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الآخـــر/أنـــا، النحـــن/هـــم... أبجديات الحداثـــة

د. جمـــال التركـــي – الطـــب النفســـي / تونـــس

turky.jamel@gnet.tn

لا تعني الحداثة رفض التراث، ولا القطيعة مع الماضي، بقدر ما تعني الارتفاع بطريقة التعامل معه إلى مستوى «المعاصرة»، أي مواكبة التقدم الحاصل على الصعيد العالمي. إن الحداثة تبحث عن مصداقية أطروحاتها في خطاب «المعاصرة» وليس خطاب «الأصالة» الذي يُعنى بالدعوة إلى التمسك بالأصول واستلهامها، لكن الحداثة في الفكر العربي المعاصر لم ترتفع إلى هذا المستوى، فهي تستوحي أطروحاتها من الحداثة الأوروبية وتطلب المصداقية لخطابها من أصولها. حتى إذا سلمنا بأن الحداثة الأوروبية تمثل حداثة «عالمية» فإن انتظامها في التاريخ الثقافي الأوروبي، ولو على شكل التمرد عليه، يجعلها حداثة لا تستطيع الدخول في حوار نقدي مع معطيات الثقافة العربية لكونها لا تنتظم في تاريخها. فهي لا تستطيع أن تحاورها حوارًا تحرك فيها الحركة من داخلها، إنها تهاجمها من خارجها مما يجعل رد الفعل هو الانغلاق والنكوص. إن طريق الحداثة عندنا يجب أن ينطلق من الفهم النقدي للثقافة العربية بهدف تحريك التغيير فيها من الداخل، لذلك كانت الحداثة تعني حداثة المنهج وحداثة الرؤية، والهدف: تحرير تصورنا لـ «التراث» من البطانة الأيديولوجية والوجدانية التي تضفي عليه، داخل وعينا، طابع العام والمطلق وتنزع عنه طابع النسبية والتاريخية. إن خصوصية الحداثة عندنا في أن تكون تحت "حداثة عربية".

مقتبس عن "التراث والحداثة" / د. محمد عابد الجابري

الملـف: أبحـــاث مـن المؤتمـــر العالمـــي

بهذا العدد الثامن من الإصدار تختتم السنة الثانية من عمر المجلة الإلكترونية، وهي فترة قصيرة للتقييم أو الحكم، لكن المؤشرات الأولية تدل أنها تبوأت مكانة محترمة بين الدوريات النفسية العربية فقد استطاعت التميز من عدد إلى آخر والمحافظة على انتظام صدورها رغم المعوقات، وساهم تخصيص كل عدد بملف حول موضوع محدد في إثراء المجلة، وجاء ملف هذا العدد محتويا بعض الأبحاث الطبنفسية التي شارك بها الزملاء العرب في المؤتمر العالمي الثالث عشر للطب النفسي (مصر، القاهرة سبتمبر 2005) والذي شهد طفرة نوعية وكمية على مستوى المشاركة العربية، حيث ساهم انعقاد المؤتمر في بلد عربي بقسط وافر في هذه الطفرة. إننا نثمن هذه المشاركة خطوة هامة في سبيل تحقيق نهضة علمنفسية والانخراط في حداثة نعدها قدرا لا خيار لنا فيها تجاوزا لواقع علمي متخلف وإحداث نقلة تحررنا من الاعتمادية والاتكاء على ذات نرجسية متضخمة، منكرة الآخر أومهمشة له وإن اعترفت به، إلى استقلالية منفتحة على المختلف معترفة به طرفا فاعلا، متفاعلة معه تفاعلا إيجابيا معززا لكيانها وغير مهدد لوجودها، إن الاعتقاد في إلغاء المختلف حماية للذات من خطر يهدد كيانها يؤسس لموقف عدائي منه لا يساهم إلا في عزلها أولا وإلغائها لاحقا خاصة وأن الآخر هو الطرف الفاعل في حضارة اليوم فهو الأقوى علميا / اقتصاديا / عسكريا / سياسيا . . .

إن من أبجديات الانخراط في حداثة عصرنا الراهن ضرورة إيجاد مساحة للآخر في وعيي وقبوله كمختلف لا يهدد وجودي، أنا في حاجة إليه كحاجته إلي (وإن اختلفت الدوافع) للتحفيز والإثراء، محتمة علي التعاون معه في سبيل تحقيق نهضة تتجاوز الإنسان في محيطه الإقليمي الضيق إلى الإنسان في محيطه الكوني.

في ملف هذا العدد نقدم النصوص الكاملة لبعض أبحاث المؤتمر العالمي، نستهلها بورقة كل من عادل زايد وعادل سرور (الكويت) حول "**الوصف الديموغرافي والمرضي للأشخاص المراجعين بمستشفى الطب النفسي في الكويت لسنة 2002**" خلصا فيه إلى أن 36.6% من المعايدين يعانون اضطرابات مزاجية، 12 % اضطرابات قلقية، 10.1% من اضطرابات فصامية و 7.9% اضطرابات ذهانية حادة. كما نقدم ورقة كل من ناهدة العرجاء وتيسير عبد الله (فلسطين) حول "**قلق الموت عند الفلسطينيين خلال انتفاضة الأقصى**"، خلصتا فيها إلى ارتفاع مؤشر قلق الموت عند المرأة مقارنة بالرجل وإلى تدني هذا المؤشر عند المتدينين. كما قدم وائل أبو هندي (مصر) وزملاؤه

بحثا ميدانيا عن "**دراسة نسبة حالات الطوارئ النفسية في جامعة الزقازيق**"بينوا فيها أن نسبة المترددين لأسباب نفسية تمثل 1.71% من مجموع المعايدين إلى قسم الطوارئ تم إيواء 35.5% منهم بالقسم الداخلي للطب النفسي وتمثلت الاضطرابات الأكثر شيوعا في الهستيريا التحولية، الاضطرابات الوجدانية، اضطرابات الفصام واضطرابات القلق، مؤكدين أهمية تحسين الظروف المعيشية وزيادة التوعية بالأمراض النفسية لمقاومة وصمة المرض النفسي في مجتمعاتنا . كما نعرض بحث ماجدة شعور وزملاءها (تونس) حول "**التوافق الزوجي والصحة النفسية للمرأة**" وأثر الخلافات الزوجية على نفسيتها، خلصوا فيه إلى ارتفاع نسبة الشكاوي الجسدية والأعراض الاكتئابية والقلقية عند المرأة التي تعاني خلافات زوجية. كما نعرض النص الكامل بنسخته العربية والإنكليزية لورقة لطفي الشربيني (مصر) حول " **متلازمة الزوجة الأولى في الزواج المتعدد**" عرض فيها بشكل مفصل للأعراض النفسية التي تتعرض لها الزوجة الأولى من خلال رصد المراحل التي تمر بها بداية من الرفض والاحتجاج إلى الاستسلام للوضع الجديد (في مدة زمنية محددة) و المتمثلة أساسا في الشكاوي الجسدية واضطرابات القلق التي تفوق اضطرابات الوجدان وسوء التوافق.

