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International Psychiatry publishes original research, country profiles, mental health law profiles and thematic overviews, dealing with mental health policy, promotion and legislation, the administration and management of mental health services, and training in psychiatry around the world. Correspondence as well as items for the news and notes column will also be considered for publication. The journal aims to be a platform for work that is generally underrepresented in the literature, especially psychiatry research and opinion from low- and middle-income countries.

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Gender differences in mental health in the Middle East

Suhaila Ghuloum MRCPsych

Senior Consultant Psychiatrist,
Rumailah Hospital, Hamad
Medical Corporation, Doha,
Qatar, email sghuloum@hmc.
org.qa

We are now seeing in clinical practice a generation of young women who are referred for psychiatric treatment by their parents because they are rebelling against society's cultural norms but it is often apparent that women fear their families finding out that they are seeking psychiatric help. Despite improvements in the cultural understanding of women's right to equality, there remain deeply rooted practices and cultural norms that continue to adversely affect women's mental health and well-being. Physical abuse, for instance, is rarely reported, for fear of shaming the family, or of retaliation with further abuse. Mental health services in many countries in the Middle East are undergoing reform, but little research has been done into gender differences in service delivery or needs.

The term 'Middle East' is often used to denote a broad geographical area. However, within the Middle East there are differences in culture, language and societal compositions and norms that have different impacts on mental health. Taking just the Gulf region as an example, which itself includes Qatar, Kuwait, Saudi Arabia, Bahrain, Oman and the United Arab Emirates, the population is widely multi-ethnic. In some countries, the number of expatriates may exceed the number of nationals. Most of the expatriates are single male labourers, on contractual work, with distinct mental health needs. Political and social rights vary widely between different countries in the region, as does the average level of education.

Mental health services in many countries in the Middle East are undergoing reform. Yet little research has been done into gender differences in service delivery or needs. Worldwide, a gender bias in the diagnosis of mental illness is well reported. In the Middle Eastern culture, it is important to consider the impact of gender-based discrimination and violence on mental health service delivery (World Health Organization Department of Mental Health and Substance Dependence, undated).

Changing cultural norms

With access to the internet, young people in the Middle East are more exposed to international influences. The website Go-Gulf.com (2013) published the following data: 88% of the region's online population uses social networking sites daily, in English and Arabic languages; these are primarily people aged 18–34. Saudi Arabia and the United Arab Emirates make up 80% of users

from member states of the Gulf Cooperation Council. These are traditionally reserved societies, very adherent to centuries of cultural rules and restrictions. The world has seen how the social media shaped the political agenda in this region with the 'Arab Spring'. This rapid change in youth culture is producing a generation that is confused, with often contradictory ideologies, between what it wants to believe and practise, Western influences, and their extended families' beliefs and expectations of them. Traditionally, men are allowed more freedom than women, including freedom of expression. We are now seeing in clinical practice a generation of young women who are referred for psychiatric treatment by their parents because they are rebelling against society's cultural norms.

Women are achieving higher levels of education than men in the Middle East. More women are now working and combining a professional career with family responsibilities. More women are expressing their sexuality openly. In several countries, this change has been too rapid for society to adapt to. Men continue to be seen to be 'in charge' of work and household; the male role is to provide financial support to the family while the woman does the housework. A study in Lebanon reported that a husband's involvement with housework was negatively associated with a woman's unhappiness and psychosocial distress (Khawaja & Habib, 2007). The increases in the women's literacy and employment rates have not been accompanied by a change in the attitude of men (Regional Consultation, 2004).

Despite vast and evident improvements in the cultural understanding of women's right to equality, there remain deeply rooted practices and cultural norms that continue to adversely affect women's mental health and well-being. The practice of female circumcision continues in rural areas, regardless of public appeals and even legislation banning it. This is prominent in East Africa and Egypt, where a study showed that circumcised women had more symptoms of depression, somatisation, anxiety and phobia than non-circumcised women (Ibrahim *et al*, 2012).

Physical abuse is seen in many parts of the region as the right of a male member of the family to 'teach' a female appropriate behaviour and rectify any perceived misconduct. Studies in Egypt, Palestine, Israel and Tunisia reveal that one in three women is subject to beating by her husband (Douki *et al*, 2003). Such abuse is rarely reported, for fear of shaming the family, or of retaliation with further abuse. In Qatar, the Women and Child Rights organisation provides shelter

for victims of domestic violence. Yet patients more often than not ask for a revelation of abuse not to be documented in their clinical notes and not to be raised with the authorities, as it might bring disgrace to their extended family and harsher consequences for the woman herself.

Clinical issues

In clinical encounters with women, it is often apparent that they fear their husbands finding out that they are seeking psychiatric help. They fear being shamed by their in-laws, their husbands marrying a second wife, divorce and losing custody of their children. This has detrimental effects on women's help-seeking behaviour. They often present to their primary care physician with somatic symptoms, or visit a hospital emergency department, perhaps several times, before being recognised as having mental health needs. Persistent headaches, generalised weakness and 'fits' are the commonest somatic presentations.

Anxiety and depression are more prevalent among women, while men have more 'externalising' disorders. The literature suggests that this difference will narrow as gender role equality improves (Seedat *et al*, 2009). A retrospective file review of in-patient admissions in Qatar revealed that Qatari females represented 47% of those admitted with affective disorders, while Qatari males represented only 19% (other nationalities accounting for the balance). Affective disorders were the single highest cause of admission among Qatari females, followed by schizophrenia. A recently published World Bank report stated that, in the Middle East and North Africa (MENA) region, depression is the disease with the highest prevalence among women; further, its rate in women is higher than it is in any other region. This is thought to be related to women's inability to work and other cultural factors (Freund, 2013).

Statistics from the psychiatry department at Hamad Medical Corporation, Qatar, reveal that more Qatari females attend the psychiatry out-patient clinics than males, yet a 3-year review of in-patient files showed that only 9% of admissions were of Qatari females, while 26% were of Qatari males. Families tend to resist female admission to the in-patient units as much as possible, and take extra measures to ensure care is provided at home, under the direct supervision, if needed, of family members. While it is, to a certain extent, acceptable for a female to attend the out-patient clinic, admissions are thus often refused. The reverse scenario can be seen with men, whose family may have difficulty managing their condition at home and more readily accept admission, sometimes without follow-up afterwards in out-patient clinics.

Reform

Mental health reforms are now occurring in most of the Middle East region, especially among the members of the Gulf Cooperation Council, with reforms in service provision, training, education and research. Among member states, the population is skewed, with more expatriates than nationals, and the impact of this situation on mental health has not been carefully considered.

Furthermore, gender-based service provision is not given sufficient (if any) emphasis in most of the reforms. Patients are not involved as major stakeholders in mental health planning. The current services are generic, with little gender sensitivity, apart from separate male and female units (driven by religious and cultural acceptability).

For the first time, mental health is being recognised as a national health priority in many countries in the Middle East. In its National Health Strategy, Qatar has recognised mental health as one of its top priorities. The same applies to other countries. Through many of the hospital-based reforms, or more broadly the Arab psychiatric organisations, there is deeper recognition of the similarities and differences within the Middle East region, which will, it is hoped, lead to collaborative research on gender difference in mental health and its impact on service planning.

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Child sexual abuse: perspectives from around the world

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London, UK, email d.skuse@ucl.ac.uk

Child sexual abuse is a topic rarely out of the headlines in the UK nowadays. What are the longer-term consequences of such abuse in different cultures? Surprisingly little has been published on the subject. In this issue of *International Psychiatry* we have commissioned three articles from diverse countries where the problem is often ignored for cultural reasons. It is worth noting that until the late 1970s this was true for the UK too. At that time, a colleague of mine from the USA came over to research the subject here, and was told it would be a waste of her time because child sexual abuse did not exist in this country.

Here, we have articles from China, the Arabian Gulf and Southern Africa. Dr Ko Ling Chan and colleagues from Hong Kong describe their well-designed survey of over 18000 adolescents from multiple regions of China. A surprising finding is that proportionately more boys than girls reported both contact and non-contact abuse. There were important mental and physical health consequences, but the level of awareness of abuse in the general population was very low.

In the Arabian Gulf, matters of sexual conduct are rarely discussed in public. Drs Ohaeri and

Al-Fayez discuss the findings from a survey of over 4000 Kuwaiti adolescents. They found the prevalence of contact abuse was substantially higher than is reported in China, but, as in China, boys more often reported it than girls. There were mental health consequences for victims, but also a pervasive fear of reporting the experience for fear of the personal social reprisals.

Finally, Neil Andersson discusses the results of a series of studies they conducted in many African countries, using sophisticated survey techniques. The sample of nearly 50000 children, in early adolescence, reported high levels of coerced sex, with little or no difference in prevalence between male and female abuse. It is worrying to discover that abused children were likely to admit to forcing other children into sexual activity, and that disdain for the safety of others through the deliberate spreading of HIV infection was often reported too.

There do appear to be cultural differences in the exposure of children to sexual abuse but, in all the areas surveyed, the problem affects a significant minority of both boys and girls. The longer-term mental health consequences are substantial.

CHILD SEXUAL ABUSE

Child sexual abuse and health outcomes in the Chinese context

Ko Ling Chan¹ PhD, Elsie Yan¹ PhD, Daniel Y. T. Fong² PhD, Agnes Tiwari² PhD and Wing Cheong Leung³ PhD

¹Department of Social Work and Social Administration, The University of Hong Kong, Hong Kong, email eklchan@hku.hk

²School of Nursing, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Hong Kong

³Department of Obstetrics and Gynaecology, Kwong Wah Hospital, Hong Kong

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Reported rates of child sexual abuse in China fall at the lower end of the range found in Western studies. However, most of the studies were conducted in only one city or province and thus their results may not be generalisable. Acknowledging the infeasibility of recruiting a truly representative sample, we conducted a survey during 2009–10 using a probability sampling procedure to obtain a large and diverse sample of school-aged adolescents from six regions in China. About one in every 13 children had had experience of sexual abuse. Routine screening in medical and social settings is urged. Efforts should be made to ensure wide awareness of this issue.

As researchers around the world pay increasing attention to child sexual abuse (CSA), the number of studies on CSA in Chinese populations has increased. Reported prevalence rates of CSA in China range from 2% to 14% (e.g. Chen *et al*, 2006; Leung *et al*, 2008), which fall at the lower end of the range found in Western studies. However, most of these Chinese studies were conducted in only one city or province, and thus their results may not be generalisable. Indeed, this problem was noted by Chen *et al* (2006), who reported that Chinese studies on CSA were often preliminary and focused on only a specific group (e.g. female adolescents). Yet, given China's huge population and geographical size, it would be extremely challenging to recruit a truly representative national sample.

The 2009–10 school survey

Acknowledging the infeasibility of recruiting a truly representative sample, we conducted a CSA survey during 2009–10 using a two-stage stratified probability sampling procedure to obtain a large and diverse sample of school-aged adolescents from six geographical regions in China. The random sampling of rural and urban districts, and then schools within the selected districts, was designed to maximise the representativeness of the sample. Details of the design and procedures have been published elsewhere (Chan, 2013; Chan *et al.*, 2013).

A total of 18 341 adolescents (53.3% boys; mean age 15.9 years, s.d. 0.1) participated in the survey. They were asked to report their experience of CSA and other types of violence using the modified Chinese version of the Juvenile Victimization Questionnaire (JVQ; Finkelhor *et al.*, 2005; Chan *et al.*, 2011). Other validated questionnaires were used to elicit demographic data and health status. Demographic factors included gender, age and number of siblings, as well as parents' marital status, educational attainment, employment status and income. Health status included symptoms of post-traumatic stress disorder (PTSD), depression, thoughts of suicide or self-harm, and health-related quality of life. Details of these questionnaires have been presented elsewhere (Chan, 2013; Chan *et al.*, 2013).

