر إلى مدينة الإسكندرية ، باحثاً عن المخطوطات النادرة الوجود لهذا الكتاب القيم.

الطب الروحاني:

فيعتبر من أهم كتبه بعد كتابيه «الحاوي - والمنصوري» وقد ألفه وهو مقيم بمدينة السلام بغداد، وقد عرّف غايته من التأليف

بعض مؤلفاته الطبية كنموذج لكتبه التي يفخر ويعتز بها، قائلاً: «وكتابنا في "الأدوية الموجودة" والموسوم "بالطب الملوكي" والكتاب الموسوم "بالجامع" الذي لم يسبقني إليه أحد من أهل المملكة ، ولا أحتذي فيه أحد بعد احتذائي وحذوي، وكتبنا في صناعة الحكمة التي هي عند العامة الكيمياء وبالجملة فقرابة مانتى كتاب ومقالة ورسالة خرجت عني إلى وقت عملي على هذه المقالة في فنون الفلسفة من العلم الطبيعي والإلهي».

وعلى ذلك، فيتضح جدياً مما سبق من الأدلة، وكلها من كتب الرازي، أنه ألف موسوعة طبية أطلق عليها اسم "الجامع الكبير" في اثني عشر جزءاً على الأقل. وكان يعد العدة لكتابة آخرين من أجزاء "الجامع الكبير"، أحدهما "الجامع في العين" والثاني "الجامع في الحميات" ، إلا أنه توفي قبل أن يحقق تلك الأمنية.

قد وجدت في مخطوطات "الحاوي في الطب" مسودات لجزأين كاملين من أجزاء "الجامع الكبير" وهما: كتاب "صيدلية الطب" وكتاب " في إستنباط الأسماء والأوزن والمكاييل المجهولة الواقعة في كتب الطب" كما وجدت مسودات كتاب "الجامع في الحميات" الذي كان ينوي الرازي نشره كجزء من أجزاء "الجامع الكبير". ووجدت في مخطوطات "الحاوي في الطب" أيضاً مسودات كتب أخرى غير هذه، لم ينشرها الرازي إطلاقاً، وهي كتبه "في البول" وفي البحران وأيامه" ، و " في تدبير الناقة" ².

وأعظم آفاق العقل وذلك أنه يقول النفسين، أعني الشهوانية والغضبية. في هذا النص يمزج «الرازي» المعرفة الطبية والنفسية ليقدم لنا خلال تحليله للسكر وحالاته رؤية عميقة ومعرفية لحال من أخذته الخمرة ونسي ذاته.

الرازي طبيب العرب الأول

يعدُّ الرازي من الروّاد الأوائل للطب، ليس بين العلماء المسلمين فحسب، وإنما في التراث العالمي والإنساني بصفة عامة، ومن أبرز جوانب ريادة الرازي وأستاذيته وتفردته في الكثير من الجوانب أنه:

* يعدُّ مبتكر خيوط الجراحة المعروفة بالقصاب.

* أول من صنع مراهم الزئبق.

* قدم شرحاً مفصلاً لأمراض الأطفال والنساء والولادة والأمراض التناسلية وجراحة العيون وأمراضها.

* كان من روّاد البحث التجريبي في العلوم الطبية، وقد قام بنفسه ببعض التجارب على الحيوانات كالقروء، فكان يعطيها الدواء، ويلاحظ تأثيره فيها، فإذا نجح طبقه على الإنسان.

* عني بتاريخ المريض وتسجيل تطورات المرض؛ حتى يتمكن من ملاحظة الحالة، وتقديم العلاج الصحيح له.

* كان من دعاة العلاج بالدواء المفرد (طب الأعشاب والغذاء)، وعدم اللجوء إلى الدواء المركّب إلا في الضرورة، وفي ذلك يقول: "مهما قدرت أن تعالج بدواء مفرد، فلا تعالج بدواء مركّب".

* كان يستفيد من دلالات تحليل الدم والبول والنفض لتشخيص المرض.

* استخدم طرقاً مختلفة في علاج أنواع الأمراض.

بأنها إصلاح أخلاق النفس. يبدأ «الرازي» كتابه هذا في توضيح فضل العقل ومدحه حيث يقول: أن الباري عزّ اسمه إنما أعطانا العقل وحبانا به، لننال ونبلغ به من المنافع العاجلة والآجلة غاية ما في جوهر مثلنا نيله وبلوغه، وأنه أعظم نعم الله عندنا وأنفع الأشياء لنا وأجداها علينا، فبالعقل فضلنا على الحيوان غير الناطق» إلى أن يقول: فعلينا أن لا نحطه عن رتبته ولا ننزله عن درجته، ولا نجعله وهو الحاكم محكوماً عليه.

ثم يبدأ في الفصل الثاني: في قمع الهوى وردعه، حيث يقول: إن أشرف الأصول وأجلها وأعونها على بلوغ غرض كتابنا هذا: قمع الهوى ومخالفة ما يدعو إليه الطباع، وتمارين النفس على ذلك. وهكذا يفند «الرازي» كيف أن على الإنسان ألا يتبع هواه بل يتبع عقله، ويستشهد بأقوال الفلاسفة وبخاصة أفلاطون، إلى أن يصل بقوله: «فزم الهوى وردعه واجب في كل رأي وعند كل عاقل وفي كل دين».

ويستمر في فصله الخامس «في العشق والإلف وجملة الكلام في اللذة» في الهجوم على من لا يكبح جماح نفسه فيقول: إن العشاق يجاوزون حد البهائم في عدم ملكة النفس وزم الهوى وفي الإنقياد للشهوات وهم مع طاعتهم للهوى وإيثارهم اللذة وتعبدهم لها، يحزنون من حيث يظنون أنهم يفرحون، ويألمون من حيث يظنون أنهم يلذون.

ولكن النص الرابع عشر، جاء «في السكر»: إن إدمان السكر ومواترته أحد العوارض الرديئة المؤدية بصاحبها إلى المهالك والبلايا والأسقام الجمة وبالجملة، فإن الشراب من أعظم مواد الهوى،

على أساس أن له بعد الموت حياة فيها سعادة أو شقاء، فعليه أن لا يتبع الهوى الذي يدعوه إلى إثارة اللذات الحاضرة، بل يتبع العقل ويقتني العلم ويستعمل العدل، وهذا هو، كما يقول الرازي، "ما يريده خالقنا الرحيم الذي منه نرجو الثواب ونخاف العقاب". وخلصه السيرة الفلسفية، هي أن يكون الإنسان في أفعاله مقتدياً بخالقه، عادلاً رحيماً رؤوفاً. أما عن تفصيل هذه السيرة، فإنه يحيلنا إلى كتاب "الطب الروحاني" الذي اقترح عليه الأمير منصور بن نوح الساماني أمير خراسان أن يكتبه ويسميه بهذا الاسم، "ليكون قريناً لكتاب "المنصوري" الذي غرضه في الطب الجسماني وعديلاً له، لما قدّر الأمير، في ضمه إليه، من عموم النفع وشموله للنفس والجسد"، وأساس ذلك ما كان يؤمن به الرازي من علاقة وثيقة بين سلامة النفس وسلامة الجسد وتأثير الأحوال النفسية في البدن، كما سنرى في بعض معالجاته النفسية.

وهو يؤسس طبيته النفسية - الأخلاقي على ضرورة استعمال العقل الذي فضل الله به الإنسان على سائر المخلوقات، وبه توصل الإنسان إلى العلوم والصناعات، وهذا يقتضي أن يكون هو الحاكم في تدبير حياة الإنسان والداعي إلى السيطرة على الهوى في متابعته للشهوات والتحكم فيها بالفكر والروية والرياضة، لأن متابعة الشهوات والتفنن في تحصيلها ينزل بالإنسان إلى مستوى البهائم.

وللرازي رأي في اللذة، وهو أنها ليست شيئاً إيجابياً، بل مجرد راحة من ألم طرأ فكثرت الحالة الطبيعية، فلا يصح أن يطلب الإنسان من اللذات إلا بمقدار الحاجة، لكي يمارس حياة الفكر والمعرفة.

* اهتم بالنواحي النفسية للمريض، ورفع معنوياته ومحاولة إزالة مخاوفه من خلال استخدام الأساليب النفسية المعروفة حتى يشفى، فيقول في ذلك: "ينبغي للطبيب أن يوهم المريض أبداً بالصحة ويرجيه بها، وإن كان غير واثق بذلك، فمزاج الجسم تابع لأخلاق النفس".

كما اشتهر الرازي في مجال الطب الإكلينيكي، وكان واسع الأفق في هذا المجال، فقد فرق بشكل واضح بين الجدري والحصبة، وكان أول من وصف هذين المرضين وصفاً دقيقاً مميزاً بالعلاجات الصحيحة.

قالت عنه المستشرق الألمانية (زيغريد هونكه) في كتابها "شمس العرب تسطع على الغرب": "في شخصية الرازي تتجسد كل ما امتاز به الطب العربي وما حققه من فتوحات علمية باهرة. فهو الطبيب الذي عرف واجبه حق المعرفة، وقُدس رسالته كل التقديس، فمالت عليه نفسه وجوانب قلبه، وهو ينقذ المعوزين ويساعد الفقراء. إنه الموسوعي الشمولي الذي استوعب كل معارف سالفه في الطب وهضمها وقدمها للإنسانية أحسن تقديم، وهو الطبيب العملي الذي يعطي للمراقبة السريرية أهميتها وحقها، وهو الباحث الكيميائي المجرب الناجح، وهو أخيراً المنهجي في علمه الذي أضفى على الطب في عصره نظاماً رائعاً ووضوحاً يثير الإعجاب"³.

الرازي الطبيب العربي الأول كان يأخذ بالبعد النفسي للإنسان ولا يقلل من شأنه في مواجهة البعد الجسدي.

وفي كتابه "السيرة الفلسفية"، دافع الرازي عن سيرته الشخصية وعن أسلوب حياة الفيلسوف، ورسم أسلوباً لحياة الإنسان

يستجيز أحد أن يكون العشق من مناقبهم وفضائلهم.

فإذا سألنا الرازي عن العلاج، فإنه يوجهنا إلى ضرورة الوقاية من المرض قبل وقوعه، "الواجب في حكم العقل... المبادرة في منع النفس وزمها عن العشق قبل وقوعها فيه وفطمها منه إذا وقعت فيه قبل استحكامه فيها، وكذلك في الإلف: الإحتراس منه يكون بالتعرض لمفارقة المصحوب حالاً بعد حال، وبأن يدرج الإنسان نفسه إلى ذلك ويمر بها عليه.

ويتحدث الرازي في علاج كثير من الأمراض النفسية - الخلقية، مما لا يتسع المقام الدخول فيه، ولكن يحسن أن نشير إلى طريقته في العلاج وأن نذكر بعض الأمثلة:

فهو يعمد إلى تحليل الرذائل ويعتبرها "عوارض نفسية رديئة"، كالعجب والحسد والبغض، ويشرح أسبابها ثم يصف العلاج، كما يعالج بعد ذلك كثيراً من "العوارض النفسية السيئة": الغضب، الكذب، البخل، الغم، والشره، وغير ذلك، ويذكر بلایا السكر والجماع... وهو في ذلك يهيب بالإنسان أن يستعمل عقله وأن يستعين بالقوى الرفيعة الشريفة في نفسه على القوى الدنيئة، خصوصاً الشهوانية، وأن يتدرّع بهمة أولى العزم الذي يتأكد في النفس وتستجيب له كل الميول والرغبات.

ولا ينسى هذا الطبيب الفيلسوف أن يحاول دفع الغم بسبب الموت، ويقول إن هذا العارض لا يمكن دفعه عن النفس تماماً إلا بأن تقتنع بأنها تصير بعد الموت إلى ما هو أصلح لها مما كانت فيه، وهذا، كما يقول، موضوع يطول فيه الكلام، وهو يحوج إلى دراسة المذاهب والديانات،

ويهتم الرازي بضرورة أن يتعرف المرء عيوب نفسه، وهذا لا يسهل عليه، بسبب الهوى ومحبة نفسه وإستحسانه لما يفعل، فلذلك عليه أن يلجأ إلى مربٍّ مجربٍ ويبقى تحت إشرافه ليبصّره بازالة الصفات الذميمة التي تعرض للنفس.

ثم يدخل في ذكر أنواع هذه الصفات ويحمل حملة شديدة على ما يسميه "العشق" وهو "بلية" عظيمة لما فيه من ذلة النفس، والخضوع والإستكانة وإحتمال التجني والإستطالة. ويضم الرازي إلى "العشق" ما يسميه "الإلف"، وهو ما ينشأ عن طول الصحبة من كراهة مفارقة المحبوب، وهو "بلية" أيضاً، فإذا انضم إلى العشق تعمس النزوع عنه، والإلف يزداد مع مرور الأيام ولا يحسّ به الإنسان، حتى إذا جاء الفراق ظهر على صورة ألم شديد وأذى يلحق النفس.

ويوجه الرازي نقده اللاذع إلى من يعتبرهم "الموسومين بالظرف والأدب" الذين يعارضون الفلاسفة في سيرتهم، ويزعمون "أن العشق إنما تعتاده الطبائع الرقيقة والأذهان اللطيفة، وأنه يدعو إلى النظافة واللباقة والزينة والهيئة، ويتبعون هذا ونحوه من كلامهم بالغزل من الشاعر البليغ في هذا المعنى، ويحتجون بمن عشق من الأدباء والشعراء والسراة ويتخطونهم إلى الأنبياء"، فيردّ الرازي عليهم "بأن رقة الطبع ولطافة الذهن وصفاء يعرفان ويعتبران بإشراف أصحابهما على الأمور الغامضة البعيدة والعلوم اللطيفة الدقيقة..."، وهذا لا يوجد إلا عند الفلاسفة، وهو يذكر هنا اليونان، ويلاحظ أن العشق في جملتهم أقلّ مما في جملة سائر الأمم، فأما الأنبياء، فلا

في الوسع، بل تكليفه وتحميله لعباده دون ذلك كثيراً⁴.

عالم في الفيزياء و الكيمياء:

وقد ذكر ابن أبي "أصيبعة" في عيون الأنبياء، أن الرازي قدم في كتاب "كيفية الإبصار" قلب نظرية الإبصار، وقد قال في هذا الكتاب: "لأول مرة في التاريخ بأن الإبصار لا يكون شعاعاً يخرج من العين إلى الجسم، بل على النقيض من ذلك، إن الشعاع أو الضوء يخرج عن الجسم المرئي، وقد نقض في هذا الكتاب نظرية إقليدوس في المناظر، ومن الجدير ذكره أن الرازي كان أقدم عهداً من ابن الهيثم وبما يتعلق بهذه النظرية بسبعة قرون.

إخترع الرازي المكثاف الذي يستعمل لقياس الأوزان النوعية للسوائل ومعرفة كثافتها، وقد سماه الرازي "الميزان الطبيعي". بدأ حب الكيمياء عند الرازي قبل الطب بدافع السعي وراء تحويل المعادن الرديئة القليلة الثمن إلى معادن نفيسة كالذهب والفضة

ويهتم بالكلام مع من يعتقد أن النفس تقنى بفناء الجسد، وأنه إذا كان يخاف الموت فإن خوفه لا أساس له من العقل.

وإذا كان الموت لا بد منه، فإن الإنسان الذي يفكر فيه لا يزال يلحقه الغم، وهو أنه لكثرة تصوره للموت كأنه يموت موتاً بعد موت كلما فكر فيه، فالأجدر به أن يتأساه ويتلطف في الإحتيال لدفع الغم عن نفسه. والمهم أنه، بحساب الإعتقاد بمصير وعاقبة بعد الموت، يجب " أن لا يخاف منه الإنسان الخير الفاضل المكمل لأداء ما فرضت عليه الشريعة المحقة، لأنها قد وعدته الفوز والراحة والوصول إلى النعيم الدائم".

أما الذي يشك في صحة الشريعة، فليس له إلا البحث والنظر، "فإن أفرغ وسعه وجهده غير مقصر ولا وان، فإنه لا يكاد يعدم الصواب، فإن عدمه - ولا يكاد يكون ذلك - فانه تعالى أولى بالصفح عنه والغفران له، إذ كان غير مطالب بما ليس

Abstract:

Abu -Baker Al-Razi had lived in the third Hijra century ,was considered as the first physician ,in the Arabic Islamic civilization, he was famous and his books were widely spread covering medicine chemistry ,physics and philosophy ,he wrote more than 220 books most of them were lost, Al-Razi had special interest in psychiatry and wrote a book on spiritual medicine.

المراجع:

موقع :

- 1- ويكيبيديا- الموسوعة الحرة.
- 2- البيرزكي اسكندر -دراسة تحليلية لمؤلفات الرازي - موقع إسلام ست.
- 3- محمد سطات الفهد- الجمعية السعودية لطب الأسرة والمجتمع - موقع الجمعية.
- 4- موقع مكتب سماحة العلامة المرجع السيد محمد حسين فضل الله دام ظله.

وليد سرحان

مستشار الطب النفسي

ص.ب 541212 أبو نصير 11937 عمان - الأردن

Sarhan@nets.com.