أبحـــاث ومقالات أصيلـــة

نستهل باب أبحاث ومقالات أصيلة بالجزء الثاني من دراسة حول "**الإنسان: الحب والحياة. . . الجسد**" ليحيى الرخاوي (مصر) بين فيها أهمية الموقف التوجسي المبدئي الذي تبدأ به حياة البشر، حيث يكون حضور الآخر في وعي الإنسان ضرورة لمواجهة بداية الطريق، فالآخر لا يكون آخرا إلا إذا كان كيانا مستقلا عن ذاتي الأمر الذي نزعم أننا نمارسه حين نتكلم عن الحب وعن قبول الآخر وعن الثقة، في حين لا نعمل علاقة إلا باحتياجاتنا نحن، وإسقاطاتنا نحن. إن حضور الآخر في وعينا يكون بداية باعتباره خطرا يهدد وجودنا، بمعنى أنه قد يسحقنا فيلغي وجودنا لحسابه، أو قد نلتهمه نحن احتياجا أو خوفا، فنلغي وجوده (وفي نفس الوقت نحرم أنفسنا منه) ومن هنا يضطرد الجدل، إن هذا النوع من العلاقة الذي يعلن أن وجود الآخر هو الخطر بعينه مرحلي، لكنها مرحلة لا تدوم وإن كانت تكمن جاهزة للتنشيط، نستدعيها كلما احتجنا إليها، وأحيانا تقتحم الوعي بعنف، في شكل مرضي. كما شاركنا بشير معمرية (الجزائر) ببحث عن "**صعوبات التعلم الأكاديمية**" مقدما في نهاية دراسته الميدانية جملة من التوصيات للحد من هذه المشكلة (الاضطراب) أهمها: إجراء دراسات مسحية للتعرف على الحجم الحقيقي لها، الاهتمام بتشخيص هذا الاضطراب وعلاجه فور اكتشافه، توفير أخصائيين للتشخيص والعلاج، تزويد المربين والمعلمين بمعلومات عن صعوبات التعلم إضافة إلى تعاون الأسرة والمدرسة والحد من اكتظاظ الأقسام للتمكن من التعرف على مشكلات التلاميذ الدراسية. ويأتي البحث الثالث في هذا الباب من فلسطين لزياد بركات "**من المسؤول عن تعليم القيم للشباب**" أكد فيه إلى أهمية كل من الأسرة ، المدرسة والمسجد في تعليم الشباب منظومة القيم المتمثلة أساسا في: النظام، الترتيب، النظافة، الاستقلالية، الطاعة، الاحترام، سعة الخيال والإبداع، الحداثة والتطور والمعاصرة، التحرر، حب الاستطلاع، استقصاء المعرفة، الخشية ومخافة الله، التسامح، العفو، المسالمة وعدم الاعتداء، . . . مقدما في نهاية البحث توصيات، أهمها: ضرورة تفعيل التربية الدينية، تقديم الآباء نماذج من السلوك الهادف، الاستماع والانتباه الجيد للأبناء، بناء علاقات سليمة وواضحة بين الوالدين، تشريك الأبناء في القيام بأدوار اجتماعية تتمثل فيها القيم والمبادئ الأخلاقية. ومن لبنان قدم لنا عدنان حب الله قراءة نفستحليلية لأحداث العنف الأخيرة التي هزت ضواحي المدن الفرنسية والتي طالت شريحة اجتماعية متفجرة متمثلة في مجموعة أثنية من المهاجرين المغاربة، في مقالته "**العنف المتفجر والخطر على الديمقراطية**" ، بين فيها كيف أن هؤلاء المهاجرين وجدوا أنفسهم منفيين من بلادهم ومنفيين في المجتمع الفرنسي ولم يكن أمامهم لكي يحافظوا على وجودهم إلا التمسك بالهوية الأولى والتعصب لها وإحياء التراث الذي كانوا قد تنازلوا عنه طمعا في الاندماج. موضحا أن ما حصل في فرنسا ليس عبثيا ولا عشوائيا فشموليته تخضع لعوامل مشتركة تجمعت وأدت إلى تنسيق غير منتظر، فهذا التطور المتأزم نتيجة نمو مستمر منذ ثلاثة أجيال، استعاد فيه الجيل الثالث مكبوت الجيل الأول وأخرج إلى العلن ما كان في الخفاء، وعندما أصبح الدين هوية تناهض الهوية الوطنية ظهرت الأزمة بأشكالها المتعددة. كما نعرض في هذا الباب بحثا آخر ليحيى الرخاوي (مصر) "**عن كبت الخوف وتسطيح البشر**" بين فيه أن الخوف حق مشروع من حقوق الإنسان وعلينا أن نتساءل كيف نتعامل مع هذه المشروعية بمسؤولية حذرة وكيف نخاف لنزداد يقظة وحرصا . بدءًا علينا أن نعترف به انفعالا طبيعيا بل ضروريا إذا حقق وظيفته التحذيرية، ثم الدافعية، بالتنبيه والانتباه والفهم فالاستعداد للمجهول، عندها يكون جديرا بموقعه التطوري الضروري. . . أما إذا تجاوز هذا فيصبح ظاهرة مرضية في حاجة إلى علاج. في خاتمة هذا الباب نعرض بحث كل من سليم عنابي (تونس) وزملائه حول "المفهوم العربي الإسلامي لنهاية الحياة" ونعمان الغرايبة (أمريكا) حول "إيجابيات وسلبيات التداوي بمضادات الكآبة دون وصفة طبية" بأن يسمح للمريض الحصول على هذه الأدوية مباشرة من الصيدلي شأن عديد الأدوية المسموح بها .

قبل نهاية هذا الباب نعرض لقراءات عديد المقالات الموجزة: "**نفور من الاعتذار وقبول بالانكسار وتقديس للعنف**"، "**ترميم وتقوية الأنا**"، "**تمثالا بوذا والأصنام المعاصرة**"، "**جان برجوري: التنظيمات السيكوسوماتية**"، "**نجاح المؤتمر العالمي للطب النفسي**"، "**المقاربة الثقافية لمعالجة الصدمة بعيدا عن الأدوية**" و"**أسامة الراضي: الأب المؤسس**

للطب النفسي السعودي". وجاءت هذه المقالات بالتوالي لكل من: قدري حفني (مصر)، خليل فاضل (مصر)، يحيى الرخاوي (مصر)، سهام بالعارف (الجزائر)، جون مزيش وفاروق السنديوني (مصر).

مراجعـــة أطروحـــات

في هذا الباب نعرض ملخص أطروحة داليا مصطفى (إشراف سينثيا نلسن- الجامعة الأمريكية بالقاهرة)، تناولت فيها "**العوامل الاجتماعية والثقافية للانهيار النفسي عند المرأة المصرية اليوم**" خلصت إلى تنوع الشدائد النفسية والضغوطات التي تتعرض لها المرأة وإلى إصابتها مبكرا بالاضطرابات النفسية لكن لجوءها إلى المداوات الطبنفسية أو العلاج النفسي يتأخر عادة لأسباب متنوعة أهمها الخوف من وصمة المرض النفسي، طول فترة العلاج والآثار الإيجابية للأدوية، وفي سلسلة عرضها لعديد الاضطرابات التي تتعرض لها المرأة تخصص وصفا مفصلا لـ"متلازمة الثانوية العامة"، و"القلق السابق للزواج" مركزة على العوامل المحفزة للاضطراب النفسي شأن الضغوطات العلائقية، عدم التوازي بين الجنسين، الصراع بين الحداثةوالتقاليد، الصعوبات الأكاديمية، العزلة والقمع الفكري، إضافة إلى عوامل أخرى سياسية، اقتصادية وثقافية. لتخلص في نهاية بحثها إلى عديد التوصيات لرفع مستوى الرعاية النفسية للمرأة وتجنبها الاضطرابات وصولا بها إلى صحة نفسية سليمة.

مراجعـــة كتـــب

نعرض في هذا الباب كتاب سوسن شاكر الجلبي (العراق) "**أساسيات بناء الاختبارات والمقاييس النفسية والتربوية**" من خلال تعريف موجز بأهم فصول الكتاب الذي يهدف إلى تقديم الخطوات الأساسية عن كيفية بناء الاختبارات والمقاييس النفسية والتربوية لاستخدامها في الحقل العملي.

كما نقدم تعريفا لكتاب كل من غيثاء الخياط (المغرب) وآلان قوسو (فرنسا) "**الطب النفسي، الثقافة والسياسة**" تناولا بالبحث العلاقة المتداخلة بين سلطات ثلاث: سلطة الثقافة، سلطة السياسة وسلطة العلم في زمن تميز بما سمي صراع الحضارات أو الثقافات أو ما أرادوه أن يكون كذلك وبسيطرة كاسحة للفكر الغربي. وكان الدافع الأساسي لهذا الكتاب ما يشعر به كل واحد منا من ثورة داخلية إزاء عديد المظاهر الصادمة: لماذا الجنون، لماذا الفقد، لماذا المعانات، لماذا تقصف حياة البعض، لماذا ليس من حق البعض أن ينعم بحياة مطمئنة... عسى أن يجد القارئ لهذا الكتاب بعضا من إجابات.