Prevalence of child sexual abuse in China

We found an 8.0% lifetime prevalence and 6.4% preceding-year prevalence of CSA among Chinese school-aged adolescents. The three most common forms of CSA were sexual assault by a known adult (3.0–3.8%), non-specific sexual assault (3.0–3.4%) and forced exposure to pornography (2.4–3.4%) (Chan *et al.*, 2013). Surprisingly, more boys than girls reported experiences of CSA ($P < 0.001$), one of the very few pieces of evidence showing male predominance in CSA victimisation.

To explore the issue of CSA from a different perspective, we further analysed the prevalence of CSA by categorising it into contact sexual abuse and non-contact sexual abuse (Table 1). Non-contact sexual abuse was the more prevalent of the two. Again, boys more frequently reported CSA ($P < 0.001$).

Factors associated with child sexual abuse in China

Demographic characteristics

Several characteristics were found to be significantly associated with increased risk of CSA in the Chinese sample (Chan *et al.*, 2013): being a boy, being older and having more siblings (adjusted odds ratios (aORs) = 1.10–1.76), as well as having a single parent and an unemployed father (aORs = 1.34 and 2.30). Although not all of the parental factors investigated were related to CSA, the findings corroborate evidence from other studies that problematic family environments are associated with higher risk of CSA.

Other types of violent victimisation

Adolescents' experience of non-sexual types of violent victimisation was associated with increased risk of CSA after controlling for demographic characteristics (Chan *et al.*, 2013). Using the JVQ, we found that direct victimisation from conventional crime, child maltreatment by parents, peer and sibling violence, and indirect experience or witnessing of violent victimisation were significantly associated with CSA (aORs = 3.74–5.29).

Physical and mental health

The experience of CSA was related to disadvantageous health conditions (Table 2). Both lifetime and preceding-year experience of CSA were positively associated with PTSD, depression and thoughts of suicide or self-harm (aORs = 1.04–2.22), with each relationship independent of the others. Furthermore, CSA was negatively related to health-related quality of life, for both physical and mental health (aORs = 0.96 and 0.97), indicating that CSA experience was associated with poorer perceived health by the victims.

Child sexual abuse in the Chinese context

The 2009–10 school survey found that prevalence rates (lifetime 8.0%; preceding year 6.4%) of CSA among Chinese adolescents were low when compared with Western figures (7–76%; e.g. Holmes & Slap, 1998; Dube *et al.*, 2005). We have proposed two explanations for the difference in reported CSA prevalence between the Chinese and Western populations (Chan *et al.*, 2013):

Table 1

Lifetime and preceding-year prevalence of contact and non-contact child sexual abuse in China

Abuse	Lifetime prevalence (%)				Preceding-year prevalence (%)			
	All (n = 18 341)	Boys (n = 9773)	Girls (n = 8568)	P (from χ^2 test)	All (n = 18 341)	Boys (n = 9773)	Girls (n = 8568)	P (from χ^2 test)
Contact sexual abuse								
Penetration	4.4	5.5	3.2	<0.001	3.6	4.7	2.4	<0.001
Non-penetrative touching	4.2	5.0	3.4	<0.001	3.3	4.0	2.4	<0.001
Non-contact sexual abuse	6.8	8.1	5.4	<0.001	5.2	6.3	4.0	<0.001
Any type of sexual abuse	8.0	9.3	6.6	<0.001	6.4	7.8	4.7	<0.001

Table 2

Independent associations between child sexual abuse and health outcomes ($n = 17\,730$): adjusted odds ratios (95% confidence intervals)

	Lifetime CSA	Preceding-year CSA
PTSD	1.67*** (1.55, 1.80)	1.65*** (1.52, 1.79)
Depression	1.04*** (1.04, 1.05)	1.04*** (1.04, 1.05)
Health-related quality of life		
Physical health	0.96*** (0.95, 0.97)	0.96*** (0.95, 0.97)
Mental health	0.97*** (0.97, 0.98)	0.97*** (0.96, 0.98)
Thoughts of suicide or self-harm	2.22*** (1.95, 2.53)	2.21*** (1.91, 2.55)

CSA, child sexual abuse; PTSD, post-traumatic stress disorder.

*** $P < 0.001$.

- Chinese adolescents might be more reluctant to report CSA (through greater sensitivity about CSA in Chinese culture)
- there is a true difference in the rates of CSA, perhaps because most children in China are single children who receive high parental care and supervision, which are protective factors against CSA perpetrated by non-family members.

Nevertheless, the profile of mental health correlates of CSA among Chinese adolescents was similar to that reported in Western studies. In particular, CSA victims were more likely than non-victims to report poorer mental health, including lower health-related quality of life, higher rates of symptoms of PTSD and depression, and more thoughts of suicide or self-harm. Despite these similarities in the mental health correlates of CSA between Chinese and Western populations, we believe CSA may have more severe negative health consequences for Chinese children. This is because they face several obstacles to help-seeking that are less of a problem for their Western counterparts:

- low awareness and knowledge of mental health (Wong & Li, 2012)
- the stigma attached to sexual abuse and mental health problems, as well as an emphasis on the concept of 'face' (Yang, 2007)
- lack of insurance for counselling services in the social security system
- poor patient–doctor relationships and mistrust of doctors and other healthcare professionals (Shu, 2011).

Since Chinese victims are often influenced by negative cultural attitudes towards seeking help from mental health professionals, they may be less likely to receive proper consultation and treatment for their mental health problems caused by CSA; consequently, these problems are likely to persist and even intensify. Left unattended, the mental health problems may be somatised, leading to a poorer perception of physical health (Najman *et al.*, 2007), as reflected in our finding that CSA was associated with poorer perceived physical health.

Conclusion

The links between CSA and various negative health correlates in the Chinese population call for effective identification and screening procedures so that timely intervention can be offered to victims. In response to the findings on the prevalence of CSA in China (about one in every 13 children had experienced CSA), routine screening in medical and social settings is urged. Efforts should be made to ensure clear awareness of this issue, on the part of both the general population and the authorities in China.

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CHILD SEXUAL ABUSE

Child sexual abuse data from an Arabian Gulf country revisited

Jude U. Ohaeri¹ and Ghenaim A. Al-Fayez²

¹Department of Psychological Medicine, University of Nigeria Teaching Hospital, Enugu, Enugu State, Nigeria, email judeohaeri@hotmail.com (formerly Department of Psychiatry, Psychological Medicine Hospital, Kuwait)

²Department of Psychiatry, Faculty of Medicine, Health Sciences Centre, Kuwait University, Kuwait

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We revisit our previous work on child abuse in Kuwait, with a focus on the sexual abuse data, and discuss the findings in the context of the local culture. In 2006, a nationwide sample of 4467 senior high-school students (mean age 16.9; 48.6% boys) at government secondary schools was studied. Over their lifetime, 8.6% had been sexually attacked, 5.9% had experienced someone threatening to have sex with them, 15.3% had experienced unwanted sexual exposure, and 17.4% had had someone touch their sexual parts (boys 21.1%, girls 14.0%; $P < 0.001$). Most perpetrators were members of the extended family. The way to assist 'dysfunctional families', where 'family honour' and the need for peaceful relations with neighbours have priority over the mental health of female victims, is to propagate the finding that child sexual abuse has a wide-ranging deleterious impact on psychosocial functioning.

Child abuse and neglect may be defined as: repeated hurtful actions on the child by caregivers and other older persons, not in keeping with healthy child-rearing practice, involving physical, verbal or sexual acts, as well as denial of the child's basic needs for food, shelter, security and affection.

Arab scholars have sought to understand why such phenomena, in particular child sexual abuse (CSA), are prevalent in a highly conservative culture that should be a bastion of family values, including the protection of children's rights, and have suggested ways in which victims could be assisted, within the cultural norms (Shalhoub-Kevorkian, 1999). Initially, they presented case histories to show that the issue was prevalent in Arab society (Doraiswamy & Al-Jabiry, 1987; and review by Al-Mahroos, 2007). However, there is a paucity of reports on the prevalence of CSA in national, community-based samples (Al-Fayez *et al*, 2012); efforts have rather focused on small communities (Elbedour *et al*, 2006), undergraduate students (Haj-Yahia & Tamish, 2001), or children and adolescents visiting social welfare centres (Usta & Farver, 2010).

Here, we revisit our previous work on child physical, psychological and sexual abuse in Kuwait (Al-Fayez *et al*, 2012), with a focus on the sexual abuse data. We place the findings in the context of the local culture and discuss the impact of the conservative culture on the mental health of former victims of abuse. We had assessed the

lifetime prevalence of sexual abuse in a stratified random sample of Kuwaiti high-school students, and explored the association of CSA with parental characteristics, subjective quality of life (QOL), self-esteem, anxiety and depressive symptoms.

Method

In 2006, a nationwide sample of 4467 senior high-school students (mean age 16.9 years, s.d. 1.2, range 14–23) in Kuwaiti government secondary schools was studied (48.6% boys). All such schools are gender segregated. The protocol for the study was approved by the institutional review boards of the Kuwait Ministry of Education and the Kuwait Society for the Advancement of Arab Children (KSAAC).

Instruments

Finkelhor (1994) has suggested the need to select instruments with international comparison in mind. Accordingly, we used a modified version of a four-item sexual abuse questionnaire developed by MacMillan *et al* (1997). All four items have a simple 'yes/no' response option, and a 'yes' response to any item was accepted as defining prevalence. The modified questionnaire reads:

As far as you can remember, did any adult ever do any of the following things to you:

- Deliberately exposed themselves to you more than once to attract your attention?
- Threatened to have sex with you?
- Touched the sex parts of your body to arouse you?
- Tried to have sex with you or sexually attacked you?

Also, we used modifications of questionnaires developed by Briere and Runtz for physical and psychological abuse, while items for anxiety and depression were selected from the Trauma Symptom Checklist for Children, developed by Briere (details in Al-Fayez *et al*, 2012). The questionnaires were translated into Arabic and checked by back-translation.

The research team critically examined the instruments for face validity. Thereafter, they were pilot tested among students (50 boys and 50 girls) who were not part of the main study.

Data were analysed by SPSS version 11.

Results

The 4467 participants hailed predominantly from fairly large, stable and harmonious family homes (the average number of children per family was 6.3; 85.1% of parents lived together; and 83.1% of respondents rated the parental relationship as

good or excellent). Most fathers were gainfully employed.

While 8.6% (boys 8.0%, girls 9.1%) claimed that someone had sexually attacked them, 5.9% reported that someone had threatened to have sex with them (boys 6.4%, girls 5.5%). There were no significant gender differences with regard to these more serious forms of sexual abuse. But with the less serious incidents – unwanted sexual exposure (15.3%; boys 22.2%, girls 8.9%), and someone touching their sexual parts (17.4%; boys 21.1%, girls 14.0%) – prevalence rates were significantly higher among the boys ($P < 0.001$). There were no significant age differences for the prevalence of the more serious forms of sexual abuse, but the less serious incidents were predominantly experienced by those aged 16–23 years (versus 14–15 years) ($\chi^2(3) = 45.6, P < 0.001$). The vast majority of perpetrators were members of the extended family.