مراجعة كتاب المرشد إلى فحص المريض النفسي محمد أحمد الفضل الخاني

صدر هذا الكتاب عام 2006 عن منشورات الحلبي الحقوقية في بيروت و يقع في أربعمئة صفحة من القطع الكبير ، و قد جاء هذا الكتاب تنويجاً لجهود الدكتور الخاني الذي بدأها عام 1979 بترجمة فحص الحالة العقلية الحاضرة، ثم طبعت النسخة العربية لهذه الطريقة في بحث حوادث الحياة و ظهور مرض الفصام ، و في عام 1996 تبعها في إستكمال تعريب جداول التقييم السريري النفسي العصبي و التي محورها هو فحص الحالة العقلية الحاضرة المراجعة العاشرة .

يقع الكتاب في ثلاث أجزاء:

الجزء الأول: يتكون من خمسة فصول يبدأ بفحص المريض النفسي و العلاقة بين المريض و الطبيب النفسي، و تجاوب المريض مع المعاينة و يقدم نموذجاً لتسجيل معلومات المعاينة التي تمت و يوضح المفاهيم و المصطلحات المتعلقة بفحص المريض النفسي.

الجزء الثاني: (القسم الأول) يشمل على سبعة عشر مجموعة ، تشمل أهم الإضطرابات النفسية ، الأعراض الجسد نفسية ،إضطرابات الأكل و النوم و الجنس، الأعراض النفسية اللاواعية و أعراض الخوف و الوسواس و الإضطرابات التالية للصدمات ، و أعراض الإضطرابات الوجدانية و إضطرابات الشخصية ، و إضطرابات السلوك الاجتماعي و الإدمان و إضطرابات الإدراك و التفكير و القدرات المعرفية ثم تقييم المظهر العام للمريض..

أما القسم الثاني من الجزء الثاني فيشمل على إسهاب في السيرة المرضية ثم الفحص الطبي السريري و الفحوصات المساعدة ، و الوصول للتشخيص.

الجزء الثالث: فقد خصص لمعينة الأطفال و المسنين و الحالات الشرعية و حالات الطوارئ.

الكتاب قيم جداً و قد بذل فيه مجهود هائل لتقديم المهارات السريرية للأطباء المتدربين والعاملين في مجال الطب النفسي ، و قد أسهب في وصف الأمراض و طرق رصدها وتدوينها و ربطها بالإضطرابات في سبيل الوصول للتشخيص الصحيح.

الكتاب كتب بلغة عربية سلسة و فيه تعريب لكمية هائلة من المصطلحات الضرورية في الطب النفسي، و لابد أن يتوفر هذا الكتاب في كل المستشفيات العربية و الجامعات و مراكز التدريب، كما أنه قراءة ممتعة و مفيدة للأطباء النفسيين من أصحاب الخبرة.

أشكر الأخ الدكتور محمد الخاني على هذا الجهد و أمل أن يستمر إنتاجه لإثراء المكتبة النفسية العربية .

وليد سرحان

مراجعة كتاب الطب النفسي المعاصر /أحمد عكاشة

صدرت الطبعة المنقحة المزيده من هذا الكتاب عن مكتبة الأنجلو المصرية في القاهرة، يقع الكتاب فيما يقارب الألف صفحة من القطع الكبير ومقسم إلى ستة عشر فصلاً. تناول الفصل الأول تطور مفهوم المرض العقلي من العصر الفرعوني حتى الإسلامي ولمحه عن خدمات الصحة النفسية المصرية، والتصنيف العالمي العاشر للإضطرابات العقلية والسلوكية والفحص السريري للحالة النفسية.

وفي الفصل الثاني تناول إضطراب القلق العام والقلق المختلط بالإكتئاب، والهلع و إضطراب القلق الرهابي وأنواع الرهاب والوسواس القهري و إضطراب الكرب وعقبى الصدمة و إضطراب التوافق والإضطرابات الإنشقاقية و التحولية، و الإضطرابات جسديه الشكل، وتناول وسائل العلاج المختلفة لهذه الإضطرابات من علاج نفسي و معرفي وسلوكي و إجتماعي وعضوي.

وفي الفصل الثالث أسهب في تقديم الفصام فيما يقارب المائة صفحة، وفي الفصل الرابع تناول الإضطرابات الوجدانية وفي الخامس تناول الإضطرابات العقلية العضوية، و أفرد الفصل السادس للإدمان و مشاكله، و كان الفصل السابع واسع غطى إضطرابات الطعام والنوم والجنس، في الفصل الثامن أعطى الأمراض السيكوسوماتية أو النفسجسدية حقها ، وفي الفصل التاسع تناول المشاكل المصاحبة للحمل والنفاس. وكان لإضطرابات الشخصية نصيب كبير في الفصل العاشر والتخلف العقلي في الفصل الحادي عشر، أما طب نفسي الأطفال والمسنين فكانا في الفصل الثاني عشر والثالث عشر، وكان الفصل الرابع العشر مخصص للصحة النفسية والوقاية ، وأما الطب النفسي الشرعي فكان في الفصل الخامس عشر، وكان الفصل الأخير متعلق بالقوانين والأخلاقيات، فأورد قانون مكافحة المخدرات وقانون حجز المصابين بالأمراض العقلية وتنظيم مهنة العلاج النفسي، وأورد قسم الطب النفسي وميثاق شرف الأطباء النفسيين، وأنهى هذا الكتاب الضخم بقائمة كبيرة من المراجع العربية والأجنبية.

والأستاذ الدكتور أحمد عكاشة علم في الطب النفسي عالمياً وعربياً ومصرياً، معروف بنشاطه العلمي الواسع، وفي هذا الكتاب أستطاع أن يوفر للمرة الأولى مرجع في الطب النفسي باللغة العربية، يفيد الدارسين والمهتمين في حقول الطب وعلم النفس والعلوم الإنسانية، كما أنه مصدر مفيد للأطباء الممارسين في مجال الطب النفسي، وله أيضاً أن يساعد من يرغبوا في ثقافة نفسية واسعة.

وهذا الكتاب هو إنجاز كبير وإضافة لسلسلة مؤلفات الأستاذ الدكتور عكاشة، وإضافة دسمه للمكتبة النفسية العربية، ولا بد من توفير هذا الكتاب في المستشفيات وكليات الطب وأن يكون في متناول كل من يقرأ لغة الضاد.

وليد سرحان

LETTER TO THE EDITOR

Dear Sir

I have read with interest the paper published in the current issue entitled: **Inpatient Psychiatric referrals from general and Specialist Hospitals in Kuwait- A Descriptive Study**

Interestingly the Authors in their introduction refer to and in their discussion compare their results with those from western culture. I would have thought it would be nice to also compare their results with those from a similar and local Arabic Culture, namely Kuwait. I am aware of at least two similar, though with different objectives, studies:

1. The first one which I was co-author of is: **"Patterns of psychiatric consultations in Kuwait general hospitals"**, which was published in the USA in **Gen Hosp Psychiatry**, 12(4):257-63, 1990 Jul. E A Al-ansari, S El-Hilu, M A El-Hihi, K I Hassan

In this study 74.4% and 11.4% of the referrals came from the departments of general medicine and general surgery respectively, which is different from the Authors' current study of 45% and 25.3 respectively. Also the most common cause of referral was assessment of suicide attempt, which is the 7th reason for referral in the Authors' current study. The third difference is that the three most common post-consultation psychiatric diagnoses were Acute situational disturbance 26%, depressive illness 19.5% and organic psychotic disorders 8.2% whereas in the Authors' current study mood disorders 27.6% were the most common diagnosis.

2. The second one is: **"Consultation liaison psychiatry in kuwait general hospitals"**, which was published in **International J. Journal of Social Psychiatry**, 35(3):274-9, 1989. A A Fido and A Mughaiseeb.

In this study, again about half the referrals were for parasuicidal behaviour. The diagnoses of depression followed by adjustment disorder predominated.

In view of the above I would ask the respected Authors if they would care to comment on the above and, if possible, try to explain, or at least hypothesize, the discrepancies in the results in two very similar Arabic cultures.

Finally, I would like to ask the Authors to please make a comment or a recommendation:

1. That Psychiatric C-L seems to be underutilized in our part of the world and this would add to the suffering of our patients and their relatives/carers and increase the financial burden of keeping them in hospitals longer than necessary.

2. **20.6%** of the referred patients had no post-consultation psychiatric diagnosis. It seems that some of our non-psychiatric colleagues make psychiatric diagnosis based on exclusion of organic/physical pathology rather than on positive evidence of psychiatric signs and/or symptoms. Therefore, psychiatrists should help their non-psychiatric colleagues in raising their awareness about psychiatric disorders in non-psychiatric settings.

Dr. Saleh M. El-Hilu, F.R.C.Psych.; Consultant
Psychiatrist/Clinical Director
Hallam Street Hospital, West Bromwich,
West Midlands B71 4NH, united kingdom

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المخلص:

بعد قصر القامة أمراً شائعاً في المجتمع. أكدت معظم الدراسات المتوفرة للبحث وجود علاقة بين قصر القامة والآثار الانفعالية والسلوكية والتعليمية وكذلك الإجتماعية السلبية. غير أن هناك عدد قليل من الدراسات أثبتت عدم وجود مثل هذه العلاقة، وعزت هذه الدراسات تلك الآثار إلى الإضطراب العضوي الرئيسي المسبب لقصر القامة وليس لقصر القامة في حد ذاته. وبالرغم من أنه ليس كل فرد قصير القامة بحاجة للتدخل النفسي والإجتماعي، لكن تقييم وجود مثل هذه الحاجة أمر يستحق البحث خاصة لدى أولئك الذين يرتادون العيادات المتخصصة باضطرابات النمو.

Correspondence to:

Dr. Fatima Al-Haidar, KSUF Psych
Associate Professor and
Child & Adolescent Consultant Psychiatrist
Department of Psychiatry # 55
King Khalid University Hospital
P.O. Box 7805, Riyadh 11472
Kingdom of Saudi Arabia
Tel: 966-1-467-1717
Fax: 966-1-467-2571
Email: alhaidar4@hotmail.com

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attributed to the non-growth hormone deficiency, with lower educational achievement and greater emotional distress. These results may indicate that short stature constitutes a psychosocial stressor for some persons, perhaps making it more difficult for them to endure additional stresses associated with graduate education and making them more vulnerable to depression and anxiety^{22, 42}.

Adults with childhood growth-hormone deficiency were significantly more disadvantaged than control with respects to social (prolong affective and financial dependence on birth family) and sport activities (preference of single sport activities rather than team sports), occupational status (high rate of unemployment and part time work). Educational achievement was similar to that control until secondary school with lower percent of university studying⁴³.

Beyond the difference in patient selection, several factors, may have contributed to the discrepancy in findings.

1-the variety of psychological instruments used,

2-various informants, including Parents, teachers and children themselves, 3-lack of adequate controls,

4-factors correlate or predict behavioral abnormality e.g. age and intelligence^{5, 28-29, 37}.

Clinics treating children with growth problems either with very short or with short normal stature need integrated psychosocial team to improve not only their final height but also their social outcome⁴⁴. However, not all short children attending clinics for growth problems need psychosocial intervention, but all of them need assessment and evaluation for such consequences⁴⁴.

Some people with short stature and growth hormone deficiency were comparing favorably with the normal stature population. Their good education and achievement was tentatively explained as a high compensatory mechanism development against feeling of inadequacy⁴⁵.

Acknowledgement:

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tal trauma has been postulated but not confirmed ³⁵.

Short preschool children from socio-economically deprived inner cities are indicated population at risk of with educational failure and persisting growth impairment. None of the children had any organic disease or disorder to account for their short stature ³⁵.

Short children have a high risk of being bullied in school. They were more than twice as likely to be victims of bullying and much more likely to say that bullying upset them. More short children were kept to themselves, which could be the cause or the result of the bullying ³¹. Few short boys and even fewer short girls would bully others ³⁶.

The rationale for association between psychosocial difficulties and short stature might include direct biological causes and indirect adverse environmental, psychological and social factors. The biological explanation suggests that intellectual, behavioral and academic deficits result from adverse neurobiological events during pregnancy affecting physical growth and brain developments or chronic ill health leading to fewer opportunities for learning³⁷. Psychosocial explanations suggest association between short stature and psychosocial disadvantage, and family adversity with later childhood growth, behavior and learning difficulties ^{33, 38}. The behavior and reactions of peers, teachers

and parents may also affect the child's perception of his or her own social skills resulting in low self-esteem and impaired behavior and academic functioning ³⁹⁻⁴⁰.

Some researchers have rejected the idea that children suffer emotional consequences directly due to their short stature ⁴⁻⁵. Sandberg et al have reported that extremes of stature have minimally detectable impact on peer perception of social behavior, friendship or acceptance in general population of school children ⁴.

Two recent studies on psychosocial adjustment of mostly non-growth hormone deficiency referred for evaluation of short stature found no evidence of significant emotional impairment among these children ^{5, 29}.

The shorter (but normal stature) children were perceived as looking younger which correlated with small increase in emotional sensitivity, victimization and passive withdrawal and small decrease in physical and verbal aggression and dominance ²⁰.

A study has shown short stature in adult affects the social and economic arenas. Short adults are also more likely to be injured in car accidents, because safety devices are designed for average-sized people ⁴¹. They have a reduced marriage rate and lower perceived competence ⁴¹.

There is association within the sample of adults who were evaluated as children for short stature and were

adults who were growth hormone deficient as children ²²⁻²³. In some studies, non-growth hormone deficient-short adults demonstrated better psychological adjustment than their growth hormone deficiency counterparts. Non-growth hormone deficiency short adults did not differ on psychosocial measures from normal – stature controls ²⁴⁻²⁵.

Evaluation of association between short stature and functional impairment was complicated by the difficulty in distinguishing whether an impairment was due directly to short stature or the underlying medical condition ³.

Most of these studies recruit children from growth clinics and had endocrinopathies or other genetic disorders ²⁶⁻²⁷. Such medical condition may increase selection bias with higher prevalence of anxious parents and children ²⁶. While other clinic based studies and children in general population did not confirm such association ^{26, 28-29}.

Numerous studies have shown children and adults affected by short stature are at a disadvantage compared with their peers ¹. During childhood, short children are at risk of being ostracized by their peers and juveniles by adults ³⁰⁻³¹.

As many as 40% of children treated with growth hormone had some form of adjustment problems ²⁰.

Children with short stature may have a variety of psychological difficulties including social isolation, nega-

tive self esteem, sense of powerlessness and incompetence, experience with being teased and behavioral problems³². Academic underachievement, behavioral problems and reduced social competency are over represented in the population of short children who are treated with growth hormone ³³.

Some studies found that most children with primary short stature scored within the normal range of functional tests. However within other studies, short stature was often associated with decreased intelligence, academic achievement and visual-motor skills ³.

In a community-based study, short children obtained lower scores on tests with verbal and non-verbal performance. These findings were related to social disadvantages ²⁶; other studies confirm the same findings despite controlling for age, social class and family size ²⁶.

Intelligence score is associated with a number of independent factors such as maternal age, low self esteem, behavioral problems, family attitudes and support networks, ethnic background and low socioeconomic status ^{26, 34}.

In short children from general population, learning difficulties and behavioral disorder associated with short stature could be related to socio-economic deprived background e.g. single parenthood, unemployment, over crowding and poverty ³⁵. Major prenatal or perina-

from major emotional and psychological trauma, for example, physical abuses, and extreme deprivations, impair child-parent relationship¹⁴⁻¹⁷. It has been associated with pituitary and hypothalamic dysfunction, possibly with interventions With nutrient deficiencies. It can cause a variety of behavioral prob-

lems such as abnormal eating habits, self-mutilation and sleep and other psychological disturbances¹⁸⁻¹⁹. It is frequently reversible when the child is placed in a nurturing, safe and stimulating environment¹⁷⁻¹⁸. The following table summarizes some problems that might be related to short stature.

Table 1 Some problems that might be related to sort stature

| Type | Problems |
|----------------------|--|
| Medical | Skeletal clysplasia Chronic kidney diseases Celiac disease Chromosomal disorders Single gene diseases Metabolic disorders Diabetes mellitus Hypothyroidism Cushing' disease Growth hormone axis abnormalities Inadequate nutrition |
| Idiopathic | Idiopathic short stature |
| Psychosocial factors | Emotional deprivation Single mother Physical abuse Impaired child- parent relationship |

Psychosocial Consequences of short stature:

There continues to be debate about whether short children suffer psychological stress from their short stature²⁰. Most reported studies on psychological effect of short stature have been conducted in the population of children who have been

referred for medical evaluation of their short stature²⁰. These short children not referred for evaluation do not experience psychological problems^{5, 21}. Most behavioral research has focused on the psychosocial studies of

gle gene disorders can result in short stature.

Psychosocial Factors related to short stature.

The association between anxiety and height could be attributed to one of three theoretical models:

1-short stature in children might predispose to anxiety,

2-anxiety in children might lead to short stature or

3- the association might result from other factors ⁷.

Adults with panic disorder, as well as major depression, have blunted growth hormone responses to challenges with clonidine which is a potent growth hormone secretory stimulus. Others have noted increment in cortisol among both anxious adults and adolescents ⁷. The association between anxiety and stature could result from these associations, because the growth hormone axis serves to stimulate growth whereas the hypothalamic-Pituitary adrenal axis inhibits growth ⁹.

Childhood growth hormone secretory profile is a major determinant of structure and clonidine, by stimulating the release of growth hormone, can treat constitutional growth delay in children effectively. If abnormalities in growth hormone axis are present in youth with anxiety or depressive disorders, they conceivably affect stature ⁷⁻⁹.