أبـــواب أخـــرى

في **مراجعة مجلات** نقدم ملخصات العدد الثالث والستون من "الثقافة النفسية المتخصصة" (لبنان) الذي جاء موضوع ملفها حول "الهجرة وأمراضها النفسية" لسليم عنابي وزملائه (تونس). **و في باب المؤتمرات النفسية** نقدم برامج المؤتمرات التالية: المؤتمر السنوي الثاني عشر للإرشاد النفسي (القاهرة، ديسمبر 2005)، الملتقى الثاني لطبنفس الطفل والمراهق (تونس، أفريل 2006)، المؤتمر الفرنسي المغاربي 24 للطبالنفسي حول الاضطرابات الثناقطبية (باريس، نوفمبر 2005) مع عرض أجندة المؤتمرات الدولية للثلاثية الأولى من سنة 2006 وأجندة مؤتمرات الجمعية العالمية للطب النفسي. أما **باب وثائق العلوم النفسية** نعرض لـ"مشروع ممارسة العلاج النفسي في لبنان" الذي قدم فيه عدنان حب الله عرضا لواقع العلاج النفسي في لبنان والبرنامج المستقبلي المتمثل في تأسيس التكوين الأكاديمي للتحليل النفسي وتنظيم مهنة العلاج النفسي في لبنان. كما نقدم وثيقة لأحمد عكاشة (مصر) عن "الميثاق العربي لحقوق الإنسان" (مصر).

وفي خاتمة العدد نعرض للأبواب القارة: انطباعات الأطباء وأساتذة علم النفس، جوائز نفسية وعالمية (جائزة ابن رشد للفكر الحر لسنة 2005)، مستجدات الطب النفسي (ملخصات ورقات الأطباء النفسانيين العرب في المؤتمر العالمي للطب النفسي- الجزء الثاني)، والمعجم النفسي (ترجمة من وإلى العربية – الإنكليزية- الفرنسية، الإنكليزية – الفرنسية- العربية، الفرنسية- الإنكليزية – العربية) لبقية الحرف "أ" من المعجم العربي، الحرف "B" من المعجم الإنكليزي و من المعجم الفرنسي الحرف "C".

قبـــل الختـــام

ونحن نودع سنة 2005 افتقدنا علمين من أعلام الطب النفسي العربي، الأستاذ الدكتور أسامة الراضي (السعودية) والأستاذ الدكتور محمد غربال (تونس)، يعتبر البروفسور الراضي أبرز مؤسسي الطب النفسي السعودي وأول من أرسى قواعد الاختصاص في بلده، تخرج على يديه نخبة من أبرز الأطباء النفسانيين السعوديين، حمل هم الاسلام والمسلمين وعمل جاهدا على إبراز الخصائص المميزة للعلاج النفسي الديني، وما لهدي الاسلام وتعاليمه من دور فعال في الحماية من بعض الاضطرابات النفسية أوخفض أعراضها، في حين كان الأستاذ غربال في تونس من أوائل الأطباء الذين سعوا إلى تأسيس المدرسة التحليلية النفسية إلى جانب مساهمته الفعالة في تكوين الجيل الأول من الأطباء النفسانيين التونسيين. لقد كان كل من الراضي وغربال من أبرز وجوه الاختصاص في الوطن العربي، أثرى كل واحد منهما الطب النفسي في بلده بطريقته الخاصة، ومساهمة في تكريمهما أدعو زملائي العرب مشاركتنا جمع أعمالهم العلمية ونشرها مستقبلا في المجلة الإلكترونية للشبكة علنا نساهم ولو بجزء يسير في إيفاء بعض من حقهم علينا. رحم الله الفقيدين رحمة واسعة آملين أن يواصل الخلف رسالة السلف والسير على هدى دربهم رفعة للعلوم النفسية في أوطاننا.

...وعليكـــم السلام

Annual treated psychopathological morbidity. Demographic and diagnostic features.

Findings from Kuwait Psychological Medicine Hospital 2002

Adel Alzayed*, MRCPsych; Kuwait
Adel Sorour*, MD; Kuwait

adelalzayed@hotmail.com

Abstract: Annual treated psychopathological morbidity. Demographic and diagnostic features

Despite extensive studies on the epidemiology of mental disorders and advances in the treatment of these conditions, there is a paucity of detailed information concerning the characteristics of psychiatric patients and how treatments are administered in routine psychiatric practice. This 2002 observational study collected information of 1532 patients on demographic, diagnostic, clinical, and treatment characteristics. Nine hundred and sixty (62.7%) were men. Nine hundred and eighteen (59.9%) were Kuwaitis. The most common diagnostic category (36.6%) was mood disorder, followed by anxiety disorder (12%), schizophrenia (10.1%), acute psychotic episode (7.9%). Non-Kuwaitis were more often given the diagnosis of schizophrenia/acute-psychotic episode (26.1%), compared to Kuwaitis (12.4%). Patients received a mean of 2.83 psychotropic medications. Three hundred and ninety seven required admission (25.9%), where as (74.1%) were treated as out patient.

الملخص : الوصف الديموغرافي والمرضي للأشخاص الذين راجعوا مستشفى الطب النفسي في الكويت خلال عام 2002

على الرغم من ضخامة أبحاث إستقصاء الأمراض النفسية والتطور الكبير الحادث في مجال علاج هذه الأمراض، إلا إنه مازال هناك كم هائل من المعلومات التي تخص طبيعة المرضى النفسانيين وكيفية المعالجة في الوضع الطبي الإعتيادي التي لا توفرها مثل تلك الأبحاث. وهذا البحث الإستقصائي الذي أجري عام **2002** في مستشفى الطب النفسي في دولة الكويت، قمنا بمراجعة كافة الملفات الجديدة التي تم فتحها خلال هذا العام لمعاينة نوعية المرضى وطرق العلاج المتبعة في المستشفى.

■ Introduction:

Over the past 10 years, scientific, political, administrative, and economic developments have led to vast changes in health care systems in general, the mental health system in particular, and the practice of psychiatry (1-3).

Given these rapid changes, it is important to understand and characterize the types of patients treated by psychiatrists and the nature of care that is provided.

Despite extensive information obtained from studies on the epidemiology of mental disorders, these have limited capacity to assess in depth the nature and patterns of care provided to patients (4).

In this observational study we have used the records of the Kuwait Psychological Medicine Hospital (the only psychiatric hospital in Kuwait) case register, to report data on the characteristics of psychiatric patients treated in routine clinical settings and to describe psychiatric patterns.

The State of Kuwait has a total population of 2252950, of whom 1,378,798 are expatriates. 1354823 are male and 898127 are female (5) (according to the 2002 Census). Health services in Kuwait are divided into five health sectors, each health sector having semi independent managerial responsibilities. However psychiatric services are only provided by the psychological medicine hospital. The hospital comprises five working units, each covering one of the health sectors. Patients received at the hospital are either referred by the primary health clinics or are self referred. All psychiatric services are provided by the hospital as no community services are available at Kuwait and family practice clinics are equipped with a very limited number of psychotropic drugs.

■ Methodology:

All newly opened case notes during the period from 1st of January – 31st of December 2002 were reviewed by one of the research team. A special form was completed for each case note reviewed, which included patient age, sex, nationality, health sector, diagnosis, number and type of treatments prescribed, and whether treatment was carried out on an in or out patient basis. To ensure patient privacy no record of patient name was made.

ICD-10 is the principal classification used at the psychological medicine hospital; the researcher had made sure to read the psychiatrists' notes to make sure that the symptoms listed comply with the diagnosis made.

■ Results:

- Patient demographics:

One thousand and one hundred and thirty five patients (74.1**%)** were seen as outpatients and 397 (25.9%) as inpatients. Non-Kuwaitis were more often treated as inpatients (42.5%),

compared to Kuwaitis (14.8%) (**Fig. 1**). Two hundred and twenty two male patients (23.1%) were treated as in patient, while one hundred and seventy five female patients (30.6%) were admitted. Percentage of female patients admitted to the hospital, have exceeded the percentage of male patients in all diagnostic categories except for schizophrenia. However differences were not statistically significant except for Adjustment disorder (**Table 2**). Most patients were men (62.7%). Nine hundred and eighteen (59.9%) patients were Kuwaitis, 614 (40.1%) were non Kuwaitis (**Table 1**). Indians were the most common ethnic minority treated at the psychological medicine hospital, followed by Egyptians (**Table 3).**

- **Clinical characteristics**

The most commonly reported diagnosis was mood disorder (36.6% of all patients; 31.9% had depressive episode, while 4.7% had manic episode); followed by anxiety disorder (12%), schizophrenia (10.1%), adjustment disorder (8.6%), acute psychotic episode (7.9%). Female patients received more diagnosis of mood disorder (40.6%), adjustment disorder (10.4%), and acute psychotic episode (9.8%) compared to male patients (34.2%, 7.4%, and 6.8% respectively) **(Table 2)**. Non-Kuwaitis received more diagnosis of schizophrenia/acute-psychotic episode (26.1%), compared to Kuwaitis (12.4%).