Students with any history of sexual abuse scored significantly higher on the indices of psychological and physical abuse ($P < 0.001$). They also had significantly higher anxiety and depression scores, lower self-esteem scores, and lower subjective QOL domain scores ($P < 0.001$).

An analysis of covariance suggested that the perceived quality of the emotional relationship between the parents had a significant effect, such that those who perceived a better quality of relationship between their parents had significantly lower scores on all indices of abuse ($P < 0.001$). A noteworthy finding from the multiple regression analyses that included physical and psychological abuse data (details in Al-Fayez *et al.*, 2012) was that the lifetime psychological abuse score attributed to the mother (i.e. the child reporting psychological abuse perpetrated by the mother) was a significant predictor of self-esteem (it accounted for 11.5% of the variance in the dependent variable), anxiety (19.5% of the variance) and depression (19.7% of the variance).

Discussion

Within the limitations of a cross-sectional study that was based on recall, the high reliability indices of the questionnaires (test–retest and internal consistency – details in Al-Fayez *et al.*, 2012) indicate that the responses of the students were credible. The obstacles to understanding and dealing with child abuse in Arab societies include children's fear of the social consequences of admitting the truth of the experience (Sharma & Gupta, 2004). The high reliability indices indicate that, in the non-threatening atmosphere in which this study was conducted, affected students were able to express their views on the matter.

School authorities need this evidence base to motivate intervention programmes. The contents of such programmes should be shaped by the findings that children with any type of abuse seemed more likely to have other problems, the predictive power of psychological abuse by the mother, and the seemingly protective role of the child's perception of the parental relationship.

Comparative prevalence

While the more serious incidents of sexual abuse were not associated with significant gender differences in the Kuwaiti study, the Canadian study (MacMillan *et al.*, 1997) on which the sexual abuse questionnaire was modelled did find a gender difference for these forms of abuse (3.9% for men and 11.1% for women), in line with the international picture (Finkelhor, 1994). Our prevalence rates for the four indices of sexual abuse were at the lower end of the range of rates reported from other countries using similar measures (7–36% for women and 3–29% for men) (Finkelhor, 1994). Interestingly, a report from Palestine also found no gender difference in the prevalence of sexual abuse (Haj-Yahia & Tamish, 2001). It is possible that the strict sexual segregation in Arab cultures has contributed to this finding. This supports the call for an integrated approach to the study of child abuse (Haj-Yahia & Abdo-Kaloti, 2003).

Implications for the mental health of victims

In furthering an integrated approach, Abu-Baker (2013) and Shalhoub-Kevorkian (1999) noted the relatively low importance attached to the mental health of female victims of CSA, versus the premium that the culture places on 'family honour' and the need to maintain peaceful relations with the family of the perpetrator. Abu-Baker (2013) has suggested that families that are characterised in this way are 'dysfunctional' and that they offer 'solutions' that usually harm the victim, such as severe physical punishment for victims who insist on complaining. The way to assist such families is widely and persistently to publicise the finding that CSA has wide-ranging deleterious effects on children's psychosocial functioning. However, the plight of male victims has received scant attention in the Arab literature.

Conclusions

These findings support the universality of the experience of CSA and its impact. The correlates of child abuse elicited, especially the vulnerability of girls, should inform public health education on this issue.

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CHILD SEXUAL ABUSE

Risk-taking, revictimisation and perpetration of sexual violence in ten southern African countries

Neil Andersson

Professor of Family Medicine, McGill University, Montreal, Canada; Scientific Director, CIET, Universidad Autónoma de Guerrero, Mexico, email andersson@ciet.org

This paper reports the results of a cross-sectional survey of 11- to 16-year-old school-going youths in ten southern African countries. The survey instrument recorded both the experience of coerced sex and the perpetration of forced sex. There were prominent school and community risk factors for increased risk-taking behaviours, revictimisation and the perpetration of sexual violence. This supports the idea that the local culture can reinforce the antisocial consequences of sexual abuse of boys and girls. There was a suggestion that the school environment can compound the effects of child sexual abuse in terms of conscious knowledge, high-risk behaviour, the risk of revictimisation and disdain for the safety of others.

The mental health consequences of child sexual abuse include increased risk-taking behaviours, revictimisation (Lindgren *et al*, 1998; Cohen *et al*, 2000) and the perpetration of sexual violence (Kendall-Tackett *et al*, 1993). Even for those not directly involved, having a friend or neighbour who is a victim of sexual abuse contributes to an environment where sexual violence is expected and almost normal (Maman *et al*, 2000; Todd *et al*, 2004).

Our recent cross-sectional surveys in ten southern African countries (Andersson *et al*, 2012) looked at the prevalence of child sexual abuse at two time points (2003 and 2007). The facilitated self-administered questionnaire documented both the experience of coerced sex and the perpetration of forced sex, as well as associated risk factors, among 11- to 16-year-old school-going youths.

The study population was a stratified (urban/rural) random sample of census enumeration areas in Botswana, Lesotho, Malawi, Mozambique,

Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe, covering 25–30 enumeration areas in each country. The 445 schools were those serving these areas that included grades 6–9 (students aged 11–17 years). Detailed field methods are described by Andersson *et al* (2012).

Frequency and risk factors of abuse in boys and girls

There is increasing recognition that boys are frequently the victims of child sexual abuse. In our study, 20% of female students (weighted value based on 4432/25 840) and 21% of male students (4080/21 613) aged 11–16 years across the region reported suffering coerced sex. We found very few differences in risk factors for child sexual abuse between male and female respondents. Older children (over 13 years old) and those living in very poor households (insufficient food in the last week) were more likely to report having been victims of forced sex.

Children were at higher risk of abuse if they attended schools where fewer students knew about children's rights. Other risk factors included living in a community where a higher proportion of adults were in favour of transactional sex. Communities reporting higher than average rates of violence against an intimate partner also had a higher risk of child sexual abuse.

Differences between victims and non-victims

Across all ten countries, victims of child sexual abuse reported lower levels of knowledge about children's rights and appropriate child care than did non-victims. They had less helpful attitudes about masculinity and sexuality, and lower levels of self-efficacy. Although the mental health consequences of their experiences varied from child

to child, across the region victims were found to possess quite different group characteristics from non-victims. Here, results are reported as the adjusted odds ratio (aOR), adjusted for cluster, age, gender, poverty and country.

Revictimisation was prominent among victims of sexual abuse. They were more likely to have been bullied at school than were non-victims (aOR 1.57, 95% CI 1.47–1.68). Across the ten countries, no less than 48% (4086/8512) of victims of sexual abuse reported they had also been bullied or picked on in the past year.

Perhaps surprisingly, 34% of victims (2894/8512) reported they had bullied another child in the past year; a victim of abuse was much more likely than a non-victim to report bullying another (aOR 1.67, 95% CI 1.54–1.80).

Both male and female victims of abuse were more likely than non-victims to say they themselves had forced another child to have sex against their will (aOR 4.8, 95% CI 3.92–4.81). Across all ten countries, this association was much stronger for girls than for boys.

Victims of child sexual abuse also had higher-risk behaviours related to HIV. They were more than twice as likely to have had multiple concurrent sexual partners compared with non-victims (aOR 2.22, 95% CI 1.96–2.52).

Although disdain for the safety of others was common among young people of the region, victims of child sexual abuse were significantly more likely to say they would deliberately spread HIV if they found themselves to be HIV-positive (aOR 1.36, 95% CI 1.26–1.45).

High levels of bullying in schools compound the risks

We found these differences between victims and non-victims were compounded by the nature of the school the children attended. We divided the schools into those with higher levels of bullying and other abuse and lower-level categories, based on whether the rate in each school was above or below the national average (each country calculated separately).

Even non-victims who attended schools with higher levels of bullying had less knowledge about children's rights and child care than did those at schools with lower levels of bullying. They also had less helpful attitudes about masculinity and sexuality, and lower levels of self-efficacy. They were much more likely to have multiple concurrent sexual partners than non-victims in lower-level schools – 28.2% compared with 18.8%. Non-victims at high-bullying schools were much more likely to have forced sex on another child (7.5% compared with 2.8%) and to say they would deliberately spread HIV if infected (29% compared with 22%).

But victims of child sexual abuse who attended schools with higher levels of bullying were especially badly off. They had less knowledge of children's rights and child care than did non-victims at the same schools or victims at low-bullying schools, less helpful attitudes about masculinity and sexuality,

and lower levels of self-efficacy. Victims at high-bullying schools were much more likely to have multiple concurrent sexual partners than those at low-bullying schools (41.4% compared with 32.1%).

Where the effect of the school was greatest was in whether or not children reported themselves to be perpetrators of sexual abuse. Victims of sexual abuse who attended schools with high levels of bullying were twice as likely to say they had perpetrated sexual abuse (27.7% compared with 13.3%) than were sexual abuse victims in low-bullying schools. They were 13 times more likely to report that they had perpetrated sexual abuse than were non-victims who attended low-bullying schools (odds ratio 13.5, 95% CI 12.5–14.7). Victims of child sexual abuse attending high-bullying schools were also much more likely than victims at other schools to say they would deliberately infect others if they turned out to be HIV-positive.

Discussion

Our finding that there are both prominent school and community risk factors supports the idea that the local culture can reinforce the antisocial consequences of child sexual abuse of boys and girls. Little is known about how cultural factors interact with victim status, or the way in which they influence the likelihood of high-risk behaviours. However, our results suggest that if a child is experiencing an environment where child sexual abuse is more common, the mental health effects of abuse may be worsened. In respect of some specific behaviours, like forcing sex on other children, there seems to be a multiplicative effect of school environments that tolerate bullying upon the risk of perpetration of sexual abuse. The results of our ten-country survey provide glimpses of some of the implications of high rates of sexual abuse of children for the mental health of the young people concerned, and potentially for society at large. There is an increased rate of inappropriate beliefs and attitudes, risk-taking, bullying and perpetration of coerced sex.

Because this was a cross-sectional study, one cannot jump to conclusions about causality. For instance, one relies on reported age of abuse and age when a perpetrator both being accurate; there is no way to be sure whether knowledge, attitudes, feeling support or self-efficacy preceded or followed the reported abuse. Nonetheless, one can say that these associations are consistent with previously published evidence on the negative mental health outcomes of child sexual abuse. It also fits with our earlier national study in South Africa (Andersson *et al*, 2004) and other studies (Cohen *et al*, 2000; Koenig *et al*, 2004; Sikkema *et al*, 2007).

The way that school culture contributes to these associations adds a layer of complexity. With all the caveats that befit a cross-sectional study, the implication is that the school environment can compound the effects of child sexual abuse in terms of conscious knowledge, high-risk behaviour, the risk of revictimisation and disdain for the safety of others.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

George Ikkos

Consultant Psychiatrist in Liaison Psychiatry, Royal National Orthopaedic Hospital, London, UK, email ikkos@doctors.org.uk

The series on mental health law returns to the Middle East with the two papers on Qatar and Jordan. In both these countries, compulsory psychiatric care and treatment have not been supported to date adequately by specific legislation. In both countries, families appear to be the fulcrum of and the primary support for the treatment of patients with mental illness. A main concern arising out of this, in the light of this issue's

editorial on gender differences and mental health in the Middle East, may therefore be the implications for the burden placed on women who have to look after relatives at home with a mental illness. Another concern is the appropriateness, nature and quality of compulsory treatment of those women in Qatar and Jordan alleged to be suffering from mental disorders. Have they been getting a fair and equitable deal compared with men?