Childhood emotional disorders show greater persistence in girls ¹⁰. Therefore, adults emotional disorders, and

the neuro-endocrine abnormalities associated with these disorders may be more likely to develop in emotionally disordered girls⁷. In females, but not males, childhood anxiety consistently predict relatively short stature in adulthood ⁷.

Extensive research documents a relationship between severe psychosocial stress in the form of maternal deprivation and childhood growth retardation that is accompanied by a blunted growth hormone response to challenges. Milder stressors could impair the biological process that promotes growth^{7, 11, 12}.

Homeless children have stunted growth. They come from large families, have young single mother with drug abuse and family violence ¹³.

Failure to Thrive:

It is a significantly prolonged cessation of appropriate weight gain compared with recognized norms for age and gender after having achieved stable pattern. It is often accompanied by normal height-velocity. It is a common problem and often multi-factorial in origin. Inadequate nutrition and disturbed social interactions contribute to poor weight gain, delayed development and abnormal behavior¹⁴. Causes of failure to thrive include emotional deprivation¹⁵.

Psychosocial short Stature:

It is a variant of failure to thrive, has been described as short stature out of proportion to decreased weight. The syndrome is thought to result

Psychosocial Aspects of Short Stature: Critical Review

Fatima Al-Haidar

الجوانب النفسية والاجتماعية لقصر القامة - مراجعة نقدية
فاطمة الحيدر

Abstract:

Short stature is a common finding in general population.

Most available studies have confirmed association between short stature and emotional, behavioral, educational and social negative consequences. Few studies have rejected such association and tried to correlate such consequences to the original organic problems that lead to short stature.

Psychosocial intervention is not indicated for all short individuals but psychosocial screening is valid especially for those who attend clinics for growth problems.

Introduction:

Short stature is a common finding in the general population. It may be defined using statistical analysis of the distribution of heights at various ages. A person with short stature has a height more than two standard deviation below the population mean (-2 SD or below).

By this definition, approximately 2.5% of children have short stature. The most recent growth charts use data from third national health and nutrition examination survey¹⁻³. Growth charts that adopt the fifth percentile (-1.6 SDs) to demarcate the lower limit of the normal range for sex and age are commonly used^{2,4-5}.

General View. Although short stature frequently represents a normal variation of height in the general population⁴, the causes of it are multiple. At one extreme, a variety of skeletal dysplasia can result in ex-

treme short stature that is occasionally associated with early death and severe musculoskeletal abnormalities. Short stature may also be associated with and may possibly be a marker for severe medical diseases such as diabetes, celiac disease or chronic kidney disease. More commonly, short children have isolated or idiopathic short stature either because of a genetic tendency toward short stature (familial) or a constitutional growth delay caused by delayed onset of puberty³.

A small number of children with short stature have abnormalities in the growth hormone axis^{3,6}. Related endocrine abnormalities, such as hypothyroidism and Cushing disease may also lead to short stature⁶.

In addition, a variety of genetic disorders including chromosomal disorders, metabolic disorders and sin-

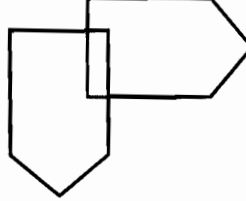
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JAMAL KHATIB, MD

Consultant Psychiatrist
Director of Psychosocial oncology program
King Hussein Cancer Center KHCC
P.O.Box 5262-11183 – Zahran
AMMAN - JORDAN
www.jkhatib-psychiatry.com
jkhatib@khcc.jo

WALID SARHAN, F.R.C.Psych.
Consultant Psychiatrist
P.O. Box 541212-Abu-Nusair 11937
AMMAN – JORDAN
Sarhan@nets.com.jo

- 1 ... 72 = 7 - 79
1 ... 65 = 7 - 72
5/ المجموع
- أو سمي أيام الأسبوع من الجمعة عودة حتى السبت
- التنكير:
5. ما هي الثلاثة أشياء التي سميتها لك من قبل ؟
- اللغة:
6. التسمية: أشر إلى " قلم " وأسأل المريض ما أسم هذا الشيء ؟
أشر إلى "ساعة اليد " وأسأل المريض ما أسم هذا الشيء ؟
7. التكرار: أطلب من المريض أن يكرر العبارة التالية "خيط حرير على حيط خليل"
8. القراءة: أكتب للمريض عبارة " أغمض عينيك " على ورقه و أطلب منه أن ينفذها
9. فهم الأوامر: أطلب من المريض أن ينفذ أمراً مكتوباً من 3 مراحل. قل له :
أ- أمسك الورقة بيدك اليمنى
ب- اطوها من النصف
ت- ثم ضعها على الطاولة
3 ...
10. الكتابة: أطلب من المريض أن يكتب جملة مفيدة فيها فعل و فاعل و مفعول به
1 ...
11. التركيب: أطلب من المريض أن يرسم الشكل التالي بعد أن تشرحه له
1 ...



المجموع الكلي 30

MMSE is the most widely used cognitive test for dementia when done by trained examiners. It should take no more than 7 minutes. Cutoff of <24 points = sensitivity of 87%, specificity of 82%. Not sensitive in patients with low education level, poor motor function, poor language skills or impaired vision . Median score related to educational level:

29 if over 9 years of school , 26 for 5-8 years, 22 for 4 years or less.

Scores range from 25-30 for normal, 21-24 for mild AD, 14-20 for moderate AD, and less than 13 in severe AD.

لمن لا يقرأ تحسب النتيجة من 25 ثم تعدل من 30 = 25*30/؟

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وصفاً (65.22%)، نوقشت النتائج في ضوء الدراسات العالمية وقدمت بعض التوصيات.

The Questnouaire:

Dear colleague we are studying the pattern of psychiatric presentation of dementia. Please respond to the following:

- | | |
|---------------------------------------|-----------------------------------|
| 1. Patients mostly. | Neuropsychiatry testing. |
| Refer themselves. | Imaging. |
| Referred by family. | Lab. tests. |
| Referred by physician. | 6. Do you use cognitive testing? |
| 2. Referring physicians are mostly. | Yes.... What test? |
| General practitioners. | No. |
| Neurologists. | 7. Drugs you prescribe are mostly |
| Internists. | Anticholine esterase inhibi- |
| 3. Most common presentation | tors. |
| Memory problems. | Antipsychotics. |
| Behavioral problems. | Antidepressants. |
| Mood problems. | Anxiolytics. |
| Personality change. | Hypnotics. |
| Sleep disturbance. | Mood stabilizers. |
| Drug side effects. | Gincobiloba. |
| 4. Patients are | Vit E. |
| Already diagnosed. | Anti-inflammatory. |
| Not diagnosed. | Others... Specify. |
| 5. On what you rely more in diagnosis | Other comment |
| Clinical. | |

Name:

Age :

Date :

فحص القدرات العقلية المصغر . MMSE

الوعي والإدراك:

- | | | |
|-----------|---|-----------------|
| 1 ... | السنة؟ | 1. ما هي |
| 1 ... | الفصل؟ | |
| 1 ... | التاريخ ؟ /؟/؟ | |
| 1 ... | اليوم؟ | |
| 1 ... | الشهر؟ | |
| 1 ... | البلد؟"شو اسم الملك؟ | 2. أين أنت الآن |
| 1 ... | المدينة؟ | |
| 1 ... | الحي/الضاحية؟ | |
| 1 ... | إحنا وين حالياً؟ اسم المكان؟ أنت عند مين؟ | |
| 10/ 1 ... | الطابق؟"طلعت درج؟" | |

التسجيل:

3. أعد من ورائي الثلاثة أشياء التالية:-
(كره، علم، شجرة). أحفظ هذه الأشياء لأنني سوف أسألك إياها مره أخرى
3/

التركيز والانتباه:

4. أ طرح 7 من 100 وحتى الوصول للعدد 65
1 ... 93 = 7 - 100
1 ... 86 = 7 - 93
1 ... 79 = 7 - 86

Discussion:

The results clearly are comparable to the research in the field with high prevalence of BPSD. Unfortunately the patients are referred by the family, mainly when the behavioral problems are difficult to manage and at the time of such BPSD the diagnosis of dementia was not yet established. This is because people are accepting the decline of memory in old persons as part of normal aging until problems arise, and this reflects the lack of awareness of the families that memory decline should be taken seriously, as some of the causes of dementia are reversible. Even if the cause is not reversible the early diagnosis will give the patient the best chance of benefiting from available treatments and services. A review of several studies reveals statistically significant and clinically meaningful advantages to initiating treatment early in the course of the disease. Epidemiologic studies and evidence from histopathology underlies a rationale for treating patients who are cognitively impaired

but do not have dementia. Clinical trial in such patients indicates that treating patients with mild cognitive impairment may delay the onset of Alzheimer's dementia⁵.

Conclusion and recommendation:

The study indicates some neglect of dementia in Jordan, and the lack of a awareness for the need to consult a specialist if the memory is declining. Only the moderate to advance cases are presented, which deprive the patient from the benefit of early proper management. We recommend the following: -

1. Public awareness activities about dementia.
2. The need for special services of care for demented patients.
3. The need for continuous medical education to improve recognition of dementia by the primary health care physicians, and may be the use of the mini mental state examination (MMSE), Arabic version, to screen all patients over 65 which only takes a few minutes.

الملخص

هذه الدراسة تهدف للتعرف على الصور السريرية التي يصل بها مرضى الخرف في الأردن للأطباء النفسيين. وقد أظهرت النتائج أن (95.65%) من المرضى قد حولوا من العائلة وكان منهم (15.22%) فقط قد شخّصوا بالخرف، وكانت الإضطرابات السلوكية هي السبب الرئيسي لوصول المرضى للأطباء (63.04%)، وكان من الواضح اعتماد الأطباء على التشخيص السريري (82.61%). وكانت مضادات الذهان العلاج الأكثر

sponded to the questionnaire and sent it back. The results were analyzed and showed that most prevalent complaints were behavioral (63.04%), followed by cognitive or memory problems (30.43%). The diagnosis of dementias was already established in (15.22%), and (84.78%) were diagnosed on presentation to the psychiatrists, which reflects the delay in presentation and the major role the psychiatrists in Jordan play in establishing the diagnosis. The diagnosis was

mainly based on the clinical examination (82.61%) and less on neuropsychiatric testing (23.91%) and (4.35%) imaging and only (2.17%) requested laboratory investigations. (23.91%) have used cognitive testing, the medications prescribed by the psychiatrists were mainly antipsychotics (65.22%) followed by anticholine esterase inhibitors (26.09%) and antidepressants (19.57%), then anxiolytics (8.7%), and (4.35%), hypnotics. The results are shown in the following table.

The Results of the Study: -

| | |
|--|--------|
| 1- Patients mostly | |
| A- Refer themselves | 0.00% |
| B- Referred by family | 95.65% |
| C- Referred by Physician | 6.52% |
| 2- Referring physicians are mostly | |
| A-General practitioners | 50.00% |
| B- Neurologists | 21.74% |
| C- Internists | 30.43% |
| 3- Most common presentation | |
| A- Memory problems | 30.43% |
| B- Behavioral problems | 63.04% |
| C- Mood problems | 2.17% |
| C- Personality change | 15.22% |
| E- Sleep disturbance | 10.87% |
| F- Drug side effects | 0.00% |
| 4- Patients are mostly | |
| A- Already diagnosed | 15.22% |
| B- Not diagnosed | 84.78% |
| 5- On what you rely more in diagnosis | |
| A- Clinical | 82.61% |
| B- Neuropsychiatry testing | 23.91% |
| C- Imaging | 4.35% |
| D- Lab tests | 2.17% |
| 6- Do you use cognitive testing? | |
| A- Yes..... What test? | 73.91% |
| B- No | 21.74% |
| 7- Drugs you prescribe are mostly | |
| A- Anticholine esterase inhibitors | 26.09% |
| B- Antipsychotics | 65.22% |
| C- Antidepressants | 19.57% |
| D- Anxiolytics | 8.70% |
| E- Hypnotics | 4.35% |

of psychological symptoms was 47 months. Mean onset of behavioral symptoms was 48 months. Behavioral disturbance seemed to cause more caregiver distress than psychological change⁴. In community based study that screened 5092 participants, it was found that (61%) had exhibited one or more mental or behavioral disturbances in the first month. Apathy (27%), depression (24%), and agitation aggression (24%). These disturbances were almost four times more common in participants with dementia than in those without. Only modest differences were observed in the prevalence of mental or behavioral disturbances in different types of dementia or at different stages of illness: Participants with Alzheimer's disease were more likely to have delusions and less likely to have depression. Agitation aggression and aberrant motion behavior were more common in participants with advanced dementia⁸.

In another study (22%) of Alzheimer's patients had delusions only, and (3%) had hallucinations only and (9%) had both delusions and hallucinations. Hallucinations we associated with less education³. It is well established that psychiatrists play a major role in diagnosis and management of dementia.

The Presentation of demented patients to the psychiatrists in Jordan has not been studied and the role of

the psychiatrists in the management of demented patient is not clear.

As more demented patients are living in Jordan with life expectancy of over 70 years, more are presenting to the psychiatrists from all types of dementia.

Studies on prevalence, neuro-psychiatric presentation and the effect on health care system and caregivers need to be addressed in research, so the planning of services for old people can be strongly based on such data.

The Study:

This study is the first in Jordan. We wanted to have a profile of dementia in psychiatric practice in Jordan, the referrals, the symptoms, the diagnosis and the management.

The Method:

A questionnaire was designed and distributed to all psychiatrists and psychiatric residents in Jordan through the Jordanian psychiatric association.

The questionnaire is composed of 8 points, 7 of them to find out the referral procedure, symptoms that patients present with, the means of the diagnosis and the management provided; one item was for personal comments. All the participants were contacted personally then the questionnaire was sent to everybody by fax or email, or by hand.

The Results:

The total number of psychiatrists and psychiatric residents is 48. Only 2 did not respond and 46 re-

totemporal dementia^{9, 6}. The natural history varies depending on the cause of dementia; however, typically, intellectual and other cognitive functions decline inexorably over 2 to 10 years. Although the decline occurs in a continuum, symptoms can be divided into mild (early), moderate and severe (late). Personality and behavioral changes may develop during any stage. Depression affects up to 40% of patients with dementia, usually where dementia is mild or moderate, and many cause vegetative symptoms (e.g.; withdrawal, anorexia, weight loss, insomnia). Depression can aggravate disability in dementia, distinguishing between cause and effect is often difficult⁹.

The Jordanian health system is not clearly organized from primary care to specialist referral system, so patients and family could seek help from general practitioners, family doctors, neurologists, neurosurgeons or psychiatrists. There are no geriatric or psychogeriatric services available and the psychiatrists are working in all the subspecialties including seeing old people with various psychiatric presentations. Any patient with dementia in our clinical experience may only reach the psychiatrists if he is agitated, psychotic or depressed, whether he has seen other specialists before or not.

When searching the literature about the behavioral and psychological

symptoms in dementia (BPSD) it appears clearly that BPSD are the clinically most significant symptoms of the illness. They are non-cognitive and include apathy, agitation, aggression, anxiety, hallucinations and delusions. BPSD are widespread and often critical with regard to life quality for the patient as well as caregiver stress. The frequency of BPSD increases as the dementia disorder progresses¹². BPSD is the major feature of Alzheimer's disease and related disorders. Diagnosis is important to enhance our knowledge of the pathophysiology of dementia and of their functional consequences for patients and caregivers. Pharmacological and non pharmacological management of dementia depends to a large extent on the presence of BPSD¹. In a study on mid and late phase Alzheimer's disease, the mean age of patients was 77 years and duration of illness 87 months. Mean MMSE was 8/30 and FAST score 6d. Of the psychological symptoms occurring at any stage, depression (56%), delusions (55%) and anxiety (52%) were most common, with hallucinations elation and disinhibition occurring less frequently. In general, behavioral changes were more common with apathy occurring in (88%) of patients, motor behavior in (70%), aggression in (66%), irritability and appetite changes in (60%) and sleep disturbance in (54%). Mean onset

Psychiatric presentation of Dementia in Jordan

Jamal Khatib, Walid Sarhan

المظاهر النفسية للخرف في الأردن

جمال الخطيب، وليد سرحان

Abstract:

The study is looking into the psychiatric presentation of dementia in Jordan, as reported by the psychiatrists and psychiatric residents. The study showed that (95.65%) of the patients are referred by the family, with only (15.22%) having an established diagnosis of dementia. Behavioral problems were the main presentation (63.04%) and the clinical approach in diagnosis was clear (82.61%). Antipsychotics were given commonly (65.22%).

The results are discussed in view of the available research and recommendations were suggested.

Key words:

Dementia, Jordan, Psychiatrist, BPSD = Behavioral and Psychological Symptoms in Dementia.

Introduction:

Jordanian demographic changes are going towards longer life expectancy like most of the developing countries, and consequently the number of persons over 65 years of age is increasing with more demented patients in the community and in the health services, including psychiatric services.

Dementia is the decline of reasoning, memory, and other mental abilities. This decline eventually impairs the ability of the person to carry out everyday activities such as driving, household chores and even personal care such as bathing, dressing, and feeding⁷. Dementia affects about 1% of people aged

60-64 years and as many as 30-50% of people older than 85 years⁷.