- **Treatment Characteristics**

Nearly 85% of patients were receiving at least 1 psychotropic medication, with a mean of 2.83 medications prescribed per patient. Twenty point nine percent of all patients were receiving 1 psychotropic medication; 38.6% were receiving 2; 21.7% were receiving 3, 4.1% were receiving 4 or more (**Figure 3**). Patients with adjustment disorder received a mean of 2.89 medications; patients with acute psychotic episode received a mean of 2.82 medications patients with schizophrenia received a mean of 2.46 medication, whereas patients with mood disorder received a mean of 2.24 medications (**Table 4**).

■ Discussion:

The data presented here provide a snapshot of "real world" psychiatry as practiced in Kuwait and serve to complement information obtained through more traditional research methods and administrative data sets. Two advantages of these national data are that they cross the range of psychiatric settings and provide the potential for understanding the relationships among the clinical and nonclinical factors that may influence clinical decision making.

These data suggest that Kuwaiti psychiatrists have shifted towards a more pharmacological treatment orientation. Despite the absence of national surveys to prove such shift, data coming from other parts of the world confirm this fact. In 1974, an APA study revealed that non-analytical psychiatrists in private practice provided medication to only 29% of their patients (4). The 1989 Professional Activities Survey found that 54.5% of out patients received pharmacologic treatment alone or combined with psychotherapy (6). The current data show that 85.3% of patients were receiving medication for their mental disorder in 2002.

While the psychopharmacological studies of newer and safer medications support the shift towards provision of medication to most psychiatric patients, most of the evidence concerning safety and efficacy is based on studies of highly selected groups of patients receiving a single medication. Few clinical trials examine multiple drug regimens (7, 8). Of the in this study, however, 64.4% were receiving more than one psychotherapeutic medication and 25.8% were receiving 3 or more. While the potential for drug – drug interactions (side effects), and noncompliance increases as the number of medications increases (9). It is unclear whether the polypharmacy or co-pharmacy (the simultaneous use of several different classes of medications) found in routine practice represents less than optimal care (10, 11).

Possible explanations for this practice include:

- Complexity. The patients seen in typical psychiatric practice may be systematically different from those seen in clinical trials, which often test single medications in homogeneous patient populations with specific exclusion criteria.
- Referral Patterns. Due to severe stigma in Kuwaiti society patients and their relatives accept referral to psychiatric hospital only when they are in a late and advanced stage of their illness, and may require more complicated treatment regimens.

Data from this report show that the number of male patients contacting the Psychological Medicine Hospital during 2002 exceeded the number of female patients. This finding does not match with figures available from the international literature (12, 13). This could be explained partly due to the high level of stigma at the local community, and by the higher rates of males in the Kuwaiti community compared to female (5). Female patients have received more diagnosis of mood and adjustment disorders, than male patients, and in both cases a higher percentage of female patients were admitted to receive in patient care. Both findings need to be closely explored and reasons should be dealt with promptly.

The other important finding, which necessitates more exploration, is that non-Kuwaitis have higher rates of psychotic diagnoses – i.e. schizophrenia, acute psychotic episode, and manic episode - than Kuwaiti patients. In spite of the substantial literature addressing the effect of immigration on psychiatric illnesses (14, 15, 16), it is important to note that most of the expatriates in Kuwait are not immigrants as such but come for temporary working purposes – that is, they are migrant workers. It is important to mention that in most cases there is a strong language barrier and psychiatrists have to depend on observation or third party translators to make a diagnosis. In addition, assessing psychiatrists have no access to past medical or psychiatric records for most patients. On the other hand the higher admission rates for Non-Kuwaitis may be due to the fact that most of this population of patients lacks the required level of social support in the community and psychiatrists find it more convenient to admit them to receive a better care. Of course the seriousness of the diagnosis given for those patients plays a major role in increasing the admission rates among them.

Adjustment disorder was significantly prevalent in this sample. In addition patients received this diagnosis, were subject to receive a mean of 2.89 drugs. As this is an observational study it is difficult to be sure of the real reasons behind this finding. However the following explanations could through some light on the shadow:

- This study has recorded only the principle diagnosis that has been made on the first contact. No note has been made of the subsequent contacts, or of the differential diagnosis. A follow up study will be of great importance to show whether adjustment disorder diagnosis has been able to stand the test of time.

- In many clinical setting, especially in psychiatry, doctors find them selves under extreme pressure by the families to prescribe medications, even if they are not clinically required. In case of adjustment disorder doctors find them selves obliged to prescribe medications to alleviate symptoms associated with the initial phase of the illness such as insomnia, irritability and mild symptoms of anxiety.

■ Conclusion:

Given the rapid evolution of managed care and the changing health care system, it will be critical continue to examine variations in practice associated with system factors (e.g., setting, health plan) and their relationship to patient outcomes. Psychiatric services in Kuwait are rapidly developing and a continuous survey of the services assures providing the best level of care.

Table (1)

Gender	Nationality		Total
	Kuwaiti	Non-Kuwaiti	
Female	344	228	572
Male	574	386	960
Total	918	614	1532

Distribution of patients seen at the psychological medicine hospital during 2002 according to gender and nationality

Table (2)

Diagnosis			Gender		Total	P value
			Female (%)	Male (%)		
Schizophrenia	Admission	No	19 (3.3%)	64 (6.7%)	83	< 0.207
		Yes	23 (4%)	48 (5%)	71	
Mood Disorder	Admission	No	189 (33%)	268 (27.9%)	457	< 0.912
		Yes	44 (7.6%)	60 (6.3%)	104	
Adjustment	Admission	No	34 (5.9%)	61 (6.4%)	95	< 0.000
		Yes	26 (4.5%)	10 (1%)	36	
Anxiety	Admission	No	50 (8.7%)	126 (13.1%)	176	< 0.053
		Yes	5 (0.87%)	3 (0.31%)	8	
Acute Psychotic episode	Admission	No	6 (1%)	9 (0.9%)	15	< 0.783
		Yes	50 (8.7%)	56 (5.8%)	106	
Other Diagnosis	Admission	No	99	210	309	< 0.405
		Yes	27	45	72	
Total			572	960	1532	

Admissions according to gender and Diagnosis:

Table (3)

Ethnicity	Frequency	Percent (%)
Kuwaiti	916	59.9
***G.C.C**	80	5.2
Egyptian	92	6.0
Iranian	43	2.8
Indian	103	6.7
Serilankin	36	2.3
Indonesian	25	1.6
Pakistani	24	1.6
Bangladeshi	25	1.6
****Other nationalities**	188	12.2
Total	**1532**	**100**

* Gulf Council Countries.
** Other nationalities includes: patients with no specified nationality, Europeans, other Arab nationalities not categorized.

