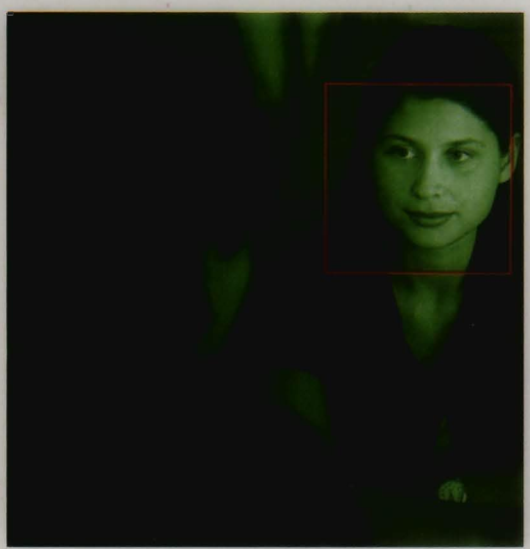
Debbie doesn't know that Cipram is now indicated for panic disorder



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

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

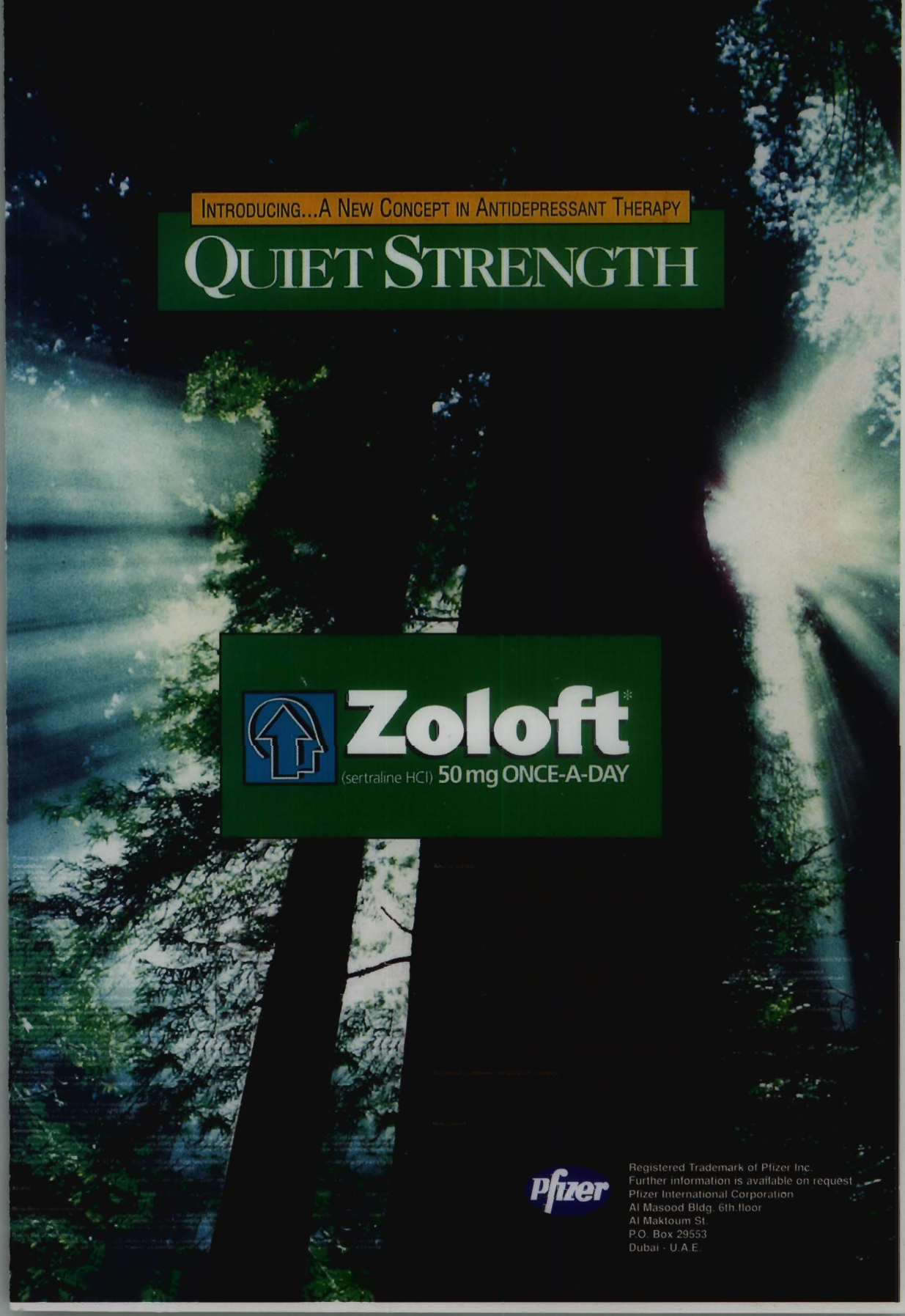
Of course, Debbie would no more talk of the recently extended indication for Cipram than its high selectivity[1,2], good tolerability[3], and low risk of drug interactions[4,5,6]. She just recognises the difference that Cipram makes to the stability and quality of her life.

Lundbeck

Cipram▼
citalopram
now indicated for panic disorder

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

1. Hyttel J. XXII Nordiska Psykiater Kongres, Reykjavic, 11 August 1988:11-21. 2. Eison AS et al. Psychopharmacology 1990; 26 (3): 311-315. 3. Wade AG et al. Br J Psychiatry 1997; 170: 549-553. 4. Sindrup SH et al. Ther Drug Monit 1993; 11-17. 5. Van Harten J. Clin Pharmacokinetics 1993; 24: 203-20. 6. Jeppesen U et al. Eur J Clin Pharmacol 1996; 51: 73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٩٠ ص

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

(تمت الفهرسة بمعرفة دائرة المكتبات والوثائق الوطنية)

تلفون ٥٦٧٨١٨١، ٥٦٩٦٦٧٢ فاكس ٥٦٦٧١٧٠

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Siham Al-Wahoush, Center for Educational Development for Health Personnel, University of Jordan

معلومات هامة للناشرين

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

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

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

الصفحة الثالثة: تحتوي على أسماء المشاركين وعناوينهم وعناوين المراسلة.

يمكن أن تخصص صفحة للشكر للأفراد والمؤسسات التي دعمت البحث.

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

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

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

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

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المجلة العربية للطب النفسي

المحتويات

The Arab Journal of Psychiatry (1998) Vol 9. No. 2 Page (117 - 120)

Epilepsy in Infants "Quoted from Management of Pregnant Women and Infants"

By Arib Ibn Said El Kateb El Kortobi

Othman Amami, Anwar Jarayeh

مرض الصرع لدى الأطفال من خلال مخطوط "تدبير الحبالى والمولود"

لعريب بن سعيد الكاتب القرطبي

عثمان عمامي، أنور جراية

الملخـــــص

نقدم مخطوطاً لعنوان "تدبير الحبالى والمولود" وصاحبه عريب بن سعيد الكاتب القرطبي (القرن العاشر ميلادي الموافق للقرن الرابع للهجرة) ونحصر الاهتمام في مرض الصرع لدى الأطفال (الأعراض، الأسباب والدواء) ونختم بابداء بعض الملاحظات.

مقدمـــــة

ارتأينا أن نساهم في التعريف بما وصل اليه السلف في ميدان الطب وتحديداً في مجال مخصوص هو مرض الصرع لدى الأطفال، وتبعاً لذلك لم يكن همنا البحث عن معطيات نجهلها عن مرض صار اليوم معلوماً أعراضاً وعلاجاً، وانما انحصرت غايتنا الى جانب التعريف في استكشاف التفكير العلمي عند من سبقنا، خاصة أولئك الذين لم تذع أسماؤهم بين الناس على مر العصور، خلافاً لأسماء أصبحت اليوم معروفة غرباً وشرقاً بقطع النظر عن كتبهم.

وقد عثرنا على مخطوط وجدنا فيه ضالتنا وعنوانه "تدبير الحبالي والمولود" مسجل بمتحف الاسكوريال (Escurial) بعاصمة اسبانيا تحت عدد ٨٣٣، وهو لعريب بن سعيد الكاتب القرطبي.

الكاتب والمخطوط

غاية ما توصلنا اليه في خصوص الكاتب ما أورده الاستاذ سليم عمار في كتابه الصادر بالفرنسية "أطباء وطب الاسلام، والذي حدد العصر الذي عاش فيه، القرن العاشر ميلادي الموافق للقرن الرابع هجري وذكر فيه معاصرين له أحدهما في ميدان السياسة، الأمير المستنصر، وثانيهما في مجال الطب وهو ابن الجزار القيرواني. هذا عن صاحب الكاتب، أما الكتاب فيقع في ست وثمانين صفحة، وفي خمسة عشرة بابا نوردهما كما جاءت بقلم صاحبها:

الباب الأول: في الزرع الذي هو علة الحيوان وأول خلق الانسان وكيف يولد ومن أين يتدفق والأسباب التي منها يكثر ويقل واصلاح مادته والزيادة في كميتة وعلة الاحتلام وما يوجبه.

الباب الثاني: في هيئة القضيب والأسباب الموجبة للانقباض وما يزكي الشهوة ويعين القوة.

الباب الثالث: في الأرحام وهيئاتها ومواضعها والعلل الموجبة لامتناع الحمل وامتحان المرأة هل تحمل أم لا ومداواة الأرحام وتعديل الحيض والعون على الحمل.

الباب الرابع: في الأسباب التي أوجبت الذكور والاناث.

الباب الخامس: في امتزاج زرع الوالدين ودلائل العلوق وتخلق الجنين.

الباب السادس: في الحمل وحدوده ومدة شهوره وأيامه والمولودين لسبعة أشهر ولثمانية ولما فوق هذه المدة.

الباب السابع: في تدبير الحبالى وحفظ قواهن ومداواة ما يعرض لهن من أول الحمل الى وقت الوضع والقول في الاسقاط وأسبابه وتلافي أعراضه والاحتراس مما يحدثه.

الباب الثامن: في دلائل الوضع وتسهيل الولادة واحكام قبول الجنين واستخراج المشيمة.

الباب التاسع: في تكون اللبن وارضاع المولود وحفظ صحته والتدبير الموافق لهما.

الباب العاشر: في أسنان المولود.

الباب الحادي عشر: في تدبير الطفل من أول حدوث سنه وقرب ولاده وما يعالج به من الأمراض العارضة له في هذا الفصل الأول.

الباب الثاني عشر: في تدبير الأطفال في الجزء الثاني من أسنانهم وذلك بعد الأربعين يوما الى وقت نبات الأضراس وما يحملون عليه من التدبير والعلاج عبر أمراضهم المخصوصة لهم في هذا السن.

الباب الثالث عشر: في تدبير الصبي بعد نبات أضراسه الى وقت اثغاره، وهو الجزء الثالث من سنه وابتداء كلامه ومشيه وفطامه، وذكر ما يصيبه في هذا الجزء من الأمراض وما يرام به من العلاج.

الباب الرابع عشر: في تدبير الصبيان من بعد اثغارهم الى وقت اشعارهم وقرب احتلامهم، وما يعرض لهم في هذا السن من العلل وما يحملون عليه من العلاج.

الباب الخامس عشر: في احتلام الغلمان وحيض الجواري ومواقيت ذلك وما يحدث معه في الحركات والصور.

يبدو من خلال هذا العرض أن الكاتب اعتمد مقياساً زمنياً فابتدأ بما سماه الزرع وخلق الجنين، وانتهى بآخر مرحلة من نمو الطفل. وقد حاول أن يكون كتابه جامعاً لكل ما يتعلق بالحبالى والمولود في حالتي الصحة والاعتلال. ومن بين العلل التي ذكر مرض الصرع.

مرض الصرع لدى الأطفال

يسمى عريب بن سعيد القرطبي هذا المرض علة الصبيان وقد وصفه في الباب الثاني عشر وهو في نظره تشنج يعرض للأطفال وضرب من الصرع أشد عليهم وأعم فيهم في الجزء الثاني من أعمارهم عند نبات أضراسهم ويعلل ذلك بقرب اللثة من الدماغ. وقد قارن الصرع لدى الأطفال بالصرع لدى الكهول، ورأى أنه أشد على الأولين وقد علل هذه الشدة بتجمد الدم في العروق مستشهداً بقول أبقراط الذي يرى أن عروق الصبيان ضعيفة ودماءهم فاترة خلافاً للمكتهلين الذين يحتملون العلة أكثر لأن عروقهم أوسع ودماءهم حارة بحيث لا تتجمد كتجمدها عند الأطفال وقد حاول

البحث عن أسباب علة الصرع فأرجعها في الغالب الى سببين أولهما المزاج البارد الرطب وثانيهما رداءة التدبير أي سوء الرعاية. والسبب الأول يزول عند مقاربة البلوغ لأن نضج الأطفال يجعلهم يميلون الى مزاج أسخن وأجف. ولكن القرطبي لا ينصح، اقتداء بأبقراط بانتظار فترة البلوغ، ويدعو مثله الى ازالة السبب المولد له كفساد اللبن الذي يستدعي الاستغناء عنه ووتعويضه بغيره. واذا تعلق الأمر بتشنج عند نبات الأسنان وهو الأعم فالحل يكمن في علاج النبات الذي يتم بدلك اللثة بالزبد والشد على منابت الأسنان ودهنا بالزيت أو العسل وسكب طبيخ البابونج على رأس الطفل، ومنعه من أكل اللحم والقيام بالحركات القوية عند التعرض للحمى. ولا يقتصر العلاج على الطفل المصاب بل يتعداه الى الأم المرضعة التي يجب الاعتناء بتنقية جسمها من الخلط الرديء وتغذيتها بأغذية حسنة المزاج.

وقد أورد الكاتب مارواه جالينوس في كتاب الأدوية البسيطة عن صبي رآه يصرع فعلق عليه عود فالونيا فشفي ولكن لما وقع العود عادت العلة وكلما علق من جديد شفي الصبي.

وقد كرر ذلك مراراً، فاستنتج نجاعة العود.

والى جانب عود الفالونيا، يتفق القرطبي مع جالينوس في نجاعة العنصل في مداواة كل أنواع الصرع سواء كان المصروع طفلاً أو رجلاً. وذكر عدة مستحضرات أنجعها عصارة العنصل التي بفضلها تخرج العلة دفعة واحدة في أربعين يوماً. ويدقق الوصف فيذكر طريقة تحضير هذهالعصارة والمقادير اليومية (ملعقة صغيرة للصبي وكبيرة للرجل).

ويتطلب صنع هذاالدواء أربعين يوماً هي المدة الضرورية لنضج جرم البصل وارخاء مائه، ولما كان الدواء مرّاً وجب تطبيبه في النهاية بعسل منزوع الرغوة.

ويذكر القرطبي، نقلا عن جالينوس طريقة أخرى لصنع الدواء تتمثل في عصر جرم البصل واضافة العسل الى مائة الا أنه يرى أن هذا الدواء أقل نجاعة من الدواء المستحضر وفق الطريقة الأولى.

تعليق

نلاحظ مما ذكرنا ولم نذكر أن مصادر القرطبي متعددة (الأطباء السابقون، أقوال العرب وتجربته الخاصة)، وقد حرص على ذكر المصادر وابداء رأيه في ما ينقل وهو يبدو ميالاً الى اختيار تلك التي انبنت على التجربة والمنسوبة غالباً الى أبقراط (460-377 ق م) وجالينوس (131-201) ويعد هذان العالمان من المصادر الرئيسية التي أخذ عنها الأطباء العرب القدامى.

هذه الأمانة العلمية هي كما نعلم من شروط الفكر العلمي، هذا الفكر الذي تجسد أيضاً في عدم الاكتفاء بأعراض المرض وفي تجاوزها الى البحث عن الأسباب حتى يسهل العلاج. وقد كان تفسيره أقرب ما يكون الى العلمية اذ استبعد التفسيرات الغيبية التي تقدم غالباً في تعليل مرض الصرع كفرضيات الجن مثلاً وأشار بوضوح الى الدماغ بوصفه مسؤولاً عن التشنج. قد تبدو فرضية المزاج الرطب البارد اليوم غريبة اذ نحن في زمن التسجيل الكهربائي للدماغ والتصوير المغناطيسي ومع ذلك لا نزال نطلق عبارة

"صرع وظيفي" عندما لا نجد أسباباً واضحة لهذا الداء.

والملاحظة الأخيرة تتعلق بجمع القرطبي بين الداء والدواء فالطبيب كان في زمنه طبيباً وصيدلانياً في آن معاً.

خاتمة

ان البسطة التي قدمناها عن الكتاب والمرض كافية في رأينا لتبين الجهد الذي كان يبذله القدامى رغم قلة الامكانيات وغياب البحث الجماعي ولكن ذلك لم يمنع من تحقيق أمرين أولهما المحافظة على التراث اليوناني في ميدان الطب وثانيهما تطوير هذا التراث، وبذلك يتقدم العلم بالأخذ والاضافة وبالتراكم ويأخذ وجها انسانياً عاماً لا يعترف بفوارق الجنس والحضارة.

Abstract

This manuscript entitled "pregnant women and the infant" which was written by Arib Ibn Said El Kateb El Kortobi (Tenth Millennium, 4th Hegire Millennium). The authors involved themselves in this manuscript with epilepsy in the infant (symptoms, causes and treatment) some observations has been put forward.

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المستشفى الجامعي الهادي شاكر

صفاقس

تونس

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Attempted Suicide in Lebanon

محاولات الانتحار في لبنان

نجوى اليحفوفي

الملخص

يهدف هذا البحث الى دراسة الخصائص الديموغرافية المتعلقة بمحاولات الانتحار. وأظهرت نتائجه أن محاولي الانتحار ينتمون غالباً الى فئة المراهقين والراشدين - الشباب، العازبين والاناث. وكان معظمهم ينحدر من عائلات تعاني من صراع بين الأباء والأبناء. ومن مشاكل نفسية تتمثل خاصة بالشعور بالاكتئاب، كما أن الغالبية العظمى من المحاولين استخدموا الأدوية والعقاقير في محاولاتهم الانتحارية. هذا وقد تطابقت نتائج هذه الدراسة مع الدراسات السابقة العربية والعالمية.