A practical approach to the diagnosis of dementia begins with the clinical recognition of a progressive decline in memory, a decrease in the patient's ability to perform activities of daily living, psychiatric problems, personality changes and problem behavior¹¹. There are four clinical dementia syndromes accounting for 90% of all cases, after excluding other common reversible causes of cognitive impairment². These four major diseases are Alzheimer's disease and vascular dementia, which together account for approximately 80% of dementias, dementia with Lewy body and fron-

| | | | |
|------------------------------------|--|---|---|
| | month) and attempt (life-time) and identity risk factors associated with suicidality. | years Mini International Neuropsychiatric Interview (M.I.N.I. suicidality module) with DSM-III criteria | cantly related with: non-married status (OR=54,95% CI, 2.0-15.7); a history of psychiatric disorders (OR= 5.3, 95% CI, 2.3-11.8); and not having children (OR= 2.5, 95% CI,1.1-5) <ul style="list-style-type: none"> • Most common disorders among ideates: MDD (23.5%); agoraphobia (23.5%); dysthymia (21.5%); OCD (19.6%); and GAD (19.6%) • 88.2% of those with ideation had comorbid disorder |
| Sudan Goldney et al. (1998). | Evaluate suicidal ideation (within the past few weeks) in two selected samples of Sudanese women | 29 female university students (age range:18-23) and 30 females from a displaced-persons area (age range: 8-66 years). Selection based on availability. 28 item General Health Questionnaire with 4 questions that assess recent (with in the past few weeks) suicide ideation | 55% of displaced vs. 27% of university students experienced suicide ideation within the "past few weeks" (p = 0.044) |

Note: Studies by Daradkeh (1992) and by Dabbagh (2004) were not included in the table because they did not share common outcomes listed under table.

***Correspondence:** Elie G. Karam, MD

Institute for Development Research Advocacy and Applied Care (IDRAAC)

POBox: 166227, Ashrafieh, Beirut, Lebanon 1100 2110Tel/Fax: 961 1583583

Email: idraac@idraac.org

Table 1. Community based studies on suicide ideation and attempts in the Arab World.

| Country /Author/ Year | Objective | Methods | Key results |
|---|---|---|---|
| Egypt Okasha et al. (1981) | Evaluate 12 month suicidal feelings and attempts, and their correlates in the general population. | 516 final year medical students chosen at random; age range: early to mid 20s Questionnaire composed of 5 questions that evaluate suicidal feelings of different magnitude and attempted suicide in the past year. | 12.2% had some suicidal feeling and 0.4% made a suicide attempt in the past year. Suicidal feelings: F>M (significant) and were significantly related to depressive symptoms ($p=0.001$) . <ul style="list-style-type: none"> Subjects with suicidal feelings experienced significantly more life events ($p < 0.001$), illnesses ($p < 0.001$), and used more tranquilizers/sleeping pills than the control group. |
| Lebanon Shediac-Rizakallah et al. (2000-2001) | Evaluate lifetime prevalence of suicide ideation and attempt. | 954 University Students; age range: 16-19 years; refusal rate: 0.9% Self-administered anonymous questionnaire including 15 lifestyle and risk areas (includes 12 month suicide ideation and attempt) | 13.9 % ($n=132$) had lifetime suicide ideation and 6.3% ($n=60$) had lifetime suicide attempts <ul style="list-style-type: none"> Suicide ideation: F>M ($p \leq 0.05$) |
| Lebanon Weissman/Karam et al. (1999). | Evaluate and compare lifetime rates of suicide ideation and attempts across 9 countries. | Lebanon sample was derived from 4 communities with different exposures to acts of war ($N=435$); age range: 18-64 years . Diagnostic Interview Schedule (DIS-III) with DSM-III criteria | Lebanon had the lowest lifetime prevalence of suicide ideation (2.09/100) and attempts (0.72/100) <ul style="list-style-type: none"> Suicide ideation: F>M (significant) Among depressed individuals, Lebanon had the lowest rate of suicide ideation (1.57%) and attempts (0.29%). |
| Morocco Agoub et al. (2006). | Evaluate the rate of suicide ideation (past | 800 participants (400 males and 400 females); age range: 15-80 years; mean age: 32.2 | 6.3% reported 1 month ideation and 2.1% (at least one attempt) reported lifetime suicide attempt <ul style="list-style-type: none"> Suicide ideation was signifi- |

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الملخص

تراجع هذه المقالة كل ما نشر حول موضوع الإنتحار في المجتمع العربي. وذلك عبر إجراء بحث منهجي بواسطة عدة "وسائل بحث" للمقالات المنشورة حتى عام 2006 (البحرين، مصر، العراق، الأردن، الكويت، لبنان، المغرب، سلطنة عمان، فلسطين، المملكة العربية السعودية، السودان والإمارات). تعددت النتائج وفقاً للبلدان والطرق المتبعة. أظهرت الدراسات التي أجريت على عيّنات من المجتمع في العالم العربي أن نسبة الأفكار الإنتحارية تتراوح ما بين 2.09% و 13.9% ونسبة محاولة الإنتحار تتراوح ما بين 0.72% و 6.3% وذلك خلال فترة حياة الشخص. لقد تمّ تحديد العديد من العوامل التي تؤدي للإنتحار. تبين في مجمل الدراسات التي أجريت على عيّنات من المجتمع أن نسبة الأفكار الإنتحارية مرتفعة أكثر لدى الإناث طوال فترة حياتهن أو خلال الأشهر الأثنتي عشر الأخيرة. بالإضافة، إن الأفكار الإنتحارية خلال الأشهر الأثنتي عشر الأخيرة لها علاقة مهمة بعوارض الإكتئاب، تجارب أكثر في الحياة، الأمراض، واستعمال المهدئات / الحبوب المنومة. أما الأفكار الإنتحارية خلال الشهر الأخير، فلها علاقة بأن يكون الشخص أعزب، ليس لديه أولاد، أو كان لديه مرض نفسي، كالاكتئاب، رهاب الخلاء، القهري الوسواسي، أو القلق الشامل. مقارنة بالتلميذات الجامعيات، إن الإناث النازحات واللجنات كان لديهن أفكار الإنتحارية أكثر خلال الأسابيع القليلة الماضية. في الخاتمة، هناك حاجة ماسة للقيام بدراسات ميدانية شاملة تتضمن عيّنات تمثل المجتمع بأكمله من أجل تقييم نسبة السلوك الإنتحاري والعوامل المؤدية إليه في العالم العربي.

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Past month suicide ideation widely ranged from 6.3% (in a randomly selected sample from the general population in Casablanca) to 55% (in a group of female refugees in Sudan). Past month suicide ideation was significantly related to being single, having a history of psychiatric disorders, and being childless.

It is very difficult and inappropriate to compare suicidality figures from the Arab world to those in other countries, since as we repeatedly stressed in this review, the published results do not allow such comparisons, in spite of clear efforts by many Arab authors to conduct carefully designed studies. Nevertheless the only international study that used similar methodology across all sites found lower rates of suicide ideation and attempts in Lebanon when compared to western countries in this cross national study⁴. Yet the Lebanon

sample was not nationally representative and was carried out during the Lebanon wars. A larger international collaborative study, involving twenty nine countries so far (and involving Lebanon and Iraq so far from the Arab World for whom our group is a training center), has been carried out recently and international comparisons on several parameters of suicidality will probably lend themselves to better comparisons⁹.

In conclusion, national epidemiological studies are needed to assess the prevalence and correlates of suicidal behaviors in the Arab World. This could lead to the homegrown development of awareness and prevention programs suited locally to offer the best against this serious and lethal behavior.

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interview, of individuals who had attempted suicide (diagnostic method not mentioned in article). Interviews took place in a hospital emergency room and later at the attempter's home. Thirty one cases were interviewed (age range: 17-42), the majority of cases were between the ages of 18-30 years old. Seventy-one percent were females and 29% males. Females were mostly married (50%), while males were more frequently single (78%). Prior to the attempt, females described their emotions as "about to explode" and as "being blinded by anger," males on the other hand described their preceding emotions as "feeling worn out," "tired," and "depressed." Females described their attempt as an impulsive reaction, a "burst of high emotion," within a period of escalating stress and anxiety, whereas males were more likely to have made a suicide plan that had been given serious thought and consideration during the context of depression and was related to the political and economic hardship that Palestinians encounter on a daily basis. Females more commonly regretted their attempt than males.

Discussion

The present review examined Arab community based suicide studies that were retrieved from the published literature spanning up to 2006. Only a few of the Arab suicide studies were community based,

while the majority was hospital based or used government and police records. Not all Arab countries are represented in this review (although we did not exclude any from our search) and it is possible we might have missed important studies in spite of our best attempt to locate the authors and retrieve the articles.

Due to the lack of national epidemiological studies in the Arab world and the methodological differences present across Arab suicide studies, it is difficult to compare results and make generalizations about the prevalence and correlates of suicidality.

In the Arab community based suicide studies we reviewed, the prevalence of lifetime suicide ideation varied from 2.09% to 13.9% and the lifetime prevalence of attempts from 0.72% to 6.3%, obviously depending on the studied samples, keeping in mind that none of them was a nationally representative sample. Lifetime suicide ideation was significantly related in these community studies to being female, while lifetime suicide attempts did not significantly differ between genders.

Twelve months suicide ideation, usually considered to be less biased in recall, was significantly related, when assessed, to: female gender, depressive symptoms, reporting more life events, illnesses and using more tranquilizers/sleeping pills.

lent among females (2.88/100) than males (1.24/100), while no significant gender difference was observed for attempted suicide. Among depressed individuals, Lebanon showed to have the lowest prevalence of suicide ideation (2.57/100) and attempts (0.92/100).

Morocco

Agoub et al⁶. assessed the prevalence of past month suicide ideation and lifetime suicide attempts and their correlates in a representative sample of the general population in the urban area of Casablanca. A stratified random general population sample was drawn from the adult population (age range: 15-80 years; mean age 32.2 years). Eight-hundred - and - fifty face - to - face household interviews were conducted by medical doctors or clinical psychiatrists, but only 800 completed (400 males and 400 females). The Mini International Neuropsychiatric Inventory (MINI) was used to assess Axis I diagnosis according to the DSM-III criteria, and the MINI suicidality module was used to rate past month suicidal ideation and lifetime suicide attempts. Out of the total sample, 6.3% (2.25% of males and 10.5% of females) reported past month suicide ideation and 2.1% reported at least one suicide attempt during their lifetime (1.5% of males and 2.75% of females). Suicide ideation was significantly related to non-married status (OR= 5.4, 95% CI, 2.0-

15.7), having a history of mental illness (OR= 5.3, 95% CI, 2.3-11.8), and not having children (OR= 2.5, 95% CI, 1.1-5). The most common disorders among suicide ideators were major depressive disorders (23.5%), agoraphobia (23.5%), dysthymia (21.5%) and OCD (19.6%). Suicide ideates were commonly diagnosed with co morbid disorders (88.2%).

Sudan

Goldney and colleagues⁷ assessed the presence of suicidal ideation in two selected samples of Sudanese females by using the Arabic version of the 28 item General Health Questionnaire, which includes 4 questions that measure suicide ideation during the past few weeks. The first group, was selected from Ahfad University (29 subjects; age range 18-23) and the second group was selected from a displaced persons area, Jebel Aulia, (30 subjects; age range 18-66), both groups were selected on the basis of convenience. The results showed a significant difference between the prevalence of recent (past few weeks) suicide ideation in the displaced group (55%) as compared to the group of university students (27%) ($p = 0.044$).

West Bank & Gaza

Dabbagh⁸ gathered qualitative data from the narratives of Palestinians living under Israeli occupation in the regions of Gaza and the West Bank, using a semi-structured in-

stands," "feel weak all over," "loss of appetite," "inability to get going," "nervousness," "prefer to be alone," "trembling and headache" ($P = 0.001$). Furthermore, subjects with suicidal feelings were significantly more likely to experience 2 or more life-events ($P < 0.001$), report 3 or more illnesses ($P < 0.001$) and use tranquilizers or sleeping pills in the past 12 months in comparison to the control group.

Jordan

In a study by Daradkeh², the effect of national and religious events on the prevalence of parasuicide was assessed by comparing the number of parasuicides during the holy Muslim month of Ramadan to the month before it and the month following it, in the Jordanian population (95% Muslim). Data concerning the frequency of attempted suicide were obtained from the Police Register records during 1986-1991. The prevalence of parasuicide significantly decreased during the Holy month of Ramadan in comparison to the month prior to it and the month after it ($P < 0.05$), whereas no significant difference in the prevalence of suicide attempts was observed in the month before Ramadan and the month after it.

Lebanon

Shediac-Rizakallah et al³. used a self-administered anonymous questionnaire to assess the 15 lifestyles and risk areas that had been previously determined in focus groups,

which included lifetime suicide ideation and attempts. One-thousand- and- sixty- five entering level university students (age range: 16-19) were selected to be studied, 954 students participated (refusal rate: 0.9%). The prevalence of lifetime suicide ideation and attempts in students was 13.9% and 6.3%, respectively. Female students were significantly more likely to report lifetime suicide ideation ($p \leq .05$). There was no significant difference in lifetime suicide attempts between males and females (6.4% and 6.3%, respectively).

In a study by Weissman and colleagues⁴, Lebanon was one out of 9 countries (United States, Canada, Puerto Rico, France, West Germany, Taiwan, Korea and New Zealand) that participated in a cross-national study that compared the rates of lifetime suicide ideation and attempts. The countries involved performed independent surveys using similar diagnostic assessments (DIS-3). Face to face interviews were conducted and a DSM-III criterion was used in order to assess and diagnose mental disorders. In Lebanon, the study was carried by Karam⁵, the sample ($N=435$) was drawn from 4 communities with different exposure to acts of war. Lebanon had the lowest lifetime prevalence of suicide ideation (2.09/ 100) and attempts (0.72/100). Lifetime suicide ideation was significantly more preva-

strongly prohibited by religion (Islam and conservative Christianity). Due to those reasons and due to the social and legal consequences associated with suicidal behavior, cases of suicide and attempted suicide are thought to be frequently hidden by the victims and their families.

The present reviews epidemiological reports on the prevalence of suicide ideation, attempts, the socio-demographic, mental health and other risk factors associated with suicidality in the Arab world.

Methodology

Community based studies assessing the prevalence of suicide ideation, plans, gestures, attempts and completed suicide in an Arab country were included in this review. A search was conducted on PubMed, PsycInfo and IDRAAC WEB/CD up to 2006 using the following key words: suicidality, suicidal behavior, suicide ideation, suicide plan, suicidal gestures, attempted suicide, parasuicide, deliberate self-harm, self-harm, and suicide. This search included the Arab world and Arab countries: Algeria, Bahrain, Comoros, Egypt, Gaza, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar; Somalia, Sudan, Syria, Tunisia, United Arab Emirates, West Bank, Yemen, and Gulf, Middle East, and Arab. An initial list of 2750 abstracts were reviewed, and 11 articles were identified as relevant but only 7 articles could be retrieved and reviewed

after several attempts to locate the original authors. The articles retrieved were often different in their specific objectives and general methodological approaches. They, furthermore, tackled different aspects of suicidality, such as suicide ideation and attempts. Hospital and government based studies are reviewed in another upcoming article.

Terminology

In the following review, non-fatal self-injurious behavior is referred to as attempted suicide or parasuicide.

Results

Egypt

In another study by Okasha et al¹, 12-month suicidal feelings and attempts, and their correlates were assessed in randomly selected final year medical students at Ain-Shams Medical School during the academic year 1978-79 (n= 516; age: early to mid twenties). The instrument comprised five main questions that assess the prevalence of 12 month suicidal feelings of different magnitude and the presence of 12 month suicide attempts. In the past year, 12.2% acknowledged some degree of suicidal feelings and 0.4% reported a suicide attempt. Suicidal feelings were reported to be "significantly" associated to being female. Suicidal feelings were significantly related to 25 psychiatric symptoms such as: "feel in poor spirits," "feel on the verge of a breakdown," "feel tired in the morning," "feel no one under-

Suicidality in the Arab World Part I: Community Studies

Elie G. Karam, Ranya V. Hajjar, Mariana M. Salamoun

الإنتحار في العالم العربي - دراسته مجتمعية - الجزء الأول

إيلي كرم، رانيا حجار، وماريانا سلامون

Abstract

This paper reviews published community based studies that assessed suicidality in the Arab world. A search was conducted on several search engines (PubMed, Psycinfo, IDRAAC WEB/CD) up to 2006 (Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Palestine, Saudi Arabia, Sudan and United Arab Emirates). Results varied across countries and methods. In Arab community studies, the prevalence of lifetime suicide ideation varied from a low of 2.09% to a high of 13.9% and the lifetime prevalence of attempts from 0.72% to 6.3%. In about all community studies which assessed lifetime and 12 months suicide, ideation was significantly related to being a female. Twelve month suicide ideation was significantly related to depressive symptoms and experiencing more life events, illnesses and using more tranquilizers/sleeping pills. One month suicide ideation was related to non-married status, not having children and a history of psychiatric disorders, specifically MDD, dysthymia, agoraphobia, OCD and GAD. When compared to female university students, females who were displaced or refugees were significantly more likely to report suicide ideation (within the "past few weeks"). In conclusion, national epidemiological studies are needed to assess the prevalence and risk factors of suicidal behaviors in the Arab World.

Key Words: attempted suicide, parasuicide, ideation, suicidal feelings

Introduction

Data on the prevalence of different suicidal behaviors commonly referred to as suicidality, and the evaluation of significant mental health and socio-demographic risk factors are essential in the efforts needed to prevent such potentially lethal behavior related to suicidality.