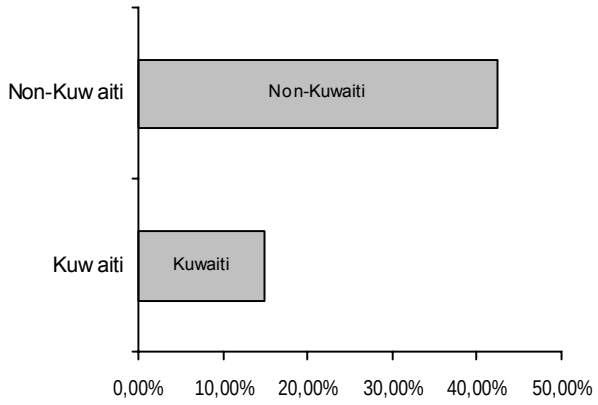
Distribution of patients seen at the psychological medicine hospital during 2002 according to ethnicity

Table (4)

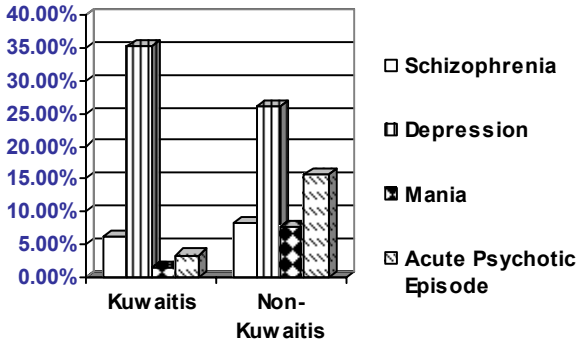
Diagnosis	Mean	N	Std. Deviation
Schizophrenia	2.46	154	1.189
Mood Disorder	2.24	561	1.130
Adjustment	2.89	131	2.204
Anxiety	2.17	184	1.255
Acute Psychotic episode	2.82	121	1.761
Other Diagnosis	4.15	381	2.490
Total	**2.83**	**1532**	**1.901**

Means of drugs prescribed according to diagnosis:

Figure (1)

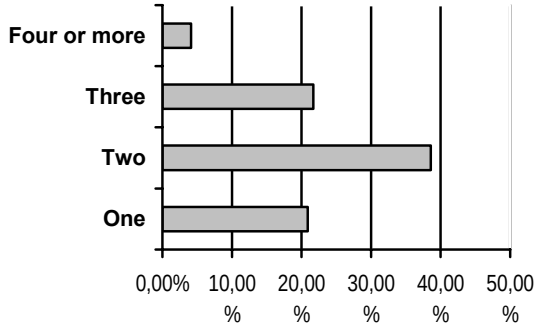


Admission rates according to nationality
Figure (2)



Diagnosis According to nationality :
Figure (3)

Number of Drugs prescribed (%)



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* PO Box 4801 Safat, Psycological Medicine Hospital, Kuwait.
Tel: (+ 965) 9041081 - Fax: (+ 965) 5319899,

Death Anxiety in Palestinians during Al-Aqsa Intifada

Nahida Al- Arja - Bethlehem, Palestine

Taisir Abdallah - Jerusalem, Palestine

Nahalarja@hotmail.com , research@admin.alquds.edu

Abstract: *The aim of this study is to explore level of death anxiety among a sample (N=601) of Palestinians living in the city of Beit Jala, Village of Al-Khader, and Aida Refugee Camp in Bethlehem area. The researchers used AbdEl-Khalek scale 1996 to test the hypotheses. The cronbach Alpha was .92. To answer the hypothesis, the researchers calculated the frequencies, the standard deviations, the percentages, the mean and median, as well as the one-way analysis of variance, the t-test and Tukey test to verify the sources of variances.*

■ Introduction

Death is a universal experience but each person must face it alone usually having an effect on others. Death is a normal part of human experience (Steel, 1997) influenced by cultural differences and material circumstances. The transitions, which individuals pass from childhood to adulthood and eventually to death, are social as well as biological in nature (Giddens, 1993). Dickenson and Johnson (1993) claim that since death is a "taboo" subject it causes extra suffering for those who are dying or grieving.

The fear of death is universal and experienced by all human beings (Hyrkas et al, 1997). Death is feared for different reasons. The loss of self, the unknown beyond death, pain and suffering, lost opportunity for atonement and salvation, and the welfare of surviving family members are just some of the sources of fear of death (Neimeyer, 1994). Religion appears to offer some understanding about death and affers some relief. It is important to understand the various beliefs of multi- cultural society. Robertson et al (1997) write that humanism focuses on a form of symbolic immortality such as people live on the memory of their loved ones.

The hate or fear of death, or any other, negative emotion, can be traced back to the oldest known record history, that of Egypt. According to Zandee (1960), ancient Egyptians considered death as an enemy (AbdEl-Khalek,2003). Egyptian belief about resurrection, immortality and afterlife, ancient Egyptian were highly interested in building tombs regardless of their financial resources. One should not forget that pyramids, one of the Seven Wonders of the World, are mere tombs. Many countries have passed since that remote time. However, following the aftermath of World War II, Thanatology emerged as a legitimate area for scientific inquiry and as a respectable interdisciplinary field of study (AbdEl-Khalek, 2003).

There was a high point of interest in death anxiety in late 1970s. Another surge of growth in the mid-1980s. Also occurred (Neimeyer and Van Brunt, 1995). In the last decade in the century, the interest in death anxiety persisted and Burgeoned (AbdEL-Khalek, 2003).

For several centuries, Palestine was the homeland of Muslim, Christian and Jewish people. In 1917 the population of Palestine was 700,000 of which 574,000 were Muslims, 74,000 were Christian, and 56,000 were Jews (Brief History,2005).

In 1948, the state of Israel was founded in a sea of Palestinian blood. The four million Jews who live in Israel now have replaced more than five million Palestinian refugees who moved out of their homeland.

In 1967, a counter attack which lasted 6 days, known as " The Six Day war" launched by various Arab countries to reclaim what they've lost, failed and with grave consequences, the rest of Palestine fell under Israeli occupation which caused more loss of life and more refugees (Brief History).

The immediate cause of the second uprising (AL-Aqsa Intifada) in 2000, was because of the visit of Ariel Sharon's advance-accompanied by over 1,000 armed Israeli police officers- on the Haram al- sharif,or Al-Aqsa Mosque on 28 September 2000 .

Since resistance to Israeli military occupation began in September 2000, over 3900 Palestinian have been killed by Israel and over 40,000 have been injured. Hundreds of homes have been demolished and shelling as a means of collective punishment and thousands are being held in Israeli prisons and detention centers many without charges, and soon for the first time in history, we hear now about hunting down individual human beings by airplanes.

One of the main consequences of the Intifada is that Israel sweeps from time to time into region A under the national Palestinian authorities, including the district of Bethlehem, were the sample of the current study was selected.

The aim of the present investigation was to explore the level of death Anxiety and the correlation that, gender, religion, social status, level of education, place of dwelling and bombed houses has on death Anxiety.

■ Method

- **The Sample**

A convenient sample of 601 men (n=219; 36.4%) and women (n=383; 63.6%) was selected. All of them were Palestinian residents of the city of Beit Jala, (n=396; 65.89%), the village of Al-Khader (n=138;22.96%), and Aida refugee camp (n=67;11.15%) in the Bethlehem area. They represented 2.45% of the original total population (n=24,518).

The mean age of the sample was 40.7 (SD. 13.3). Their

ages ranged from 22 to 76 years. Of this sample, 517 (86%) were married, 45 (7.5%) divorced, 26 (4.3% widows, 9 (1.5%) separated, whereas 4 cases were undefined. Regarding sex 218 (36.4) were males, whereas 381 (63.6) were females. As for religion, 328 (54.6%) were Christians whereas 273 (45.4%) were Muslims.

Regarding education, 24 (4.5%) were illiterate, 70(11.7%) ending the primary school, 129 (21.5%) preparatory school, 202 (33.6%) secondary school, 105 (17.5%) diploma, 69 (11.5%) university and post graduate, whereas 2 cases were not defined. Half of the participants have homes, whereas the houses of the other half have been demolished by the Israeli army.

- **The Scale**

The Death Anxiety Scale (DAS) (AbdEl-Khalek, 1996) contains 15 items. Each item is answered and rated on a 5-point Likert-type format, anchored by 1: No and 5: Very much. The total scores can range from 15 to 75, with higher scores denoting higher death anxiety.

Cronbach's alpha reliabilities of the DAS among Palestinian Parents were .87, .79, .83, .67, for males, females, and the combined group of males and Females, respectively, denoting both high internal consistency and stability.

Four Factors were disclosed- fear from the dead, fear of after death, fear of deadly diseases, preoccupation by death and its thoughts-denoting a clear and viable factorial structure, interpretable factors, and factorial validity (Abdel-khalek, 1998).

■ Results

The finding of the study reveals that the significant correlations were found only on age, gender (with female sex) (Figure 3), and religion in females and the total group only (with Christian religion) (Figure 4) and a negative correlation between death anxiety and age in the total scores which reached (-.2133) at statistical significant difference (0.05).