مقدمة

تتداخل العوامل المؤدية الى محاولات الانتحار مع عملية الانتحار، فالعديد ممن يحاولون الانتحار تتملكهم النية في ذلك، لذا يجب دراسة الصفات الديمغرافية لمحاولي الانتحار والعوامل النفسية والاجتماعية والثقافية للمساعدة على التنبؤ ببعض هذه الحالات، اذ وجدت الدراسات السابقة علاقة وثيقة بين السلوك الانتحاري، وبعض المتغيرات كالوضع العائلي، الجنس، الاضطرابات النفسية.... كما أعطيت الأدوات المستخدمة في محاولات الانتحار اهتماماً بالغاً من قبل الباحثين وغالباً ما تطابقت معظم نتائج الأبحاث المتعلقة بهذه المتغيرات عبر مختلف الثقافات.

فيما يتعلق بالوضع العائلي وجدت البحوث الغربية أن نسبة محاولات الانتحار أعلى لدى العازبين فالأرامل فالمطلقين منها لدى المتزوجين[1,2] وهذا ما توصلت اليه الدراسات العربية في كل من البحرين، السعودية، ومصر[3,4,5]. أما الدراسات التي تتعلق بالعمر فقد سجلت أعلى نسبة لمحاولات الانتحار للذين تتراوح أعمارهم على التوالي بين ١٥ و ٢٥ سنة، ٢٥ و٣٥سنة، ٣٥ و ٤٤ سنة، ٤٥ و ٥٤سنة وكانت أكثر انخفاضاً لدى الذين زادت أعمارهم عن ٥٥ سنة[1,6] وهذا ما أكدته البحوث العربية[4] فنسبة محاولات الانتحار أعلى للذين تتراوح أعمارهم بين ١٦ و٢٥ سنة وتنخفض بين ٢٦ و ٤٠ سنة وتصل الى أدنى مستوى لها بين ٤١ و ٤٥ سنة. كما أشار (Lotaif Okasha) [5] الى أن محاولات الانتحار بين ١٥ و ٢٤ تتعدى نسبتها الضعفين مقارنة مع الذين تتراوح أعمارهم بين ٢٥ و ٣٤ سنة. أما بالنسبة للفروق الجنسية فتشير الدراسات الى أن نسبة محاولات الانتحار لدى الاناث تفوق هذه النسبة لدى الذكور[7,8,1,6,9] وقد أكدت (Choquet,6) أن النسبة تبلغ ذكراً واحداً مقابل خمس اناث. أما دراسة (Osman, Ibrahim, 4) فدلت على أن النسبة تبلغ ذكراً واحداً تقريباً مقابل أربع اناث وهي نسبة أعلى

مما وجد في العالم الانجلوساكسوني والبالغة ذكراً واحداً مقابل ثلاث اناث[10] وتوصلت دراسة Al Ansari, 3) الى نفس النتيجة. وقد وجدت نتائج جميع الدراسات العربية والعالمية أن نسبة النساء اللواتي يحاولن الانتحار تفوق نسبة الرجال عدا دراسة واحدة في مصر أشارت الى أن نسبة الرجال الذين يحاولون الانتحار تفوق نسبة النساء [5](1,6 رجل لكل امرأة واحدة). أما الأدوات المستخدمة في محاولات الانتحار يبدو أن الأدوية هي الأكثر استخداماً[12,4,8,5,11,7] تليها المواد السامة، فالأسلحة النارية وأدوات أخرى.

بالاضافة الى متغيرات الوضع العائلي، والعمر، والجنس، حاولت الدراسات معالجة أسباب محاولات الانتحار والتي تركزت على العوامل الاجتماعية، والنفسية والاضطرابات العقلية، وبصورة خاصة على العلاقات الأسرية المضطربة. وأكدت على الدور الحاسم الذي يلعبه التفكك الأسري في محاولات الانتحار فالنسبة كانت أعلى لدى الأفراد الذين يعاني أحد آبائهم أو اخوتهم من مرض عقلي، أو الادمان، أو الخلافات المستمرة بين الوالدين، أو الطلاق، أو الموت، أو الانفصال عن العائلة (كالأبناء الذين يعيشون في المدارس الداخلية أو المؤسسات العامة[15,25,14,1,9,13,12,16] وقد ذكر (Paris, 17) أن العوامل التي لها علاقة بارتفاع محاولات الانتحار في السنوات الأخيرة في مختلف الثقافات تتلخص بانتشار سوء استخدام العقاقير والأدوية[11] وتفسخ العرق الاجتماعي والباتولوجية العائلية. أما فيما يخص لبنان فثمة دراسة وحيدة حول محاولات الانتحار أجرتها (Muller, 7) عام 1976 على النساء اللواتي أدخلن احدى مستشفيات بيروت. وقد أظهرت النتائج أنه بالنسبة للعمر سجلت أعلى معدلات لمحاولات الانتحار بين ١٦ و ٣٠ سنة، ونسبة العازبات اللواتي يحاولن الانتحار تفوق نسبة المتزوجات، أما الأدوات المستخدمة فكانت الأدوية، المواد السامة، فقطع الشرايين. ونظراً لعدم وجود أية دراسات أخرى في لبنان حول محاولات الانتحار فان هدف البحث الحالي هو دراسة عدد من التغيرات الديمغرافية والنفسية المتوفرة في ملفات محاولي الانتحار في بعض مستشفيات بيروت لالقاء المزيد من الضوء على هذه الظاهرة.

منهجية البحث

في العام ١٩٩٤ أمنّت سبعة مستشفيات[1] في غرب بيروت وضاحيتها الجنوبية خدمة الطوارىء لحوالي ٨٠٠ر٠٠٠ ألف مواطن من الطوائف المسلمة. لكن الدراسات الحالية شملت ٦ مستشفيات، ولم نتمكن من الحصول على معلومات من احدى المستشفيات السبعة لصعوبات ادارية. تم الاطلاع على ملفات محاولي الانتحار للعام ١٩٩٤ واحصاؤها وقد بلغت ١٤٧ محاولة. وتجري عادة مقابلة محاولي الانتحار في قسم الطوارىء من قبل طبيب صحة عامة. دونت جميع المعلومات المذكورة في ملفاتهم وكانت تحتوي على العمر، الجنس، وأدوات الانتحار، الوضع العائلي (٥٢ حالة فقط) والأسباب المؤدية الى محاولات الانتحار (٤٧ حالة) وهناك عوامل أخرى

[1] بلغ عدد المستشفيات في غرب بيروت وضاحيتها الجنوبية ١٧ مستشفى عام ١٩٩٤، وكانت كبرى هذه المستشفيات وعددها ٧ تؤمن خدمة الطوارىء لمحاولي الانتحار. أما باقي المستشفيات فلم تكن تستقبل هذا النوع من الحالات.

بالغة الأهمية لم تذكر في هذه الملفات كالطبقة الاجتماعية (المهنة، المستوى التعليمي) لذا فان المعلومات المتوفرة لدينا تنحصر في نطاق ما كان مسجلاً في الملفات. كما أجرينا عدداً من المقابلات مع محاولي الانتحار من مختلف الأعمار والأجناس للحصول على معلومات أكثر حول العوامل النفسية والعائلية المتعلقة بتلك المحاولات وسنذكر بعض الأمثلة من هذه المقابلات في مناقشة النتائج.

نتائج الدراسة

يوضح جدول رقم (١) أن عدد محاولات الانتحار بلغ ١٤٧ محاولة في المستشفيات الستة التي شملتها الدراسة بمتوسط قدره ٢٤ر٥ وبما أن هناك سبعة مستشفيات تقدم خدمة الطوارىء لـ ٨٠٠ر٠٠٠ يمكن حساب النسبة بـ ٢١ر٤ لكل ١٠٠ر٠٠٠نسمة.

جدول رقم (١): نسبة محاولي الانتحار حسب متغير كل من العمر والجنس

العمر	الجنس		التكرار	ن م
	ذكر	انثى		
١٠ – ١٥	٣	٥	٨	٤٤ر٥
١٦ – ٢٥	٢٥	٥٩	٨٤	١٤ر٥٧
٢٦ – ٤٥	٥	٩	١٤	٢٥ر٩
٤٦ – ٥٥	٣	٤	٧	٧٦ر٤
٥٦ – ٦٥	١	١	٢	٣٦ر١
	٦٩ر٣٤٪	٣١ر٦٥٪	١٤٧	١٠٠٪

يبين جدول رقم (١) أن الغالبية العظمى من محاولي الانتحار تتراوح أعمارهم بين ١٦ و ٢٥ سنة (١٤ر٥٧٪) وتهبط هذه النسبة الى ثلاثة أضعاف تقريباً بين ٢٦ و ٣٥ سنة وتصل الى أدنى مستوى لها بين ٥٦و ٦٥سنة. أما فيما يتعلق بالجنس فان نسبة المحاولات لدى الاناث تبلغ حوالي ضعف نسبتها لدى الذكور.

يتضح من الجدول رقم (٢) أن معظم الذين يحاولون الانتحار يستخدمون الأدوية (٨٦ر٥٩٪) وذلك بغض النظر عن أعمارهم، ويلجأ حوالي الربع الى المواد السامة فيما تستخدم أقلية وسائل أخرى كقطع الشرايين، أو الغرق أو الأسلحة.

تشير نتائج الجدول رقم (٣) الى أن نسبة المشاكل الأسرية التي تقف وراء محاولات الانتحار ترتفع الى أكثر من ضعفين (٨٣ر٦٣٪) مقارنة بنسبة المشاكل النفسية، والى أكثر من عشرة أضعاف مقارنة بنسبة المشاكل الاقتصادية.

جدول رقم (٢): الأدوات المستخدمة في محاولات الانتحار حسب العمر

العمر / الأدوات	١٠ - ١٥	١٦ - ٢٥	٢٦ - ٣٥	٣٦ - ٤٥	٤٦ - ٥٥	٥٦ - ٦٥	ن م
دواء	٤	٥٠	١٨	٩	٥	٢	٥٩ر٨٦
مواد سامة	٢	٢٣	١٠	٤	١		٢٧ر٢١
مواد مخدرة		٥	٣				٥ر٤٤
قطع شرايين	١	٣					٢ر٧٢
غرق	١	١					١ر٣٦
أخرى		٢	١	١	١		٣ر٤٠
م							١٠٠٪

جدول رقم (٣): النسبة المئوية للأسباب المؤدية الى محاولات الانتحار

الأسباب	العدد	ن م
مشاكل أسرية	٣٠	٦٣ر٨٣
مشاكل نفسية	١١	٢٣ر٩١
مشاكل اقتصادية	٣	٦ر٢٥
أخرى	٣	٦ر٢٥
	م = ٤٧	١٠٠٪

جدول رقم (٤): النسبة المئوية لمحاولات الانتحار حسب الوضع العائلي

الوضع العائلي	التكرار	ن م
أعزب	٤٠	٧٦ر٩٢
متزوج	١٢	٢٣ر٠٨
	م = ٥٢	١٠٠٪

يتضح من جدول رقم (٤) أن نسبة العازبين الذين يحاولون الانتحار أعلى بأكثر من ثلاثة أضعاف (٧٦ر٩٢٪) نسبة المتزوجين.

مناقشة النتائج

دلت نتائج البحث على أن محاولات الانتحار في لبنان بلغت أعلى نسبة لها لدى المراهقين والراشدين- الشباب. أما فيما يخص متغير الجنس فان نسبة الاناث تفوق نسبة الذكور. أما فيما يتعلق بالوضع

العائلي، كانت نسبة محاولات الانتحار لدى العازبين أعلى منها لدى المتزوجين وتدعم هذه النتائج ما توصلت اليه البحوث في البلاد العربية والغربية والتي بينت أن محاولي الانتحار ينتمون غالباً الى الاناث، والمراهقين والراشدين–الشباب والعازبين[1,3,4,19,22,21,20] هذا وقد بلغت نسبة محاولات الانتحار في الدراسة الحالية ٤ر٢١ لكل ٠٠٠ر١٠٠ فيما بلغت النسبة في القاهرة ٣٨ لكل ٠٠٠ر١٠٠[5] وهو فرق شاسع وما يثير الاستغراب أن المعلومات جمعت في لبنان أعقاب انتهاء الحرب وكان متوقعاً أن تكون نسبة المحاولات أكثر ارتفاعاً في لبنان منها في مصر. لكن الدراسات تشير الى وجود فروق في المجتمعات العربية بالنسبة لمحاولات الانتحار (جوة وأخرون)[12] ، دباغ[23] وقد يكون الدعم الاجتماعي وعوامل اجتماعية–ثقافية أخرى من العوامل المؤثرة في هذا المجال. ويذكر أن تقدير محاولات الانتحار منخفض بشكل عام ولا يعكس الأرقام الحقيقية وذلك لأسباب اجتماعية ودينية تتمثل بالحرص الشديد على اخفاء هذه الظاهرة. وكذلك تدعم الدراسة الحالية الدراسات السابقة بالنسبة لأدوات الانتحار اذ استخدم الغالبية العظمى من المحاولين الأدوية والعقاقير والمواد السامة بالمقارنة فان استخدام وسائل العنف كان قليلاً[7,11,5,8,12,4,18,24] ويعلل (Osman, Ibrahim, 4) هذه الظاهرة بانخفاض مستوى العنف في المملكة العربية السعودية لكن اللجوء الى الأدوية بدلاً من وسائل العنف ليس مقتصراً على المملكة بل لوحظ عالمياً ونعتقد أن ذلك يرجع الى الفروق بين الجنسين فغالبية محاولي الانتحار من النساء ويملن بشكل عام الى استخدام الأدوية[25] اذ أن العديد من المحاولين لا ينوون قتل ذواتهم لذلك يلجأون عمداً الى استخدام أدوات غير مميتة[3]. ومن العوامل التي تزيد ربما من استعمال الأدوية الخطرة هي سهولة الحصول عليها من الصيدليات فالقوانين اللبنانية لا تمنع شراءها بدون وصفة طبية، ونلاحظ نفس الظاهرة في أقطار عربية أخرى.

كما أظهرت نتائج هذا البحث أن السبب الأول المؤدي الى محاولة الانتحار هو المشاكل الأسرية، وهذا ما أجمعت عليه الدراسات السابقة[1,9,13,16,15,12,2,5,14] وقد تبين من المقابلات التي أجريناها مع عدد كبير منهم أنهم ينحدرون من عائلات مفككة (خلافات مستمرة بين الوالدين، ادمان الأب، موت أحد الآباء، طلاق...) وقد اقتطفنا بعض الأمثلة التي تعبر عن هذه المشاكل.

قالت فتاة في الثالثة والعشرين "حياتنا لا تطاق في البيت الخلافات هي خبزنا اليومي، قلت سأترك لهم هذا العالم وأرحل لكن للأسف أنقذوني"، وقالت أخرى في السادسة عشرة "تشعرني أمي دائماً بأني عبء ثقيل عليها بعد أن توفي والدي، وتسيء معاملتي". وأضاف شاب في العشرين: "تمنيت دائماً الموت لوالدي فهو مدمن ولا يعرف الرحمة وأمي ضعيفة تجاهه"، وأردف فتي في الرابعة عشرة" أعيش في الجحيم جراء خلافاتي المستمرة مع والدي كذلك فقد رسبت في امتحان المدرسة"، وعبرت احدى الحالات بشكل واضح عن الصراع العائلي المجتمعي الذي تعانيه المرأة قائلة: "أبي انسان معقد وعلاقتي به معدومة، لأنه متعصب ومتزمت ومتسلط أشعر بأنه لا يحبني فهو يراقبني باستمرار،ويكبتني دائماً، لا يسمح لي بالخروج مع أصدقائي أو من البيت (الأب يضربها)، أمي مثله، امرأة قوية، متسلطة وغير متفهمة. أكرههم لأنهم رجعيون ويريدون أن يفرضوا

آراءهم علي عن طريق السيطرة. كما أنهم يميزون جداً في المعاملة بين البنت والصبي ويعطون كل الحرية للصبيان. أيضاً اشمئز من المجتمع لأنه يعامل المرأة كغرض جنسي فقط، وليس كانسان يفكر ويحس ويتألم ويربيها كي تكون ربة منزل وتخدم الرجل فقط".

بالنسبة للمشاكل النفسية فقد أكدت النتائج أنها السبب الثاني لمحاولة الانتحار. هذا وقد أشارت معظم البحوث الى أن غالبية المحاولين يعانون من الاكتئاب بشكل خاص ومن اضطرابات نفسية أخرى[26,27,1,28,9,16,29,30,11]. ويذكر أن نسبة أعراض الاكتئاب لدى هؤلاء المحاولين هي أكثر ارتفاعاً لدى النساء منها لدى الرجال. وهذا ما يثير التساؤل عما اذا كانت هناك علاقة بين نسبة محاولات الانتحار المرتفعة لدى النساء وكذلك ارتفاع نسبة أعراض الاكتئاب بينهن بصورة عامة اذ وجد (Kessler 31) أنه من بين كل ١٠٠ شخص يوجد ١٣ رجلاً مقابل ٢١ امرأة ممن يعانون الاكتئاب في فترة ما من حياتهم.

هذا وقد عبر معظم الذين قابلناهم من محاولي الانتحار عن اكتئابهم قالت سيدة في الأربعين "أشعر بأنني حزينة دائماً ولا أستطيع القيام بأي عمل، العالم كله أسود فلماذا نحيا؟" وقال آخر في الثانية والاثلاثين "أشعر أني عاجز عن تحمل أي مسؤولية وأن وجودي لا فائدة منه، أكره نفسي لذلك أردت قتلها" وأردفت اخرى في السابعة والعشرين "حياتي ليس لها أي معنى فكل من حولي يكرهني ولا أستطيع المواجهة أكثر" وقالت أخرى في السادسة عشرة "أبكي دائماً وأشعر بأنني فاشلة في كل شيء وأن وضعي ميؤوس منه".

بالنسبة للمشاكل الاقتصادية والمشاكل الاخرى (الصحية مثلاً) فقد سجلت أدنى نسبة لها، ويبدو أن العلاقة بين الأزمة الاقتصادية في لبنان، وبين محاولات الانتحار منخفضة جداً وهذا ما أكدته (Moullembe et al 28) في دراستها عن عدم وجود صلة مباشرة بين الأزمات الاقتصادية، وارتفاع معدلات السلوك الانتحاري.