Studies that assess the prevalence and risk factors of suicidality are far

more common in the developed countries. Epidemiological studies investigating the prevalence of suicidal behaviors and their correlates in the Arab world are nonexistent on a national level and a rarity in specific Arab communities. In Arab countries, more so than many other areas of the world, suicide and attempted suicide are considered shameful and sinful acts that are

Table (6): Psychiatric interventions recommended by psychiatrists*

| | <i>Count</i> | <i>%</i> |
|--------------------------------------|--------------|--------------|
| Pharmacotherapy | 161 | 45.9 |
| -Start oral medication | 110 | 31.3 |
| -Parenteral medication | 47 | 13.4 |
| -Modification of previous medication | 3 | 0.9 |
| -Stop previous medication | 1 | 0.3 |
| Outpatient follow-up | 101 | 28.8 |
| Family intervention | 28 | 8.0 |
| Transfer to psychiatric hospital | 18 | 5.1 |
| Investigations (rad.&lab.) | 18 | 5.1 |
| Psychotherapy | 6 | 1.7 |
| Medicolegal opinion (competency) | 4 | 1.1 |
| No psychiatric intervention | 15 | 4.3 |
| Total | 351** | 100.0 |

**These are interventions recommended for 212 patients as, in 51 requests, information related to interventions were missing.*

***Total No. of recommended interventions exceeds that of the requests, as in many cases more than one intervention were recommended.*

Mohamed Ahmed Mustafa

Psychological Medicine Hospital – Kuwait

Ministry of Health - Psychological Medicine Hospital – Kuwait

mustafa537@yahoo.com

Abdul-Rahman Fawzy Hassan

Psychological Medicine Hospital – Kuwait

Ministry of Health - Psychological Medicine Hospital – Kuwait

Table (4): Psychiatric diagnoses of referred patients according to sex

| Psychiatric Diagnosis | Female (n=109) | | Male (n=93) | | Total (n=202)# | | Significance | |
|----------------------------|----------------|------|-------------|------|----------------|------|--------------|-------|
| | N. | % | N. | % | N. | % | Chi-Squ. | P |
| Adjustment disorders | 33 | 30.3 | 12 | 12.9 | 45 | 22.3 | 8.75 | .003* |
| Mood Disorders: | 26 | 23.8 | 19 | 19.2 | 45 | 22.3 | 0.34 | .560 |
| - Depressive disorders | 20 | 18.3 | 17 | 18.3 | 37 | 18.3 | 0.000 | .991 |
| - Bipolar disorder (manic) | 6 | 5.5 | 2 | 2.2 | 8 | 4.0 | 1.48 | .223 |
| Organic brain disorders | 19 | 17.4 | 24 | 25.8 | 43 | 21.3 | 2.10 | .147 |
| Substance related dis. | 6 | 5.5 | 12 | 12.9 | 18 | 8.9 | 3.348 | .147 |
| Anxiety disorders | 10 | 9.2 | 4 | 4.3 | 14 | 6.9 | 1.85 | .174 |
| Psychotic disorders | 6 | 5.5 | 7 | 7.5 | 13 | 6.4 | 0.081 | .777 |
| Somatoform disorders | 3 | 2.8 | 1 | 2.2 | 5 | 2.5 | - | - |
| Mental retardation | 0 | 0.0 | 2 | 2.2 | 2 | 1.0 | - | - |
| Extra pyramidal S.E. | 1 | 0.9 | 1 | 1.1 | 2 | 1.0 | - | - |
| No psychiatric disorder | 5 | 4.6 | 10 | 10.8 | 15 | 7.4 | - | - |

in 61 requests, diagnosis was not recorded or the patients were discharged or left against medical advice before being assessed by the C-L psychiatrist. * = Significant

Table (5): Psychiatric diagnosis in both referring specialties

| Psychiatric Diagnosis (n=199)# | Medical spec. | | Surgical spec. (n=56) | | Significance | |
|--------------------------------|---------------|------|-----------------------|------|--------------|-------|
| | (n=143) | | | | | |
| | N. | % | N. | % | Chi-Squ. | P |
| Adjustment disorders | 42 | 29.4 | 3 | 5.4 | 13.26 | .000* |
| Mood Disorders: | 37 | 24.9 | 8 | 14.3 | 3.09 | .079 |
| - Depressive disorders | 30 | 21.0 | 7 | 12.5 | 1.91 | .167 |
| - Bipolar disorder (manic) | 7 | 4.9 | 1 | 1.8 | 1.01 | .315 |
| Organic brain disorders | 28 | 19.6 | 15 | 26.8 | 1.23 | .267 |
| Substance related dis. | 10 | 7.0 | 7 | 12.5 | 1.56 | .211 |
| Anxiety disorders | 8 | 5.6 | 5 | 8.9 | 0.73 | .392 |
| Psychotic disorders | 3 | 2.1 | 10 | 17.9 | 13.87 | .000* |
| Somatoform disorders | 4 | 2.8 | 1 | 1.8 | - | - |
| Mental retardation | 1 | 0.7 | 0 | 0.0 | - | - |
| Extra pyramidal S.E. | 1 | 0.7 | 1 | 1.8 | - | - |
| No psychiatric disorder | 6 | 6.3 | 6 | 10.7 | - | - |

In 61 requests, diagnosis was not recorded or the patients were discharged or left against medical advice before being assessed by the C-L psychiatrist and in 3 requests, data related to referring specialties were missing. * Significant

Table (2): Sex and age of patients in both referring specialties

| | Medical specialty | | Surgical specialty | | Total | | Significance | | |
|----------------------|---------------------|------|---------------------|------|---------------------|------|--------------|----|-------|
| | N | % | N. | % | N. | % | Chi-Sq. | df | P |
| Sex (n=260)# | | | | | | | | | |
| Male | 84 | 32.3 | 45 | 17.3 | 129 | 49.6 | 2.91 | 1 | .088 |
| Female | 98 | 37.7 | 33 | 12.7 | 131 | 50.4 | | | |
| Age (n=254)## | | | | | | | | | |
| Mean \pm SD | | | | | | | | | |
| Age groups | 33.58 \pm 16.03 Y | | 40.89 \pm 18.36 Y | | 35.99 \pm 18.36 Y | | ### | | .002* |
| < 21 Y. | 42 | 32.5 | 8 | 10.5 | 50 | 19.8 | 10.49 | 3 | .015* |
| 21-40 Y. | 87 | 49.2 | 38 | 50.7 | 125 | 49.6 | | | |
| 41-60 Y. | 36 | 20.3 | 16 | 21.3 | 52 | 20.6 | | | |
| > 60 Y. | 12 | 6.8 | 13 | 17.3 | 25 | 9.9 | | | |

in 3 requests data related to referring specialties were missing ## In 9 requests data about patients' age were missing ### ANOVA * = Significant

Table (3): Reasons for psychiatric consultation

| Reasons for psychiatric consultation | N. | % |
|--------------------------------------|-------------|--------------|
| Suicidal attempt (or threat) | 86 | 24.6 |
| Behavior problems | 80 | 22.9 |
| Agitation/Excitement | 20 | 5.7 |
| Aggression/Violence | 18 | 5.1 |
| Refusal of medication&food | 11 | 3.1 |
| Uncooperativeness | 5 | 1.4 |
| Disturbed behavior (unspecified) | 26 | 7.4 |
| Positive past psychiatric history | 60 | 17.1 |
| Depressed mood | 34 | 9.7 |
| Substance related problems | 30 | 8.6 |
| Disorientation&Confusion | 21 | 6.0 |
| Unexplained somatic symptoms | 20 | 5.7 |
| Insomnia | 10 | 2.9 |
| Hallucinations | 4 | 1.1 |
| Medico legal reasons | 3 | 0.9 |
| Psychotropic side effects | 2 | 0.6 |
| Total | 350* | 100.0 |

- Number of reasons for consultation (350) exceeds number of requests (263), as in many requests, more than one reason for consultation have been mentioned.

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Table (1): Frequency of psychiatric consultation requests received from different specialties

| Medical Specialties | | | Surgical specialties | | |
|---------------------|-------------|-------------|----------------------|------------|-------------|
| | N. | % | | N. | % |
| General medicine | 15 | 58.0 | Orthopedics | 41 | 15.8 |
| Physical medicine | 1 | 4.6 | General surgery | 22 | 8.4 |
| Oncology | 12 | 1.9 | Neuro-surgery | 5 | 1.9 |
| Neurology | 5 | 1.5 | Obst.&Gyn | 4 | 1.5 |
| Chest | 4 | 1.2 | Plastic surgery | 3 | 1.2 |
| Infectious dis. | 3 | 1.2 | ENT | 2 | 0.8 |
| ICU | 3 | 0.8 | Urology | 1 | 0.4 |
| Pediatrics | 2 | 0.8 | | | |
| | 2 | | | | |
| Total | 182* | 70.0 | | 78* | 30.0 |

- Total number of requests in the table is 260 as in 3 requests data related to referring specialties were missing.

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يشمل هذا البحث 263 طلب إستشارة نفسية تم استلامهم في مستشفى الطب النفسي بدولة الكويت عام 1999. وقد تمت دراسة هذه الطلبات دراسة إسترجاعية من حيث التخصصات الطبية الطالبة للإستشارة ، وأعمار وأجناس المرضى، ونوع طلب الإستشارة من حيث الإستعجال ، وسبب طلب الإستشارة ، والتشخيص النفسي للمرضى ، وتوصيات الطبيب النفسي بخصوص هؤلاء المرضى.

وقد وجد أن 131 مريضاً (49,8%) من الذكور و 132 (50,2%) من الإناث وتراوح أعمار المرضى بين 10 سنوات و 91 سنة ومتوسط عمر المرضى 35,99 عاماً. ووجد أن 182 طلب استشارة نفسية (70%) تم استلامهم من تخصصات باطنية و 78 طلب (30%) من تخصصات جراحية وأن 78 طلب استشارة (29,7%) كانت طلبات عاجلة و 185 (70,3%) غير عاجلة.

لقد وجد أن محاولة الإنتحار هو أكثر سبب لطلب الإستشارة النفسية من حيث العدد (24,6%) وأن اضطرابات عدم التوافق (22,3 %) واضطرابات المزاج (22,3%) واضطرابات المخ العضوية (21,3%) هي أكثر التشخيصات شيوعاً وأن العلاج عن طريق العقاقير هو أكثر أنواع التوصيات شيوعاً (45,9%).

وقد خلصت الدراسة إلى أن محاولة الإنتحار هي أكثر أسباب طلب الإستشارة النفسية انتشاراً في الكويت وأن الأطباء النفسيين لا يميلون إلى تسجيل تشخيص " اضطراب الشخصية " للمرضى المحولين للإستشارة النفسية وأن العلاج النفسي يتم استعماله بمعدلات أقل مما يجب في علاج المرضى المحولين للإستشارة النفسية.

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psychiatric consultation was drug overdose. However, this is expected as the most frequent reason for psychiatric consultation in our study was suicidal attempt.

The findings of the present study indicate that the consultation process in Kuwait has been largely influenced in its almost all aspects by the high frequency of suicide attempters referred for psychiatric consultation. Similarly, British C-L psychiatry is dominated by the assessment of attempted suicide¹⁹. Because the numbers are very large; few British hospitals meet national guidelines¹³ that all patients should be psychologically assessed. Most units that do provide organized care have found that it is neither feasible nor necessary for C-L psychiatrists to assess all patients who have attempted suicide, preferring to combine initial systematic assessment by non-psychiatrists (nurses, social workers, emergency-room doctors) with selective psychiatric review²⁰.

Conclusions:

1. Suicidal attempt (or threat) is the most frequent reason for psychiatric consultation in Kuwait.

2. Patients with ages between 21 and 40 years are referred for psychiatric consultation more frequently than patients of other age groups.
3. "Adjustment disorders", "mood disorders", and "organic brain disorders" are the most frequent psychiatric diagnoses made by C-L psychiatrists in patients referred for psychiatric consultation.
4. C-L psychiatrists do not tend to record the diagnosis of "personality disorder" for patients referred for psychiatric consultation.
5. Pharmacotherapy is the most frequent intervention recommended by C-L psychiatrists.
6. Psychotherapy is underused by Kuwait C-L psychiatrists in the management of patients referred for psychiatric consultation.

Limitation:

Only 36% of the referrals (263 out of a total 734) could be included in the study because 64% of the referrals had missing data. This reduces representativeness of referred cases.

المخلص

يعتبر التداخل بين الطب النفسي وباقي فروع الطب من مجالات البحث العلمي الجديرة بالاهتمام وذلك بسبب ارتفاع معدل حدوث تزامن المرض النفسي مع باقي الأمراض. يهدف هذا البحث إلى فحص عناصر الإستشارات النفسية للمرضى الداخليين بالمستشفيات العامة والتخصصية بدولة الكويت ومقارنة نتائج هذا الفحص بما توصلت إليه الأبحاث المشابهة في أماكن أخرى من العالم.

chiatric consultation. Al Hamad et al²¹ in their study at King Khalid University Hospital, Saudi Arabia found that depressive disorder was the most common psychiatric diagnosis.

Comparing our findings with those of the above mentioned previous studies shows that, apart from low rates of personality disorder, the percentages of psychiatric diagnoses found in our study are more or less consistent with previous studies. According to Wise and Rundell¹⁷ the most frequent associated psychiatric diagnosis in suicide attempters is personality disorder. Similarly, Hale et al¹⁸ found that suicide attempters had significantly more Axis II diagnoses, than other patients referred for psychiatric consultation. In our study, although suicidal attempt was the most frequent reason for psychiatric consultation, none of the referred patients was diagnosed as personality disorder. This indicates that the diagnosis of personality disorder was under recorded by the C-L psychiatrists in our study.

Under recording personality disorder by C-L psychiatrists has been reported and addressed by Ramchandani et al⁹. who found that there was some reluctance on the part of C-L psychiatrists to record the diagnosis of personality disorder. This may well have been motivated by the desire to maximize reimbursement by giving more defini-

tive or less controversial diagnoses to patients. Difficulty to arrive at an Axis II diagnosis after the relatively brief evaluation of a C-L setting, and being harder to explain such diagnoses to our colleagues in the general hospital may be other likely reasons⁹.

Suicide attempters are usually given the diagnosis of "adjustment disorder" or "reaction to severe stress" by C-L psychiatrists. This explains why "adjustment disorders and reaction to severe stress" and suicidal attempt have similar patterns of frequency. Both of them were found in our study to be more frequent in females than in males and in patients referred from medical specialties than in those referred from surgical specialties.

Ramchandani et al⁹. found that psychotherapy was the most frequently practiced and most useful intervention. Psychotherapy was defined in its broadest sense to mean attempt to soothe psychological or social stresses that unduly disrupted the patient's equilibrium in the face of acute physical illness. The authors recommended that psychotherapy should be practiced in a manner that could be tolerated by the patient and by the hospital milieu⁹. Compared with the later study, psychotherapy was less frequently recommended by our C-L psychiatrists.

The most frequent physical diagnosis found among patients referred for

for psychiatric consultation^{8, 14}. The lower mean age of referred patients in our study compared to that found by Vas and Salcedo⁸ and Smith et al¹⁴. (44.03 and 49.1 years respectively) can be explained by the higher frequency of suicide attempters whose mean ages were 26.5 years. Additionally, lower mean age of patients referred from medical specialties and higher frequency of below 21 year-old patients among them than among patients referred from surgical specialties can be explained by the statistically significant higher frequency of suicide attempters referred from medical specialties than those referred from surgical specialties.

Some of the referred patients (7.4%) were found to have no psychiatric disorders. These patients were misdiagnosed by the referring physicians as having psychiatric disorders. This type of referrals, known as "misdiagnosis conditioned requests", constituted 3.5% of the received requests in the study of Vas and Salcedo.⁸ "No psychiatric disorder" found in patients referred for psychiatric consultation in our study may give an indication those physicians who graduated in Arab medical schools had little or no grounding or training in psychiatry as undergraduate medical students.

Rundell and Murray¹⁵ also reported the percentage ranges of psychiatric diagnoses made by consulting psychiatrists; depression (14 - 50%), psychoactive substance use disorder (7 - 31%), personality disorder (5 - 22%), adjustment disorder (5 - 19%), organic mental disorder (12 - 18%), anxiety disorder (1 - 12%), somatoform disorder (1 - 5%), and schizophrenia (1 - 5%).

Lipowski and Wolston¹⁶, in their study of 2,000 medical and surgical inpatients referred to their C-L service, found that adjustment disorder with depressive mood and organic mental syndromes, notably delirium, accounted for about 70% of the diagnoses assigned by their C-L team. Smith et al¹⁴. found that at least one "organic mental disorder" was made in 36% of patients referred for psychiatric consultation. Other frequent diagnoses found in their study were "Psychoactive substance use disorder" (35%), adjustment disorder (21%), personality disorder (19%), and mood disorder (17%). Vas and Salcedo⁸ found that the most frequent psychiatric diagnosis made by C-L psychiatrists was organic mental disorder (23%), followed by mood disorder (21.3%), personality disorder (12%), and somatoform disorder (9.2%). Ramchandani et al⁹. found that cognitive disorders (delirium and dementia) and adjustment disorders were the most frequent psychiatric diagnoses made in patients referred for psy-

sons for a psychiatric consultation request.