On the other hand, social status (figure 5), education (figure 5), place of residency (figure 7) and house sheltering (figure 8) did not significantly correlate with DAS.

■ Discussion

Male and female Palestinian samples had lower mean DAS scores than their Arabic counterparts living in a safer environment, such as Kuwait, Syria, and Egypt.

Palestinian participants had been historically accustomed to live in a "climate of war" since 1967, i.e., the occupation of Israel of this part of Palestine in which they live. So there are 38 years of occupation, unrest, violence and counter violence, view the sight of dead corpses and so forth, without a feasible or visible solution. These severe conditions may operate in much the same manner as the psychotherapeutic principle of flooding (Davison& Neale, 1996).

The present result on the low DAS mean score among Palestinians is congruent with a previous study on death carried out among Lebanese adolescents and college students in January 1986 during the civil War (1975-1991). AbdEl-Khalek (1991) found that the Lebanese samples had either the same or a lower mean score on Templer's death anxiety scale (1970) than their Arab counterparts: Egyptians, Kuwaitis, and US samples. He interpreted this result as a sequence of continuous exposure to an insecure environment. It is worth mentioning that the mean age of the present Palestinian sample (M=40.7, SD 13.3 year) was higher than most of the samples used in the DAS, i.e. college students in their twenties. In a similar field, it was found that the elderly might report lower levels of death anxiety than more youthful subjects might. Likewise, well-designed large-scale surveys indicate that death subjects decreases from mid-life to old age (Neimeyer et al., 2004).

Giving the large size of the present sample (N=601), and the wide range of ages (from 22 to 76), computing the DAS-age correlation may be viable. A significant negative correlation between the DAS and age in the total scores reached (-.2133) at statistical significant difference (0.05).

The significant sex-related difference on the DAS in the present Palestinian sample was congruent with previous investigations on Lebanese participants.

Based on the present findings, it seems that there are no relationships between the DAS and specific demographic variables such as social status, bombed house, education, social status and place of residence.

■ Conclusion

- Findings show that females have higher average than males.
- The findings of the study revealed that the significant correlation was found on religion for the favor of Christians.
- There are no relationships between the DAS and specific demographic variables such as bombed house, social status, education, and place of residency.
- The findings show a low average in death anxiety among the study sample that was 50.9%.

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Prevalence of psychiatric emergencies
attending Emergency department in Sharkia

Abdel Shafy MK, Rafik RA, Wael Abo-hendy, Saber A. Mohamed, Mohammed A. Elmahdy

Egypt

doctor@maganin.com

Background: - Psychiatric emergencies make up a large number of conditions treated by emergency room physicians. It is mostly first seen by non-psychiatrists in emergency departments.

Aim of Work: *- To ascertain the prevalence and evaluate the Socio-demographic data, alertness, and rates of hospitalizations and severity of psychiatric emergency cases.*

Subjects and Methods: *- out of 11,699 attendant patients at medical emergency department, 200 patients with psychiatric emergency were recruited for this cohort study. Patients were submitted to medical assessment and psychiatric evaluation by semi-structured clinical interview, mini-mental state examination, brief psychiatric rating and Crisis Triage Rating Scales.*

Results: *- 200 (1.71%) patients (97 males, 103 females, and aged 29±12.5) with psychiatric emergency attended ZUH emergency department. The most prevalent psychiatric diagnoses were somatoform (24.5%), mood (18.5%), schizophrenia (11%) and anxiety (9.5%) disorders. Also, we found lower hospitalization rate (35.5%), most patients were alert (65.5%), and female (51.5%) patients were more common than males (48.5%) to present in psychiatric emergency. Hospitalized patients were found to be more dangerous, has less social support with little cooperativeness than Nonhospitalized ones.*

Conclusion: *- Psychiatric emergency constitutes a significant proportion of all medical emergencies, and it is more often in low socio-economic classes. Psychiatric education, proper social support, family education and early detection of psychiatric disorders will minimize the hazards of psychiatric illness.*

الملخص العربى: دراسة نسبة حالات الطوارىء النفسية فى قسم الطوارىء بمستشفى جامعة الزقازيق

يمثل عدد المترددين لاسباب نفسية على اقسام الطوارىء نسبة لا يستهان بها . وقد حاولنا فى هذه الدراسة قياس نسبة حالات الطوارىء النفسية، ومعرفة مدى وعيهم وحاجتهم للادخال للقسم الداخلى للعلاج. اجرى هذا البحث على 11699 متردد على قسم الطوارىء، ووجد ان مائتين (1.71%) منهم قدموا لاسباب نفسية طارئة، وقد اجرينا لهم فحص طبى ومعملى شامل بالاضافة للتقييم النفسى الذى تضمن : دراسة اجتماعية ديموجرافية، فحص نفسى كامل باستخدام البروتوكول الخاص بقسم الطب النفسى بجامعة الزقازيق، كما اجرينا القياسات النفسية التالية عليهم

1- اختبار الحالة العقلية المصغر

2- المقياس النفسى المختصر المندرج

3- المقياس المندرج للازمات الطارئة

وقد وجدت الدراسة ان 1.71% من المترددين كانوا لاسباب نفسية طارئة، اغلبهم من السيدات وقاطنى المدن وينتمى معظمهم لطبقات اجتماعية منخفضة، وقد تم ادخال 35.5% منهم للقسم الداخلى للعلاج. وقد وجدنا ان الاضطراب الخولى ثم الاضطرابات الوجدانية ثم الفصام الذهانى ثم القلق النفسى هى الاكثر شيوعا لدى هؤلاء المرضى. هذا وقد خلصنا الى انه يجب تحسين الظروف المعيشية مع زيادة التوعية بالامراض النفسية عند الاسرة والمجتمع بالاضافة الى تدريب العاملين فى الحقل الطبى من اطباء وفريض على التعامل مع طوارىء الامراض النفسية لتقليل وصمة المرض النفسى لدى مجتمعاتنا .

■ Introduction

Psychiatric emergency has been extensively studied along years with different Trans-cultural presentations. Psychiatric patients make up 3-11% of the total general hospital emergency visits *(Gerson & Bassuk, 1983).* However, *Oyewmi et al., (1992)* found that visits for psychiatric emergency services during their study in Canadian City represented 2.32% of the total number of visits to emergency facilities. *Gerard, (1998)* classified psychiatric emergency into: Major psychiatric emergencies: Represent a threat to life e.g.: suicidal, overdose, homicidal, agitated and sever adverse drug reaction, and Minor psychiatric emergencies:

severely distressing but not a threat to life e.g. grief, panic attacks, and rape. During the past 25 years there has been a shift away from institutionalizing mentally ill patients towards reliance on community services. Psychiatric emergencies facilities are often the only source of treatment and support for many of the chronically disabled people living in the community *(Perlmutter et al., 1986). Witkin et al.*, (1989) reported that, during the past 15 years there have been a rapid increase in the growth and utilization of psychiatric emergencies facilities in the United States. The psychiatric emergency service is now the main entry point into the network of mental health service for people in need of help.

The accessibility of emergency room, the belief emergency treatment is none stigmatizing and a lack of community to long term treatment, make psychiatric emergency facilities desirable in communities to manage the emotional and behavioral problems of its members (*Oyewumi et al.,* 1992).

- **Aim of work**

The objective of this study was to assess the prevalence and evaluate the socio-demographic aspects of psychiatric emergency cases attending emergency department at Zagazig University Hospital (ZUH) in addition to studying some clinical contributions regarding severity of illness, cognitive state, and rate of hospitalization among those patients.

- **Subjects and methods**

200 consecutive referral patients (97 males, 103 females, aged from 9-78 with mean age 29±12.5) who attended the emergency department at ZUH with Psychiatric emergency, were recruited for participation in this cohort study. Patients were assessed by proper medical examination and routine laboratory tests. Psychiatric evaluation done to the patients by two psychiatrists using:-

1- Semi-Structured Clinical Interview (SSCI) derived from Psychiatric department protocol of ZUH. It covers, mainly, socio-demographic data, personal history, past history, family history, and diagnosis according to DSM-IV diagnostic criteria.