بالرغم من الصعوبات البالغة التي وجدناها في الحصول على معلومات كافية حول محاولات الانتحار، فان الدراسة الحالية تلقي الضوء على بعض المتغيرات المتعلقة بهذا الموضوع. وقد تمكنا من دراسة متغيرات العمر، الجنس، الوضع العائلي، الأدوات وأسباب محاولات الانتحار، في ستة مستشفيات، الا أن ملفات هذه المستشفيات كانت تفتقر الى العديد من العوامل الديمغرافية، الاجتماعية والنفسية المهمة لدراسة محاولات الانتحار، فهي تهمل ذكر الطبقة الاجتماعية (المهنة، المستوى التعليمي) وذكر الأسباب النفسية والاجتماعية بالتفصيل، وتكرار المحاولة، وتاريخ المحاولة (التوقيت، اليوم، الشهر) كما أن الوضع العائلي لم يذكر في العديد من المستشفيات. لذا فالضرورة تقضي تسجيل كل هذه المعطيات في الملفات، لأن دراسة العوامل الديمغرافية المتعلقة بمحاولات الانتحار بالغة الأهمية ويشير (Paris, 17) في هذا الصدد الى أن معدلات محاولات الانتحار تتغير عبر الزمان والمكان أكثر من عمليات الانتحار لأنها تتأثر أكثر بالعوامل الثقافية على الصعيدين القومي والعالمي.

Abstract

The aim of the present study was to investigate the demographic characteristics associated with attempted suicide. It was found that the attempters tend to be young (adolescent or young-adults), unmarried and belong to the female sex, they also tend to come from families that suffer from conflictual and disturbed parent-child relationship. Psychological problems, particularly depression, tend to be assocciated with attempted suicide. The major method used was medical drugs. All our results are consistent with others reported in the Arab countries and international research.

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دكتورة نجوى اليحفوفي

استاذة مساعدة في علم النفس الاجتماعي، الجامعة اللبنانية،

كلية الآداب والعلوم الانسانية

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Possession is it Real or Fancy?!

Elham Khatab Abdullah

التلبس حقيقة أم وهم .....؟!

الدكتورة الهام خطاب عبدالله

الملخص

التلبس (Possession) تعبير شائع يطلقه البعض على حالات مرضية مؤكدة مع اختلاف وجهات النظر في مسبباتها، وأعراضها، وتشخيصها، وأسلوب علاجها. وهذه الحالات قد تكون إصابة بمرض نفسي، أو نفسجسمي أو مرض عضوي.

الهدف الأساسي من هذه الدراسة هو تشخيص المشاكل التي قد يسببها هذا النوع من العلاج أي الذي يسمونه إخراج الجن Exorcism المسبب لهذه الأمراض والذي بدوره يؤكد الوهم الذي يسميه هؤلاء المعالجون بالتلبس.

شملت العينة ١٠٠٠ مراجع لعيادتي الخاصة، وبالتحديد الذين وصفت أعراض اصاباتهم بأنها حالات تلبس، وسبق لهم مراجعة أشخاص يمارسون نشاطاً محدوداً في علاج ما يسمى بالتلبس.

فقد أظهرت النتائج بأن نسبة الإناث من المراجعين (٥٨٪) أكثر منها في الذكور (٤٢٪) وكانت الفئة العمرية الأكثر نسبة (٦٤٪) من بين المراجعين هي (٢٠-٣٩) سنة. أما التشخيص فكانت الاصابة بالأمراض الذهانية (٦٢٪) والأمراض العصابية ٢٤٪ أما الأمراض العضوية فقد شكلت نسبة (١٤٪) فقط.

ظهر بأن هناك تفاوت في المستويات الاجتماعية والثقافية والعلمية. وان الوسائل المستعملة في هذا النوع من العلاج أغلبها وسائل عنف وقسوة كاستخدام الربط بالسلاسل، أو استخدام السكين، وقد أدى هذا النوع من العلاج إلى وفاة مريضتين.

استخدمت طرق علاج طبية استندت على العلاج النفسي، والعقاقير الطبية، أو الصدمات الكهربائية، وقد تحسنت حالة جميع المراجعين بدرجات متفاوتة.

ان الاستنتاج الذي تخلص اليه هذه الدراسة هو أن الطب النفسي يستند في معالجة جميع الحالات المرضية على المنطق، والحس، والتجربة مما لا يدع مجالاً للتأويل، وإقحام تفاسير مبهمة في غير مواضعها.

المقدمة

ما هو التلبس؟. هل نعتبره مرض استعصى على الأطباء تشخيص مسبباته وايجاد الدواء لعلاجه، ام أنه مجرد بدعة افرزتها تراكمات الحياة المعاصرة الممزوجة بهواجس الانسان الضعيف، المستكين والعاجز عن مواجهة الواقع الجديد المتسم بتسارع حركة الحضارة والعلم في جانب وسكون القيم والروح بدون حوافز في الجانب الأخر الموازي في النفس، فيلجأ الى ملاذ أخر لا يدركه العقل الواعي ولا يحيط به علم ولا منطق، حيث الخيال واللامعقول يلبسان مسوح الحقيقة لكي تلمسها الأيدي، وتطالها الحواس حتى يمثل لكل سائل أنه وجد الاجابة لكل سؤال ويحظى صاحب الداء بالدواء.

من خلال هذا التناقض الصارخ، وجدت نفسي كطبيبة نفسانية أمام جملة من الحالات يعتقد أصحابها أو ذووهم بأنها حالات تلبس، وبعد الفحص والتدقيق اكتشفت أنها في أغلبها أمراض نفسية أو أمراض عضوية، أو ما يسمى بالأمراض النفسجسمية. وأن أغلب أولئك المرضى راجعوا أشخاص للاستشفاء على أيديهم دون علم ولا دراية، وكان البعض منهم يعالج أمراضاً خطيرة على هذا الأساس كالسكر، والسرطان، وارتفاع ضغط الدم، والذهان والكآبة... وغيرها مستندين على اعتقادهم بأن سبب هذه الأعراض هو تلبس الجان). وأنهم قادرون على إخراجه (Exorcism) من جسد المصاب ضاربين عرض الحائط بكافة التجارب والنظريات والاسس الطبية التي بذل علماء أجلاء منذ قرون مجهودات جبارة في سبيل انجازها وتطويرها والادعاء بأن هذا النوع من العلاج هو الشافي، وينصح المريض من قبل هذا المعالج، أو ذاك بعدم استعمال العقاقير الطبية... وهنا تبدأ المشكلة إذ يصاب المريض بانتكاسة وتسوء حالته الصحية الى درجة لا يجد معها العلاج، وقد تنتهي بالموت وقد ازداد الاهتمام بهذا الموضوع بشكل لا يخلو من الاثارة، وبدأ البعض من المشعوذين والمستفيدين من ضبابية التشخيص لحالات مرضية معروفة يمارسون أعمالاً مربحة مستغلين طيبة البعض، وجهل البعض الأخر بحقيقتهم. ثم أخذوا ينسبون لانفسهم قدرات لا يمتلكونها في شفاء الأمراض النفسية، والعقلية، والعصبية وحتى الأمراض العضوية[٢٠١].

والتلبس (Possession) بالمفهوم الشعبي المتعارف عليه هو دخول الجان الى جسم الانسان واحداث تأثيرات مرضية عضوية، ونفسية، وعقلية بحيث يفقد الانسان قدراته الاعتيادية في التفكير والعمل، ويشاع بين المعتقدين بأن الجان يحتاج الى فرص مواتية للدخول في الجسم البشري منها حالات الغضب الشديد، والخوف الشديد، هذه الانفعالات عرضها أبو زيد البلخي (٢٣٦-٣٢٠هـ) في كتابة الأبدان والأنفس، وهي الغضب، الخوف، الوسواس،

إذاً فالطب النفسي يستند في معالجة جميع الحالات المرضية على العلم والحس، وليس على التأويل والغيبية، وبشيء من الهدوء والصبر سوف تناقش جوانب هذا الموضوع مستندين على المنطق والتجربة مع عدم اغفال الطاقات الحيوية الخفية التي يمتلكها البعض والتي تؤثر بصورة ما في الحالة المرضية وقد تؤدي الى تحسن مؤقت للمريض تتفاوت مدته حسب

الحالة المرضية وقناعات المريض. إلا أنها حالات جديرة بالاهتمام رغم ندرتها[1] .

طريقة البحث

شملت عينة البحث كل المراجعين الذين راجعوا العيادة الخاصة والبالغ عددهم (١٠٠٠) مريض أي بنسبة واحد الى عشرة للفترة من ١٥ ك (٢) ١٩٩٦ - ١٥/نيسان ١٩٩٧ والذين أقر ذووهم بأنهم قبل هذه المراجعة كانوا قد راجعوا أشخاصاً لا علاقة لهم بالعلاج الطبي لفترة قد تصل الى سنوات قبل مراجعة الطبيب، ويسبب فشل هذا النوع من العلاج تدهور الحالة النفسية، أو يسبب ظهور المضاعفات لدى المصاب الذي يلجأ الى الطبيب المعالج.

استخدم الاستبيان المرفق لغرض جمع المعلومات اللازمة لهذه الدراسة كما طبق الدستور التشخيصي الاحصائي الثالث المعدل DSMIII لأغراض تصنيف نوع الاصابة النفسية وقد أعطي العلاج اللازم وتم تتبع الحالة المرضية، نوقشت النتائج بصدد العلاج وتم تفريغ الاستمارة، وعوملت النتائج إحصائياً.

ملاحظة: كان هناك تسجيل (فيديو) لقسم من الحالات التي سمح لنا ذووهم بتصويرها قبل وبعد العلاج.

النتائج

أولاً: الطرق العلاجية المستعملة

أظهر الجدول رقم (١) بأن الطرق المستعملة في العلاج مبنية على أسس غير علمية والتي يصفها هذا النوع من المعالجين بأنها وسائل إخراج الجان من جسد المصاب مثل الضغط على العين، والضرب بالعصي، الصراخ على الجان وتهديدهم بالكلمات، والقتل، وفتح الأبواب له للنفاذ من الجسم مثل وخز الابهام الأيمن بالابر لكي يخرج الجان مع قطرات الدم وكل هذه الوسائل تؤكد على أنها وسائل عنيفة، وبعيدة عن المفهوم العلمي، والمقومات العلاجية الصحيحة.

ثانياً: الجنس والعمر

أظهر الجدول رقم (٢) بأن الاناث (٥٨٪) وكالمعتاد من أعمار ٢٠-٣٩ (٦٤٪) عينة للمراجعة طلبا لهذا النوع من العلاج، وهذا يؤكده أن النساء أكثر قابلية للايحاء وتلبس الفكرة من الذكور بفضل العوامل الاجتماعية، والتكوين النفسي، والثقافي، والعلمي، والمعتقدات الموروثة... الخ.

ثالثا: تشخيص المرض

أظهرت النتائج في جدول (٣) أن (٨٦٪) من المراجعين كانوا مصابين بإصابات نفسية (٦٤٪) مرضهم عضوي، وأن الأمراض الذهانية هي الأقل استجابة لهذا العلاج (٦٢٪) تليها الأمراض العصابية ٢٤٪.

رابعاً: الفترة الزمنية

في الجدول رقم (٤) ظهر أن الفترة التي استخدم فيها العلاج الشعبي قبل مراجعة الطبيب النفساني استغرقت في أغلب الأحيان (٨٢٪) بين ٣ أشهر الى سنتين علماً بأن هناك حالات استمر معها العلاج أكثر من خمس سنوات بدون مراجعة أي طبيب بسبب الوعود التي تؤكد لذوي المريض بأن مراجعة الطبيب قد تؤدي الى سوء الحالة الصحية للمريض وصعوبة شفائه.

خامساً: مصدر المعلومات

أظهر جدول رقم (٥) بأن مصدر المعلومات عند المريض وذويه عن التلبس وطرق علاجه جاءت من المعالج نفسه (٤٢٪) الذي يلجأ اليه المريض بقصد قراءة شيء من القرآن الكريم أي (العزامة) ويؤكد بأن حالته هي حالة تلبس وبحاجة الى علاج خاص لاستخراج الجان كما شكل أقارب وذوو المراجع وكذلك جيرانه ومعارفه نسبة (٥٢٪) أما القناعة بالمراجعة نتيجة قراءة الكتب المنشورة عن هذا الموضوع فقد شكلت أقل نسبة (٦٪).

المناقشة

استطاعت هذه الدراسة أن تبين حجم المشكلة التي تواجه الطب بصورة عامة، الطب النفسي بصورة خاصة، فقد اتضح بأن ٢٠٪ من المراجعين لعيادتي الخاصة جاء يعاني مع ذويه من نتائج هذا النوع من العلاج أي استخراج الجن، وهذه النسبة أكثر مما عرضه عبدالله السبيعي[١٠] في بحثه عن هذا النوع من العلاج في المملكة العربية السعودية (٨٪) ولكنها أقل بكثير مما وجده الجلبي[١١] (٥٧٪)، والاختلاف ناتج عن طريقة اختيار عينة البحث واعتبرها منشأ المشكلات النفسية، وأكد خصائصها النفسية. وأضاف كذلك بأن أساس الصحة النفسية يعتمد على التوافق بين النفس وميولها الداخلية ومهماتها الخارجية.

مهما كانت مصادر هذه المعتقدات الشعبية الشائعة فهي لا تهمنا بقدر ماتهمنا الحالة القائمة والمشخصة بغض النظر عن الخوض في التفاصيل وتداخل المسببات، اننا نؤمن بالله وكتبه ورسله، ولا نشك بوجود الجان استناداً الى ما جاء بالقرآن والسنة، ولكن هل يجوز أن تنسب إليهم إصابات الإنسان ببعض الأمراض العضوية، والنفسية، والعقلية؟ وإن بالإمكان إدراك الشفاء التام منها باخراج الجان المتسبب من جسم الانسان، وابتداع وسائل تتسم بالغرابة، والقسوة، والعنف أحيانا؟[٣،٤] .

وقد كانت هذه الظاهرة منتشرة قديماً قبل اكتشاف الطرق العلاجية، والعقاقير الطبية حيث كان هناك ما يسمى بالشمان (Shamans) ، أو المعالج الشعبي (Native healers) والذي كان يعمل بطب الأعشاب، ويستخدم الإيحاء لحالات كثيرة سواء كان المصاب مريضاً بمرض عضوي، أو نفسي كما كان يطلب من ذوي المريض تقديم القرابين (Sacrifice) الى الروح الشريرة المسببة للمرض. وقد ترهق هذه المطاليب العائلة بالأثمان الباهظة[٥] .

عادت هذه الطرق العلاجية بعد آلاف السنين من اكتشاف العلاج الطبي الناجح، علما بأن هذه الظاهرة هي ظاهرة عالمية تمارس في دول أمريكا وأوروبا، ودول العالم الثالث. ولكن علم النفس صنف هذا النوع من العلاج في مجال ما يسمى بالطب النفسي عبر المجتمعات Transcultural Psychiatry[٦] . ونحن لا نشك بأن للمحيط الذي يعيش فيه المريض النفسي اضافة الى ثقافته تأثيراً في نظرته للأعراض التي قد تنتابه، فمنهم من يهمل هذه الأعراض، ومنهم من يلجأ الى التفكير المستمر بها، ويسأل الأطباء عن الدواء، ومنهم من يراجع معالجاً شعبياً[٧] .

اذاً بما أننا ناس نؤمن بالله عز وجل وبكتبه وما جاء بها، فاننا نؤمن بقوله تعالى بسم الله الرحمن الرحيم ((*وننزل من القرآن ما هو شفاء ورحمة للمؤمنين*)) صدق الله العظيم، ونؤمن أيضاً بأن القرآن الكريم هدى

للناس ورحمة... ونؤمن أيضاً بقوله تعالى في سورة الرعد ((*الذين آمنوا وتطمئن قلوبهم بذكر الله، الا بذكر الله تطمئن القلوب*)) صدق الله العظيم.

هذا يؤكد على دور الايمان في تحقيق الراحة النفسية للإنسان وشفاء من معظم الأمراض النفسية (العصابية خاصة)، وبالتالي يخفف من حدة أعراض الإصابة ببعض الأمراض العضوية مثل ارتفاع الدم، داء السكري، السرطان... الخ[٩٠٨] فالله عز وجل هو الشافي وهو اذا أراد شيئا أن يقول له كن فيكون، وليس للجن أي دور، أو مكان في هذا الموضوع.

فقد تناول الجلبي في عينته كل المراجعين. أما عينة بحثي فكانت المرضى الذين جاء ذووهم يشكون من آثار هذا النوع من العلاج.

أما نوع العلاج المتبع من قبل هؤلاء المشعوذين فقد كانت كلها وسائل عنف موجه إلى جسد المريض بحجة السيطرة على الجن واخراجه من المنافذ التالية: العين، إبهام اليد أو القدم. والجدول (١) يوضح بأن ٩٠٪ من المرضى عانوا من الضغط على العين، أو الضرب على الراس، أو الأطراف (٦٠٪) وهناك وسائل أخرى كالوخز بالابر ١٠٪ لإخراج الدم لانهم وكما يدعون بأن الجن يسير مع الدم تحريفاً لقول الرسول (ص) ان الشيطان يجري مجرى الدم من ابن آدم وفي احدى الحالات كانت الوسيلة هي الربط بالشجرة والضرب لمدة شهر كامل أدت هذه الحالة الى شلل في الأطراف السفلى، والمريض لازال مقعداً وحالة أخرى لمريضة مصابة بالسحايا عولجت من قبلهم بقطع جرح أعلى الفم لغرض جريان الدم والذي أدى الى تسمم ووفاتها.

في هذه العينة تبين أن النساء أكثر عرضة لمثل هذه العلاجات ومن أعمار (٢٠-٣٩) سنة ٦٤٪ وهذا مقارب لما هو موجود في دراسات أخرى[١٣٠١٢] والنساء أكثر تقبلاً للايحاء من الرجال وهن أيضاً أكثر اقتناعاً بالمعتقدات الغيبية، وأشد تأثراً بالخرافات وحديث المشعوذين لأسباب تتعلق بالثقافة، والتنشئة الاجتماعية والتكوين الجسدي والنفسي.

يوضح جدول (٣) بأن نسبة الأمراض الذهانية ٦٣٪ مقارنة الأمراض العصابية ٣٤٪ وهذا يؤكد أن كثيراً من الأمراض العصابية يعالج بواسطة العلاج النفسي التدريجي سوءا بواسطة طبيب نفساني، أو سواه أما الأمراض الذهانية فتحتاج الى علاج بالوسائل الطبية وقد استغرقت مدة العلاج كما أوضحها جدول (٤) المتبع من قبل هؤلاء المشعوذين من ٣ أشهر إلى ٥ سنوات، وهي فترة طويلة يؤكد فيها هؤلاء المعالجون على عدم مراجعة الطبيب والا سوف تتدهور حالة مريضهم، وقد وضح جدول (٥) بأن الأقارب والأصدقاء والمعالج ذاته هم المصدر الأساسي في نشر هذه الفكرة والتأكيد على وجودها، ولم يلجأ هؤلاء الناس الى الكتب العلمية أو الكتب الصادرة عن هؤلاء المعالجين لتقصي حقيقة هذا النوع من العلاج، مما يؤكد بأن الايحاء هو الوسيلة التي تستخدم في نشر هذه الأفكار، والسيطرة على المريض بواسطتها.