Comparing our findings with those of the above mentioned studies shows higher frequency of suicidal behavior, as a reason for psychiatric consultation, in our study. This may be attributed to the policy followed in Kuwait hospitals that routine psychiatric consultation should be requested for each patient hospitalized because of drug overdose or following any behavior suspected to be a deliberate self-harm. This policy meets the British national guidelines¹³ that all attempted suicide patients should be psychologically assessed.

In our study, suicidal attempts were significantly more frequent in females than in males and in subjects whose ages are between 21 and 40 years than those of other age groups. These two findings are compatible with those found by Emara ET al²⁴ in their study of 227 cases of parasuicide by drug overdose in Kuwait. The authors found that 75 percent of cases were female and younger age groups were over-represented. Suleiman ET al²⁵ (who studied 92 cases of parasuicide in Kuwait) and El-Islam²⁶ (in his study of parasuicides in Qatar) found similar findings. However, in an Egyptian study, Okasha and Lottaif²⁷ found that more males made suicide attempts than females. The authors attributed this finding to a

fact that female parasuicide is more likely to be concealed in Egypt.

Apart from suicidal attempt, the high frequency of undesirable or unacceptable behavior as a reason for psychiatric consultation in our study is consistent with that of Ramchandani et al⁹. Also, in the study of Vas and Salcedo⁸, if patients having agitation were grouped with those having disruptive behavior, as in the study of Ramchandani et al.⁹, disruptive behavior will be the most frequent reason for psychiatric consultation.

In our study, refusal of medication and/or food and uncooperativeness were the reasons for psychiatric consultation in 4.5% of cases. However, based on a study of 2,000 patients referred for psychiatric consultation, staff-patient conflict, and issues regarding competence to refuse treatment were among the most common reasons for referral²². Noncompliance or refusal to consent to procedure is among the most common reasons for psychiatric consultation²³.

The majority of suicide attempters (81%) had no past history of psychiatric disorders. This has contributed to the less frequency of patients having positive past psychiatric history (26%) in our study compared with that in the study of Ramchandani et al.⁹ (75%).

Previous studies have shown subtle difference between number of females and number of males referred

obtained in previous studies. Vas and Salcedo⁸, in their analysis of 528 consecutive consultation requests received by C-L team over a 2-year period, found that 69.3% and 30.7 of the requests were received from medical and surgical services respectively. Ramchandani et al⁹ found that 76% of the consultation requests were received from medicine and medical subspecialties while 24% came from surgical services. In Saudi Arabia, Abdulrazzak et al²¹ found that psychiatric referrals were more frequent from Department of Medicine.

This finding can be explained by the real higher prevalence of psychiatric morbidity among medical inpatients compared to surgical inpatients^{10, 11}. Another explanation may be the higher frequency of suicide attempters, who are usually admitted to general medical wards, among patients referred for psychiatric consultation (as will be shown later). Similarly, our finding that most requests received from surgical specialties came from orthopedic wards can be explained by the high frequency of patients referred from these wards because of suspected suicide through intentional falling from height.

In our study, 29.7% of the requests were urgent. This percentage approximates to that found by Vas & Salcedo's⁸ (21%). No statistically significant difference was found in our study between urgency of psy-

chiatric consultation and psychiatric diagnoses. These findings confirm the finding of Ungerleider¹² that in the general medical hospital setting, there are no established procedural definitions for which clinical situations are designated as emergencies; rather, the emergency designation is based on the requesting physician's perceived need for prompt service¹². In our study, The relationship between urgency of the request and reason for referral could not be determined as in most requests more than one reason for referral were mentioned.

In previous studies, the order of frequency of reasons for psychiatric consultation varied from one study to another. Ramchandani et al⁹ found that undesirable or unacceptable patient's behavior (including refusing treatment, agitation, exaggerating symptoms, and being manipulative) is the most frequent reason for psychiatric consultation (50%), followed by suicidality (18%), depression (12%), and past psychiatric history (8%). Vas and Salcedo⁸ found that depression (18.3%), agitation (14.3%), family problems (7.7%), absence of organic findings (medically unexplained somatic symptoms) (7.5%), disruptive behavior (6.3%), drug/alcohol-related problems (6.3%), suicidal behavior (4.7%), and psychiatric antecedents (past psychiatric history) (3.3) were the main rea-

cantly more frequently referred from medical specialties than from surgical specialties ($P = .000$).

"Reaction to severe stress and adjustment disorders" and "Mood disorders" were the most frequent psychiatric diagnoses in patients referred for psychiatric consultation (22.3% for each) followed by "mental disorders due to a general medical condition" (21.3%). Less frequent diagnoses included substance related disorders (8.9%), anxiety disorders (6.9%), psychotic disorders (6.4%), and somatoform disorders (2.5%). Fifteen patients (5.7%) were found to have no psychiatric disorders. Only one case, out of the 16 cases referred for psychiatric consultation because of refusal of medication and/or food, and uncooperativeness, was found to have no psychiatric disorders.

The diagnosis of "Reaction to severe stress and adjustment disorders", was statistically significantly more frequent in females than in males ($P = 0.003$). No statistically significant difference was found between males and females regarding frequencies of other psychiatric diagnoses (**Table 4**). There was no statistically significant relationship between urgency of psychiatric consultation and psychiatric diagnoses of referred patients. The diagnoses "Reaction to severe stress and adjustment disorders" were significantly more frequent in patients referred from medical spe-

cialties than in those referred from surgical specialties ($P = .000$), whereas "Psychotic disorders" were more frequent among patients referred from surgical specialties ($P = .000$) (**Table 5**). In 44.2% of cases diagnosed as mental disorders due to a general medical condition, the mental disorders were not specified by the consulting psychiatrists. However, Delirium and dementia were the most frequently specified organic mental disorders (18.6% and 16.3% respectively).

Pharmacotherapy (45.9%), especially starting oral medication, was the most frequent recommended psychiatric intervention. Less frequent recommended interventions included outpatient follow-up (28.8), family intervention (8%), and transfer to psychiatric hospital (5.1%), physical investigations (5.1%), and psychotherapy (1.7%). In 15 cases, the psychiatrists did not recommend any psychiatric intervention (**Table 6**). These 15 cases were noted by the psychiatrists as having "No psychiatric disorder" and 6 cases of them were referred for psychiatric consultation because of behaviors suspected by the referring physician to be aiming at committing suicide.

Discussion:

In our study, referrals from medical specialties were more frequent than those from surgical specialties (70% and 30% respectively). These figures are nearly similar to those

ings and recommendations noted by psychiatric consultants. Items which were studied included referring medical/surgical specialty, sex and age of referred patients, types of requests as regards urgency (according to the referring physician's judgment), reason for psychiatric consultation, psychiatric diagnosis, and recommended psychiatric interventions.

Similar studies carried out in other parts of the world were reviewed and their findings were compared with those of our study.

Results

Of 263 patients referred for psychiatric consultation, 131 (49.8%) were male and 132 (50.2%) were female. Ages of referred patients ranged from 10 to 91 years with a mean (\pm SD) of 35.99 ± 17.19 . Patients with ages between 21 and 40 years were more frequently referred for psychiatric consultation than patients of other age groups ($P=0.015$) (**Table 2**).

Seventy percent of the studied requests were received from medical specialties and 30% came from surgical specialties. Most of the requests received from medical specialties (58% of all requests) were from general medicine wards. More than half of the requests received from surgical specialties (15.8% of all requests) were from orthopedics wards (**Table 1**). No significant difference was found between medical and surgical specialties regarding

frequency of males and females referrals. The mean age of patients referred from medical specialties was significantly lower than that of patients referred from surgical specialties ($P=0.002$) (**Table 2**).

Seventy-eight requests (29.7%) were urgent, while 185 (70.3%) were not urgent. No statistically significant difference was found between medical and surgical specialties as regards urgency of psychiatric consultations. Suicidal attempt (or threat) was found to be the most frequent reason for psychiatric consultation (24.6%) followed by behavior problems (agitation, violence, refusal of medication and/or food, uncooperativeness, and unspecified behavioral disturbance) (22.9%). Less frequent reasons for consultation included presence of past psychiatric history (17.1%), depressed mood (9.7%), substance related problems (8.6%), disorientation (6%), unexplained somatic symptoms (5.7%), insomnia (2.9%), evaluation of the patient's competency to sign formal papers (0.9%), and psychotropic side effects (0.6%) (**Table 3**).

Suicidal attempts were statistically significantly more frequent in females than in males ($P=0.002$) and in subjects whose ages are between 21 and 40 years than those of other age groups ($P=0.000$). The mean age \pm SD of suicide attempters were found to be 26.51 ± 11.85 years. Suicide attempters were signifi-

tients being cared for in the medical and mental health care systems^{1, 2, 3}. Comorbidity research is of particular importance for consultation-liaison (C-L) psychiatry, a growing area of psychiatric practice in which approximately 25% of psychiatrists regularly perform consultations on medical patients⁴.

The continued medicalization of psychiatry, in which psychiatrists are increasingly called upon to evaluate and briefly treat persons with comorbid physical disorders, makes expertise in C-L psychiatry a valuable asset⁵. In the general hospital, one sees individuals who, under normal circumstances, would never see a psychiatrist. These individuals' psychiatric symptoms may be caused or precipitated by being hospitalized with inability to adapt or cope with ward atmosphere, being stressed by multiple diagnostic procedures or staff-patient conflicts²². Psychiatric side effects of medications and psychological reaction to being informed about having a serious illness are other factors related to hospitalization. Here, the focus extends beyond the themes of psychopathology and psychiatric diagnosis to include adaptation and coping of "normal" people to crises and how to affect them⁶.

In medical wards of the hospital, C-L psychiatrists must play many roles: skillful and brief interviewer, good psychiatrist and psychothera-

pist, teacher and knowledgeable physician who understand the medical aspects of the case. The C-L psychiatrist must be viewed as part of the medical team who makes a unique contribution to the patient's total medical treatment⁷.

In Kuwait, responding to inpatient psychiatric referrals from general and specialist hospitals is a part-time responsibility of general psychiatrists working in Psychological Medicine Hospital which is the only psychiatric hospital in Kuwait. The objectives of this study are to examine the elements of inpatient psychiatric consultation in Kuwait and to compare our findings to those of similar studies carried out in other parts of the world.

Methods:

The study involved 263 inpatient psychiatric consultation requests received by Kuwait Psychological Medicine Hospital from all Kuwait hospitals concerning Kuwaiti and non-Kuwaiti patients in the year 1999. Those were the requests whose data were found available and kept in the Registration Department of Psychological Medicine Hospital, while the rest of the requests received in the same year (471 requests) were not included in the study as their data were lacking.

The requests were studied retrospectively through collecting data noted by the referring physician in the requests and psychiatric find-

Inpatient Psychiatric Referrals from General and Specialist Hospitals in Kuwait – A Descriptive Study*

Mohamed A. Mustafa - Abdul-Rahman Fawzy

الإستشارات النفسية للمرضى الداخليين بالمستشفيات العامة

والتخصصية بدولة الكويت – دراسة وصفية

محمد مصطفى و عبد الرحمن فوزي

Abstract:

Psychiatrists are increasingly called on to evaluate and treat persons with comorbid physical disorders. The objectives of this study were to examine different elements of the psychiatric consultation process in Kuwait and to compare our findings to those of similar studies carried out in other parts of the world. The study included 263 psychiatric consultation requests received by Kuwait Psychological Medicine Hospital from all Kuwait hospitals in year 1999. The requests were studied retrospectively regarding referring medical/surgical specialty, sex and age of referred patients, types of requests as regards urgency (according to the referring physician's judgment), reason for psychiatric consultation, psychiatric diagnosis, and recommended psychiatric interventions. Results showed that males and females were almost equally represented in the study (49.8% and 52.2% respectively), 70% of the requests were received from medical specialties and 30% from surgical specialties. Patients with ages between 21 and 40 years were more commonly referred for psychiatric consultation than those of other age groups ($p=0.015$), suicidal attempt (or threat) was the most common reason for consultation (24.6%), adjustment disorder, mood disorders, and organic mental disorders were the most common psychiatric diagnoses (22.3%, 22.3%, and 21.3% respectively), and pharmacotherapy was the most frequently recommended psychiatric intervention (45.9%). The study concluded that suicidal behavior is the most common reason for psychiatric consultation in Kuwait, consultation psychiatrists do not tend to record the diagnosis of "personality disorder" and they are less likely to recommend psychotherapy for their patients.

Introduction

An important field of research in health care service focuses on the interface between medicine and psychiatry. Such research is impor-

tant clinically because of the high incidence of psychiatric and medical disorders that coexist (psychiatric – medical comorbidity) in pa-

* See letter to the editor

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***Correspondence:**

Mohammed T Abou-Saleh

Division of Mental Health-Addictive Behaviour
St George's, University of London
Cranmer Terrace, London SW17 0RE, UK

Tel: +44 208 725 0368

Fax: +44 208 725 2914

Email: mabousal@sgul.ac.uk

Christopher John

Division of Mental Health-Addictive Behaviour
St George's, University of London
Cranmer Terrace, London SW17 0RE, UK

Tel: +44 208 725 0368

Fax: +44 208 725 2914

الطريقة: تم توزيع التحديات إلى ثلاث مجالات: ما يتعلق بمجموعة الأفراد المعنيين في السلوك والصحة، وما يتعلق ببيئة الخدمات التي يتم فيها إختيار أفراد العينة، وما يتعلق بتصميم الدراسة.

النتائج: التحديات التي تواجه هذه الدراسات تتعلق بسلوك الفوضى والدافعية لدى متعاطي المخدرات، وارتفاع معدل عدم الإلتزام بالعلاج، بالإضافة إلى جوانب تتعلق ببيئة الخدمات وتعريف هذه المجموعة من المدمنين و إختلاف طرق الإختبار في مراكز الخدمات، وإلى تصميم طريقة البحث والتعويض الذي يدفع للمشاركين و إستخدام العاملين الموظفين بدل الباحثين المتمرسين كمعالجين.

الخلاصة:

الدروس المستفادة كانت واضحة في ضرورة عمل دراسة أولية ريادية للعلاجات الجديدة، كأمر أساسي قبل الخوض في دراسات مقارنة ضابطه عشوائية للمداخلات النفسية في ميدان الإدمان. كما أن وجود البنية التحتية الثقافية للمداخلات النفسية ضرورية لتنفيذ البحث التطبيقي في بيئة الخدمات، كما أن الدعم المالي ضروري لتوفير المعالجين المؤهلين القادرين على تقديم هذه المداخلات.

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presents challenges that are very different from those encountered in US studies upon which research in addiction is often modelled, as was the case in this project. RCTs in the US are usually conducted against a background of higher funding which facilitate pilot work, the formation of larger research teams, and therapists who are dedicated to the trial rather than relying on service staff trained in delivering the experimental and control interventions. Research in the US also benefits from a well-established clinical research infrastructure, which aids the introduction of new interventions, increasing compliance from staff and users. Indeed, the development and fostering of a culture of research within the services involved in the present trial was a task that had to be instigated. There is also reason to believe that the clinical populations in the US are different to those in the UK, with those engaged in treatment being older, and more socially stable; this

is of consequence because it is important that service users are well-engaged in standard drug treatment regimes before introducing further demands such as structured counselling sessions. Another of the lessons learnt is the need for piloting of the new intervention in an area of research that involves the development of new interventions amongst a difficult clinical population, with only limited guidance available from other research.

One of the main policy implications for conducting trials of psychological interventions within addiction health care settings is for funding bodies to provide the necessary resources to improve the quality and comprehensiveness of treatment including the provision psychological interventions. This would provide the necessary infrastructure and capacity for the development of innovative interventions and thus offering opportunities for the evaluation of their effectiveness and costeffectiveness in pragmatic clinical trials

الملخص:

الخلفية: لقد أنهينا دراسة مقارنة عشوائية ضابطه، لفعالية الإرشاد المحفز الوقائي في الوقاية الأولية من مرض إلتهاب الكبد الوبائي (C) في مستعملي الحقن الذاتي للمخدرات. من خلال الدراسة واجهنا تحديات منعتنا من إيجاد العدد المناسب من المشاركين، وبالتالي لم نتمكن من تحديد فعالية الإرشاد المحفز الوقائي في تخفيض الإصابة بالتهاب الكبد الوبائي (C) بين المدمنين على الحقن الذاتي للمخدرات.

الهدف: وصف التحديات التي تواجه إجراء دراسات مقارنة ضابطه عشوائية للمداخلات النفسية، والبحث الناقد لإنعكاسات ذلك على إجراء مثل هذه الدراسات للمداخلات النفسية في مجال الإدمان.

their discussion is beyond the scope of this paper.

Randomisation in psychological interventions

The RCT has long been the "gold standard" for all types of research, yet it is more problematic for psychological trials than it is for pharmaceutical drug trials. Participants many of whom were ready to address issues of health and risk, and having the motivation to do so, may have been allocated to the control group. Randomisation works both in favour of and against pragmatism; it is not feasible to test an intervention if only those most likely to change are included, as this will likely become a self-fulfilling prophecy. Also in real-world applications, it is unlikely that individuals who are considered by the therapist to be unsuitable for a particular intervention at that time would be encouraged to participate in it. It is difficult to strike a balance between these competing needs, and the randomised controlled trial remains the best method of investigation that we have, despite its drawbacks.