2- Mini-Mental State Examination (MMSE) designed by Folestien and colleagues from Baltimore (Folestien et al 1975) as the most widely used and studied screening measure of cognitive impairment. It has the advantages of brevity, ease of administration, and high inter-rater reliability. It can be easily incorporated into routine clinical practice. It is not useful for the detection of focal cognitive deficits and insensitive to frontal lobe disorders. A score of less than 24 was initially suggested for distinguishing between impaired and normal subjects with a reasonably high degree of specificity and sensitivity. It has been clearly established that the MMSE is very vulnerable to the effects of age, education, and socio-economic status. It takes on average 5-10 minutes to be completed.

3- Brief Psychiatric Rating Scale (BPRS) (Over &Gorham 1962) has been widely recognized and used both for the routine follow up and research assessment of psychiatric patients.

4- Crisis Triage Rating Scale (Bengeldrof et al 1984) to expedite the rapid screening of emergency psychiatric patients who require hospital admission from those who are suitable for out patient crisis intervention treatment. It has three dimensions: - Dangerousness, Support system, and Motivation and Ability to cooperate.

Data management and statistical methods:

The data has been coded and entered on an IBM compatible personal computer using the statistical package SPSS ver. 9.0.

The data was summarized using the mean and standard deviation for continuous type, while percent was used for the qualitative type. The differences between groups were tested using the student's t-test and ANOVA for continuous data. The chi-square test was used for qualitative data. The correlation between two continuous groups was assessed using the Pearson's correlation test. The level of significance for all above mentioned tests was at $P<0.05$ (Saunders & Trapp, 1994).

■ Results

There were, along 3 months period, 11699 attendants to the emergency department, 200 (1.71%) of them (97 males and 103 females, with mean age 29±12.5, age range 9-78 with peak age 17-34) presented with psychiatric emergencies with the following diagnoses in chronological order:- Somatoform disorder 49 (24.5%), Mood disorders 37 (18.5%), including major depression 21 (10.5%) and bipolar disorder 16 (8%), Schizophrenia 22 (11%), Anxiety disorders 19 (9.5%) (mainly panic attacks & PTSD), Substance abuse 16 (8%), Mental disorder due to general medical condition 14 (7%), Adjustment disorders 12 (6%), Suicidal 13 (6.5%), Drug induced movement disorder 6 (3%), Delirium 4 (2%), Acute Grief Reaction 3 (1%), Personality disorder 2 (1.5%), Dissociative disorder 2 (1%), Psychosexual 1 (including Gender identify disorder) (0.5%).

Figure (1)

Prevalence of psychiatric emergencies according to DSMIV classification

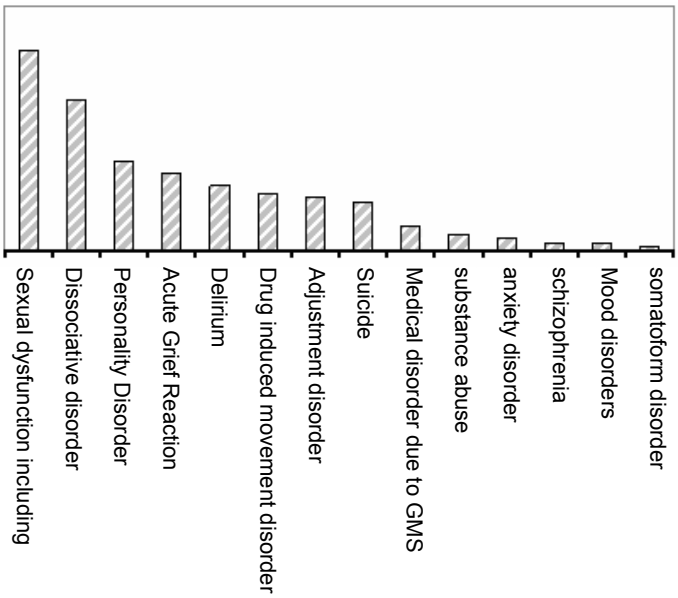


Table (1)
Age Distribution

Age	Number	Percentage
< 10	6	3%
10 – 20	39	19%
20 – 30	71	35.5%
30 – 40	46	23%
40 – 50	18	9%
50 – 60	10	5%
> 60	10	5%

Table (2)
Sex, Marital status, Residency, Education, and Occupation of psychiatric emergency patients

Item		Number	Percentage
Sex	Male	97	48.5%
	Female	103	51.5%
Marital status	Married	80	40%
	Single	94	47%
	Divorced	15	7.5%
	Widowed	11	5.5%
Residency	Rural	83	41.5%
	Urban	117	58.5%
Education	< 6 years	71	35.5%
	6-12 years	90	45%
	> 12 years	39	19.5%
Occupation	Not working, housewife	63	31.5%
	Students	48	24%
	Semiskilled	49	24.5%
	Skilled	40	20%

Figure (2):
Precipitating factors in psychiatric emergencies shows that Familial & social problems form the two most common precipitating factors of psychiatric emergencies:- they represents 23% & 21% respectively.

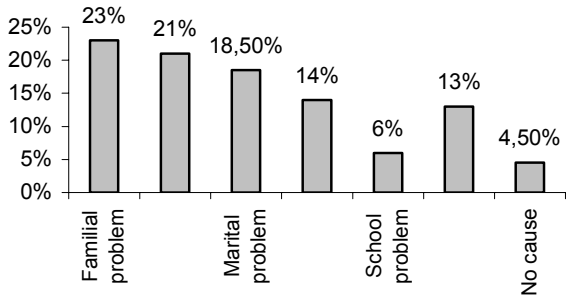


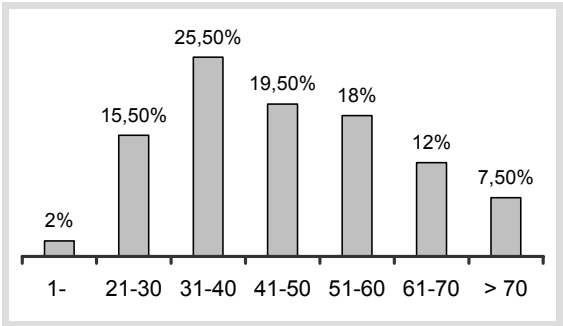
Table (3)
Results of MMSE in hospitalized & non hospitalized patients shows that alert 65.5%, drowsy 26.5%, stupor 6.5%, to coma 1.5%.

Item	Nonhospitalized		Hospitalized		Total	
Result of MMSE	N = 129	%	N=71	%	200	%
Alert	90	69.7	41	57.7	131	65.5
Drowsy	25	19.3	28	39.4	53	26.5
Stupor	9	7.5	2	4.9	11	6.5
Coma	3	2.5	0	0	3	1.5

Table (4):
CTRS in hospitalized & non hospitalized patients

CTRS	Total		Hospitalized		Non hospitalized		T	P
	N	%	N	%	N	%		
3	4	2	4	5.6	0	0	16.58	≤0.001 high sign.
4	9	4.5	8	11.3	1	0.7		
5	11	5.5	8	11.3	3	2.3		
6	21	10.5	16	22.2	5	3.9		
7	29	14.5	16	22.2	13	10		
8	18	9	8	11.3	10	7.7		
9	16	8	4	5.6	14	10.8		
10	11	5.5	2	2.8	9	7		
11	32	16	2	2.8	30	23.3		
12	16	8	2	2.8	14	10.8		
13	18	9	1	1.4	17	13.2		
14	14	7	0	0	14	10.8		
15	1	0.5	0	0	1	0.7		
Mean	8.5		7.18		11.8			
S.D.	2.4		2.59		2.9			

Figure (3)
Results of BPRS shows that most patients (90.5 %) scored from 21 – 70 on the BPRS.



Discussion

Our major findings in this study were the low prevalence rate of psychiatric emergency in comparison to other emergencies, the chronological order of psychiatric disorders as a causative factor in attending patients in emergency, the low rate of hospitalization to psychiatric ward, higher percentage in females than in males, singles and married patients were more prone to come in emergency, and most of patients were alert.