وفي الختام نؤكد أن التلبس ما هو إلا تلبس فكرة، ولا علاقة له بالجان، أو الشياطين، وما يقوله البعض عن تلبس الجان بالإنسان ما هو الا مرآة العقل الباطن عندما يضطرب العقل الواعي، وتتداخل الصور، وتتشابك الأحداث بفعل ضغوط الحياة المعاصرة، وما نراه ونسمع عنه من عجائب وغرائب تنسب للتلبس خطأ، ما هي إلا ظواهر ينبغي شرحها بسهولة وبدون تعقيد. لأن للفكر البشري قدرات قد تبدو عسيرة،

وغير طبيعية اذا لم ندرسها بإمعان وتروّ. ان للفكر سلطة قوية على الجسم إلى درجة القهر والاخضاع، واليوغا واحدة من الأمثلة على ذلك حيث يقوم محترفوا اليوغا بأعمال لا يمكن للطب الحديث أن يشرحها اطلاقاً كالتصرف بالجهاز العصبي، ونبضات القلب والتدخل بأفعال الجسم اللإرادية استناداً الى الآلات الطبية الاختبارية كل هذا بفضل الفكر وقوة الذهن.

ولا نريد الإطالة عن قوة التأثير الفكري على الجسم إلا أنها قد تصل أحياناً الى أن يظن البعض أن الظواهر الفكرية النفسية التي يبديها قسم من الناس هي ظواهر من فعل الجان وفي الحقيقة ما هي الا سلطة الارادة الواعية وغير الواعية التي تستطيع التحكم بالجسم، وأحياناً بالآخرين عن طريق الإيحاء والتأثير المباشر، وغير المباشر، هي جزء من شخصية الانسان ذاته بما وهبه الله العزيز القدير من قدرات قسم منها بات معروفاً على نطاق واسع، والآخر ما زال قيد الاستطلاع والبحث والإثبات، وهذه القدرات في جميع الأحوال متطورة، ومتكيفة بصورة مذهلة، ولا تخضع لحواجز المادة بل تتخطى حدود الزمان والمكان.

وفكرة التلبس – وان كثر اللغط حولها– فهي فكرة من صنع الإنسان، ووهم أراد له البعض أن يتحقق ولو بحدود أنماط البشرية ذات السمات خاصة المعروفة في الطب النفسي، وعلوم النفس الانسانية. لذا علينا أن ندع فكرة التلبس جانبا، لأنها واحدة من نتاجات ثقافة العصر، حيث يمثل الناس الجان حسب نظرتهم العلمية، والمامهم بالثقافات الدينية السائدة وقد وضعوا لهم صفات حسب ما يسوغه إليهم الخيال المتأثر – بالبيت، والثقافة، والموروث الديني.

ان التلبس بالجان والشيطان هو خرافة فإن وجد فوجوده في دواخلنا وتفكيرنا وحسب، وهذا نابع من الجهل وهو اسطورة هذا الزمان، فان شئنا تلبسنا الفكرة، وان أردنا هجرناها إلى غير رجعة.

جدول (١): نوع العلاج المتبع من قبل المعالج

١- الضغط على العين	٩٠٪
٢- الضرب المبرح على الرأس والأطراف	٦٠٪
٣- الوخز بالابر (شك المخاط في جلد الرقبة)	١٠٪
٤- شرب الماء	٨٪
٥- ذبح الحيوانات	١٠٪
٦- الربط على الشجرة لمدة شهر مع الضرب	١٪
٧- اضافة الى الأدعية المختلفة	٩٥٪

جدول (٢): يبين توزيع مجتمع البحث حسب العمر والجنس

العمر	٪ ذكور	٪ اناث	المجموع
١٠ – ١٩	٪١٢	٪١٢	٪٢٤
٢٠ – ٢٩	٪١٤	٪٢٠	٪٣٤
٣٠ – ٣٩	٪١٢	٪١٨	٪٣٠
٤٠ – ٤٩	٪٢	٪٦	٪٨
٥٠ – ٥٩	٪٢	٪٢	٪٤
المجموع	٪٤٢	٪٥٨	٪١٠٠

جدول رقم (٣): تشخيص المرض لدى المراجعين

التشخيص	العدد	المجموع
أمراض ذهانية		٦٢
الفصام العقلي	٣٢	
اكتئاب ذهاني	١٤	
ذهان النفاس	١٦	
أمراض عصابية		٢٤
اكتئاب انفعالي	٨	
نفسجسمية	٦	
داء الوسواس القهري	٢	
مخاوف	٤	
هستريا	٤	
أمراض عضوية		١٤
صرع	٨	
ورم الدماغ	٤	
سحايا	٢	

جدول رقم (٤) الفترة الزمنية التي استغرقت عند المعالج قبل مراجعة الطبيب النفساني

الفترة الزمنية	٪ الحالات
أقل من ٣ أشهر	٪٣٠
٣ - ٦ أشهر	٪٣٢
٦ - ١٢ أشهر	٪٨
١ - ٢ سنة	٪١٢
أكثر من ٢ سنة	٪١

جدور رقم (٥) مصدر المعلومات عن التلبس وعلاجه

مصدر المعلومات	٪ الحالات
الأقارب والأصدقاء	٪٣٤
المعالج ذاته	٪٤٢
الجيران	٪١٨
الكتاب	٪٦

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12. الدكتور باسل الجلبي. المعالجون التقليديون الشعبيون والطب النفسي بحث غير منشور القي

Abstract

Possession is regarded as one of the rare psychiatric syndromes even in Iraq. It has been noticed recently that it is one of the commonest problem that psychiatrist faces. Psychiatric, psychosomatic, organic diseases, like cancer, hypertension, D.M., ... etc. has been treated by the so called Exorcism.

The aim of this study is to direct the attention to the size of this problem, the danger of what is called Exorcism, who is responsible for spreading this belief?...

1000 patients consulting the primary mental health care clinic, has been told to have possession and received treatment (Exorcism) for it, but invain.

Results revealed that females consulted more than males 58%, 42% respectively. The commonest age affected 64% was of (20-39yr). 2/3 suffered from psychoses. Sociodemographic factors vary. Aggressive type of treatment used, which resulted in death of two patients.

There is urgent need to Educate the public about the dangerousness of such beliefs and about the role of psychiatric methods used in disease management.

الدكتورة الهام خطاب عبدالله

استاذ مساعد في الطب النفسي

كلية الطب – جامعة الموصل، الموصل ، جمهورية العراق

التلبس حقيقة أم وهم

استبيان الفحص

العمر: الجنس: متزوج: أعزب:

المستوى التعليمي: الحي السكني

١- يعرف الشخص أنه مصاب بالتلبس من خلال:

١-

٢-

٣-

٢- ما هو باعتقادك السبب المباشر لحالتك:

٣- الأعراض الجسدية التي يمكن أن تعزى للتلبس

١- ٤-

٢- ٥-

٣- ٦-

٤- الأعراض النفسية التي يمكن أن تعزى للتلبس:

١-

٢-

٣-

٥- مشاكل أخرى يمكن أن تعزى للتلبس

٦- العلاج:

العلاج الروحي ١ . ٢ . ٣ . لمدة

العلاج الطبي

كلاهما

٧- مصادر المعلومات عن التلبس:

ماذا قرأت عن الموضوع أذكر اسم الكتاب

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Table 4: Body image problems (perceived ugliness)

	Yes	No
Suicidal adolescents	25.00%	37.50%
Neurotic adolescents	53.57%	23.31%
Control group	21.43%	39.29%
($x^2 = 7.82$ d.f = 2 $p < 0.05$)		

Discussion

The use of ALCEQ is justified on the grounds of it's sound psychometric basis as originated by Yeaworth et al.[1] and replicated in a Turkish Study[13]. Children in Turkey are believed to have many common variables with Jordan's children as they have a common cultural heritage.

The results of this study indicated that both suicidal and neurotic groups experienced significant stressful life events more than the control groups. Also, suicidal adolescents were slightly more stressed than neurotic adolescents.

These results confirmed previous findings of a positive relationship between life events and suicidal rates[12, 10, 9, 7, 5, 4].

Conflict with parents, especially concerning relationships with the opposite sex in females, and scholastic performance in males was a prominent feature in precipitating suicidal behaviour in adolescents in this study.

In my opinion people in Jordan as a whole place a considerable emphasis on the value of the opinions of others and the compliance to social pressures to excel at school. Also they have a double-standard generally about females mixing with the opposite sex which is not as strict with male adolescents.

Further studies are needed to examines many variables concerning deliberate self harm in relation to comorbidity with other psychiatric disorders, personality characteristics etc.

الملخـــــص

تتضمن هذه الدراسة جميع المراجعين بسبب محاولة انتحار لدى مستشفى الجامعة الأردنيـة خلال ثلاث أعوام والذين يقل عمرهم عن عشرين سنة.

لقد طبقت عليهم الاستبانة المسماه (ALCEQ) أو استبانة أحداث الحياة لدى المراهقين.

وكانت النتيجة أن أحداثاً معينة هي الأكثر احتمالاً أن تـؤدي لمحـاولات الانتحـار عنـد هـذه الفئة العمرية وهي الخلاف مع الأهل والفشل المدرسي وخسارة الصداقة خاصة مع الجنس الآخر.

group) adolescents. Suicidal x = 417.07, Neurotic x = 346.75. On the other hand results indicated that significant differences existed between suicidal adolescents (Group I) the control group (Gr. 3), the neurotic adolescents (Gr. 2) and control group. (S-C: t = 4.53 p < 0.0011 NN-C: t = 33.12 p < 0.01). There were no parent deaths among the three groups. Only one subject experienced "sibling death" within groups one and two. However, the incidence of "death of a close friend" was found to be higher in the suicidal group than the two other groups. Of the thirty one experiences in ALCEQ significant differences were found in four factors among the three groups:

1. Conflict with parents, especially when concerning the choice of a marriage partner or relationships with the opposite sex. (x2 = 10.36 p < 0.001). Frequency of this experience was found higher in suicidal adolescents.
2. "Starting to have friends of the opposite sex" (x2 = 7.35 p, 0.05): This experience had higher incidence in suicidal adolescents.
3. "Loss of a close friend" (x2 = 14.29, p, 0.01): Both suicidal and neurotic adolescents suffered this experience more than controls.
4. Body image problems "acne, overweight, underweight, too tall, too short....etc.: (x2 = 7.82 p < 0.05): Neurotic group suffered more from such experiences than the other two groups: Table 1, 2, 3, 4.

Table 1: Conflict with family regarding scholastic performance

	Yes	No
Suicidal adolescents	56.00%	23.72%
Neurotic adolescents	32.00%	33.89%
Control group	12.00%	42.89%
(x 2 = 10.36 d.f = 2 p < 0.01)		

Table 2: Breaking with a close friend

	Yes	No
Suicidal adolescents	47.22%	22.92%
Neurotic adolescents	41.66%	27.08%
Control group	11.12%	55.00%
(x 2 = 14.29 d.f = 2 p < 0.01)		

Table 3: Starting to have friends of the opposite sex

	Yes	No
Suicidal adolescents	54.17%	25.00%
Neurotic adolescents	16.66%	40.00%
Control group	29.17%	35.00%
(x 2 = 7.35 d.f = 2 p < 0.05)		

In this regard Nigerians and Saudi Arabians would not be found to have similar results concerning the effects of their life events, using designs and materials adopted from the Western studies and without modifying them[1].

For this reason some minor modification in the content of some items of ALCEQ were made before its application on this study population. Modifications involved the wording of the item concerning "the first dating experience", which was altered to "starting to have friends of the opposite sex". Other items concerning their actions, such as "marriage to second wife" was added. However, this factor proved to be a very rare event. Besides, two experts has been consulted and they found that the content validity of ALCEQ is not influenced by such alterations.

Methods and Material

Over a period of three years data was collected from three sample groups, which consisted of 36 subjects with an age range of between 14 and 19:

1. Group one: Suicidal adolescent - mean age 17.46: This group included 36 adolescents who had been admitted to Jordan University Hospital during the three years period starting in 1995.
2. Group two: Adolescents who presented to the hospital with complaints which were considered neurotic such as types of anxiety disorder, somatoform disorder or dysthymia... Their mean age was 18.35.
3. Group three: Control group of adolescents from schools located around the University. Their mean age was 17.21.

The data was collected by using the Adolescent Life Change Events Questionnaire (ALCEQ)[2]. This questionnaire was designed by Yeaworth, York et al. It is based on concepts contained in Holmes and Rahe "Social Readjustment Rating Scale", which was developed primarily for adults[8]. ALCEQ contains 31 events which are relevant to the adolescent years. It was used in Turkey after being found to have acceptable internal consistency, reliability and validity and a stable factorial structure across samples and ages[13]. Children in Jordan are widely believed to have and to a great extent a common cultural heritage with those in Turkey, which makes the application of ALCEQ relevant.

Originally Yeaworth et al. obtained weighting of ALCEQ by administering the questionnaire to 207 subjects aged between 10-18, with a mean-age of 14.1.

Comparison of the total weight of life change events for the three groups. Student T Test was used.

Chi-square was used to determine if statistically significant differences exist among the three groups. The Fisher Exact Test was used to determine between which groups differences existed.

Results

There were no significant differences between total life change events, the score of suicidal adolescents and neurotic adolescents (groups one and two). S-N: $t=1.27$ $p> 0.05$. However, mean-score of the suicidal adolescents was higher than the mean-score of the neurotic (second

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Paper

Stressful Life Events and Suicidal Behaviour in Adolescents

Nizam Abu-Hijleh

ضغوط أحداث الحياة وأثرها على محاولات الانتحار عند المراهقين

نظام أبو حجلة

Abstract

This study involves all suicidal attempts of individuals between the ages of 12-20 years who presented to Jordan University Hospital over a period of three years starting in 1995. The above were compared in regards to changes that had occurred in their lives with a neurotic disorders group and a control group. The data was collected by using the Adolescent Life Change Events Questionnaire (ALCEQ).

The objective of this study was to examine the role of life events in precipitating suicidal behaviour in adolescents in Jordan.

Results showed that conflict with their families, scholastic failure and breaks with close friends are the most frequent events which precipitate suicidal behaviour in adolescents.

Introduction

There is a clear increase of suicide rates during adolescence, probably universally and suicidal attempts are more frequent in females[3].

Suicide as an act and as a communication may represent hopelessness, self-hate, depression, displaced aggression and in many cases a cry for help[11].

In evaluating suicidal attempts there is little difficulty in appreciating the risk in a severely depressed adolescent whose clinical picture fulfills the criteria for major depression, psychosis or drug dependence. But as a Garrison (1991) stated that by clinical experience most suicidal adolescents do not demonstrate such severe pathology, and consequently we have found that management decisions are more difficult to make[6].

A common pathway that leads to increased vulnerability to suicidal behaviour involves an early disadvantageous childhood and family circumstances. These usually lead to increased risk of psychopathology in adolescence and consequently an increased suicidal risk[5]. The effect of life events vary from culture to culture for example losing a partner or a job is considered highly stressful. In other societies marrying one's child could be considered a quite a stressful experience, especially when the choice of marriage partner is a subject of conflict between the family and the child.

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have been encouraged[31], so it would be sound to conduct a study recruiting a large number of patients with delusions of pregnancy. This may lead to devising the culturally sensitive and specific methods in the assessment and treatment of delusions of pregnancy.

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الملخـــص

ان أوهام الحمل هي بمرض غير شائع ويمكن أن تتواجد في الاناث والذكور على السواء وهؤلاء يعانون من اضطرابات نفسية عضوية كانت أم وظيفية.

وتعرض هذه الورقة ستة مريضات سعوديات أربعة منهن يعانون من الفصام المزمن واثنتان منهم يعانون من اضطرابات مزاجية. وقد استنتج الباحثون أن هذا العرض يخدم وظائف اجتماعية ثقافية متعددة.

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testing. All these factors are obviously operating in sensitizing such women to develop delusion of pregnancy even after mere touching by caring nurses.

Like other cultures, the delusions of pregnancy in Saudi female patients appear to be thematic. The delusion might serve the purpose of a wish-fulfillment in a situation where a female patient is divorced [case 1-4], separated from her children [case 2-3], not bearing any child [case 3] and sexually frustrated [case 6]. It seems also that separation division of their families, by marriage for example may be an issue for Saudi female patients in terms of physical separation from their children who have either grown up or have been taken from them by other family members, including ex-spouses. The delusions of pregnancy may also represent an attempt to recapture the loss of a loved one, such as a husband or child and probably in this respect the delusion is purposeful.

In particular the role of women in Saudi society is often limited to wife and mother. This is an important factor in understanding the abnormal psychology and treatment of Saudi female patients. In this context, the content of delusions of pregnancy may be an unconscious attempt to change the life situation of an otherwise helpless, dependent female patient. The delusions of pregnancy in female patients [case 1, 2, 6] may be a purposeful reflection of sustaining the cultural beliefs that pregnancy may be magically induced by evil eyes and spirits like jinn. In the same fashion the delusions of pregnancy in female patients may be perpetuating the strong religious belief that the Almighty God is capable in doing all things, possible and impossible. The beliefs in magic and evils spirits that may cause a variety of diseases is not uncommon in Saudi society. Similarly, the traditional therapies, such as reading from the Holy Quran, cautery, the use of honey and black seeds based on strong religious beliefs are rampant in Saudi Arabia[29].

However, it is emphasized that expression of psychotic symptoms, including delusions, may differ according to cultural themes. The authors further proposed that differences in symptom expression between ethnic groups can be explained by two possible mechanisms that occur during schizophrenic illness, 1) a release of suppressed cultural attitudes and fears, 2) an amplification of cultural themes. Therefore, the symptomatology of psychotic patients are no more but reflections of attitudes, expectations, beliefs and fears of a society with a distinctive culture and traditions.