Pragmatic or efficacy trials

A pragmatic trial is one in which the object is to not only test an intervention, but to test it in a reasonably realistic manner that replicates to an extent the conditions under which it is likely to be adopted if it were found to be effective and then introduced more

widely. In contrast, an experimental trial is less concerned with practical implementation and more with ensuring that a satisfactory test of an intervention is made. In the traditional model, experimental trials come first, and then their practical application in real-world settings is made. Pragmatic trials attempt to combine both stages into one, and when successful, solve two problems at the same time. When they do not, it is often not possible to disentangle the two stages, such that it remains unclear whether it is the intervention or the specific implementation of it that was at fault, or perhaps both. The research that we carried out was substantially of the pragmatic variety. Pragmatic trials have advantage over efficacy trials as their findings could be generalised and widely implemented in service settings. The research is carried out in real situations, with inclusive criteria, representative populations, and by regular staff. In such situations, a negative finding is just as important as a positive one. In the present study, the close modelling on similar previous research and the inherent face-validity of the new intervention were important aspects of its effectiveness as evaluated in the National Health Service setting.

Lessons learnt

One of the main lessons learned in this project is that conducting research in UK treatment settings

both CBT and MMT due to high staff turnover and motivational issues; low level of client engagement in CBT.

In discussion, we suggest the following over-arching issues for consideration:

Psychological interventions

The environment from which participants were recruited was not often resourced for the provision and testing of psychological interventions. There was also the legacy of drug addiction services being largely perceived, again by both service users and the services themselves, as primarily in the realm of medical science as opposed to psychological, and focused around the provision of substitute drugs. Service users arrive at services with varying expectations, but for many the availability of substitute drugs and perhaps needle exchange facilities is primary. They do not necessarily anticipate psychological input, and therefore do not desire it or demand it. This is reinforced by lack of resources for providing psychological treatment on the part of services, and a culture that does not lay emphasis on working in this way.

Pilot the intervention

The provision of a pilot study would have helped address many of the problems that we faced when attempting to implement the trial. Indeed, this is the very purpose of any pilot study, yet they are fre-

quently not carried out. In this instance the research team and funding body assumed that it would not be necessary due to the close modelling on other existing research, and the experience of the team in conducting research of this nature. In the context of bidding competitively for available research funding, the ability to deliver a research project at the absolute minimum cost is essential, and it is often most practical to cut down on the piloting aspects of work wherever possible. Although the research succeeded in generating a wide range of useful findings above and beyond those reported in this paper, the inability to prove the primary hypothesis of the project was disappointing, and perhaps could have been avoided if sufficient time and effort was spent prior to the research in investigating aspects that were later found to be troublesome. However, pilot studies are only useful insofar as they mimic the conditions of the actual trial, and the closer they are to the actual conditions, the more useful they become, but also more costly and time consuming. Although our trial may have benefited from being piloted first, it is equally likely that a small-scale limited pilot study would not have identified many of the issues that were found to be problematic in the main trial. The benefits and disadvantages of conducting pilot studies are many, but

consent was fully informed. As such, pre- and post-test counseling sessions were sometimes longer and more involved than the control intervention was, and may have provided sufficient information and understanding such the trial intervention was no longer seemed as necessary as it might have done before. Service users may have felt that they knew all they needed to know for the time being, and declined to take part in the research. Thus, although it was problematic for the research in terms of achieving sufficient numbers and in ensuring adherence to the Trial intervention, it was an unequivocal benefit to the service users that testing was made as widely available and accessible as possible, and that knowledge and awareness of hepatitis C was increased amongst the population.

Discussion

The Trial clearly had several indirect benefits, and several shortcomings. The first positive outcome was the impact of the research on clinical practice, through the introduction of a new method of testing that has continued to be adopted by the services, and the increased knowledge, awareness and understanding of hepatitis C, both for service users and the staff. Secondly, the therapists were trained and accredited in the delivery of a manual-guided in-

tervention that although still unproven in effectiveness, is strongly believed to be useful and is amenable to adaptation and incorporation into the routine therapeutic armamentarium of the service. Thirdly and most importantly that over the three-year period that recruitment for the research was active, the vast majority of those at-risk for contracting hepatitis C were tested and made aware of their HCV status. Moreover those who were HCV negative may well be motivated to remain so, and those who were found to be HCV positive will access the treatment of HCV infection. The shortcomings and problems encountered during the trial have informed the research team, the clinical teams, and others of the difficulties of conducting research in addictions.

Similar difficulties were encountered in conducting the UK RCT¹¹ on the effectiveness and cost effectiveness of cognitive behaviour therapy (CBT) for opiate misusers in methadone maintenance treatment (MMT): Low baseline levels of CBT trained staff; low rates of subject eligibility and willingness to participate, particularly in certain sites; poor engagement in, and drop out from, standard methadone treatment; delay in obtaining treatment costs for the trial interventions; high turnover of staff; delays in therapists obtaining training accreditation; attrition of therapists in

work priority preferring to attend to their clients treatment needs probable arising the dynamics of the service, and in the context of performing multiple roles in a demanding service with a difficult client group. Motivation was a larger issue as time went on, as recruitment to the trial was first delayed due to factors out of our control, and then much slower than expected when it began. Hence, intrinsic goodwill and motivation that was abundant at the beginning of the trial was diminished as time went by and the therapists sometimes faced weeks or months with no participants to engage. The lower-than-expected recruitment to the trial meant that participant flow through the therapy process was not regular, and it was difficult for therapists to establish a routine of setting aside time for the research on a regular basis. Hence when the demand came, the ability to respond to it was hampered, affecting adherence to the trial intervention. Efforts to address these problems included the instigation of regular therapist group meetings in order to help raise the profile of the research and provide a forum for problem solving, and although these were productive initially, interest soon waned as the main problem of competing commitments and low participant re-

cruitment persisted. Therapist drop-out was not a major problem despite the relatively long recruitment period of the trial (which was extended twice to more than 3 years), but over time the therapist roles evolved and changed and circumstances sometimes made it difficult for therapists to honour commitments made at the beginning of the research. These problems would have been averted if we had the resources to employ dedicated therapists to deliver the intervention.

9) *The confounding effect of testing*

In retrospect, it is believed that a major problem affecting engagement with the trial intervention was the confounding effect of testing for hepatitis C that was necessary in order to establish eligibility. This turned out to be both a positive and negative outcome of the research. Good ethical practice entailed pre and post-test counselling to help the service users understand the implications of testing. For many service users, this was the first time that hepatitis C became an issue for them, and an awareness of the current risk they were presenting became salient. Pre- and post-test counselling was guided by best practice in providing necessary and sufficient knowledge and understanding, at an appropriate level, ensuring that

sibility of other longer-term benefits. As such, it was relatively easy for service users to agree to take part in the research and receive their initial compensation for completing assessment measures, and then disengage from the research when further demands such as the trial intervention were arranged despite their informed consent to take part in the research. There might have been a tactical element to disengaging, whereby participants could "gamble" on the possibility of being randomised to the control intervention, which was a less demanding 15-minute non-interactive intervention, rather than the experimental intervention, which required up to four one-hour sessions of their time in personal therapy. In the intention-to-treat analysis, all participants were followed-up at six months regardless of whether they had engaged for any sessions of the intervention, and so they could also play a stalling game, holding off from the trial intervention until the time of the next research assessment, the easier part of the research and receive their second compensation voucher. In reality, the six-month follow-up was often stretched as late as possible if it was felt that there was still a chance that the participant might still engage in the intervention,

but this did not improve adherence significantly. Additionally, it was felt that the introduction of compensation for the research-specific aspects of the trial might have worked against engagement in the trial therapy by encouraging participants to conceive of all aspects of the research as "paying for their time". This may have affected the experimental intervention much more than the control intervention. Compensation can increase recruitment under some circumstances, but it can also create other problems.

8) *Therapist issues*

Although modelled on research carried out in the USA, an important difference with this UK trial was that the therapists trained to deliver the interventions were not directly funded by the research. Rather, in keeping with the pragmatic implementation nature the study, all trial therapists were recruited from the services from which the participants were recruited and all were full-time NHS employees with caseloads and ongoing commitments. To enable them to take part, the therapists were relieved from some of their routine duties though without any other compensation. However, we found that the therapist motivation to take part to vary and some did not give the research

blood spot (DBS) sample [10]. Using the DBS, the testing was carried out in-situ by the service staff, and without the need for trained phlebotomists. Both the service staff and service users responded very positively to the introduction of this method of testing, and testing rates increased fivefold. However, even with this new method of testing, and even when the research team did testing opportunistically, a significant proportion of IDUs remained untested. Therefore, estimates of prevalence of hepatitis C within the population, although accurate, did not reflect the proportions of eligible participants that we anticipated due to the significant proportion of IDUs whose hepatitis C status could not be determined.

6) Variation in service set-up

Drug services were variably effective in participant recruitment. Some of this variation was accounted for by the differing levels of enthusiasm that the staff at recruitment sites had for the research. This seemed to be related to the service philosophy of care, treatment approaches (harm minimisation versus abstinence models) and the perceived value of the research. It is easier to encourage service users to take part in the research when service staff and managers are enthusiastic, when the research

is perceived as an opportunity for innovation, and when the service has had previous positive experience of research. The other reason was related to the ease with which the research staff could recruit from each site, mainly as a result of service set-up. Research was made easier in those services which offered a strict appointment system, or where they had designated sessions for appointments at set times of the week, as opposed to more informal drop-in type systems.

Issues relating to the trial design

7) Therapy compliance and compensation

For taking part in the trial, monetary compensation in the form of vouchers was provided at baseline, post-intervention, and at six-month follow-up. Participants were not compensated for their attendance for therapy for ethical reasons, so that participants' motivation to engage in therapy was not influenced by financial reward. Although the availability of financial reward undoubtedly increased recruitment rates in this difficult-to-engage client group, it is believed that it may have played a role in the relatively poor adherence to the experimental trial intervention. Participants may have been motivated by short-term reward rather than the pos-

perceived risk of contracting it, in relation to other more immediate concerns. Although many service users were on a stable substitute drug treatment, continued drug use remained a significant problem for many, and an array of difficult legal, health, social, and psychological problems took precedence over the personal health risks of contracting a blood borne virus. Although these risks were serious and very real, in the context of other issues that service users faced, the need to address them immediately and participate in assessment and intervention was not a priority.

Issues relating to the service environment

4) Definition of IDU

During the design of the trial, estimates were obtained of the number of IDUs engaged and the proportion of new referrals to the service over the course of the research. However, the definition of IDU varies between “injected ever, even once”; or “only those currently injecting”, or somewhere in-between. For this present study, the definition of IDU was operationalised to have “Injected at least once in the last twelve months”. A subsequent revision to the research protocol changed this to “injected at least once in the last six months” in order to identify a more “at-risk”

group, but this excluded a significant number of potential participants from our original estimates.

5) HCV testing

Apart from service users having injected within the last six months, the other main inclusion criteria for the research was that the participants be currently not infected with hepatitis C. This was established by a blood test within the last month, and prior to recruitment. It was assumed, and confirmed by the staff of the service, that testing for blood-borne viruses was a routine part of the service offered. However, in reality, the levels of testing were found to be far lower than expected, and this was initially a significant obstacle to recruitment. Whether testing was regularly and routinely offered or not, it was not regularly taken up, due largely to the need to attend a special clinic or visit the local hospital in order to have a blood sample taken. Somewhat unexpectedly, a proportion of IDUs claimed to be phobic about having blood samples taken, and a similar proportion were not keen to have someone else interfere with their veins. This problem was successfully addressed through the introduction by the research team of an innovative new method of testing for hepatitis C using a finger-prick dried

our attempts to overcome them, followed by a general reflection on the lessons that we learnt and recommendations for future research into this and related areas.

Issues relating to the client group behaviour and health

1) Chaotic nature

The chaotic behaviour of the IDU population has been well documented, and was anticipated to be a significant problem for our research. However, the scale of the problem was such that despite our best efforts to ensure that the measures and the interventions were as amenable to service users as possible, it still presented an obstacle over and above that anticipated. Disengagement with the treatment services, disengagement with the research, missed appointments, and concurrent forensic or health issues all impeded the progress of the research. In the context of larger and unexpected problems emerging in service users lives, their commitment to the research often was not sustained, even if their original intention to participate was genuinely made.

2) Service-user reporting of injecting behaviour

One of the main inclusion criteria for this trial was that the participants had injected at least once within the last six months. This was in order to identify a suitably "at-risk" group who

could realistically benefit from the trial intervention. During the design of the trial, estimates were obtained of levels of injecting behaviour, but during recruitment we found significantly lower levels of recent injecting behaviour than anticipated, and this had an impact on the predictions of numbers of eligible participants over the course of the trial. The IDU's reporting of injecting behaviour may differ depending on how and by whom the question is asked, and that direct questioning by researchers may elicit lower levels of injecting than in reality. The two main reasons for this are the general social stigma, even amongst many drug users, of admitting to injecting behaviour, and possibility of sanctions within the context of drug treatment services that lead to lower self-reporting. Anonymous data collection of injecting behaviour, or indirect methods of estimating (such as key worker informants) may give more accurate levels of real injecting behaviour, but these are not likely to be achieved when service users are asked directly.

3) Importance and relevance of hepatitis C

Related to the issue of IDUs chaotic behaviour is the importance and relevance of being educated in hepatitis C, and the

and those not followed and between those who received EPC and SEC. On the primary outcome measure of the rate of seroconversion, 8 out of 62 patients followed-up at twelve months seroconverted, three in the EPC group and five in the SEC group, indicating incidence rates of 9.1 per 100 person years for the EPC group, 17.2 per 100 person years for the SEC group, and 12.9 per 100 person years for the cohort as a whole. Analysis of the secondary outcome measures on alcohol use, risk behaviour, psychological measures, quality of life, and service use measures showed no significant differences between the EPC and the SEC groups. However, there were significant changes on a number of measures from baseline values indicating positive change and improvement in these measures for both groups.

We were not able to prove the efficacy of EPC and hence its cost-effectiveness in comparison with SEC in the prevention of hepatitis C in IDUs. This was related to low recruitment and retention rates of the participants. Moreover there was a low adherence rate to EPC.

This paper provides an overview of the main problems that we faced and our attempts to overcome them, in the hope that it will guide other researchers in the field of addiction. Our findings and the lessons learnt may also be of general interest to researchers planning to conduct

RCTs of psychological interventions in health care settings.

Main problem areas encountered

As with many large RCTs, a wide range of problems were encountered during the course of the research, some of which were amenable to minimisation by the research team, and some of which were beyond our control. The main problems affecting the outcome of the research were the lower than expected levels of recruitment to the trial, and the low adherence to the psychological intervention (only 45% of those randomised to the EPC intervention (4 interactive sessions) engaged for at least one session). Retention was a lesser problem, as more than 80% of those recruited were followed-up, and adherence to the informational one brief session intervention was not a problem, as more than 90% of those randomised to the SEC informational intervention received it. The reasons for these two main problems can be grouped under the following subheadings:

- Issues relating to the type of client group, behaviour, and health
- Issues relating to the service environment from which participants were recruited
- Issues relating to the trial design

There follows a brief discussion of these obstacles that we faced, and

Key words: Addiction; drug misuse; psychological interventions; randomised trials;

Introduction

Viral hepatitis C is a global public health problem, and has been considered one of the major challenges in the third millennium¹. The hepatitis C virus (HCV) is a leading cause of chronic liver disease in the general population, with an overall prevalence in the USA of 1.8%² and of 0.5% in the UK³. Injecting drug use is the main route of transmission, mediated by the sharing of injection equipment, especially needles and syringes but also spoons, cotton filters and other paraphernalia⁴.

The recently introduced Hepatitis C strategy for England⁵ laid strong emphasis on preventing new cases of hepatitis C infection in IDUs by health promotion activities and the provision of needle exchanges schemes. This is best achieved in the context of treatment for drug dependence complemented with information about hepatitis C and harm minimisation messages. However, this new policy falls short of recommending specific preventive interventions which are evidence based; hence the importance of this project which aims to evaluate a new preventive intervention for Hepatitis C in IDUs.

We have reported the results of a randomised controlled trial of the effectiveness and cost effectiveness

of enhanced counselling in the primary prevention of hepatitis C in injecting drug users⁶. The aim of the study was to develop and evaluate the effectiveness and cost effectiveness of enhanced prevention counselling (EPC) in comparison with simple educational counselling (SEC) in reducing hepatitis C viral (HCV) infection in sero-negative injecting drug users (IDU). Ninety-five IDUs were recruited and randomised to receive EPC ($n = 43$) or SEC ($n = 52$). Subjects were assessed at baseline using the Addiction Severity Index (ASI)⁷, the Injecting Risk Questionnaire (IRQ)⁸, and Drug Injecting Confidence Questionnaire (DICQ)⁹. The primary outcome was measured by the rate of sero-conversion at 6 months and 12 months from baseline and by the ASI, IRQ and DICQ at 6 months from baseline. Hepatitis C testing was undertaken by the innovative test of the dried blood spot (DBS)¹⁰ tests, which increased, the rate of testing by 4 fold compared to routine blood testing. Seventy-eight subjects (82%) out of the 95 recruited were followed up at 6 months and 62 (65%) were followed up at 12 months. There were no differences in demographic, clinical and psychological characteristics between those followed up

Conducting randomised controlled trials of psychological Interventions in the field of drug addiction – trials and tribulations

Christopher John, M T Abou-Saleh

إجراء الدراسات المقارنة الضابطة العشوائية للمداخلات النفسية في مجال الإدمان: محاولات و إخفاقات.
كريستوفر جون، محمد أبو صالح

Abstract

Background: We have completed a randomised controlled trial (RCT) of the effectiveness of enhanced prevention counselling (EPC) in the primary prevention of Hepatitis C viral (HCV) infection in injecting drug users (IDU). In the conduct of the trial we faced many challenges, which have not enabled us to recruit the required number of participants. Hence, we were not able to demonstrate the effectiveness of EPC in decreasing the incidence of HCV in IDUs.