MENTAL HEALTH LAW PROFILE

Mental health law in Qatar

Mohammed T. Abou-Saleh¹ MPhil PhD FRCPsych
and Mohamed Abdelalaim Ibrahim² FRCPsych

¹Chief Executive Officer, Naufar (Qatar Addiction Treatment and Rehabilitation Centre), Doha, Qatar; and Professor of Psychiatry, St George's, University of London, UK, email mabousal@sgul.ac.uk

²Senior Consultant Psychiatrist, Hamad Medical Corporation, Doha, Qatar

This article provides a brief outline of mental health services in Qatar, historical notes on the use of informal traditional conventions under common law for the care under compulsory conditions of people who are mentally ill and information on the ongoing development of the Mental Health Law and its key provisions in the context of the new National Mental Health Strategy.

In Qatar, a national mental health programme was introduced in 1990 with the aim of setting up a community-based mental healthcare model. A planning committee for mental health was established in 2008 within the Supreme Council of Health (SCH) and is responsible for providing policy direction as well as developing mental health services across the spectrum of promotion, prevention, treatment and rehabilitation. The vision is to protect, promote and enhance the mental health

of all the people of Qatar. Importantly, among the guiding principles is the protection through legislation of the rights of people who are mentally ill.

Mental health services

The organisation of healthcare is divided between the Ministry of Health and the Hamad Medical Corporation (HMC), with the understanding that the Ministry of Health's role is mainly regulatory, and in policy-setting and coordination. Mental health services in the public sector are provided by the HMC through the Department of Psychiatry attached to the Ramaillah Hospital. The Department of Psychiatry, besides providing mental healthcare to the whole country, also works with three other services that provide mental healthcare: school health, the armed forces and the police force.

Present arrangements

There has been no Mental Health Law in Qatar to safeguard the human rights of people who are mentally ill, although one is presently in draft. Instead, common law has governed their treatment and management.

In the old days, by necessity people with serious mental illness at high risk to themselves or to others were restrained by their families in their own homes, and received care from faith healers. With the introduction and availability of treatment for these conditions, families started to approach the Department of Psychiatry for help. These days, usually a community psychiatric nurse will see the patient at home and if the patient is willing to come forward voluntarily he or she will be brought to the Department; otherwise, the family are advised to call the police for help in bringing the patient to the psychiatric in-patient unit for compulsory treatment.

There are no specific provisions within the law to address the issue of voluntary and involuntary hospital admissions. Working provisions for compulsory treatment take the form of a joint decision made by a consultant and the next of kin or relative escorting the individual involved. In a joint interview, which includes the individual to be admitted, the consultant explains the imminent risk(s) to the life, safety and health of the patient and others in order to justify the recommendation of hospital admission. If the patient refuses voluntary admission, then compulsory admission is generally arranged after the agreement of the escorting relative(s) is obtained. Patients are informed that they can appeal against compulsory admission to the hospital director or to a law court. Escorting relatives can dissent against the consultant's advice if they feel able to ensure the fulfilment of treatment at the psychiatric out-patient clinic.

There has in fact been no legal appeal against compulsory admission. The procedure is completely without formalities and there is no specific paperwork to complete.

Once the patient has been admitted (voluntarily or compulsorily) treatments are decided by the

consultant or specialist in charge. Up until 1983, verbal consent for electroconvulsive therapy (ECT) was sufficient; since 1983, written consent, with a signature, has been required.

The admitting consultant decides on the patient's discharge to the care of the family, which is the main welfare agent in Qatar for sick and healthy family members alike (El-Islam, 1978).

In 1992, the Attorney General's Office was empowered to order the admission of a disturbed patient for a maximum period of 2 weeks, which can be extended on the recommendation of the treating psychiatrist. The Attorney General's Office established links with local police stations and empowered them to take appropriate action. Psychiatrists arranged for compulsory admission for the said period. Within this assessment period the psychiatrist is expected to provide a medical report to the Attorney General on the patient's condition and to advise whether compulsory detention is required for a further period for assessment and treatment.

Nurses have the power to initiate restraint of a severely disturbed patient but should immediately inform the on-call doctor, who should see the patient within 6 hours.

The new Mental Health Strategy

Qatar, in its National Vision, has made a commitment to having a healthy population both physically and mentally through the provision of a comprehensive world-class healthcare system; Qatar aims to be an advanced society capable of sustaining its development and providing a high standard of living for all its people by 2030. Qatar's National Mental Health Strategy, 'Changing Minds, Changing Lives', is aligned with the Qatar National Strategy 2011–16. The plan aims to develop comprehensive mental health services that provide care across the life span, from prevention, early detection, treatment and rehabilitation, to raising public awareness.

Mental health legislation

Qatar recognises the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (adopted by General Assembly Resolution 46/119 of 17 December 1991) as providing important guidelines to ensure the human rights of persons with mental disorders. Moreover, Qatar is guided by all the recommendations from the World Health Organization's Eastern Mediterranean Region on the development of comprehensive mental health services, including the issues of human rights (Abou-Saleh, 2012).

The new Mental Health Law in Qatar (the first such legislation) has been drafted and is awaiting approval by the Council of Ministers. The aim of the legislation is to organise mental and medical care for patients who are mentally ill, to protect their rights and to designate methods of caring for and treating them in mental health institutions, as well as to protect the community.

In line with regulations adopted internationally, this law establishes basic rules for the treatment of individuals. Importantly, it sets out a series of definitions, of the following terms: mental health; mental disorders; mental illness; mental capacity; consultant psychiatrist; treating physician; the guardian; voluntary admission; compulsory admission; home leave; and mandatory community treatment order. It also sets out the role of the 'Competent Entity': the Competent Entity will supervise and monitor the implementation of the Mental Health Law, inspect approved healthcare services, consider appeals from patients and their families, discharge patients from compulsory admission and assign guardians.

The articles of the law cover: the rights of people who are mentally ill; compulsory admission for treatment; temporary compulsory admission for treatment; compulsory admission for the purpose of assessment; termination of compulsory admission; home leave; mandatory community treatment orders; compulsory readmission; admission by judicial order or court sentence; termination of admission by judicial sentence; transfer of patients to other institutions; and penalties for physicians who violate the human rights of people who are mentally ill.

Conclusions

While there has not been a mental health act in Qatar, the provisions of common law have enabled mental health professionals to provide appropriate treatment and care for people who are mentally ill under compulsory conditions with the support of the courts and the police and, importantly, the patients' families. The long-awaited Mental Health

Law has been drafted in the context of the National Mental Health Strategy. The vision of the Strategy is to protect, promote and enhance the mental health of all the people of Qatar. The legislation will incorporate provisions on the rights of persons with mental disorders and disabilities. The Mental Health Law is soon due to receive assent. It draws upon international mental health laws and best practice, including the Mental Health Act 2007 in England and Wales and the new Egyptian legislation (Loza & El Nawawi, 2012). Its provisions are complimented by executive by-laws (codes of practice).

No doubt the new Law will be tried and tested in practice and may need amendment and reform (as has the Egyptian Mental Health Act). The introduction of the Law will encourage other countries in the Eastern Mediterranean Region to follow suit and develop mental health legislation, as recommended in the Regional Mental Health Strategy (World Health Organization, 2011) and the World Health Organization Global Comprehensive Mental Health Strategy.

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Mental health law in Jordan

Walid Sarhan¹ FRCPsych and Ali Alqam² MRCPsych

¹Consultant Psychiatrist, Amman, Jordan, and Editor of the *Arab Journal of Psychiatry*, email sarhan34@orange.jo

²Consultant Psychiatrist, Amman, Jordan, and Assistant Editor of the *Arab Journal of Psychiatry*, email alialqam7777@gmail.com

The history of the psychiatric scene in Jordan is briefly described, and the Jordanian Public Health Law is highlighted, as its chapter on mental health regulates compulsory admission. Some notes are included on the criminal law and civil law, and Jordan's forensic psychiatric services are briefly described.

Jordan was served until 1967 by Bethlehem Hospital in the West Bank, Palestine, a hospital that was established in the 1930s, during the British colonial period. In 1967 the East Bank of the

Kingdom was left without a psychiatric hospital. Soon after that, a psychiatric hospital dealing with severe mental illness was established in Amman and the Royal Military Medical Services started a comprehensive in-patient and out-patient department at King Hussein Medical Centre. At the same time, the Ministry of Health expanded out-patient services. Soon after that, a few private psychiatric clinics were opened, and in 1996 the first private teaching psychiatric hospital was established.

There is only one forensic unit in Jordan, the National Centre for Mental Health; there are no units in prisons, but psychiatrists visit prisons

regularly, and they write reports to the courts about fitness to plead, criminal responsibility and competence.

Mental health provisions in public health law

For decades, Jordan did not have a mental health act. Common law gave psychiatrists the authority, at the request of the family, to admit patients or to treat them against their will. It was only in 2008, with the implementation of Public Health Law No. 47, that psychiatric care came to be governed by statute. Chapter 4 of that law concerns mental health. It has four parts:

Part 1

This part mandates that patients with a mental illness or addiction be admitted to a psychiatric hospital or a psychiatric unit in a general hospital that is equipped with everything necessary for the safety of the patient, and that is staffed by a mental health team. This has stopped the previous practice of admitting such patients on general hospital medical wards.

Part 2

This part governs voluntary and involuntary admissions to psychiatric hospitals and units. The law describes three reasons for the compulsory admission of patients with a mental illness or addiction:

- their condition requires in-patient treatment
- they present a danger to themselves or others (danger can be in the form of a risk of either physical or verbal aggression)
- there is a court order for admission.

In relation to the first two, the family (next of kin) has to apply to the hospital director, and there needs to be a psychiatric report supporting the application. Admission proceeds once the approval of the director of the hospital is obtained.

Part 3

This part specifies that the Minister of Health has the authority to ask a committee to review a case where there is a complaint about psychiatric care. Accordingly, the Minister has the authority to stop the admission or discharge of the patient, except where admission was by court order.

Part 4

Following improvement in the health of the patient, the treating psychiatrist, with the approval of the hospital director, will inform the family about the date of discharge, except if the patient was admitted through a court order, in which case the court will be informed about the readiness of the patient for discharge.

Mental health in criminal law

The criminal law is still based on the British McNaughton rule: offenders are considered either sane or insane, and if insane are committed to the Forensic Unit of the National Centre for Mental Health until they are completely cured. The issue of cure is controversial, as application of the criminal law in this regard has led to injustice; for example, some patients with schizophrenia are maintained on treatment for years, with very little chance of being discharged, despite full remission. Furthermore, court procedures are stopped when a patient is deemed unfit to plead, for example because of an intellectual disability; such patients may then remain in hospital for the rest of their lives, even without having been found guilty in court.

Mental health in civil law

In guardianship, divorce and child custody cases people suspected of having mental health problems are not routinely referred for psychiatric evaluation; it is up to the judge to decide whether the person is sane or not.

Psychiatric disorders in Jordanian law

Beyond Public Health Law No. 47, neither psychiatric disorders nor psychiatry are mentioned in any other Jordanian legislation, except for one law that deals with court procedure, where the terms 'insanity' and 'chronic illness' are used and psychiatrists are requested to deal with relevant issues in court in cases relating to guardianship, criminal responsibility and mental capacity.

Discussion

The implementation of the mental health provision in the Public Health Law since 2008 has been working well, as most of our patients are cared for in the community, by their families – even patients who are severely ill. The majority of admissions are done on a voluntary basis, with the help of the families. The majority of psychiatrists in Jordan do not see the need for more sophisticated mental health legislation, but would like some amendments to the law. In the authors' opinion, the addition of safeguarding provisions in relation to the patients' rights would be desirable, as would measures for the protection of psychiatrists.