Finally, there is no specific treatment for delusions of pregnancy *per se*. Mono-symptomatic hypochondriacal psychosis presenting as delusion of pregnancy has been successfully treated with pimozide[5] and non-psychotic pseudocyesis by means of psychotherapy[17]. Pseudocyesis and delusions of pregnancy emerging in chronic psychosis during relapses may well be treated by appropriate antipsychotic drugs as well. Besides biological treatments it is suggested that early discussion aimed at modifying the psychosocial and cultural factors contributing to the development of delusions of pregnancy would perhaps be the most effective intervention. Moreover, recent investigations involving symptoms

Although she had normal menstrual periods plus a negative pregnancy test she continued to entertain delusions of pregnancy. She further reported that her elder son was inside her abdomen as she had performed pilgrimage with him three months previously. Since this time she believed she had become pregnant and now had begun to feel fetal movements. When she was counselled about facts negating pregnancy, including her husband's impotence due to severe heart disease, she explained that Almighty God can do anything. She was treated mainly with lithium carbonate [blood level = 0.98 meq/l] along with brief counselling and her delusions of pregnancy disappeared within three weeks.

Discussion

The clinical vignettes of these female patients conform to the concept of delusions of pregnancy. This symptom is defined as a firm and unshakable false belief of pregnancy by a male or female person. Collectively all patients were characterized by some sociodemographic stressful and negative factors, including marital problems, divorce, illiteracy, rural background where superstitious beliefs are very common, extended large families, low socioeconomic class and dependent status. Additionally, all presented with non-retrospective delusions of pregnancy during active relapses of chronic psychoses which is consistent with other case reports[8,9]. Exceptionally case 5 manifested, besides delusional pregnancy shared delusions of labour pains and childbirth, whereas case 4 of chronic schizophrenia uniquely developed sudden delusion[32] of pregnancy lasting just three days.

At aetiological level, multiple explanations could be invoked in these patients. Notably all patients but 5 and 6 probably misinterpreted weight gain, amenorrhoea and vague abdominal sensations in terms of false pregnancy. These physical changes, plus spontaneous lactation, tend to reinforce the idea of pregnancy in chronic psychotic patients with considerable fantasies. It has been reported that relatively intellectually incompetent women tend to somatize their stresses which arise from multiple revealed sources. This somatic mode of communication helps them in many ways, such as seeking socially acceptable medical consultations, attracting due attention and respect of their spouse and relatives and avoidance of hostile criticizms of being labelled mentally ill. Similar mechanism of cognitive misinterpretation of body sensations and physical changes had been proposed by other researchers[7,10,11]. Alternatively these somatic changes could have been perceived subliminally by patients for incorporating into their dreams, just as visual subliminal perceptions were reported to influence the content of dreams[27]. Likewise the incipient organic changes can be perceived in dreams before they reach consciousness[28]. It is speculated that all this might have contributed to the reinforcement and eruption of the delusion of pregnancy into patients' consciousness.

According to Cramer (1971) delusion of pregnancy indicates the presence of severe ego pathology, primitive nature of the psychology of the person and poor reality

telephone hand set in working order and a doll, for which she had intense delusional love. She liked it as her baby. She often repeated that by magic she given birth to the doll without pregnancy. She would let the doll sleep on the bed with her. If anyone tried to take it she would go into temper tantrums. This complex behaviour was rectified by removing the baby doll. However, temporarily she showed intense anger which was managed by sedation and counselling.

Two months ago she developed psychotic exacerbation, characterized by impulsivity, persecutory delusions and auditory hallucinations but no confusion or disorientation. Additionally she suddenly manifested delusions of pregnancy. She said that her tummy is growing with a baby inside. She reported that one female nurse softly smacked her on her buttocks. She interpreted it as intercourse which resulted in pregnancy. She had been postmenopausal for a long time. Besides biological treatments a female social worker discussed with her issues regarding the delusional pregnancy. Within three days her delusions of pregnancy disappeared completely. Subsequently whenever she was asked, "are you still pregnant?", she would shyly say "no".

Case 5

This 40-year-old, illiterate Saudi women with a positive family history of mood disorder had her first episode of postpartum depressive illness 17 years ago. She was adequately treated but no prophylactic therapy was offered. Therefore she had four further recurrences of severe depression, two of them post-delivery and two after her daughters marriages. Three years ago, she was brought to the clinic in mania which occurred just after the first normal delivery of her daughter. Besides manic features she communicated delusions of pregnancy, labour pains and childbirth. She also firmly believed that she, rather than her daughter was pregnant. Likewise she, but not her daughter developed labour pains and delivered the baby girl. She was further deluded that her daughter must get rid of the baby girl otherwise some unknown people might hurt both her daughter and the baby. The patient was treated with haloperidol, 30 mg/day, diazepam, 20 mg/day, and benztropine mesylate, 4 mg/day. Within eight weeks all her manic symptoms disappeared but she switched into depression which was adequately treated with antidepressants. Later she revealed in psychotherapy about her apprehensions that, like herself, her daughter might develop agonizing post-partum depression. Notably her daughter did not manifest any mental problem following delivery.

Case 6

This 35-year-old, illiterate married Saudi female patient is a case of mood disorder diagnosed six years ago. In her first three pregnancies she had episodes of depression and hypomania, beginning at six months into her pregnancy and resolving with adequate treatment within seven months. During the last three years she was notably euthymic. Two months ago she developed a relapse of mania, this time while not pregnant. However she strongly believed that she was three months pregnant.

term normal deliveries. But just after her fourth delivery she developed psychotic features of schizophrenia. Notably she was pregnant for the fifth time and had a similar episode post-delivery. For these psychotic breakdowns she was treated with neuroleptics in several hospitals. Throughout she had regular menstrual periods with a considerable gain in weight, (particularly in her abdomen). There was no evidence of cognitive impairment. At age 41 she developed acute relapse following divorce. This time, besides other psychotic features she delusionally believed that she was nine months pregnant. Additionally she complained of vague abdominal pain and fetal movements. Sometimes she related that she became pregnant by magic through evil spirits. Other times she attributed it to a female nurse who performed intercourse with her. Arguably she believed that the baby did not have the will to be delivered. In the hospital she was treated with adequate doses of antipsychotic drugs. Simultaneously she had brief psychotherapy in which delusional pregnancy was the focal point of reference. The delusion of pregnancy was improved within nine weeks.

Case 3

This 35-year-old illiterate Saudi female patient with eight years of chronic schizophrenia was brought to the hospital with an acute psychotic relapse four months ago. In the past she had been treated with antipsychotics, electroconvulsive therapy and supportive psychotherapy. The psychotic decompensations, including the most recent one were due to marital stresses, such as two recent divorces and deprivation from her three children who were taken by ex-spouses. Notably these children were rarely allowed to visit her. After her third marriage three years ago she did not conceive and was persistently preoccupied with this problem. The current three weeks relapse was characterized by psychotic features including delusions of nihilism, inappropriate emotions and autistic thinking. Furthermore the patient was delusionally preoccupied with the belief that her three children had been killed. She also reported that she was four months pregnant. She also stated that she often perceived sensations of a moving fetus. She also had hypomenorrhoea. She reported no nausea and vomiting but insisted a follow-up by an obstetrician. The detailed investigations, including abdominal CT were negative. She was treated with antipsychotic drugs and brief psychotherapy. Following 10-weeks of combined therapy she remained defensive but stopped entertaining delusions of pregnancy.

Case 4

This 56-year-old, unmarried Saudi woman was suffering from schizophrenia for 15 years. Although she was clinically maintained on chlorpromazine, 100 mg/day, and trihexiphenidyl, 2 mg/day, the institutionalized course of her illness was often characterized by psychotic exacerbations and partial improvements effected by antipsychotic medications. It was also recorded that she had preferential liking in keeping articles, such as a

psychotic types. Although symptoms of gravid state are helpful in the diagnosis of pseudocyesis[17], this is not its sole determinants[5,16,11]. This condition was reported in patients having somatoform (hysteria) disorder, depression, schizophrenia[19,20], and monosymptomatic hypochondriacal psychosis[5,20]. The pseudocyesis may[21,22], or may not[23], be associated with infertility. Pseudocyesis has also been conceptualized both as a form of hysterical conversion[21], or the affective equivalent[24]. It afflicts both genders and in females may occur before or after the menarche or menopause. It has been very rarely reported in childhood and adolescence. 2) simulated (malingering) pregnancy; here a person professes to be pregnant knowing he or she is not. The patient's objective as to falsify pregnancy is easily identifiable. 3) pseudopregnancy; caused by a genuine ovarian tumour associated with endocrine changes mimicking pregrancy[25,17], and 4) Couvade syndrome; a husband develops symptoms of pregnancy when his wife becomes pregnant but knows that he is not pregnant[26].

In the genesis of delusions of pregnancy nonbiological factors appear to be of greater significance. Therefore, from those perspectives we report six cases of delusions of pregnancy identified in Buraidah Mental Health Hospital, Saudi Arabia.

Case 1

This 35 year-old illiterate Saudi female patient was suffering from schizophrenia for 14 years and had multiple admissions due to relapses which were mainly attributed to five consecutive pregnancies. During each relapse she showed partial response to antipsychotic drugs. A year ago she was divorced, and subsequently she, along with her five children moved to live with her brothers who were the sole care takers. Immediately after divorce she developed psychotic relapse and was hospitalized. Besides other psychotic features she manifested bizarre delusions of pregnancy of five month duration. She also perceived vague abdominal sensations from a moving fetus. She reported that her tummy had bulged out because of progressive pregnancy. She repeatedly requested doctors to palpate the abdomen for checking her pregnancy and to transfer her to the maternity hospital. On psychological exploration it was revealed that she had not had any sexual intercourse following her divorce. But six months before she had vivid dreams of multiple sexual intercourse with her ex-husband. According to her, soon after she became pregnant magically. Physical and systemic examinations were negative and so the relevant investigations. But she did have eight months of neuroleptic-induced amenorrhoea. Besides supportive therapy twice a week she was treated with trifluoperazine, 30mg/day, benztropine mesylate, 2mg/day and depot fluphenazine decanoate, 50 mg, IM monthly. Besides overall improvement delusions of pregnancy were encapsulated within six weeks.

Case 2

This 43-year-old divorced illiterate Saudi woman had 14-year postpartum schizophrenia. Initially she had three full-

changes in gender role when more women began to take the roles of men, which in fact invited additional stresses and strains on women.

The delusion of multiple pregnancies and births[3,10] is comparatively very rare, and therefore delusional single pregnancies remain the most common presentations. Recently researchers from India reported delusional animal pregnancies in eight male patients after they alleged being either touched or bitten from a dog. The delusional pregnancies were explained by a cultural belief which states that a dog bite can evolve into a puppy pregnancy in human males[15]. The diagnostic breakup of these patients was; obsessive compulsive disorder [n=3], anxiety-phobia [n=2], and solitary symptoms of delusional animal pregnancy [n=3]. Interestingly, one of the patients was an eleven-year-old child who, due to the aforesaid cultural belief, allegedly vomited out an embryo of a dog fetus. The delusion of pregnancy, retrospective[10,8,9] or non-retrospective, might persist in a patient from few days, i.e., 7 days[8], to many years, i.e, 10 years[5,16]. However, early intervention frequently does lead to quick recovery from the symptom.

Aetiological Explanations of Delusion of Pregnancy

The aetiology of delusions of pregnancy and pseudocyesis may be the same. But it is determined by multiple factors. These factors are grouped into the following; 1) organic factors as found in cases of mental subnormality and degenerative neurological disorders[1,4], 2) psychodynamic models where delusions of pregnancy are explained by rebirth fantasy[1], wish-fulfillment, parental deprivation, over-identification, rivalry and projection[17], loss of love or of a loved object[6,9], overwhelmingly emotional relationships with pregnant women[13], disturbed family dynamics[10], sexual identity confusion[12], and an intense ambivalence about pregnancy[18], 3) primary somatic sensations arising from abdomen and other parts of the body[7,10,11] and endocrine body changes[7,5,16,9] are misinterpreted as signs of pregnancy, and 4) sociocultural, where the social and cultural constructs and beliefs are utilized in the interpretations of delusional pregnancy. These invoked concepts are chronic social deprivation, excessive societal pressure on women to have a large number of children[18], a dog bite evolving into animal pregnancy[15], expression of stresses and experiences into delusion of pregnancy, belief in spiritual deities and evil eye inducing pregnancy. It is prudent to comment that in each case or delusions of pregnancy or pseudocyesis there might be single or multiple explanations. It is equally important to extensively explore the settings and circumstances in which the delusions of pregnancy develop in a person.

Differential Diagnosis of Delusions of Pregnancy

Delusions of pregnancy should be differentiated from four main related disorders. These are: 1) pseudocyesis (false pregnancy); characterized by a fleeting idea or conviction of pregnancy in a non-pregnant young woman who often complains of somatic manifestations of the gravid state[17,18], and is of non-psychotic or

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Case Report

Delusions of Pregnancy: Saudi Social and Cultural Perspectives

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الأبعاد الثقافية الاجتماعية لأوهام الحمل

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Abstract

Delusion of pregnancy is an uncommon symptom and has been reported both in male and female patients who suffer from a variety of organic and functional psychiatric disorders. Six Saudi females who developed this symptom in the course of chronic schizophrenic [n=4] and affective [n=2] psychopathologies are reported. It is concluded that this symptom in female patients subserves multiple sociocultural functions.

Introduction

It is documented that the first case of delusion of pregnancy was reported by Esquirol in the 19th century[1]. Since then it has been described in a wide variety or organic and functional neuropsychiatric disorders. The organic disorders are senile dementia, general paresis of insane, post-encephalitic Parkinson syndrome, epileptic psychosis, mental retardation and delusion of infestation[1,2,3,4] while functional conditions include schizophrenia and schizoaffective disorders, monodelusional states, mood disorders, melancholia and somatoform disorders[5,6]. The drug-induced lactation and amenorrhoea accompanied by breast changes may also induce delusion of pregnancy in young girls[7]. Notably delusions of pregnancy is not a disease but a symptom with heterogeneous explanations.

Sociodemography of Delusions of Pregnancy:

The epidemiology of delusions of pregnancy is not known and its occurrence is rare. However, recent reports emphasized that it is rather common[8,9]. This symptom has been described in adult males[1,3,4,6,8,10,11,12,13], and female patients[5,7,9], who may be either educated, illiterate or intellectually subnormal. Further, they may be single, married or divorced. Moreover, the female patients may be postmenopausal, virginal or both[14]. Recently more cases of delusions of pregnancy have been reported in females than in males. This sex-divergent shift may be due to purely bias reporting or

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between being depressed on the initial assessment and being depressed for approximately one year following the injury. This finding is supported by previous studies performed by Lawson[11], Malek and Neimeyer[12], who found that depression during the initial hospitalization was predictive of poor long-term adjustment.

In the present study it was found that SCI patients maintained high scores on the depression scale (BDI = 16.0).

The lack of reduction in depression in the SCI group may well be difficulties resulting from SCI. In addition the stress of coping with architectural barriers. This means finding access to public buildings etc. for people who are in wheelchairs difficult, (thus causing stress in coping, as stated), economic costs, vocational limitations, strains on family roles and relationships and demands upon others who lack an understanding of SCI persons resulting in unnatural interactions.

Such problems are found to be clearly obvious for our patients. One possible explanation is that our community still lacks the correct facilities and cultural adjustments which makes it difficult for the SCI patient to be adapted for and accepted easily into society. Also, most of our patients are of poor socioeconomic class which adds to the difficulty in making some adaptations to ease their lives. It is also important to provide more psychological services and assistance which could enhance adjustment to SCI.

Subjects in this research are being followed up to one year post injury. It is necessary to have further studies and to follow up SCI persons for a longer period in order to determine whether this pattern of prolonged depression remains.

الملخص

هذه الدراسة تقارن بين عينتين متساويتين تتألف كل منهما من ٣٨ شخصاً. المجموعة الأولى هم مرضى الإصابة بالنخاع الشوكي والأخرى ضابطة وقد أستعمل إختبار بك للكآبة على ثلاث مراحل ٨-١٢ اسبوع بعد الاصابة و١٠-١٢ أسبوع عند الخروج من المستشفى و١٠-١٢ أسبوع كمريض عيادة خارجية. وقد أظهرت النتائج أن هناك فرقاً إحصائياً بين المجموعتين بالنسبة للإصابة باضطراب الكآبة في جميع المراحل التي أجرى فيها القياس. وقد نوقشت هذه الفروق من قبل الباحثين.

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was designed to assess the severity of depression in adolescents in Jordan by Hamdy and his colleagues and was found to be reliable as well as valid[5].

The BDI consists of 21 statements. In scoring the inventory self-evaluation statements for each symptom category are numerically graded to reflect the range of severity, from neutral (0) to maximal (3).

The possible total score range is zero to 63. Scores of zero to 9 indicate no depression, 10-15 mild depression, 16-19 moderate depression, 20-29 moderately severe, and 30-63 severe depression.

Results

Evaluation throughout the acute treatment, rehabilitation phase and out patient follow up using T.Test showed that SCI patients differs significantly from the control group by having higher scores on the depression scale in the first assessment and moderately significant on discharge after 10-12 weeks and reassessment on the out-patient clinic after 10-12 weeks following the second assessment, as shown in Table 2.

Table (2)

Scale	SCI (N = 38)	Control (N = 38)	P - Value
BDI 1	30.1	9.2	0.001
BDI 2	20.3	8.1	0.01
BDI 3	16.0	8.3	0.05

BDI 1 = Beck Depression Score on the first assessment
BDI 2 = on discharge
BDI 3 = assessment in the out patient clinic

Discussion

Results demonstrated that psychological upset is a reality for a significant number of SCI persons within the first year of spinal injury in comparison to a matched control group.

This finding is consistent with some other research findings which have found similar levels of depression present in SCI persons[2,3,4,6]. Our results indicated higher scores on the revised BDI scale than other research into psychological adjustment following SCI which indicates that psychological morbidity decreases over time[7,8,9].

Comparing this to the present study; depression decreases across time but was maintained at higher levels on the depression sclae, (BDI3 = 16.0 = moderate depression).

There are models which suggest that people with SCI progress through a series of psychological stages, whereby the passage of time alleviates psychological distress. A common example of the stage include shock, denial, anger, depression and acceptance. Some clinicians have suggested a requirement of mourning model[2,10], which states that it is necessary for a person to mourn his loss through the display of depressive behaviour in order to adjust well to SCI. However this theory was not supported by the present study which showed a positive correlation

recurrent thoughts of death, suicide ideation or suicide attempt.

Failure to recognize depressive illness, or differentiate grief from depression may adversely influence both the short and long term rehabilitation of SCI patients. In an attempt to clarify some of these questions a prospective study was conducted to assess the prevalence of intensity of depression following SCI in a group of Jordanian patients.