Objective: To describe the challenges encountered in carrying out the RCT and critically discuss their implications for conducting RCTs of psychological interventions in the field of drug addiction.

Method: The challenges faced were organised into 3 main themes: issues relating to the type of the client group, behaviour and health; issues relating to the service environment from which participants were recruited; and issues relating to the trial design

Results: The main challenges encountered were related to the chaotic behaviour and motivation of drug users, to the high disengagement rates with the treatment; to issues relating to the service environment such as the definition of IDU, HCV methods of testing and to the variation in service set-up; to issues relating to research design including compensation for participation and the use of trained regular staff rather than dedicated research workers as therapists.

Conclusion: The main lessons learnt were that piloting of a new intervention is a crucial first step before conducting pragmatic RCTs of psychological interventions in the field of addiction; that an infrastructure and culture for psychosocial interventions is needed to enable applied research in the service environment, and research funding is needed for enabling the recruitment of dedicated trained therapists for the delivery of these interventions.

الملخص

عرفت المصادر الغربية المختلفة الأخلاق أنها سلسلة من القواعد التي تهتم بما يجب أن يكون. أما العلوم الاجتماعية فاعتبرت الأخلاق هي القواعد الموجودة بالفعل على أرض الواقع. أما الروحانيات فهي علم توصيفي، تصف ماهو حقيقي في مجتمع أو مجموعة من البشر. وهي تمثل مايتشارك فيه المجموع من افكار وتقاليد بصرف النظر عما إذا كانت تمارس أم لا. وفي الغرب يتضح أن هناك خلط بين ما هو أخلاق وما هو سياسة. و لا يوجد مايمكن إعتباره أخلاق عالميه. أما الأخلاق في الإسلام فهي تعتمد على واجبات الشخص تجاه الله وليس الأفراد أو المجتمع. هذا البحث يقدم وجهة نظر إنتقادية في الرؤية الغربية للأخلاق ذات العلاقة بمرض الإدمان مقارنة بالنظام الإسلامي في رؤيته للأخلاق.

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Hamdy Fouad Moselhy, MBBCh, MSc, MD, MRCPsych,
Associate professor in psychiatry,
Faculty of Medicine and Health Sciences,
United Arab Emirates University, P.O. Box, 17666
Email: hamdy.fouad @fmhs.uaeu.ac.ae

ethical or public health consequences of their actions. There was a strong antismoking movement in Victorian times, and the reforms of the Children's Act of 1908 included prohibition of the sale of tobacco to anyone aged less than 16. However, there is evidence that tobacco companies have allowed manufacturers of candy cigarettes (cigarette sweets) to use cigarette pack designs encouraging future smokers without any ethical concerns.

The Independent newspaper on Thursday the 3rd of June (2004) in its cover page came out with how the tobacco giant plans to strike back. Britain's largest tobacco company has been testing chocolate and alcohol flavoured cigarettes, which campaigners say are aimed at enticing children to smoke. British American Tobacco, whose brands include Rothmans and Lucky Strike, has been carrying out scientific trials on animals in Canada. As well as chocolate, wine and sherry, it has also experimented with cocoa, corn syrup, cherry juice, maple syrup and vanilla. These are the sort of ingredients that could make cigarettes more attractive to children. The anti-smoking lobby groups ask for more regulations, as adding chocolate will be the smoking version of Alco pops. The main issue is financial profit without any con-

cern about the health of children or the whole humanity. The human rights groups, the animal rights groups and department of health are asking for tightening of the law, but where is the ethics, which allowed this type of research to happen in the beginning? Therefore, it seems that the politicians removed from the law books any penalties related to private morals (victimless crime). If anyone wants to kill himself by using drugs or alcohol that is their affair. Of course as far as alcohol is concerned it is a nationally produced substance (Western). Certainly, within this scope it seems that what we do with ourselves is no business of our government.

In conclusion, generally it seems that fabricated ethics, which are set by governments and politicians, are mainly financially motivated and biased toward the profits of the state generally without consideration of the individual specifically. On the other hand God-made ethics give consideration to the individual, society and the whole human family.

It appears imperative for Muslims to highlight the justice of Islamic ethics to a wider audience particularly during times when a negative picture of Islam is being widely portrayed.

produced synthetic Western opium to substitute the natural Eastern opium that is no longer under control and no profits came from it, so a harm reduction policy was introduced and was given large-scale media propagation and exported to the undeveloped world to achieve profits.

Think of the many programs identified as part of harm reduction: needle exchange, methadone maintenance, and now bupronorphine substitute, medical use of marijuana, drug-testing services at raves, and so on. Harm reduction supporters as a way of helping addicts to reduce the harms of drug use have pursued all these and more. However, in order to carry out their stated objectives, they required laws, regulations and ethical umbrella to reduce the harshness of the guilt feeling that they are giving illegal drugs. Nevertheless, as soon as a drug is Western made and has a Latin scientific name it becomes ethical. Harm reduction claims to reduce the harmful effects of drug use without requiring users to be drug free. So it is gratifying the addict desire and satisfying the drug companies to achieve profits of billions of pounds annually. Harm reduction has spread so successfully around the world because it has been useful to governments, politicians, and other forms of authorities. It has also succeeded for reasons of hope about the power of the state.

Alcohol beverages are used for political occasions such as state functions and the making of war or peace, and the use of alcohol is common during and after recreational activities such as bowling, skiing, and golf and while watching sports events. At present, beer is the most popular drink among both adults and university students. The media encourages this, as part of western culture not for ethical reasons but because of financial motivations.

Another important issue is the issue of using tobacco. Few people now dispute that smoking is damaging human health on a global scale. However, many Western governments have avoided taking action to control smoking because of concerns that their interventions might have harmful economic consequences, such as permanent job losses. Additionally tax comprises about two thirds of the retail price of cigarettes in most high-income countries but is less than half of the total price, on average, in lower income countries. So economical issues are the power behind any legislation and the moral ground is not there. Tobacco and alcohol advertising is intended to increase consumption as well as brand share and has a powerful effect on young people. However, tobacco and alcohol advertisers are driven by a commercial imperative to increase sales, and they show no concern for

to stop the criminal act, before it is committed, by stopping people from drinking. The difference between Islam and the West is that Islam punishes before there is the chance for a serious crime to be committed.

2. Islam prohibits eating meat and products of swine (pork, bacon, ham, lard), blood, wild animals that use claws or teeth to kill their victims (tiger, wolf, leopard, etc.), all birds of prey (hawks, vultures, crows, etc.), rodents, reptiles, worms and the like, dead animals and birds that are not slaughtered properly.
3. Islam prohibits all forms of gambling and vain sports.
4. Islam prohibits all sexual relationships out of wedlock and all manner of talking, walking, looking and dressing in public that may provoke temptation, arouse desire or show immodesty and indecency.
5. Islam prohibits all forms of stealing, taking of innocent life and sets very harsh punishments for these.

In Islam accountability for individual actions remains with the individual whether or not these actions affect society. This is reflected in a Muslim's belief that he will be held accountable for "immoral" behaviour by God himself, whether or not

his or her actions are seen as "illegal" by his society. Islam concentrates on individual morals, as individuals are the building blocks of the society they live in⁸.

Looking at the history of legislation and prohibition of drugs in the West will guide us to how deceitful it is to legislate for the prohibition of opiate and not of alcohol. All research studies show that all substances that have been misused by man throughout history have the same effect on the brain either directly or indirectly. The British Empire was the first ever drug trafficker in history when it was trading opium in Chinese ports. Simply put, when profits were achieved from trading opium it was ethical and the opium wars were ethical wars. Now they are achieving profits from alcohol taxes and alcohol production. So alcohol is a social and cultural drink and prohibition is an interference with individual freedom according to the ethics of the democratic society. This is a clear example of confusion of ethics and politics.

In addition, when research showed that spending one pound on treating an addict saves some pounds in the criminal justice system, treating addicts became ethical and a duty of doctors and the whole society¹⁰. The moral ground is absent here but the political ground is obvious. The drug prohibition policy failed mainly because drug companies

4. The rights of those powers and resources that God has placed in his service and has empowered him to use for his benefit.

All ultimate authority under the Shariah of Islam rests in Allah. Islam makes no sharp division between sacred and secular affairs, whereas in the modern world there is a sharp division between law and morality, between secular and religious affairs. Islam expects secular authority to be exercised in righteousness and, on that condition, enjoins obedience to such authority. The concept of morality in Islam centres on certain basic belief principles. Among these are the following ⁸:

1. Allah is the Creator and source of all goodness, truth, and beauty
2. Man is a responsible, dignified, and honourable agent of the Creator.
3. Allah has put everything in the heavens and the earth in the service of mankind.
4. By His mercy and wisdom, Allah does not expect the impossible from man or hold him accountable for anything beyond his power
5. All things are permissible in principle except what is singled out as obligatory, which must be observed, and what is singled out as forbidden, which must be avoided.

6. Man's ultimate responsibility is to Allah.

The Muslim's moral obligation is to be a vivid example of honesty and perfection, fulfil his commitments and perform his tasks well, seek knowledge and virtue by all possible means, correct his mistakes and repent his sins, develop a good sense of social consciousness and nourish a feeling of human response. To help man to satisfy these requirements Islam has laid down two types of regulations: positive measures and preventive ones ⁷.

Positive measures: A believer should:

1. Bear witness to the oneness of Allah and the messengership of Muhammad (PBUH).
2. Observe the daily prayers regularly
3. Pay Zakah (charity to poor).
4. Fast the Month of Ramadan.
5. Make a Pilgrimage to Mecca if possible (Hajj)

Preventive Measures ⁹:

1. Islam prohibited all kinds of intoxicants and anyone who will commit this offence will be exposed to punishment in Islamic law. In the West, drunkenness is not in itself a crime. However, there are punishments for crimes committed while drunk e.g. drunken driving, and offences of violence while drunk. Islam, of course, totally forbids believers to drink, and sets out

this constitutes the base, like the foundation of a house on which the rest of the higher floors are built. There are two basic kinds of principles in Islam on which ethical judgments are based. The first entails the existence of core duties and obligations of a person (judgements derived from religion by necessity). These should be clearly stated in the Qur'an or the Prophet's sayings (PBUH). For example: "you should not kill, lie, or steal." "You should keep your promises." These judgements often assert or imply a moral 'ought.' In this sort of ethics if a person is in breach of the moral principle he will be punished whether the breach was committed in private with no victim (victimless crime) or with the involvement of a victim. Therefore, the emphasis is on the individual as well as the societal ethics. Individual ethics include personal ethical conduct of the individual towards family, society, the state or within international relations ⁵.

The second ethical principle focuses on human excellence and the nature of the "good life" man aspires to. These types of ethical judgements employ as their most general aim the pursuits of happiness, excellence, and in general the 'good life'. This includes pleasure, friendship, intellectual development and physical health. In this type of ethics, it is up to society to produce suitable punishment system or leg-

islation for misconduct. Man can use his intellect to produce judgments where no clear one is given by religion. This allows for the development of ethical laws, which are also appropriate for the time and place ⁶.

Islamic ethics assume that man's knowledge is limited. Not every man in every age, by himself, knows what is good and what is evil, what is beneficial and what is harmful to him. The sources of human knowledge are too limited to provide him with the pure truth. That is why God has spared man the risks of trial and error and revealed to him the law, which is the right and complete code of life. Shariah (Islamic Law) provides guidance for the regulation of life in the best interests of man. Its objective is to show the best way to operate and provide him with the ways and means to fulfil his needs in the most successful and most beneficial way. The scheme of ethics, which the Shariah envisages, consists of a set of rights and obligations, and every Muslim, who accepts this religion, is enjoined to live up to them⁷. It imposes four kinds of rights and obligations

1. The obligations to Allah, which every Muslim is obliged to fulfil
2. The person's own rights upon his own self
3. The rights of other people (both Muslims and non-Muslims) on the person

Editorial

Ethics in the West versus the moral system in Islam in Addiction

Hamdy Fouad Moselhy

أخلاقيات المهنة في معالجة الإدمان: مقارنه بين الغرب والاسلام
حمدي فؤاد مصلحي

Abstract

The Oxford dictionary of current English defined ethics as a set of moral principles. It is the science of morals in human conduct¹. In the Oxford dictionary of sociology it is defined as the concern with what ought to be, whereas social science is concerned with describing reality, as it actually exists. A study of human behaviour because of beliefs about what is right or wrong, or good or bad, in so far as that behaviour is useful or effective².

Morals are a descriptive science; it seeks to establish "what is true" in a society or group. Often morals are considered the shared ideals of a group, irrespective of whether they are practised. In the sense of descriptive ethics or morals, different persons, groups, and societies have different moral standards³. There is a consensus that there is no universal ethical standard and there appears to be no universal moral standard. However, the American media is trying to convert the world into mimicking the "Western style" under the name of globalisation and anyone who tries to refuse is at risk of being labelled as "anti-western", whatever his morals or ethics are. This view throws light on the confusion between ethics and politics, where Western administrations judge actions and policies from a political standpoint. They consider whether ethics will promote or hinder their political objectives. For example someone might think alcohol is as ethically unacceptable as heroin. However, a government might consider it politically wrong to ban it for fear of losing the support of a section of the population and so put at risk its chances of being re-elected⁴.

On the other hand, normative ethics is the discipline concerned with judgements of setting up norms. For example, when an act is right or wrong, the terms ethical, unethical, moral or immoral could have different meanings. Consider the recent changes of softening the rules related to cannabis in the UK. How could these changes be described in the light of probable consequences both mental and physical?

Ethics in Islam are built on the duties of the individual toward Allah.

If the heart and mind of the individual is filled with faith in Allah,

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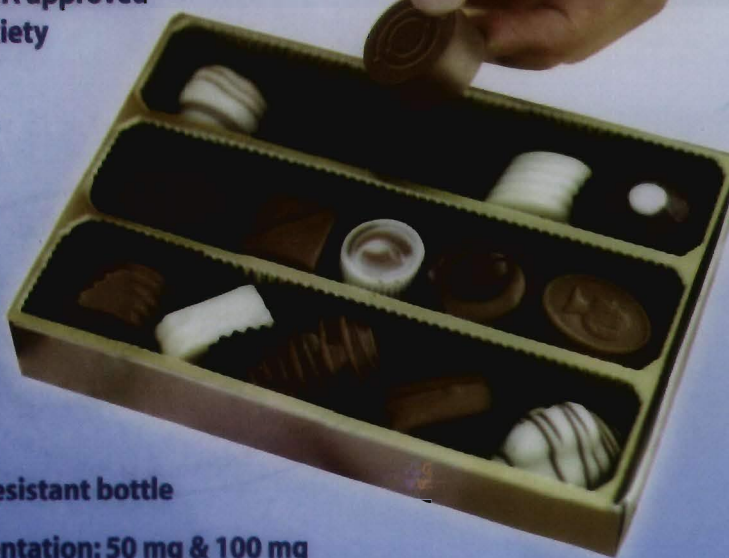


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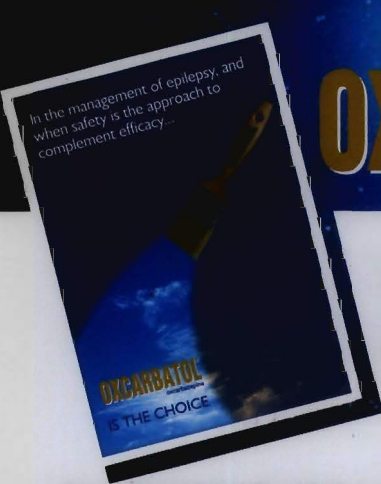
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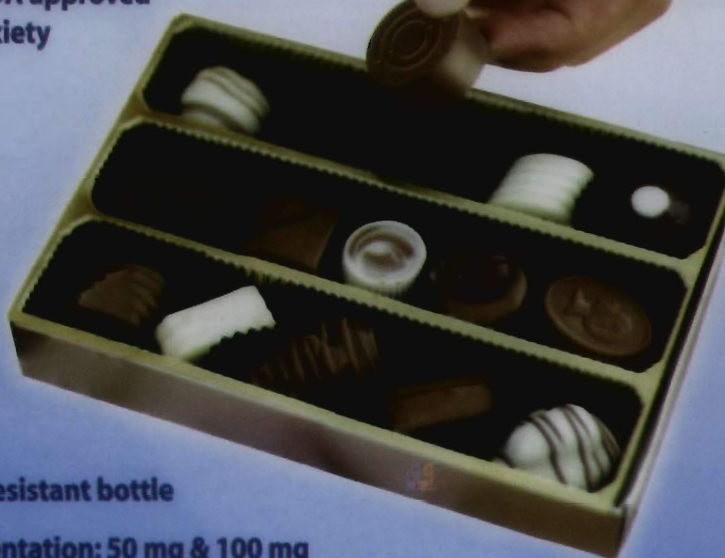


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المجلد الثامن عشر، العدد الثاني، تشرين ثاني (نوفمبر) 2007

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