The main problem facing psychiatrists in Jordan is the way in which psychiatric patients are dealt with by the legal system. Psychiatrists are called upon as witnesses but not specifically as experts, and the legal explanation given is that psychiatrists are witnesses in relation to any reports they prepare. The qualifications and experience of the psychiatrist are not necessarily taken into consideration, because psychiatrists are not mentioned in any law. Judges can therefore give whatever weight they choose to professional psychiatric opinion.

Prevalence of post-traumatic stress disorder among the survivors of two suicide bombings in Iraq

Mohammed J. Abbas¹ MB ChB MMedSci MRCPsych,
Amir Fadhil Al Haidary² MB ChB FICM Psychiatry and Sabah Alghanimy³ MB ChB

¹Consultant Psychiatrist,
Leicestershire Partnership NHS
Trust, UK, email mohdgum@
hotmail.com

²Lecturer in Medical College,
Karbala University, Iraq

³General Practitioner, Depart-
ment of Health, Karbala, Iraq

The prevalence rates of post-traumatic stress disorder (PTSD) and subthreshold PTSD (SPTSD) were measured in 258 survivors of two suicide bombings in Karbala, Iraq, 2 months after the incidents. Of the total sample, 112 (43.4%) had PTSD and 59 (22.9%) had SPTSD. PTSD was more prevalent after the incident that was associated with more civilian deaths.

Post-traumatic stress disorder (PTSD) is common following disasters, especially man-made ones (Neria *et al.*, 2008). Patients can develop some but not all of the symptoms of PTSD, a condition sometimes called subthreshold PTSD (SPTSD), which can still reflect significant clinical and psychosocial impairment (Zlotnick *et al.*, 2002).

Between 2003 and 2010 there were more than 1000 suicide bombings in Iraq, resulting in more than 12000 civilian deaths (Hicks *et al.*, 2011). In April 2007, there were two such incidents in Karbala city, 120 km south-west of Baghdad, with an estimated population of 800000. The first occurred on 14 April, at a crowded bus station, and at least 46 people were killed; the second occurred on 28 April and killed 73 (see <http://www.iraqbodycount.org/database>). We report on the prevalence of PTSD and SPTSD among survivors of these two incidents.

Method

Karbala Health Authority developed this project in order to screen for PTSD in survivors of terrorist incidents in the city. Those who screened positive were offered further assessment and psychiatric intervention. A team of one consultant psychiatrist (AH), three general practitioners and eight health workers was assembled. AH provided the rest of the team with training, which consisted of three 3-hour sessions of lectures, interactive exercises and mock interviews. It covered the theoretical and clinical aspects of PTSD and the use of the Arabic version of the PTSD module (module I) of the Mini-International Neuropsychiatric Interview (MINI).

The team surveyed the scenes of the two incidents 4 days after the attacks. All those shops which had a direct view of the scenes were visited. Workers aged 16 and over who were present during our visits were approached. No attempt was made to contact workers who were not present during our visits. Those who had witnessed the incidents

and who gave verbal consent to be interviewed at a later date were included in this study. Apart from 17 people, all who were approached gave consent and were interviewed. None of the participants had suffered physical injury as a result of the attacks (possibly because those injured were absent, as they were still receiving treatment). They were interviewed at the Primary Healthcare Centre 2 months following the incidents by two professionals from the same team described above. Interviews took about 20 minutes. Demographic details were recorded and the MINI was administered. Scores were agreed by the two professionals.

The MINI is a brief, reliable and valid structured diagnostic interview (Lecrubier *et al.*, 1997; Sheehan *et al.*, 1997). The PTSD module (module I) follows the DSM-IV criteria for PTSD (Sheehan *et al.*, 1998). Six criteria need to be met:

- 1 experiencing or witnessing a traumatic event
- 2 response with intense fear
- 3 intrusion symptoms
- 4 avoidance or numbing (at least three symptoms out of a list of seven)
- 5 hyperarousal (at least two symptoms out of a list of five)
- 6 interference with functioning.

We followed Blanchard *et al.* (1994) in their definition of SPTSD. SPTSD was defined by the fulfilment of criteria 1, 2, 3, 6 and either 4 or 5. This is a widely used definition of SPTSD, with a very good level of agreement with a definition based on the presence of a clinically significant distress or impairment (Franklin *et al.*, 2002).

Analysis

Numbers and percentages of patients with PTSD and SPTSD were calculated and compared across other variables using χ^2 tests. Multinomial logistic regression was used to test for correlates of PTSD and SPTSD diagnoses. All analyses used SPSS for Windows, version 19.

Results

In total, we interviewed 258 people: 139 who witnessed the first incident and 119 who witnessed the second incident. The majority (251; 97.3%) were male, because shops in the city are owned and staffed mostly by men. Demographic and clinical characteristics are summarised in Table 1.

Table 1

Demographic and other characteristics of participants with no PTSD, PTSD and SPTSD

Variable		No PTSD (n = 87; 33.7% of sample)		SPTSD (n = 59; ^a 22.9% of sample)		Full PTSD (n = 112; 43.4% of sample)		χ^2	P
		n	%	n	%	n	%		
Incident	First incident	54	38.8	36	25.9	49	35.3	8.182	0.01
	Second incident	33	27.7	23	19.3	63	52.9		
Gender	Female	1	14.3	2	28.6	4	57.1	1.221	0.54
	Male	86	34.3	57	22.7	108	43.0		
Age group	< 20	7	36.8	5	26.3	7	36.8	10.538	0.22
	20–29	28	28.6	20	20.4	50	51.0		
	30–39	28	35.0	24	30.0	28	35.0		
	40–49	11	30.6	7	19.4	18	50.0		
	50–59	13	52.0	3	12.0	9	36.0		
Marital status	Single	28	37.8	15	20.3	31	41.9	2.999	0.82
	Married	58	32.6	42	23.6	78	43.8		
	Divorced	0	0.0	1	33.3	2	66.7		
	Widow	1	50.0	0	0.0	1	50.0		

PTSD, post-traumatic stress disorder; SPTSD, subthreshold PTSD.

^aMarital status not recorded in one instance.

Of our total sample, 112 (43.4%) met the diagnostic criteria for PTSD and 59 (22.9%) for SPTSD. We used multinomial logistic regression with diagnosis as the dependent variable (no PTSD as a reference category) and incident (first or second), gender, age group and marital status as predictors. This revealed only one significant association: PTSD was more prevalent among the witnesses to the second incident (which had led to more civilian deaths) than the first incident (odds ratio 1.97, 95% confidence interval 1.08–3.61; $P = 0.02$)

Discussion

This study investigated the prevalence of PTSD and SPTSD among the survivors of two suicide bombings in Karbala, Iraq. As expected, the prevalence of PTSD in our sample (43.4%) was much higher than the 2.5% lifetime prevalence of PTSD in the general population found by the Iraq Mental Health Survey (Alhasnawi *et al*, 2009). Direct exposure to disasters is suggested to be the most important risk factor for PTSD (Galea *et al*, 2005), as it leads to the highest rates, from 30% to 40% (Galea *et al*, 2005; Neria *et al*, 2008).

The prevalence of SPTSD in our study is comparable to that reported in studies employing a similar definition to the one we used (Galea *et al*, 2003). The fact that participants were interviewed 2 months after the attacks in our study is another reason for the high rates. Previous reviews of PTSD following disasters, including man-made incidents, concluded that prevalence rates decline over time (Galea *et al*, 2005; Neria *et al*, 2008).

The prevalence of PTSD was significantly higher after the second incident, which was associated with more civilian deaths. Neria *et al* (2008) in their review suggested that the frequency of fatalities is one of the predictors of a high rate of PTSD. However, other risk factors (see Limitations, below)

might have contributed to the difference. Female gender was not a predictor of PTSD in our study, in contrast to previous research (Galea *et al*, 2005), but this could be because our sample included only seven women.

This study highlights the need to explore the concept of SPTSD further, especially in light of its association with clinical and psychosocial impairment (Zlotnick *et al*, 2002). It raises again the issue of the 'threshold dilemma' (Horowitz, 1987) and the number of criteria sufficient to diagnose PTSD.

The Iraqi context

This study provides some support for the trans-cultural validity of PTSD as a diagnostic category in Iraq, at least in the immediate aftermath of a major traumatic event. The cross-sectional nature of this study limits our ability to answer the question of whether PTSD, as a reaction to trauma, would remain valid in the long term in Iraq. It is possible that, in the long term, the psychiatric consequences of trauma might present in a different way, for instance as anxiety disorders, which were found by the Iraq Mental Health Survey to be the most common class of disorders (Alhasnawi *et al*, 2009).

The high rates of PTSD and SPTSD in this study raise important questions in relation to service provision, especially as the Iraq Mental Health Survey found that only 10.8% of patients with diagnosable mental disorder receive treatment (Alhasnawi *et al*, 2009). The fact that the mainstay of treatment for PTSD is psychological therapy, for example cognitive-behavioural therapy (CBT), highlights the difficulties even further in light of the very limited resources for such treatment in Iraq. It is worth noting here that training in CBT has recently become mandatory for members of the Iraqi Board of Psychiatry (Al-Uzri *et al*, 2012).

Limitations

One limitation of this study is that the concept investigated (PTSD) and the instruments used to measure it are Western. The transcultural applicability of PTSD has been challenged by a number of authors (e.g. Bracken *et al*, 1995). However, others have suggested that the criteria for PTSD are useful across cultures (Cheung, 1994) and that the similarity between the findings in different cultures supports the wide applicability of the concept (Njenga *et al*, 2004). A qualitative approach might be helpful in this area.

Another limitation of this study is that we did not control for the presence of psychiatric illness, which is a risk factor for PTSD (Galea *et al*, 2005). Other risk factors which were not measured include low socioeconomic status, poor coping skills and psychological factors such as anger and external locus of control (Galea *et al*, 2005). There were no injured individuals in our sample and therefore any conclusions cannot be generalised to this specific group. We did not investigate whether participants were exposed to previous incidents or whether PTSD existed prior to the attacks, because the design of this governmental project was to screen for possible cases to be offered further assessment and intervention by the psychiatric services; therefore, we use the term 'prevalence' in this study rather than 'incidence' (Galea *et al*, 2005).

Conclusion

This study confirms that the prevalence of PTSD is high following terrorist attacks. A large proportion of victims develop symptoms which are insufficient to diagnose PTSD (SPTSD). However, those patients could still experience significant impairment.