Method

The Royal Jordanian Rehabilitation Centre (RJRC), King Hussein Medical Centre in Amman, is the only specialized centre in Jordan that has the capability to provide the appropriate care for SCI patients. Thirty-eight SCI patients, mean age 30.4 years, who were admitted to the RJRC within one or two weeks of sustaining their trauma were asked to participate in this study. Only subjects who sustained a traumatic SCI, had no head injuries or any pre-exiting psychopathology or organic mental disorder and were at least 17 years of age were selected for the study.

The sample was divided into 28 paraplegia and 10 tetraplegia. The majority had complete lesions, 51%, while 43% were incomplete. The main cause of injury was due to road traffic accidents (RTA), followed by falling down and bullet injuries (Table 1).

Table (1)

Reason for Injury	Percentage
Road Traffic Accidents	54%
Falling Down	24%
Bullet Injuries	20%

Assessment took place on three occasions:

1. 8-12 weeks post injury, when patients were mobile in a wheelchair and attending rehabilitation therapies.
2. On discharge from hospital, 10-12 weeks following the first assessment.
3. In the out-patient follow-up clinic, 10-12 weeks following the second assessment.

Assessment was not carried out during the acute stage following SCI, since this period is characterized by complete bedrest, sedation and lack of sensory stimulation, which make it an unprecise stage.

By 8-12 weeks the majority of patients, having made the transition to a wheelchair and sufficient time to realize the implications of their injury and the long struggle they will have to face in the future as well as the present are seen to be in a more appropriate position to begin assessment.

The control subjects were a group of able-bodied persons with no permanent history of psychopathology, matched for the SCI group for age, sex, education, and as far as possible occupation. Subjects who volunteered were recruited from technical colleges, hospital auxiliary staff and acquaintances known to the research team suitable for selection criteria. The time frame for assessment was the same as for the SCI group.

All subjects were interviewed individually and asked to complete a Depression Inventory (Beck 1987). This instrument

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Paper

Depression Following Spinal Cord Injury Among Jordanian Patients

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الكآبة المسببة عن إصابة النخاع الشوكي في عينة أردنية

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Abstract

This paper involved 38 patients who sustained spinal cord injury (SCI). Beck depression inventory was applied to them and to a similar number of a control group. The assessment took place on three stages: 8-12 weeks following the injury, on discharge from hospital 10-12 weeks later and as an outpatient 10-12 weeks later. The results showed that there was a significant difference between the study group and the control group. The results were discussed.

Introduction

The traumatic nature of spinal cord injury (SCI) necessitates loss. These patients suffer from physical symptoms such as immobility, loss of sensation, impaired sexual function incontinence and pain that may often result in vocational and social losses and place great demands on family roles and relationships.

Depressed mood is thought to be common after SCI, but the nature of this mood disturbance is debated. Previous opinions viewed depression as an almost inevitable consequence[1] and suggested that denial was occurring if a patient was not experiencing depression and was a cause of concern. However, these opinions were mainly based on subjective, anecdotal evidence rather than on empirical evidence.

Empirical studies report depression to be present in only 20-45% of patients[2,3,4] indicating that severe psychological disruption is not an inevitable consequence of SCI.

Depressive illness must be differentiated from other mood disorders such as despondency, grief, conservation, withdrawal and regression.

A depressive illness based on DSM-R (1992) characterized by a pervasive lowering of mood, with loss of interest or pleasure in all, or almost all activities and pastimes. Depressive symptoms include sleep and appetite disturbance, psychomotor retardation or agitation, loss of energy or fatigue, feelings of worthlessness, self reproach or excessive or inappropriate guilt, poor concentration and slowed thinking, indecisiveness and

النتائج

أظهرت النتائج بأن الأطفال الذين حولوا لمراكز الصحة النفسية المجتمعية كان يعـــانون بنســبة عالية من الاضطرابات الجسدية (42%)

لقد أكد الوالدين بأن هناك مشاكل نفسية وكانت نسبة هذه المشاكل حوالـــي 70% فـــي الأطفـــال المحولين لعيادات الصحة النفسية المجتمعية و 30% للأطفال المحولين لمستشفى الأطفـال و 18% للأطفال المحولين لمراكز الرعاية الأولية

الخلاصة

الأطفال المحولين نتيجة لأعراض جسدية يمكن أن يكونوا يعانوا من مشاكل نفسية

التعاون المستمر ما بين الخدمات الصحية النفسية للأطفال والتدريب المستمر في موضوع الصحة النفسية للطفل مهم جداً للعاملين في مراكز الرعاية الأولية ومستشفى الأطفال

الكلمات الرئيسية: الطفل، الصحة النفسية، الأمراض النفسية، غزة

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الملخـــــص

الأهداف

وصف نظام التحويلات لحالات الأطفال الذين يعانون من مشاكل نفسية الـــى مراكـــز صحيـــة مختلفة في قطاع غزة

الطريقة

تتألف العينة من 150 طفل تتراوح أعمارهم ما بين 6 الى 13سنة والذين تم تحويلهم الى مراكـــز الصحة النفسية المجتمعية والى 5 مراكز للرعاية الأولية والى مستشفى الأطفال بغزة (العدد = 50 طفل في كل مجموعة)

في هذه الدراسة أكمل الوالدين مقياس راتر للمشاكل السلوكية والانفعالية للأطفال والأخصـــائيين المعالجين شخصوا حالات الأطفال على حسب التشخيص العالمي العاشر

Table (2): Child Psychiatric Scores (Rutter Scale, N = 150)

	Mental Health Centre (N = 50)	Paediatric Hospital (N = 50)	Primary Health Centre (N = 50)
Disorder (above cut-off)*	35 (70%)	15 (30%)	9 (18%)
Mean conduct score**	3.3	1.2	0.9
Mean hyperactivity score***	3.2	2.2	1.9
Mean Neurotic Score***	2.5	1.5	1.0
Mean total score**	18.5	10.0	7.1

* chi square: $p < 0.0005$,
** Kruskal-Wallis One-Way ANOVA: $p < 0.005$,
*** Kruskal-Wallis One-Way ANOVA p 0.01

Discussion

This study described the mental health characteristics of children referred to Primary Health, Paediatric and Psychiatric Services in the Gaza Strip. This is a heavily populated area and the child population carries several risk factors for developing psychiatric disorders, particularly the exposure to war trauma. Most Health Care Services have been developed in the last few years, are well co-ordinated and accessible to children and their families. Although the general health problems have not been described in this paper the primary reasons for referral appeared appropriate both for General Practice and Hospital Paediatrics.

The findings on child mental health problems highlight two interesting patterns. Firstly, children referred for general health problems had significant psychiatric morbidity of between 18-30% according to parental reports. This is similar to findings from studies in general practice and paediatric services in western societies, and indicates the need for liaison and consultation work by child and adolescent psychiatrists to other child health care professionals. Also, the need for incorporation of child psychiatry teaching in undergraduate and postgraduate curriculums, particularly in new universities and medical schools.

The nature and presentation of child mental health problems is possibly related to cultural factors. Many children seen at the mental health centre (n = 21 or 42%) primarily had some form of somatic presentation (particularly enuresis, which often underlies emotional and behavioural problems). In this group it is important to establish the links between physical presentation, developmental delay and mental health symptoms[7]. Only three children had a primary clinical diagnosis of emotional disorder. The authors have recently reported concerning samples of other children and adolescents from the general population of the Gaza Strip who, on more detailed investigation were found to present with high rates of anxiety and post-traumatic stress disorders[8,9]. As these services evolve it is anticipated that emotional problems and disorders will be increasingly recognised always in the cultural context of this society. For this reason it would be very interesting to repeat this study at a later stage. Also, to establish relevant referral patterns and child mental health characteristics in other Arab Countries.

Arabic version). The Rutter Scales[5] have been standardised and widely used as a measure of behavioural and emotional problems in epidemiological research. The scales consist of 31 items rating behavioural and emotional problems on a 0-2 scale. Children with a total score of 13 or more have been found to be potential "cases", i.e. presenting with a possible mental health disorder. Scores are also provided for the hyperactivity, conduct and neurotic subscales.

Results

Out of the 150 children, 88 were male (59%) and 62 female (41%). The mean age was 8.9 years (range 6-13). The majority of families (N=121, or 80.7%) had at least four children. Large families (with at least four children) were more likely to be referred to the Mental Health Service (x^2 = 7.8, DF = 2, p = 0.02), which is consistent with previous findings that family overcrowding is a risk factor for child psychopathology. Forty-two fathers (28%) were unemployed or unskilled workers, and four fathers (2.7%) had a criminal record. Eleven mothers (7.3%) had established psychiatric illnesses, these being evenly distributed among the three groups (x^2 = 4.2, DF = 2, p = 0.12).

The psychiatric diagnoses as made by the clinician according to ICD-10 criteria[6] are presented in Table 1. Only two children seen at the Pediatric Hospital received a psychiatric diagnosis (conversion/hysteria) while none of those referred to a Primary Health Centre were. However, when presence of possible disorder was established by scores on the Rutter Scales prevalence rates were high among all groups. The rates of children whose total mental health care score indicated a disorder were: 70% of referrals to the Mental Health Centre, 30% of referrals to the Paediatric Hospital and 18% of children seen in Primary Health Care (x^2 = 32.9, DF = 2, p < 0.0005 – Table 2).

Table (1): Child Psychiatric Diagnosis (N = 150)

Diagnosis	Mental Health Centre (N = 50)	Paediatric Hospital (N = 50)	Primary Health Centre (N = 50
Depression	1		
Phobia	1		
Hysteria	1	2	
Post-traumatic stress	1		
Conduct disorder	6		
Hyperactivity	3		
Enuresis	18		
Encopresis	2		
Learning difficulty	7		
Specific language disorder	5		

rose to 47% for reported psychological factors associated to somatic presentations. Less is known about the rate and nature of child mental health problems seen in different Health Care Settings in non-western countries. In a two-stage study in Nigeria[4] it was found that 20% of children treated in Paediatric Primary Care had a psychiatric disorder (6% depressive disorders, 4.7% anxiety-related disorders and 6.1% conduct disorders). The aims of this study were (1) to identify the mental health characteristics of children referred to three types of Health Care Services in the Gaza Strip, and (2) to compare the type of mental health problems among referrals to these services.

Method

The study was completed in the Gaza Strip, which had a population of 860,369 in 1995, excluding returnees from abroad after the peace process. The Gaza Strip has a high population density of 2,300 people per km^2, which is a psychosocial risk factor for child psychopathology. The total refugee population is 62.6%. About 55.1% live in eight crowded camps, and 44.9% live in villages and towns. Half of the population (50.8%) are younger than 15 years of age. In 1995, the annual infant birth rate was 49.4 per 1000 population, the infant mortality rate was between 26-50 per 1000 infants, and the general population death rate was 8 per 1000. Respiratory diseases and diarrhoea are major causes of infant morbidity and mortality. The annual increase of population growth in the Gaza Strip is 4.5%.

Referrals were selected from the following Health Care Settings:

a) A Community Child Mental Health Service in Gaza. The Mental Health Centre was established in 1994, together with a Community Mental Health Centre in the Khan Younis area. Referrals are made by other clinicians, schools and parents. There are two Community Clinics for both children and adults, as well as an out-patient clinic at the Gaza Psychiatric Hospital. These services are managed and clinically supervised by the first author.

b) Five Primary Health Centres in Gaza and Rafah City. These Primary Health Care Settings are usually drop-in Centres without a referral procedure. In total, there are 31 Primary Health Care Centres distributed in the five districts of the Gaza Strip, ten of which operate a 24-hour service. The United Nations run similar clinics in the refugee camps in the Gaza Strip. The majority of cases are seen by General Practitioners and there are weekly Specialist Clinics.

c) A Paediatric Hospital (Gaza El Naser – Out-patient and In-patient Departments). This is the only Paediatric Hospital in the Gaza Strip, although there is one Paediatric Department at the Khan Younis General Hospital. The hospital has 240 beds and accepts emergencies and routine out-patient referrals from the Primary Health Centres.

Fifty consecutively referred children between the ages of 6-13 years were selected from each Health Care Setting, excluding established cases of moderate to severe learning disability. Data were collected concerning family and socioeconomic status and primary reason for referral. In addition parents completed the Rutter Scales for their child (form A2,

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Report

Child Mental Health Problems in the Gaza Strip: Referrals to Three Clinical Settings

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الصحة النفسية للطفل في قطاع غزة: نظام التحويلات لثلاث مراكز للرعاية الصحية

Abstract

Objectives: To describe the mental health characteristics of children referred to various health services settings in the Gaza Strip.
Method: The sample consisted of 150 children between 6-13 years of age, who had been referred to a Community Mental Health Centre, five primary health centres and a paediatric hospital N=50 for each group). Parents completed the Rutter A Scales on behavioral and emotional problems and clinicians made an ICD-10 psychiatric diagnosis.
Results: there was a high rate of somatising disorders among children referred to the Mental Health Centre (42%). Parent-reported rates of significant mental health problems were high for all groups, i.e. 70% in the Mental Health Centre group, 30% in the paediatric group and 18% among children referred to Primary Health Centres.
Conclusions: Children primarily referred for physical health problems may have underlying psychiatric disorders. Liaison with Child Psychiatry Services and ongoing training in child mental health issues are important for Primary Health Care and hospital staff.
Key words: child, mental health, psychiatric, Gaza.

Introduction

Children with mental health problems and disorders are seen by a variety of Health Services and Health Care Professionals, often in an uncoordinated way. Garralda and Bailey[1,3] found that 23% of children between 7-12 years of age attending General Practice had psychiatric disorders which were associated with family breakdown and parental stress. The same authors found a psychiatric prevalence of 28% among the same age group of referrals to general paediatrics, which was mainly accounted for by emotional disorders (two-thirds of psychiatric disorders). The rate

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b. Precipitating factors: These are events, losses or stresses that are temporarily and causally associated with the onset of the psychiatric disorder.

الملخـــــص

ان العوامل الاجتماعية – الثقافية معروفة الأهمية ولكن مهملة في الطب النفسي. أحد الأمثلة المهمة على أهمية هذه العوامل مثلاً العلاقة بين البطالة وزيادة نسبة الانتحار بين الشباب في البلدان الغربية. ان التدريب الطبي النفسي يغلب عليه التفكير بالعوامل البايولوجية ويقل فيه الاهتمام بالعوامل الاجتماعية والثقافية. ان هذا المنحنى قد يقلل من امكانية الطبيب النفسي من فهم أهمية العوامل وبالنتيجة يقلل من فعاليته في معالجتها.

أن تبني كلية الأطباء النفسانيين الملكية البريطانية للصيغة النفسية الدينامية (Psychodynamic Formulation) قد وضع العوامل النفسية في قلب مناهج التدريب للأطباء النفسيين. هناك حاجة ملحة لاهتمام مشابه بالعوامل الاجتماعية والثقافية لتأمين معرفة المتدربين في الطب النفسي بهذه العوامل.

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In Los Angeles Koegel et al (1988)[24], showed the difficulty of assessing psychiatric problems in homeless people without adjusting for their social circumstances. They found that the lifetime prevalence of antisocial personality disorders among the sample dropped by 10% when three items were removed from the assessment. These items were: not having a regular place to live, not working for six months, and having three or more jobs in the past three years. They were removed because they did not correlate with childhood conduct disorder, which is important in reaching the diagnosis of antisocial personality disorder in the DSM-III. These items appeared related to homelessness rather than personality disorder.

The examples above illustrate that neglecting cultural and social factors can lead to a distortion of diagnostic information and may invalidate the assessment. Much of the research on homeless people has overestimated the diagnosis of psychosis in the psychiatric surveys undertaken[9]. It was suggested that this was due to the failure of the interviewing psychiatrists to control the adaptation of these individuals to homelessness[19]. Moving homeless people to a less stressful environment resulted in the disappearance of psychotic symptoms in some of the homeless mentally ill[2].

The current debate about the increases rate of the diagnosis of schizophrenia among second generation West Indian patients is relevant[10]. It might be an example of our ignorance of the role of socio-cultural factors[7].

The Socio-Cultural Factors and Psychiatric Training

The psycho-social formulation was a device that was used to identify the psychological and social characteristics of the patient that makes him unique and that are important in patient care. From this arose the dynamic formulations[1] that served to include psychodynamic factors in psychiatric assessment.

It is important to give the same emphasis to socio-cultural factors in clinical psychiatric assessments. Training and education in this area should be an integral part of the requirements for the Membership of the Royal College of Psychiatrists (MRCPsych). The socio-cultural factors that need to be emphasised in training could include[13,12]:

a. Social variables:
    1. Age
    2. Sex
    3. Social class
    4. Employment / Unemployment
    5. Social activities / support
    6. Life events / losses
    7. Social needs
b. Cultural variables:
    1. Ethnic origin / Immigration
    2. Family systems
    3. Health beliefs
    4. Religious / Spiritual beliefs

These could be considered within the framework of:

a. Vulnerability factors: Long standing characteristics that are not temporarily associated with the onset of psychiatric disorder but contributed to the aetiology by making the patient vulnerable to the social, psychological or biological precipitating factors.

impression that the course of these disorders is mainly biologically determined[12]. The WHO pilot study of schizophrenia[22] which showed a different outcome of the disorder in different cultures is one of many illustrations of the importance of the "social course" of psychiatric disorders[6]. Studies of the relationship between mental illness and socio-demographic variables, such as gender, social class, ethnic origin, marital status and age indicate the influence of these variables in the origin and course of these illnesses[13].

Interest in understanding psychiatric illnesses through sociology and social sciences increased after the Second World War. Pioneers of modern psychiatry have strongly emphasised the importance of social factors in psychiatry[14,20]. In the fifties the development of chlorpromazine and the demonstration of its effectiveness in controlling the symptoms of schizophrenia stimulated interest in biological psychiatry[12]. One view was that psychiatric disorders were fundamentally diseases of the brain in their aetiology, course and outcome.

On the other hand an extreme sociological perspective of psychiatric nosology is of psychiatric disorders as medical terms imperfectly applied to problems in human relationships[12]. The labelling theory sees psychiatric diagnosis as stigmatising and handicapping[18]. Psychiatric treatments in this model are perceived as methods of social control, mainly serving to suppress distress rather than eliminate it[16]. The anti-psychiatry views of Laing, Szasz and Basaglia completely ignore biological aspects of psychiatric disorders[12].