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Fundraising trek to Burma, 7–17 February 2014

The College's Volunteer Scheme aims to facilitate contact between hospitals, clinics, projects and communities in need of psychiatric expertise and training, and psychiatrists who are willing to offer their time and support. Following the hugely successful fundraising trek to Kerala in 2009, which raised over £30 000 for the Volunteer Scheme, a second trek is being organised, to Burma, 7–17 February 2014. Trekkers will have the opportunity to discover one of the least-explored countries in South-East Asia, and will see temples, trek through colourful hill-tribe villages and explore the Inle Lake, with its villages on stilts. More information can be found on the College website, at <http://www.rcpsych.ac.uk/workinpsychiatry/internationalaffairsunit/fundraisingtrektoburma.aspx>

Rapid tranquillisation: practice in Zambia, before and after training

Mahesh Jayaram,¹ Ranga Rattehalli,² Lindsay Moran,³ John Mwanza,⁴ Paul Banda⁵ and Clive Adams⁶

¹Consultant Psychiatrist, Aire Court, Lingwell Grove, Leeds, UK, email mahesh.jayaram@nhs.net

²Consultant Psychiatrist, Newsam Centre, Seacroft Hospital, Leeds, UK, email rdrattehalli@hotmail.com

³General Practitioner, The Gables Surgery, Leeds, UK, email lindsaymoran@doctors.org.uk

⁴Chainama Hills College Hospital, Lusaka, Zambia, email mjmwanza24@yahoo.com

⁵Chainama Hills College Hospital, Lusaka, Zambia, email paulbanda01@yahoo.com

⁶Professor of Psychiatry, University of Nottingham, Nottingham, UK, email clive.adams@nottingham.ac.uk

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The evidence base for rapid tranquillisation is small in higher-income countries but is even smaller in sub-Saharan Africa. We initiated the first ever survey on the use of rapid tranquillisation in Zambia in 2009; a further survey was then done in 2010, after a programme of teaching and training. It demonstrated an overall improvement in clinical practice, safety, awareness and use of medications within therapeutic doses. It also led to a reduction in inappropriate use of medications. These improvements in practice occurred within a short time span and with minimal effort. Further international collaborative partnerships are required to build stronger mental health infrastructure in Zambia.

The provision of mental health services in low- and middle-income countries is varied and is often particularly poorly resourced (Saxena *et al*, 2005). Sub-Saharan Africa has suffered from political strife and financial instability. The region carries 24% of the world's disease burden but has only 3% of health workers and less than 1% of the world's financial resources (World Health Organization, 2006a). In the midst of all this, governments in sub-Saharan Africa perceive funding for mental health to be a luxury. When conditions such as HIV/AIDS, cerebral malaria and perinatal morbidity are such major causes of low average life expectancy, funding the care of an often heavily stigmatised group of people with long-standing depression, dementia and other serious and enduring mental illnesses may not seem attractive. This has led to chronic underinvestment in mental health services, with consequent overcrowding, erosion of morale among staff and derelict infrastructure. Locked wards, infringements of human rights and patient autonomy, and a skeleton staff of overworked and undertrained personnel are common problems associated with mental health services in Zambia. This is compounded by inadequate provision of food for patients and the limited availability of drugs. These only begin to highlight the issues encountered by patients and staff at the Chainama Hills College Hospital, a tertiary mental health hospital in Lusaka, Zambia.

Episodes of acute agitation or behavioural disturbances due to psychiatric illnesses may be a feature of presentations in out-patient clinics, in-patient wards and emergency room settings, as well as in police custody. Acute agitation can occur in up to 10% of psychiatric emergencies. Common

causes include psychotic symptoms (Sachdev, 1996), substance misuse, severe anxiety states (Atakan & Davies, 1997) and delirium. It is often members of the patient's family who become victims of violence and, not uncommonly, medical and nursing staff. Patients themselves or other patients are also at risk (Bourget *et al*, 2002).

Clinicians have to decide quickly what intervention is the safest in managing these episodes. Calming the patient down rather than sedation is often thought to be desirable. Guidelines predominantly drawn up in higher-income countries recommend the use of non-pharmacological alternatives as the first line of management, although this may be an impractical approach in lower-income countries, where resources are stretched and the number of patients often very large (Andrade, 2007). In these crowded circumstances disturbance is common and rapid tranquillisation is one approach used to solve the problem.

Leeds and York Partnership NHS Foundation Trust and Chainama Hills College Hospital set up a collaborative partnership. The first stage of our collaboration was to survey the frequency and circumstances of these difficult situations, and the drugs used.

Method

The protocol for this work was discussed and approved by the local drugs and therapeutics committee, which was the only committee to sit regularly at Chainama Hills College Hospital. All patients attending the out-patient clinic for a period of 5 consecutive weeks (beginning June 2009) requiring rapid tranquillisation were included. A simple survey questionnaire was completed by trainee clinical officers and medical students not involved in the clinical decision-making or the administrative aspects of patient care.

Following the period of data collection, results were disseminated and discussions took place around best practice. A local protocol was drawn up using available resources. An interactive training session was conducted for all the staff in the hospital aimed at improving knowledge and building skills in the area of rapid tranquillisation. Following this, a repeat survey over a shorter period but otherwise using the same methods was undertaken in March 2010 to see whether there had been any improvements in practice.

Results and discussion

During the first survey period, 105 patients required rapid tranquillisation (around 8% of the

Table 1

Medications used for rapid tranquillisation

Drug group	Number (%) of patients		Route	Drug	Mean dose (mg)	
	2009 (n = 105)	2010 (n = 16)			2009	2010
Antipsychotic	84 (80%)	13 (81%)	i.m.	Haloperidol	9.6	10
			Oral	Haloperidol	6.0	5
			Oral	Chlorpromazine	85.5	100
			Oral	Fluphenazine	25	NA
			i.v.	Haloperidol	10.9	10
			Oral	Trifluoperazine	5.2	5
			i.m.	Chlorpromazine	55.5	NA
			Oral	Risperidone	2	NA
Anticholinergic	46 (44%)	4 (25%)	Oral	Trihexyphenidyl	5	5
Mood stabiliser (including antidepressants)	10 (10%)	5 (31%)	Oral	Carbamazepine	200	200
			Oral	Amitriptyline	37.5	NA
			Oral	Sodium valproate	100	100
Benzodiazepine	53 (50%)	10 (63%)	i.m.	Diazepam	16.2	10
			i.v.	Diazepam	13.8	5
			Oral	Diazepam	4.6	10
Antihistamine	3 (3%)	3 (19%)	Oral	Promethazine	25	25
Antiepileptic	11 (10%)	7 (44%)	Oral	Phenobarbitone	30	30
			i.m.	Phenobarbitone	200	200
Others	9 (9%)	0 (0%)	Oral	Vitamin B	NA	NA
			Oral	Cloxacillin	500	NA

i.m., intramuscular; i.v., intravenous; NA, not available (no use recorded).

Table 2

Diagnoses of patients receiving rapid tranquillisation

Diagnosis	%	
	2009	2010
Non-affective psychosis	37	24
Alcohol/substance misuse	25	12
Affective disorder	4	0
Acute confusional state	5	6
Dementing illnesses	3	6
Not mentioned	9	0
Encephalitis	1	0
Epilepsy	13	35
Intellectual disability	2	0
Post-traumatic stress disorder	2	0
Personality disorder	0	17

total number of patients attending the hospital casualty department). No patient was lost to follow-up. About two-thirds were men (68%); the average age was 32 years (s.d. 14.9, range 2.5–83 years; note that local practice is to bring even young children with epilepsy to psychiatric hospital, which could explain the lower end of this range). The degree of agitation as rated by clinicians (based on their observation of the patient's behaviour and their general clinical impression) was categorised as mild in 53% of cases, moderate in 30% and severe in 16%. Numerous combinations of medications and means of delivery were used; 87% of patients received either intramuscular or intravenous preparations (in some instances both) and 13% only oral preparations.

In light of the discovery of the varying rapid tranquillisation practices, and a lack of formal

teaching, we piloted an interactive training programme for all the staff in the hospital working with people presenting with a mental illness. Two such training workshops were held over a 2-week period so that all staff could attend. Each 3-hour training session was facilitated by a consultant general adult psychiatrist and a mental health nurse visiting from the UK. Each was divided into the following five sections:

1. an interactive discussion on staff and trainee psychiatrists' experiences of dealing with psychiatric emergencies needing rapid tranquillisation (in these discussions, a sense of uncertainty was a prominent theme)
2. an overview of the available guidelines on rapid tranquillisation, including the principles of rapid tranquillisation and the suitability of locally available drugs, their dosage and route of administration
3. a practical approach to the key elements of control and restraint, and the importance of de-escalation and its techniques
4. a discussion of the study findings and the available evidence in this area and how this evidence applies to the patients seen in that hospital
5. real-life case studies and case vignettes suitable for this training, which were discussed in smaller groups to build their confidence in handling psychiatric emergencies.

The second survey, in 2010, was conducted over 1 week only, due to resource limitations and lack of suitable professionals to continue data collection for 5 weeks. Otherwise, the same method of data collection was used and no loss to follow-up was ensured. Sixteen patients required rapid tranquillisation (around 15% of the total attendances at casualty). Again, around two-thirds (60%) were men and the average age was 30.2 years. Of those requiring rapid tranquillisation, about 31% were rated as being in a mild state of agitation, 44% a moderate state and 16% a severely agitated state, based on the general clinical impression of the clinician.

Table 1 presents summary statistics for the two surveys. Table 2 shows the use of rapid tranquillisation according to the diagnosis of the patients. In 2009, 27% of the patients subject to rapid tranquillisation had been brought in under restraint to the hospital. These restraints took the form of shackles, ropes and physical restraint by a member of family. Most (61%) of those admitted in this manner continued to need restraint until after rapid tranquillisation. Overall, 25% of those who received rapid tranquillisation had to be restrained. Nearly 20% of patients required repeat medications for sedation. In 2010, 30% were brought in under restraint, of whom 50% required restraint for rapid tranquillisation.

Zambia and the UK are collaborating to improve psychiatric training – although more needs to be done. The work done by our teams

in terms of teaching and training appears to have had an impact in a short time. Discussions around the value of rapid tranquillisation, in particular the safe and effective use of available resources, appears to have been incorporated into some areas of local practice. For example, during the second survey, it was clear that more people with psychosis were getting medication, the doses of medications used were more in line with available evidence of safe use and fewer people with intellectual disabilities or affective disorders were rapidly tranquillised. In summary, the training seemed to have made a difference in the following areas:

- clearer recognition of when rapid tranquillisation was needed
- judicious use of medications at appropriate doses, leading to better availability of medications for those who needed them most
- de-escalation techniques used more effectively
- drug prescribing closer to recommended guidelines, in keeping with resource limitations.

Conclusions

There are few surveys worldwide of what goes on in this unattractive end of healthcare. This study highlighted variations in treatment, although in fact practice was similar to that in other places (Pilowsky *et al.*, 1992). More widely, the use of rapid tranquillisation may be becoming more consistent and rational than it was in the past (Huf *et al.*, 2002a). Inconsistency thrives when good evidence is lacking. When the evidence base is small or biased, guidance can be contradictory and confusing; the situation is worsened by studies that produce recommendations that are impossible to apply. This inconsistency is further promoted by intermittent drug supply and poor levels of training. At Chainama Hills College Hospital, although the staff are hard-working and willing, the high attrition rate and lack of training and mentorship compound the problems.

Zambia can do something about the poor evidence of this most vulnerable (albeit aggressive) group of patients. After all, one of the first and most influential trials of healthcare came from a country ravaged by war, with insufficient funding for its health services to pay for the experimental treatments for everyone in need (Medical Research Council, 1948). The treatments used in Zambia in the management of aggression are not all evidence based. For example, use of haloperidol versus chlorpromazine for acute aggression caused by psychosis has been evaluated in one small trial. As these are the only two antipsychotic drugs that can be used for this purpose on the World Health Organization's List of Essential Medicines (World Health Organization, 2006b), the frequency of use worldwide is likely to be high. Brazil and India have already proven that relevant real-world trials of high methodological quality in this area are possible (Huf *et al.*, 2002b; Alexander *et al.*, 2004). Zambia could conduct similar or better trials to evaluate these medications and by doing

so show the world how the river of evidence does not have to flow all in one direction.

There needs to be a clear career pathway for budding psychiatrists during their formative years, with more local training. Presently, many students take the often one-way journey out of the country to Kenya, Malawi or further afield. There are ongoing collaborative efforts to promote sharing of skills and knowledge transfer, both institutionally and nationally. Through some funding from the UK Department for International Development (DFID), working with the Tropical Health Education Trust (THET) and other organisations, the first ever Masters in Psychiatry course has been running in Zambia since May 2010. It is hoped that this will improve both the quality of care and the retention of psychiatrists.

Zambia is a land of immense beauty. The English language is widely spoken. Despite enormous poverty, people remain optimistic. In the 1980s, during a period of buoyant copper prices, significant improvements in healthcare occurred, including in the mental health services. Then copper prices collapsed and health provision fell. The situation is responsive and not entrenched. Things have improved before and can do again. This time, disengaged from the vagaries of the interests of big business, with modest support and the deep goodwill of local practitioners and organisers, improvements could and should last.

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The Mysore Declaration

Peter Lepping¹ MD MRCPsych MSc and
B. N. Raveesh² MBBS MD (Psy) MSc LLB MBA PGDMLE PGDMLS

¹Consultant Psychiatrist and Associate Medical Director (Betsi Cadwaladr University Health Board) and Honorary Professor (Bangor University); Centre for Mental Health and Society, Wrexham Academic Unit, Technology Park, Wrexham, Wales, UK, email peter.lepping@wales.nhs.uk

²Professor and Head, Department of Psychiatry, Mysore Medical College and Research Institute, Mysore, India

Coercion is recognised as a problem in health services around the world. Very little is known about the use and utility of coercive measures in psychiatry and other medical specialties in India, although the existing evidence supports the view that coercion is widely used. In February 2013 experts from India and Europe came together in Mysore, India, for an international symposium on coercion. A Declaration was drafted, discussed and ratified which defines coercive measures for the Indian context and which outlines ways to minimise coercion in medical settings in India. This paper describes the main points of the Declaration.

Background

Coercion is recognised as a problem in health services around the world. There is a growing body of evidence analysing the prevalence of coercive measures as well as randomised controlled trials comparing various types of coercion (Abderhalden *et al*, 2008; Steinert *et al*, 2010). Recent studies of 'leverage' have opened up the field to include soft pressures exerted on patients by services (Monahan *et al*, 2005; Burns *et al*, 2011). Almost the entire current literature comes from higher-income countries. Very little is known about the use and utility of coercive measures in psychiatry and other medical specialties in India. What evidence there is supports the view that coercion is widely used, although patterns of its use may differ. Some evidence suggests that there are relatively high levels of cooperation between family members and clinicians in the use of coercive measures (Srinivasan & Thara, 2002).

There has been a rapid change in the socio-economic, cultural and psychosocial profiles of the traditional, rurally oriented and family-centred societies of India and Asia in general. Despite the fact that family and friends are often intimately involved in patients' care in India, standards of coercion and restraint have not been defined. With a lack of international comparisons it is all the more important to be aware of patients' individual rights and preferences regarding the necessity, mode and place of psychiatric treatment, but also to recognise the legitimate interests and wishes of family members. The recent draft proposal to amend the Indian Mental Health Act has not brought certainty to issues of coercion (Shah & Basu, 2010).

Drafting of the Declaration

In February 2013 experts from India and Europe came together in Mysore, India, for an international

symposium on coercion (on which see <http://www.mysorecoercion.com/content/mysore-declaration>). The experts included members of the newly founded Indian Forensic Mental Health Association and the European Violence in Psychiatry Research Group. The meeting was supported by senior staff from Betsi Cadwaladr University Health Board and Bangor University (North Wales, UK). A Declaration was drafted, discussed and ratified which defines coercive measures for the Indian context and which outlines ways to minimise coercion in medical settings in India.

The Declaration

The Declaration asserts that:

There is an urgent need for the recognition and implementation of the rights of persons with mental illness, following principles with regard to equality, security, liberty, health, integrity and dignity of all people, with a mental illness or not.

It goes on:

All parties responsible for the care and treatment of mental illness should work towards the elimination of all forms of discrimination, stigmatisation and violence, cruel, inhumane or degrading treatment. We affirm that disproportionate, unsafe or prolonged coercion or violence against persons with mental illness constitutes a violation of the human rights and fundamental freedoms and impairs or nullifies their enjoyment of those rights and freedoms. We will strive to uphold the human rights of persons with mental illness. We will work towards the prevention of violation, promotion and protection of their rights.

The Declaration recognises the potential tension between the rights of patients who refuse medication and the benefits of potential restoration to normal functioning through involuntary treatment, as well as the wishes of family members, who often play an important role in the treatment of mental illness in India. The Declaration states that:

Notwithstanding this debate, persons with mental illness are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

It reiterates the rights and responsibilities of patients as well as society towards persons with mental illness. There is an emphasis on capacity and patient rights, but the Declaration also focuses on facilities and least restrictive treatment. It suggests that a balance has to be struck between patients' autonomy and the suffering that no treatment may cause. The Hawaii Declaration (see <http://www.codex.vr.se/texts/hawaii.html>) suggests that compulsory treatment may (or even should)

be given provided it is done in the best interests of the patient. Patients should nonetheless be encouraged to participate as fully as possible in all decisions about their care.

The role of the family in caring for people who are mentally ill in India needs due consideration. The Declaration takes into account this specific Indian context:

The family in India plays a major role in health seeking for its constituents. Any intervention planned for the patient should take into account the family's considerable influence over many aspects of patient management, including outpatient consultation and continuing care.

The Declaration names possible barriers standing in the way of achieving the desired standards. Barriers are partly of a legal nature because the Indian Mental Health Act does not, for example, define when a patient is competent to make decisions. There is no separate provision for enforced treatment. However, there are clear rights for people with mental illness under the Indian Constitution (Pyle, 2004). Additional barriers include lack of awareness, prejudice, lack of resources and lack of adequate advocacy. The Declaration sets out measures that are needed to overcome such barriers and in so doing describes a potential road map to achieving less coercion in India:

- raising awareness
- benchmarking, using validated tools to count and document the use of coercive measures
- agreeing a definition of restraint and other coercive measures.

Standardisation and benchmarking are internationally recognised as ways to drive forward quality improvements. In addition, guidelines for the use of medication should be developed regionally or nationally. They should be based on evidence, and be practical in the Indian context. Guidelines for restraint and rapid tranquillisation can improve safety and avoid idiosyncratic practice (Lepping, 2013). Staff training both to reduce the use of coercive measures (including training in control and restraint that emphasises physical restraint as the intervention of last resort) and to introduce safer methods of restraint has proved an effective measure in many parts of Europe. Comparisons of benchmarking results have been another important tool in Europe. This allows the identification of areas where practice is outside the norm, which can then be prioritised for intervention.

The Declaration defines various types of restraint for the Indian context. An agreed definition of restraint allows better communication without misunderstandings between various stakeholders. The Declaration asserts that the phrase 'violence and/or coercion against a person with mental illness' means an act of violence that results in or is likely to result in physical, sexual,

economic or psychological harm or suffering to a person with a mental illness, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. The definitions cover physical restraint, chemical restraint, mechanical restraint, environmental restraint, seclusion and psychological restraint. The Declaration broadly separates unplanned and planned restraint.

Legal and policy reform is a key strategy identified to promote human rights. Mental health policies and laws in low- and middle-income countries often fail to incorporate current international human rights and best practice standards to prevent violation of human rights (Drew *et al*, 2011). The Mysore Declaration should stimulate advocacy and education campaigns, and it suggests establishing legal and oversight mechanisms to prevent human rights violations.

In order to achieve these goals the Declaration calls upon healthcare providers in India to develop strategic plans. Benchmarking, regular analysis of data, regional, national and international comparisons and transparency can help to raise awareness and allow key stakeholders to prioritise funding where deficiencies are identified. Organisational strategies will be needed to implement training and raise awareness. This will require the support of senior management in stakeholder organisations. Raising awareness among patients and their families will be an important aspect of any national strategy.

The full Declaration is available online at <http://www.mysorecoercion.com/content/mysore-declaration>.

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Mental health problems: journey from Baghdad to Europe

Yasir Abbasi¹ MRCPsych and Adel Omrani² MD BA

¹Leeds Addiction Unit, Leeds, UK, email yabbasi@nhs.net

²Tunisian Bipolar Forum, Tunis, Tunisia, email omrani.adel@gnet.tn

We thank Professor Peter E. Pormann MA DPhil, Professor of Classics and Graeco-Arabic Studies, School of Arts, Languages and Cultures, University of Manchester, for his help in providing access to valuable literature and for reading an earlier draft of this article.

This article looks at the evidence that not only did mental health problems affect people in the past, but that the physicians of past eras made numerous attempts to understand, classify and treat mental illness. Our aim is to show the strong scientific reasoning during the medieval era, in the Islamic world in particular, and how the complexities encountered by physicians centuries ago still haunt psychiatrists today.

Leave aside what confuses common idiots, namely [the idea] that one can hit on [the right treatment] by experience [*tajriba*] without any reference to [scientific] knowledge [*ilm*]. For such a thing does not exist, even if one were the oldest person, because the benefit which one derives from an appropriate treatment [in such a case] is merely the result of good luck. (Abu Bakr al-Razi [died circa 925], Muslim physician and philosopher, on evidence-based practice; see Akhlaq al-tabib, 1977, pp. 77–78)

Although some Muslim scholars have been recognised in the West for their contributions to science, many have been forgotten. Others are remembered by their Greek names. It has been claimed that descriptions of schizophrenia-like disorders were uncommon before the beginning of the 19th century in the Western world. But there are numerous cases of various mental health problems reported during the medieval Islamic era and they highlight the difficulty physicians faced in managing these conditions.

Islamic culture flourished during the medieval period (from the 7th to the 15th century). Under the aegis of the Muslim emperors, not only Muslim, but also Christian, Jewish and other scientists prospered, whether or not they were Arab. They drew on ancient Greek physicians such as Hippocrates, Rufus of Ephesus and Galen (Morgan, 2007, pp. xvi–xvii). And their work had a profound effect on European medicine, as works by Johannitius (Hunain ibn 'Ishaq), Avicenna (Ibn Sina) and Averroes (Ibn Rushd) were translated into Latin and became the core curriculum in the nascent universities of Europe. In this way, a constant interchange of ideas took place between the different shores of the Mediterranean (Pormann, 2008a, pp. 179–196). The knowledge of previous civilisations was thus not just transmitted to another culture, but constituted the basis for innovation and change.

The creation of dedicated hospitals and medical schools

In the medieval Arab world, hospitals were generally called *bimaristan*. The word is of Persian origin, *bimar* meaning 'illness' or 'disease' and *stan* 'location' or 'place'. They not only cared for people who were ill but also became important centres

for medical instruction, asylums for people with a mental illness (preceding Europe by over 500 years), retirement homes (meeting the basic maintenance needs of elderly and infirm people who lacked family support) and institutes for medical research (Pormann & Savage-Smith, 2006, pp. 100–101).

When the new Abbasi dynasty ousted the previous Umayyad dynasty in the 750s AD, the capital moved from Damascus to Baghdad. Professor Peter Pormann (2008b) writes:

This city witnessed the foundation of the first hospital in the modern sense, that is to say institutions which were secular in orientation and open to a wide public irrespective of their creed; in which both poor and powerful sought treatment; and where elite physicians not only looked after the patients, but also carried out research and trained the next generation of practitioners. These hospitals also developed important facilities for treating the mentally infirm.

Michael Dols (1992), in his book *Majnun: The Madman in Medieval Islamic Society*, discusses how hospitals became central institutions in the provision of mental healthcare in medieval Baghdad.