Together with differences in research methodology and ideology[5], these writings have made sociology and social sciences seem as if to be in opposition to psychiatry instead of being a contributing science[17]. A proper understanding of psychiatric disorders, their aetiology, course, management and outcome must draw on contributions from both the biomedical and social models.

Limitations of Biomedical Psychiatry

In there classical study, Hollingshead and Redlich (1958) "found that psychiatrists tended to be class biased in their assessment, diagnosis and treatment of schizophrenic patients. The authors concluded the class bias of the psychiatrists, who themselves were middle class. Psychiatrists gave different diagnoses and treatment to patients from lower classes who presented the same problems as those form higher social classes. This might have been a result of ignorance and unfamiliarity with the social circumstances and environmental conditions in which the patients lived.

In a research project to assess the psychiatric needs of homeless hostel residents[9], the Social Behaviour Schedule (SBS) was used to detect behavioural problems associated with chronic psychiatric disorders[23]. A hostel resident scored positive on the following SBS items: posturing, mannerisms and talking and laughing to himself. On closer inquiry, it was discovered that these "behavioural problems: were the resident's daily Muslim prayers in the hostel corridor which he used because there was no space in his cubicle to pray.

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Annotation

Socio-Cultural Factors and Psychiatric Clinical Assessment

Walid Abdul - Hamid

العوامل الاجتماعية - الثقافية والتقييم الطبي النفسي

وليد عبد الحميد

Abstract

Social and cultural factors are very important, although they are both neglected aspects of the psychiatric health of the population. One example is the finding of a link between unemployment and the rising incidence of suicide in young men[15]. Psychiatric training is sometime dominated by biological thinking which takes little account of social and cultural factors. This may limit understanding of these important factors and thereby reduce the effectiveness of psychiatric management.

The adoption of the psychodynamic formulation by the Royal College of Psychiatrists has managed to put psychological factors into the curriculum of training in clinical psychiatry. A similar emphasis on social and cultural factors is needed to ensure trainees awareness of these factors.

Introduction

Since Koch identified and isolated the bacillus responsible for tuberculosis at the end of the nineteenth century there has been within medicine both narrow and broad conceptual approaches. The narrow approach saw disease as consisting of biologically determined causes and often failed to account for social, environmental and psychological factors. Infections were often viewed by physicians in micro-biological rather than in public health terms inspite of the inability of microbiologists to explain why epidemics happened during certain times and places. This mono-causal biological bias of medicine has repeatedly threatened the potential prospects of Public Health as a speciality and has probably wasted opportunities to develop more effective preventive medicine[21].

Psychiatry is a speciality within medicine and some psychiatrists have been keen to be seen to be as biologically oriented as their colleagues in other medical specialities. Of the papers presented to the 1992 American Psychiatric Association, 86% were biomedically oriented[4]. In Britain the Medical Research Councils list of priorities in researching schizophrenia is dominated by genetic and neuropsychiatric investigations[16].

Social Factors in Mental Health

A narrow perspective on the natural history of mental disorders would give the

بالاضافة الى استعمال الـ نالوتروكسون وغيره من العلاجات للاستعمال الطويل المدى لمنع الانتكاسات وقد ناقشت المقالة الجوانب المتعددة لتدبير الادمان.

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treatment[12]. Buprenorphine is administered sub-lingually and it is recommended that its administration is supervised in view of its highly soluble property: it could be easily prepared for injection and tablets can also be ground up and sniffed.

The use of injectable drugs should only be done under strict controlled conditions of a drug specialist clinic[13].

A true advance in substitution therapy is the recent introduction of lx-acetyl methadol (LAAM) approved by the US Food and Drug Administration in 1993. It is the alternative to methadone with the advantages of slow onset of action, long acting effect, oral administration and active metabolites. Peak therapeutic effects are observed within 90 minutes or oral administration and active metabolites. Peak therapeutic effects are observed within 90 minutes or oral administration with maximum effects by 4 hours persisting for 72 hours. Single doses of 30 - 60 mg of LAAM suppress withdrawal symptoms for 24 - 48 hours and repeated oral doses of 70 - 100 mg 3 times weekly block the subjective "high" of subsequently administered heroin for up to 72 hours[7]. The recommended starting dose is 20 - 40 mg 3 times per week, which should be 1.2 - 1.3 times the current daily dose of methadone but not to exceed 120 mg[14].

Buprenorphine as maintenance treatment is still under development and has not been licensed in the USA or the UK as a treatment for opiate dependence. Studies showed that it is a good alternative to methadone and naltrexone treatment. It is well accepted by patients who have a mild withdrawal syndrome, which facilitates its discontinuation. It reduces opioid and possibly cocaine abuse, and has greater safety and lower diversion potential to the black market than methadone[7].

In summary, there have been true advances in the pharmacotherapy of opiate dependence. Lofexidine is an effective non-opiate treatment for withdrawal symptoms with less hypotensive side effects that clonidine. For maintenance therapy, the introduction of LAAM and Buprenorphine have provided alternative treatments to methadone.

الملخـــــص

ان المعالجة الناجحة تتطلب التقييم الشامل للمصاب من حيث شدة الادمان والحالة النفسية والطبية فيما اذا كان يعاني من اضطرابات نفسية وطبية مصاحبة. كما أن دراسة رغبة المريض في تلقي المساعدة والدعم الاجتماعي المتواجد له قيمة كبيرة.

تبحث المقالة في علاج أعراض الانسحاب على المدى القصير من حيث استعمال العلاجات المخففة للأعراض مثل المثادون ومضادات المغص والاسهال والتقيء. كما تبحث استعمال العلاجات مثل كلونيدين والعلاج الأحدث لوفيكسيدين.

patients continue to take it after 6 weeks and only 10% of patients take if after 3 to 6 months[7].

An important advance is the use of Naltrexone combined with clonidine to accelerate detoxification: Naltrexone precipitates withdrawal symptoms within minutes in opiate dependent patients which decreases the duration of subsequent withdrawal symptoms. The dose of Clonidine needed is lowered by using higher doses of naltrexone[8].

Maintenance Therapy

Maintenance therapy is the prescription of a substitute drug on long term if not indefinite basis with the aim to harm prevention or minimization of medical, psychological and social harm that is associated with the use of illicit drugs[9]. The standard drug for maintenance therapy is methadone which has been extensively evaluated for opiate misuse. Its benefits range from reduction of illicit use of drugs, or risk-taking behaviour when illicit drugs are injected and of reduction of drug-related criminality. It has a long duration of action which suppresses the symptoms of drug induced euphoria and withdrawal symptoms. However, methadone has high potential toxicity and mortality associated with overdose. Methadone used on a once a day dose regime also helps to break the psychological conditioning element to dependence by dissociating the use of the substitute drug from the external/internal cues which prompt the use of drugs. There is evidence that methadone prescribed in higher doses (50-100 mg daily) is associated with less illicit drugs use. The duration methadone maintenance varies between short-term maintenance of 6 months to long term maintenance at time indefinitely.

Maintenance therapy may also involve the use of other substitute drugs such as dihydrocodeine and diamorphine (heroin). The use of either of these substitute drugs is discouraged in view of their short duration of action with the result that the patient experiences withdrawal symptoms within 12 hours of the last dose and the need to take it 3 to 4 times per day. There have been few comparative studies of methadone verses heroin maintenance treatment. The study by[10] Hartnoll et al (1980) showed no difference in illicit opiate use with heroin or methadone maintenance over a period of 1 year. It was noted however that those who were treated with heroin continued to use illicit drugs as much as before whilst those who were treated with methadone either achieved abstinence or relapsed with high levels of illicit opiate use. Patients in the methadone group were more likely to be arrested during the follow up period and drop out of treatment. A recent study however showed that heroin maintenance therapy is effective for heroin users who fail in conventional drug treatment programmes[11]. The study concluded however that even in this population, another attempt at methadone maintenance may be successful and help the patient to stop using injectable opioids.

The interest in providing new treatments resulted in the introduction of buprenorphine an opiate partial agonist as an alternative drug. Studies showed that it is as effective as methadone maintenance

regimes to patients however involve the use of centrally acting alpha adrenergic agonists which inhibit the release or nor adrenaline. The conventional drug for this is clonidine which has the disadvantage of a hypotensive effect followed by rebound hypertension on withdrawal. The introduction of lofexidine however has been a major advance in view of its lower likelihood to cause hypotension. A recent study of lofexidine showed that an accelerated 5 days lofexidine regime attenuates opiate withdrawal symptoms more rapidly than the conventional 10 days lofexidine regime without exacerbating hypotensive side effects[2].

A randomised double-blind comparison of lofexidine and clonidine in the out-patient treatment of opiate withdrawal showed equivalent efficiency and an advantage for lofexidine which produced less hypotensive effects[3]. Clonidine or lofexidine is prescribed in an increasing dose over the first 3 days after opiate withdrawal, then maintained at the maximum tolerated dose as determined by the degree of postural hypotension for another 5 days before it is decreased and completely withdrawn in 3 days. It is preferable to use the lofexidine regime in hospital although it has been used in day care facilities and the out-patient clinic. The emergent insomnia, which is not affected by lofexidine, could be treated with a non addictive hypnotic such as zopiclone.

Very rapid inpatient detoxification from opiates could be achieved by the use of barbiturate anesthesia with methohexitone (100 mg intravenous pretreatment, followed by 400 mg intravenously) and naltroxone (10 mg intravenously) within 48 hours[4]. This procedure requires intensive medical management and is therefore controversial.

Opiate Intoxication and Withdrawal

The safest approach to the treatment of opiate intoxication and overdose remains naltrexone hydrochloride, a pure opioid antagonist (0.4 - 0.8 mg intravensouly) to reverse neurological and cardiorespiratory depression. Care should be taken to monitor the occurrence of a major withdrawal syndrome and rebound sympathetic activity which may result in cardiac arrhythmia and pulmonary edema[5].

Antagonistic Treatment

Once detoxification is achieved it is worthwhile to aim for relapse prevention by introducing an opiate antagonist such as naltrexone[6]. This should be introduced after two weeks from completion of the detoxification programme lest it provokes an opiate withdrawal syndrome. Naltrexone is prescribed to be used on daily basis to start with but a three times per week regime may also be used if this is likely to improve compliance. It would be prudent to initiate naltrexone treatment once the patient is in hospital to prevent an aggravation of withdrawal symptoms in case the patient continues to use opiates. Naltrexone should not be prescribed to patients with hepatitis C as it is potentially hepatotoxic.

Naltrexone has the advantages of a long half-life and oral administration. It could be administered daily, twice or thrice weekly. However, it has not been accepted well by addicted patients: only 50% of

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Review Article

Pharmacotherapy of Opiate Misuse: An Update

M.T. Abou-Saleh

الجديد في استعمال العلاجات في سوء استعمال مشتقات الأفيون

محمد أبو صالح

Abstract

The optimal treatment for opiate misuse starts with a comprehensive assessment of the patient to establish the severity of dependence and his/her psychological and physical well being. Importantly it is crucial to establish whether there is a co-morbid psychiatric condition such as depressive illness or personality disorder. It is also important to assess the patient's motivation and the degree of social support. This review will focus on recent advances in pharmacotherapy of opiate misuse: short term and long term detoxification and maintenance therapy.

General Considerations

Where substitute drugs are indicated there are considerations to be taken for optimum therapy. The prescribed drugs cross tolerance with other drugs of misuse. patient preference. the likelihood of diversion to the black market and the mode of administration. There is a balance to be negotiated between the degree of control and supervision required and the degree of the individual autonomy and independence. There should be safeguards to ensure good compliance and to minimize diversion to the black market. There is also the consideration of the negotiated outcome whether the agreed goal is abstinence or harm minimization by reducing the risks of physical, psychological and social harm associated with uncontrolled opiate misuse. There should also be frequent monitoring including urine testing to ensure that prescribed drugs are consumed and to detect the use of non prescribed drugs[1].

Short Term Detoxification

Once opiate dependence is established, a detoxification programme could be instituted. Detoxification from opiates could involve opiate or non-opiate treatment. Opiate detoxification involves the use of methadone with a dose that is titrated against withdrawal symptoms with frequent assessment to establish the minimal effective dose.

Detoxification is then started by decreasing the dose of daily methadone over a period of two to four weeks. This may be used in an inpatient setting or with well motivated patients in the outpatient clinic. Non-opiate based detoxification involves the use of anti-spasmodics, anti-diarrhea and anti-emetics to achieve symptomatic relief. More acceptable non-opiate detoxification

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contacted to ensure early intervention if they experience a recurrence in their illness.

The list of routine investigations carried out prior to commencing lithium and during treatment is shown in Table 1.

Prior to starting lithium, it is crucial to investigate renal and thyroid functions, measure body weight to monitor its increase during treatment and take appropriate dieting measures and most importantly to do a pregnancy test. Lithium is contraindicated in the first trimester of pregnancy in view of its teratogenic effects.

Conclusions

The hospital-based lithium clinic provides an ideal and cost-effective setting for the long-term management of affective disorders. In this context, patients receive high quality care and treatment from an expert team of workers, with regular clinical supervision to prevent recurrences and to provide management of unwanted effects, supportive psychotherapy and regular monitoring of thyroid and renal function. There is evidence that patients who receive closer supervision are better managed and experience fewer recurrences and incidents of toxicity that those managed in general psychiatric clinics or in general practice. The setting also provides a "therapeutic milieu" in which patients actively help and encourage each other.

Table 1: Routine assessments / Investigations Performed

- Physical examination
- Haematology and clinical chemistry, including urea, creatinine, electrolytes, thyroxine and TSH
- Weight
- Pregnancy test, if necessary
- ECG

During Lithium Treatment

- Physical examination, ECG, full blood count, 24-hour urine volume
  - once a year
- Clinical chemistry, urea, creatinine, T_4 and TSH and urine test
  - six monthly
- Weight and electrolytes
  - with each lithium estimation

الملخـــص

لقد وفرت عيادة العلاج بالليثيوم الوسط الأمثل والأقل كلفة للرعايـة الطويلـة الأمـد لمرضـى اضطرابـات المزاج. بالمقابل ظهرت نزعة لتوفير هذه الرعاية في العيادة النفسية العامة وعيادة الرعاية الأوليـة فـي سياق التحـول مـن الرعايـة الاختصاصيـة الـى الرعايـة العامـة. ويسـتوجب والحالـة هـذه الحفـاظ علـى ايجابيات عيادة الليثيوم لجهة الرعاية المؤثرة والتزام المريض بأخذ العلاج ومتابعة وتوفير الدعم النفسـي له في العيادة العامة وفق أدلة الممارسة العلاجية القويمة.

often in general practice patients who were prescribed their lithium once daily[14].
General practitioners are insufficiently resourced to provide optimal long-term care for the majority of patients with severe affective disorders without strong support of specialist services. It would be difficult to monitor compliance and prevent toxicity in primary care setting.

Cost Effectiveness

Fieve[15] showed that the cost of managing a patient in a lithium clinic was 20-50 percent less than that of managing the patient in another setting. The author evaluated the service requirements of a large cohort of patients attending the lithium clinic associated with the MRC Neuropsychiatry Laboratory in Epsom[16].
Of the 128 patients treated with lithium at the clinic during 1983, 14 percent (four men and 14 women) received some treatment as in patients for a relapse in their affective illness. These 18 patients required a total of 217 weeks of in patient treatment (3.3 percent of the clinic's treatment time). The average length of stay in the ward for those admitted was 12 weeks. In the control group of patients treated with placebo lithium, 76 percent of the group required admission to hospital.
For affective disorder patients maintained on lithium therapy, approximately four in-patient beds are required per 100 patients. For patients not maintained on lithium, but receiving ad hoc treatment, this figure rises to about 15 in-patient beds per 100 patients.

Organisation and Running of the Lithium Clinic

Lithium clinics are often held in the mornings, an ideal arrangement, which allows the measurement of plasma lithium levels 12 hours after the last dose. On arrival, patients have their blood taken for on the spot lithium estimation in the neighboring laboratory.
The patient then joins fellow patients in the waiting room, which provides informal contact and "therapeutic milleu": patients who are ill are reassured and encouraged by those who are well, with access to the attending nurse and social worker as required. This time is also used for weighing and, if required, the completion of rating scales/side effects checklist.
Once a patients plasma level has been estimated, he/she is seen by the clinician for an assessment of physical and psychiatric status, including their experience of side effects, dosage adjustment, and prescription of extra medication if necessary, arrangement of routing laboratory investigations and supportive psychotherapy.
It is useful to record all this information on a chart, which can also be used to estimate the patients affective morbidity over time by the calculation of an affective morbidity index[17]. At each interview with the clinician, the patient's affective state is plotted on this chart using a global scale from 0-3. Moreover, lithium plasma levels, the presence of physical illness, side effects and extra medication are also recorded on this chart. Patients are given free access to the clinic outside the normal clinical time. Those who fail to attend are

bipolar illness, prophylactic treatment should be given after the second episode.

Controlled studies of the optimum plasma level for effective prophylaxis have indicated that levels of 0.45 - 0.8 mmol/l are adequate for the majority of patients[11]. Moreover, lithium given in lower dosage to achieve these lower plasma levels causes fewer side effects and adverse effects on thyroid and renal function.

A recent US study suggested that bipolar patients require higher dosages of lithium to achieve plasma levels of 0.7 mmol/l[12]. These workers have not, however, evaluated the efficacy of the middle range of levels between 0.6 - 0.8 mmol/l. As a rule, lithium should be given once daily, as daily dosing encourages compliance and, more importantly, is associated with less toxicity on the kidney[13].

The Lithium clinic

The complexities of managing patients with affective disorder demand the expertise of a team that includes psychiatrists, nurses, social workers and laboratory technicians. These complexities are partly inherent in the nature of the illness and the nature of lithium therapy.

The concept of the lithium clinic was pioneered by psychiatrists who carried out studies on its efficacy in the 1960s and was part of the movement for the establishment of specialist clinics for patients with conditions such as diabetes, epilepsy and schizophrenia. It is estimated that there are 100-150 clinics in the UK, i.e., less than one clinic per health district; it is more common for patients to be treated in general psychiatric clinics. The proportion of the lithium-treated patients managed by their general practitioners is unknown, but presumably small.

Lithium clinics serve a number of functions. Primarily, they provide an expert assessment and treatment setting in which patients treatment is supervised, and there is regular monitoring of plasma lithium levels and of thyroid and renal function. A few clinics, however, also provide education to patients and their families on the nature of their condition and the benefits/hazards of lithium therapy. They often act as tertiary referral centres, receiving referrals from general psychiatrists.

In addition to all the aforementioned functions, these clinics provide psychotherapy services and support groups for patients and their relatives.