Affective disorders

Depression and melancholy

There is no evidence that the mindset of medieval Islamic physicians was comparable to our modern nosology. The concept of melancholy was greatly influenced by the works of Rufus, who theorised in terms of vapours, humoral imbalance and excess of black bile.

Ishaq Ibn Imran (died AD 903) explains that in the case of hypochondriac melancholy (Pormann 2008a, citing Garbers, 1977, p. 19), vapours rise from the stomach into the brain, where they damage the cognitive faculties. Sourcing his hypothesis on ideas by Galen, Ibn Imran divides melancholy in the hypochondriac and brain variety. The latter is further subdivided into four varieties, which broadly reflects how we currently categorise mental disorders: brain fever (organic causes, e.g. encephalitis); stupidity (intellectual disability); animal rage (manic or psychotic episode); and intense mood swings (bipolar-type illness).

The Jewish physician Ibn Maimun (Maimonides, died AD 1204) treated the Egyptian Sultan al-Afdal (son of Saladdin), who suffered from melancholy (*Malinkhuliya*). He gives an account in his 'medical swansong', where he describes the following symptoms of the sultan: 'he also mentions the occasional occurrence of melancholy, evil thoughts, desire for solitude and foreboding of death' (Pormann, 2008a). Hence Ibn Maimun possibly describes low mood, negative cognitions,

demotivation and reclusiveness, followed by suicidal ideation.

Ibn Miskawaih (died AD 1030), a neo-platonic philosopher, when critically appraising Rufus's statement that 'those who devote too much thinking about a certain science end up suffering from melancholy', concluded that not all acts of thinking, especially not the kind of thought which results in the knowledge of the forms (Pormann, 2008a), are bad. Only engaging excessively in mental activities leads to melancholy.

Elated mood or mania

Ibn Sina states in one of his letters:

By this [cure], I have already treated people of the same station as Kings who suffered from difficult melancholy which turns into elation that is a lion-like madness [gunun sab'ī]. (Pormann, 2008a, citing a translation by Bar-Sela et al, 1964, p. 36)

Al-Razi, in a chapter entitled 'On melancholy and other kinds of madness' of his *Book of Experiences (Kitab al-Tajarib)*, describes two interesting case studies (Pormann, 2008a), one of a young man who 'plucked his beard and showed his anger by tearing out clay from the wall', and another of a woman who spoke in a confused way, laughed excessively and had a red face.

He also differentiated between melancholia and madness (*junun*, possibly psychosis), where the sufferer of the latter experienced loss of reason and the former did not.

Psychosis

Physicians have described psychosis-like illness in their essays and case histories. Ishaq Ibn Imran, in his *Essay on Melancholy (Maqala fi l-Malikhuliya)*, describes a patient with low mood and symptoms such as foolish acts, fear, delusions (*waswas*) and hallucinations (Youssef & Youssef, 1996).

The most celebrated medieval medical encyclopaedia written by a physician is Ibn Sina's *Canon of Medicine (al-Qanun fi l-tibb)*. He defined *junun* (madness) as an illness where reality is replaced by fantasy; he thought that the origin of such illnesses was from the middle part of the brain (Youssef & Youssef, 1996).

Al-Masudi (died AD 956) described the condition of a king, Al-Mutadid, who experienced sudden onset of ideas of being persecuted and visual images with emotional turmoil.

Sexual health

Abu Bakr al-Razi wrote extensively about sex (Pormann, 2008a) in his treatise *On Sexual Intercourse, Its Harmful and Beneficial Effects, and Treatment*. In it, he suggested that too much sex weakens the eyesight, wrecks and exhausts the body, and speeds up ageing and senility. But he also reaffirmed Galen's view that when young men who have a lot of sperm do not have intercourse, they can have a heavy head, feel sad and lose their appetite and joy. There is a possibility that they were describing things the other way round and the loss of libido was actually due to low mood.

Al-Razi also describes people who abandoned sexual activity because of constant tension of the penis accompanied by pain and spasm.

A Christian author of Greek origin, Qusta Ibn Luqa (died AD 912) said that women also suffered from not having sex (Pormann, 2009) and described them as being afflicted by the 'suffocation of the womb' (*ikhhtinaq al-rahim*) and apnoea (*butlan al-nafas*). It seems to be the equivalent of what the Greeks called 'hysteria', a term which also has its origins in the word for 'womb' (in Greek, *hystera* meant the uterus).

Psychology, psychotherapy and other therapies

Al-Razi was the first ever to postulate the existence of a form of melancholy that does not involve any humoral alteration. Such *sine materia* psychogenic melancholy should not be treated medically but rather receive psychological treatment.

Abu Zayd Al-Balkhi (died AD 934) asserted that the mind and body are interconnected (*ishtibak*) and that an imbalance of body and soul can affect the person in different ways (Haque, 2004).

Al-Tabari (died AD 870), in his ground breaking book *The Paradise of Wisdom (Firdaws al-Hikma)*, explained that certain patients suffering from melancholia might benefit from talking to a witty physician who could build good rapport and trust (Haque, 2004).

Ibn Maimun also advocated 'psychic' remedies, such as listening to music, because they can provide calm and rest from anxieties and worries (Pormann, 2008b).

Conclusion

We need to revisit the origins of psychiatry and rediscover its history, so that we are able to comprehend it better and give due credit to all scientists, physicians, philosophers and thinkers lost in history.

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Volunteering and International Psychiatry Essay Prize

The College Volunteering and International Psychiatry Special Interest Group (VIPSIG) has established an annual prize to promote interest and encourage excellence in volunteering (UK or abroad) and international psychiatry. Entrants are invited to submit an original essay of their choice. Submissions may include: a description of a clinical or charitable experience or project; elective report; reflective essay; editorial; research; audit; or literature review. Entrants who are uncertain whether their essay is suitable for submission may contact the VIPSIG directly.

Entry is open to medical students, foundation trainees, psychiatry trainees (CT1–ST6), staff grades and associate specialists. A project involving collaboration with psychiatrists or any other discipline may be submitted, but the prize will be awarded to a single entrant. Where collaborative work is submitted, there should be a clear indication of the contribution by entrant and collaborator(s).

Notice of the award will be sent out annually in September and displayed on the VIPSIG section of the College website. The essay must be the entrant's own work and no more than 3000 words. Essays will be judged on their overall quality and relevance. Consideration will be given to an entrant's seniority and expected level of experience. The winner will receive a trophy and a certificate.

For further details see <http://www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/volunteeringandinternational/vipsigprizes.aspx>

Mental Health Gap Action Programme in Iraq

'An introduction of the mhGAP curriculum for local health departments' was a training programme I delivered along with my dear colleague Sherese Ali, who is now working with Syrian displaced people. The programme was organised by the Ministry of Health in Iraq and the Ministry of Health in the Kurdistan Region in collaboration with the World Health Organization (WHO), Sulaimaniya, Iraq, 26–31 August 2013. It was on the introduction of the WHO Mental Health Gap Action Programme (mhGAP) curriculum for local health departments.

I have been a member of the Iraq Sub-committee of the College for some years but had not visited Iraq. We were in the Kurdish region, which is separate from the rest of Iraq, although not completely independent. It was a humbling experience to deliver a mental health training programme to mental health practitioners from throughout Iraq. It was the bloodiest week in Iraq over the year, with over 20 bombings, and it was ironic that we were asked to deliver an mhGAP implementation guide



Dr Peter Hughes (second right) with WHO staff Mr Revan Nafaa Yakoub (left), Miss Raghad Al-Khafaji (second left), Dr Sherese Ali (centre) and Dr Abdul Hameed S. Ali (far right), in Sulaymانيyah, Iraq, August 2013, at training

for a new stress module. It was an opportunity to discuss post-traumatic stress disorder (PTSD) and the probably erroneous belief that it is inevitably high after a traumatic event. Through the training on the stress module we were able to learn about careful and judicious case identification of PTSD. We discussed normal stress reactions and the need to avoid pathologising normal distress and grief. During the training we heard that critical-incident debriefing was still practised in Iraq. Among this group, we were able to end this.

It was fortuitous as well for us to be present in Sulaymانيyah when there was a large conference on national health strategy. We met many of the drivers of health in Iraq and in some way I hope we raised the flag for mental health. In Iraq, the focus is shifting to family medicine and this fits perfectly with the mhGAP model of capacity building in primary care to cover mental health, with a clear referral system to secondary care for more complex cases. In primary care they see many cases of somatoform disorders, anxiety and depression, as well as drug use. The average consultation lasts about 5 minutes, so during our training we emphasised identification and psychosocial treatments that can fit into this period.

Training was conducted in English. There were some participants (social workers and psychologists) who did not speak English well, but their examination scores were impressive even with this language limitation.

In the future we hope that this training can be rolled out among all governates of Iraq.

Peter Hughes, Consultant Psychiatrist

Forthcoming international events

27–30 November 2013

German Association for Psychiatry,
Psychotherapy and Psychosomatics:
Congress

Berlin, Germany

Website: <http://www.psychiatry-congress-berlin.org>

1–4 March 2014

22nd European Congress of Psychiatry
Conference

Munich, Germany

Website: <http://www.epa-congress.org>

14–15 March 2014

21st International Symposium About
Current Issues and Controversies in
Psychiatry

Barcelona, Catalunya, Spain

Website: <http://www.controversiasbarcelona.org/en/index.php>

22–25 March 2014

4th Global Conference: Trauma: Theory
and Practice

Prague, Czech Republic

Website: <http://www.inter-disciplinary.net/at-the-interface/evil/trauma/call-for-papers/>

15–17 April 2014

10th International Conference on
Psychiatry. 'Psychiatric Models: Biological
and Psychological Perspectives'

Jeddah, Saudi Arabia

Website: http://jed.sghgroup.com.sa/index.php?option=com_content&view=article&id=248&Itemid=42&lang=en

28–30 April 2014

International Society for Affective
Disorders Congress

Berlin, Germany

Website: <http://www.isadconference.com/>

13–16 May 2014

19th International Conference of the
Association of Psychology and Psychiatry
for Adults and Children (APPAC):
Recent Advances in Neuropsychiatric,
Psychological and Social Sciences

Athens, Greece

Website: <http://www.appac.gr/displayITM1.asp?ITMID=18&LANG=EN>

21–24 May 2014

17th EPA Section Epidemiology and Social
Psychiatry Meeting: 'Disease Burden and
Service Delivery'

Ulm/Neu-Ulm, Germany

Website: <http://www.epa2014ulm.eu>

5–7 June 2014

Neurobiology and Complex Treatment
of Psychiatric Disorders and Addiction
(World Psychiatric Association Thematic
Conference)

Warsaw, Poland

Website: <http://www.wpatcwarsaw2014.com>

12–14 June 2014

3rd International Symposium on
Controversies in Psychiatry

Mexico City, Mexico

Website: <http://www.controversiasmexico.org/>

24–27 June 2014

Royal College of Psychiatrists International
Congress 2014, 'Psychiatry: The Heartland
of Medicine'

The Barbican Centre, London, UK

Website: <http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/internationalcongress2014.aspx>

14–18 September 2014

XVI World Congress of Psychiatry: Focusing
on Access, Quality and Humane Care

Madrid, Spain

Website: <http://www.wpamadrid2014.com/scientific-information/abstracts-submission/>

4–7 December 2014

10th International Congress
on Mental Dysfunction and Non-Motor
Features of Parkinson's Disease
and Related Disorders

Nice, France

Website: <http://www.kenes.com/mdpd2014>

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