Some of these clinics have provided the setting for quality research on lithium. It is estimated that there are at least 200 lithium clinics in the USA, with the large majority being university based and manned by specialist nurses under supervision from psychiatrists.

Some of the US studies have reported greater treatment compliance, lower recurrence and fewer episodes of toxicity in patients attending these clinics compared with those attending general psychiatric clinics.

Studies in the UK support these findings. A recent study, which compared lithium clinics with psychiatric out patient clinics and general practice supervision, found that the lithium clinic provided closest patient supervision and the best low level control of plasma lithium. Moreover, glomerular impairment occurred more

should continue on their medication until full remission.

The majority of patients with recurrent affective disorders benefit from prophylactic medication. Numerous studies have proved the value of lithium in the prophylaxis of bipolar and unipolar disorders, while patients with unipolar illness could also benefit from conventional and newly introduced antidepressants[3,4].

However, the efficacy of lithium as a prophylactic and antimanic treatment has been questioned[5] and naturalistic retrospective studies concluded that it is less effective than the previous evidence had suggested[6]. These studies have not taken note of the shift in diagnosis for schizophrenia to affective disorders, the high prevalence of substance misuse and the use of antidepressants in bipolar illness which all contribute to high recurrence rates. These naturalistic studies emphasise that two thirds of patients with major affective illness do not seek treatment, those who do seek treatment comply poorly with it and most importantly that treatment of these patients in the community is not as effective as treatment in specialist clinics[7].

A more recent development has been the study of the effects of lithium in reducing the mortality associated with recurrent affective disorders[8]. Studies showed that prophylactic lithium reduces suicide rates by 80 percent in comparison with patients who had ad hoc treatment.

Lithium Therapy

Lithium is an effective antimanic treatment compared with neuroleptics and has the added advantage of not constraining the patient's feelings, i.e., it does not put the patient in a "chemical strait-jacket". Its disadvantage is that it takes longer to establish a full therapeutic effect. In general, it is desirable to use neuroleptics only for short-term treatment, because their use is associated with serious side effects, including tardive dyskinesia. It would be advisable to use lithium as first-line therapy in less severe cases.

The value of lithium as an antidepressant has been questioned, except for its particularly effective use in bipolar depression and as part of combined therapy with tricyclics/monoamine oxidase inhibitors in the treatment of resistant depression. However, it is particularly effective in the long-term management of severe recurrent affective disorders and has a role as continuation treatment following ECT[9].

The majority of patients with bipolar and unipolar disorders benefit from prophylactic lithium and a minority experience recurrences which require extra medication. Within the unipolar group of disorders, it has been shown to be particularly effective in those with endogenous/psychotic illness, familial depression and patients with no premorbid or intermorbid abnormal personality characteristics[10].

A crucial decision for the clinician is when to start lithium prophylaxis. The World Health Organisation has recently provided guidelines: prophylaxis should be started in unipolar depression after three episodes, particularly if there was one discrete episode within the last five years apart from the present (index) episode. In

The Arab Journal of Psychiatry (1998) Vol 9. No. 2 Page (57 - 62)

Review Article

Have Lithium Clinics Outlived their Usefulness?

M. T. Abou-Saleh

ما هي جدوى عيادة العلاج بالليثيوم؟

محمد أبو صالح

Abstract

The Lithium Clinic provides an ideal and cost-affective setting for the long-term management of affective disorders. There has however, been a drive for Lithium-treated patients to be managed in hospital-based psychiatric clinics and rarely in primary care as part of the move from specialism to generalism in health care. The advantages of the lithium clinic in ensuring better care, compliance, monitoring, and support need to be safeguarded in general psychiatric and primary care clinics by adherence to clinical practice guidelines.

Introduction

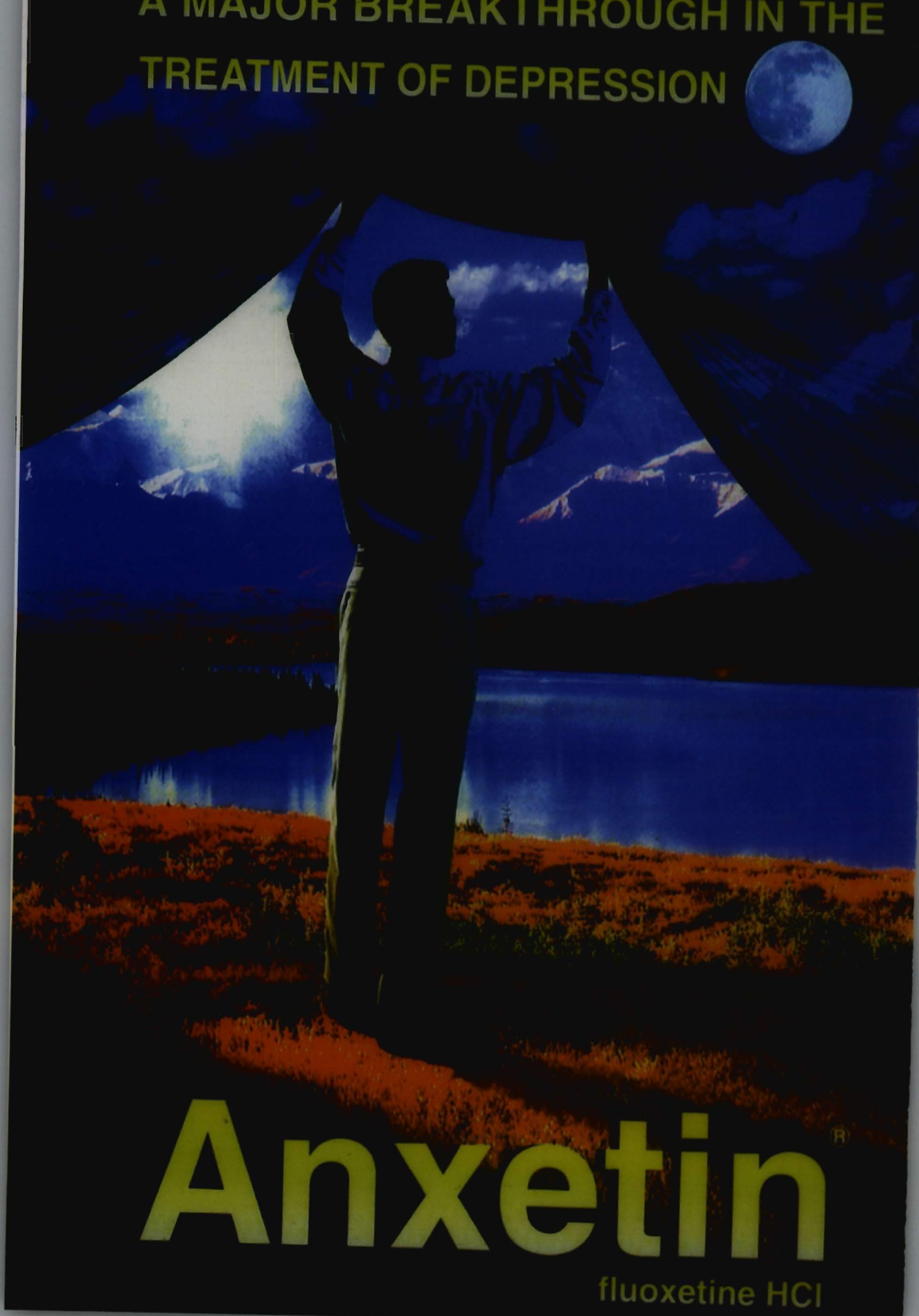
The most common group of psychiatric disorders encountered in general and hospital practice is affective disorders. About one in five people develop an affective disorder, with the majority (50 - 90 percent) having recurrences. Affective disorders cause severe disability and distress to the sufferers and their families. About one in ten of those affective die by suicide. Moreover, there is an increased risk of death from cardiovascular disease and from psychiatric complications such as secondary alcoholism. Whilst the majority of patients with mania and depression recover from their illness, a minority (5-10 percent) experience chronic affective morbidity that resists conventional physical and psychological treatments.

Long-Term Management

Depressive patients who recover from their illness required continuation therapy with antidepressants for six to twelve months to prevent relapse. Placebo-controlled studies of the value of continuation therapy with antidepressants showed that patients maintained on active medication had fewer relapses (50 percent fewer) than those maintained on placebo[1].

Similar considerations apply in the management of mania; although the period of continuation therapy with lithium or neuroleptics is shorter (three to six months). The guidelines for the length of continuation therapy are empirical: patients who have fully recovered from their illness should be maintained on treatment for four to five months[2] and patients with mild or residual symptoms

A MAJOR BREAKTHROUGH IN THE TREATMENT OF DEPRESSION



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Preliminary Programme

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Manuscripts

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

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

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

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

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

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

Arabic abstract follows the references section (last page).

Tables

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

Illustrations

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

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1. Zeigler FJ, Imboden, JB, Meyer E. Contemporary conversion reactions: a clinical study. Am. J. Psychiatry 1960; 116:901-10.
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Antipsychotic agent

Presentation
Clozapine
Tablets (scored): 25 and 100 mg
Ampoules (2 mL): 50 mg for i.m. injection

Indication
Schizophrenia in patients who are non-responsive to or intolerant of classical neuroleptics. See full product information.

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12.5 mg (1/2 tablet 25 mg) once or twice on the first day, 25 or 50 mg on the second day, followed by stepwise dosage increases up to 300–450 mg p.o. (in some patients 600 mg) per day in divided doses. Maximum oral dose: 900 mg/day. For maintenance treatment lower doses may suffice. See full product information; also for intramuscular dosage.

Contraindications
Hypersensitivity to the drug; history of drug-induced granulocytopenia/agranulocytosis; impaired bone marrow function; uncontrolled epilepsy; alcoholic and other toxic psychoses, drug intoxication, comatose conditions; circulatory collapse; CNS depression; severe hepatic, renal, or cardiac disease.

Precautions
Leponex can cause agranulocytosis. Its use should be limited to treatment-resistant schizophrenic patients who have normal leucocyte findings, and in whom the mandatory white blood cell counts (weekly during the first 18 weeks, at least monthly thereafter) can be performed. Concomitant use of drugs with a substantial potential to depress bone marrow function and of long-acting depot antipsychotics should be avoided. For instructions on how to proceed in the event of infection and/or granulocytopenia, see full product information.
Caution when patients drive a vehicle or operate machinery; with patients with a history of seizures; in the presence of cardiovascular, renal or hepatic disorders, prostatic enlargement, narrow-angle glaucoma; in children and in elderly patients; during pregnancy and lactation.

Interactions
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Side effects
Granulocytopenia, agranulocytosis, thrombocytopenia, eosinophilia, leucocytosis, drowsiness, fatigue, sedation, dizziness, headache, confusion, restlessness, agitation, delirium, EEG changes, myoclonic jerks, seizures, rigidity, tremor, akathisia, very rarely neuroleptic malignant syndrome; dry mouth or hypersalivation, blurred vision, disturbances in sweating and temperature regulation; tachycardia, postural hypotension, hypertension, in rare cases circulatory collapse, respiratory depression or arrest, ECG changes, isolated cases of cardiac arrhythmias, pericarditis, myocarditis; rare cases of thromboembolism; dysphagia, aspiration, nausea, vomiting, constipation, ileus, weight gain, hepatic dysfunction, rarely cholestasis or acute pancreatitis; urinary incontinence or retention, in a few cases priapism, isolated cases of acute interstitial nephritis; benign hyperthermia, hyperglycaemia, CPK elevation, skin reactions; isolated reports of unexplained sudden death; isolated cases of leukaemia and tardive dyskinesia have been reported.

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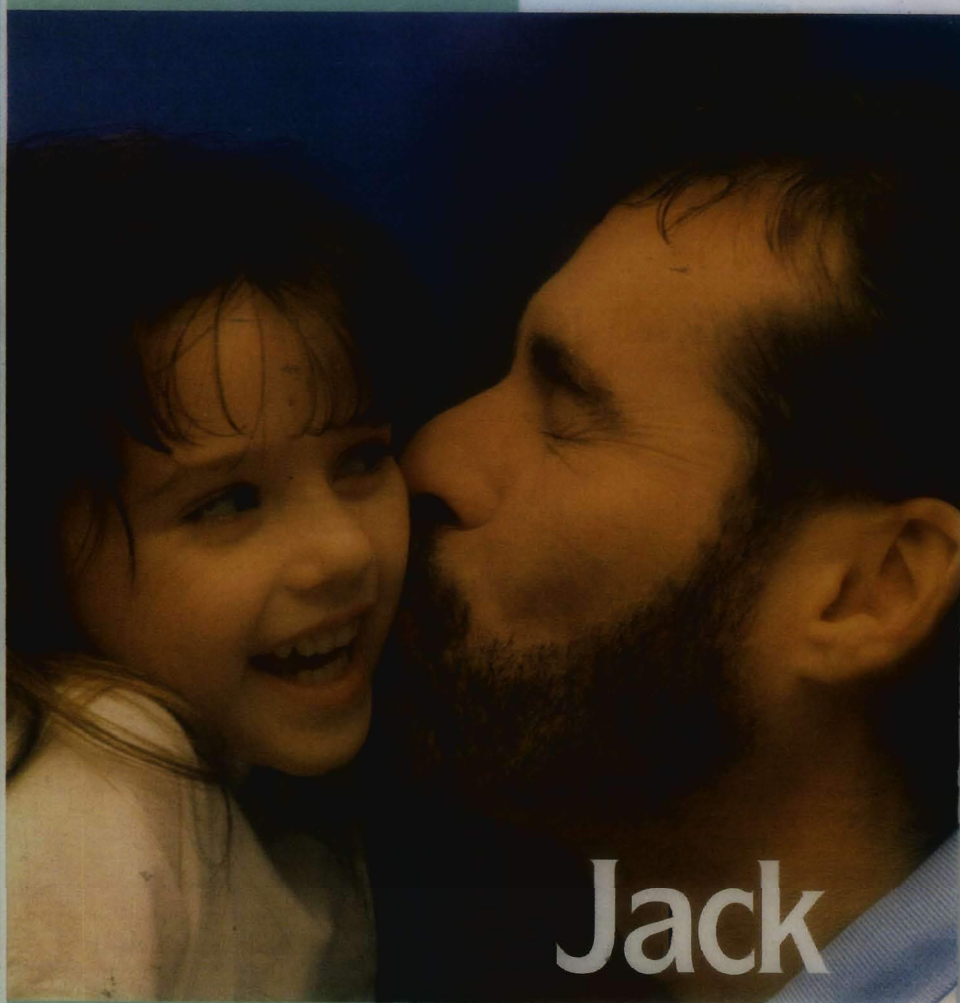

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Volume 9, No. 2, November 1998

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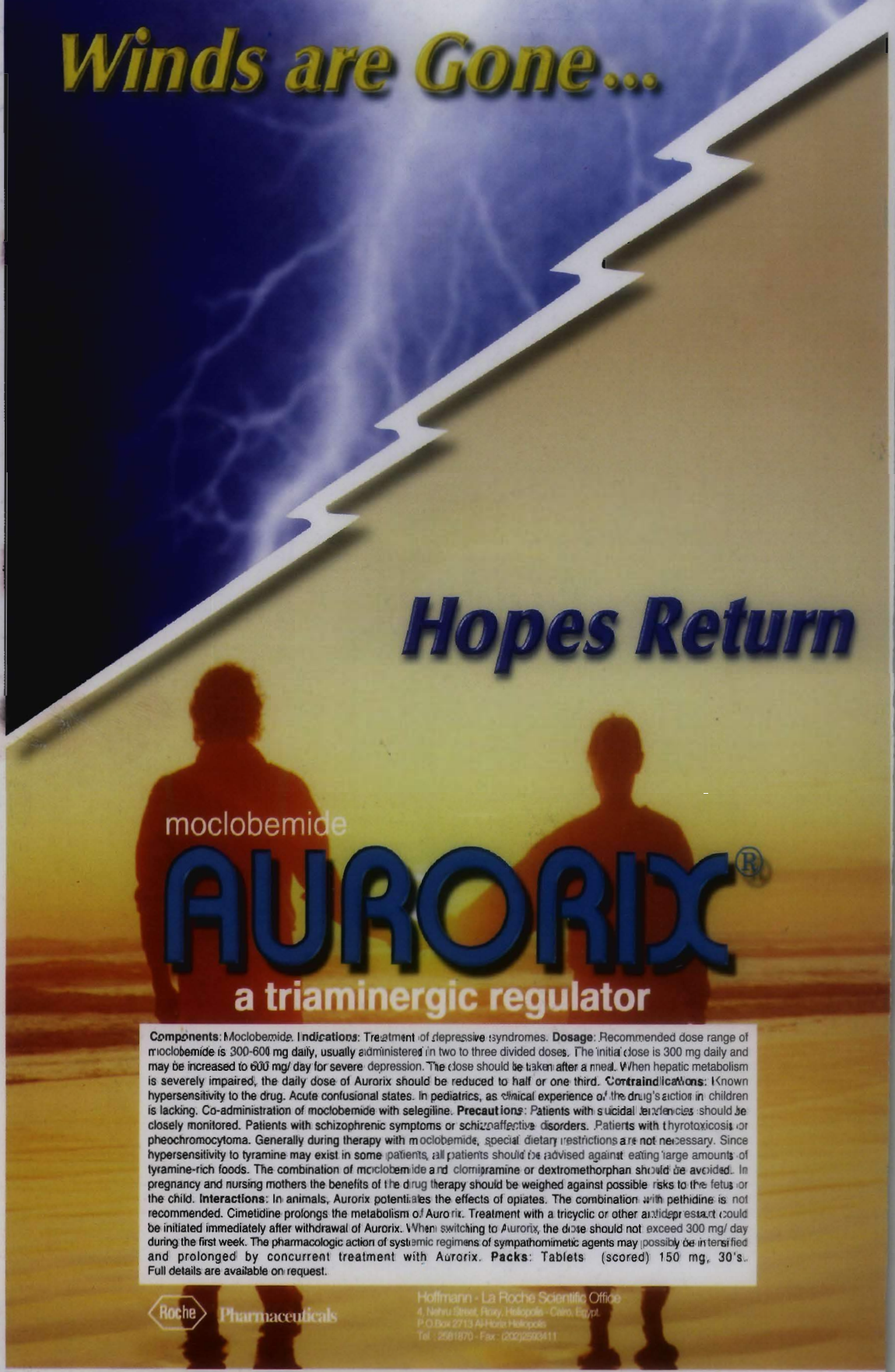

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