One of the major findings in this study was the low prevalence rate of psychiatric emergency (1.71 %) cases which is very close to Adityanjee et al., 1988 (2%) reports in an Indian study despite it is, at the same time, so far from German findings (9.2%) reported by Pajnok et al. 2002. We think that the relatively low prevalence rate in our study might be explained by the role of mental stigma, emergency doctors trials not to stigmatize their patients, the limited physician-patient contact time, medical co morbidity, patient resistance for mental illness, and the inadequate psychiatric training for emergency doctors all might contribute to the lower reporting of psychiatric emergency in our community. We found that the most common psychiatric disorders are in a chronological manner: Somatoform disorder (24.5%) followed by Mood disorder (18.5%)

then schizophrenia (11%), anxiety disorder (9.5%), and lastly substance abuse (8%) which reported as the lowest psychiatric disorder in emergency department. Contrary to our results, Oyewmi et al., 1992 Moecke et al., 2001 and Kadels et al., 2003 found that substance and alcohol abuse disorders were the most common prevalent causes (29%, 70%, and 32.8% respectively) of psychiatric emergencies. These differences between our results and others` might be attributed to the cultural, legal and religious factors in lowering the rate of substance abuse in our population.

However, in our study, 35.5% only of cases necessitated admission at psychiatric ward while 64.5% were suitable for outpatient management. These figures are in consistence with Taylor et al. 1996 (31% hospitalized vs. 69% outpatient), Prokudin 1985 (33% vs. 67%), and Schyder et al. 1999(34.1% vs. 65.9%) findings despite the different causes of admission between our studies and theirs`. Our major causes of admission were found to be schizophrenia followed by bipolar disorder manic type and then lastly major depression. However, James et al., (1991) found 61% of psychiatric cases need admission because of the violence. These differences in the causes of admission between us and others might be attributed to the overcrowding of patients in hospitals in Prokudin 1985 study and the high social support and familial ties in our culture.

Interestingly, In our sample, female patients (51.5%) found to be more common than males (48.5%) to seek emergency psychiatric service in consistence with Gabbard et al., 1994 and contradictory to an Egyptian study by Okasha 1966 who reported that males are more common (57.4%) than females (42.4%). This difference may be attributed to the fact that many females in our society are exposed to many stressors, more easily to express themselves in psychiatric terms, and the prominent somatoform disorders in our sample.

Moreover, we found 55.5% of emergency patients came from urban areas which is very close to the findings of (Tsuang et al., 1992) & (Baxter et al., 1988) While Pajonk et al. 2002 and Baretels et al. 2002 found no significant difference between rural and urban residency in emergent psychiatric patients. This may indicate the hazards of overcrowding of urban areas with subsequent social deprivation and weak family ties. Also, the stresses associated with life style in urban areas may play a role.

Interestingly, 65.5% of our patients were alert followed by drowsy, stupor and coma, (26.5%, 6.5%, 1.5% respectively) in accordance with Henneman et al., (1994) BPRS in our hospitalized patients was 64.8±7.99, While in non hospitalized patients it was 47.9. The cut off score of BPRS was 54 (i.e. more than or equal 54 indicates hospitalization and less than 54 indicates that oupatient treatment is sufficient. Our result found to be very close to that of Paulette et al. 1989 While inconsistent with Apsler et al. 1983 who found that the mean score of BPRS in hospitalized and non hospitalized patients were 54, 40 respectively. This controversy might be due to the higher severity of illness among our sample patients.

The mean score of CTRS in our hospitalized patients was 7.18±2.9 while in non hospitalized patients, it was 11.8±2.3. There was negative correlation between CTRS score and hospitalization. Those who were admitted were more dangerous, had less social support with little cooperativeness. It is supported with results of Bengeldrof ET al.1993 who reported the same results by his opinion that patients with 3- 8 CTRS requires hospitalization.

Conclusion

Psychiatric emergency constitutes a significant proportion of all medical emergencies, and it is more often in low socio-economic classes. Psychiatric education, proper social support, family education and early detection of psychiatric disorders will minimize the hazards of psychiatric illness. Proper psychiatric training is inevitable for undergraduate medical students and emergency doctors to improve their clinical skills to cope better with the increasing psychiatric emergency cases.

Acknowledgment to Dr. Amira Fouad

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إضحـــى مبـــارك 1426

تتقدم أسرة شبكة العلوم النفسية العربية إلى الزملاء الأطباء و أساتذة علم النفس و كافة المسلمين بأحر التهاني بمناسبة عيد الأضحى المبارك سائلين الله العلي القدير أن يلهمنا الرشاد وأن ينير بصيرتنا ويهدي عقولنا إلى ما فيه خير المسلمين والإنسانية جمعاء.

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البقـــاء للـــه وحـــده

الأستاذ الدكتور أسامـــة محمـــد الراضـــي في ذمـة اللـه

"يا أيتها النفس المطمئنة ارجعي إلى ربك راضية مرضية فادخلي في عبادي وادخلي جنتي"

ببالغ الحزن والأسى تنعى شبكة العلوم النفسية العربية إلى أساتذة علم النفس والطب النفسي وفاة المغفور له الأستاذ الدكتور:أسامة محمـد الراضـي (أستاذ الطب النفـسي – الطائف، السعودية -رئيس الجمعيـة العالمية الإسلاميـة للطب النفسـي (سابقاً) - مدير خدمـات الطب النفسـي في المملكة العربية السعودية)

بهذه المناسبة الأليمة ، نتقدم إلى أسرة الفقيد و إلى جميع الأطباء النفسانيين العرب بأحر التعازي سائلين الله العلي القدير أن يتغمده برحمته الواسعة و يسكنه فراديس جنانه و يرفع درجاته. وإنا لله وإنا إليه راجعون.

شبكة العلوم النفسية العربية

Marital satisfaction and Women's Health

Cheour M, Ellouze F, Ellouze S, Hssairi A.

Razi Hospital – Mannouba- Tunisia

majda.cheour@rns.tn

Objective: *We already know the marriage benefits to health and the devastating effects of divorce on health. What we wanted to investigate was the impact of marital conflicts on women's health.*

Method: *Subjects :Sample of 140 married women, representative of the population of Greater Tunis selected according to age, school level, and environment (quota method). Assessment: Socio-demographic parameters, Lock-Wallace Marital Satisfaction test, Beck Depression Inventory, Beck Anxiety Inventory, open questions exploring the physical status.*

Results: *Nearly one woman out of two experiences conjugal conflicts. While less than one third of women incriminate work in generating conflicts, three out of four report significant impact on their professional activities.*

There are more somatic disorders among women experiencing marital conflicts compared to women with marital conflicts (72% vs 28%). The difference is significant p=0,00005.There is a significantly greater / higher rate of depression (BDI score > 03) among women with conjugal conflicts (96% vs 50%) (p =0, 00000001). Women with conjugal conflicts, experience more severe forms of depression, while women without marital conflicts report milder forms

There is a higher rate of anxiety among women with marital conflicts 76% vs 24% (p=0,004)

Conclusion: *There is an evident need for appropriate preventive and therapeutic strategies, given the serious consequences of domestic conflicts on women's physical and mental health.*

Keys word : *women's health, marital's conflicts*

▪ INTRODUCTION

What we already know was the marriage benefits to health and the devastating divorce effects on health. What we wanted to investigate is the impact of marital conflicts on women's health.

This study is the first one in Tunisia, in the context of a woman's empowerment policy.

▪ MATERIAL AND METHOD

1-Subjects: Sample of 140 married women, representative of the population of Greater Tunis.(capital and suburbs – n= 2 million inhbts) . Selected according to age, school level, and environment (quota method).

2-Assessment:

a-Socio-demographic parameters (age, number of children …)
b-Lock-Wallace Marital Satisfaction test
c-Beck Depression Inventory
d-Beck Anxiety Inventory
e-Open questions exploring the physical status

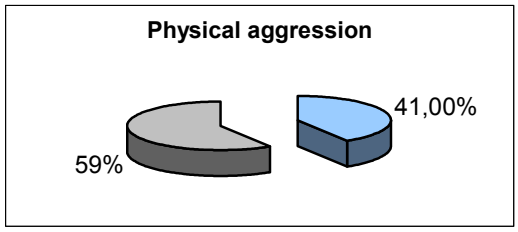
3- Results:

1-Frequency of conflicts:
Nearly one woman out of two experiences marital conflicts 43,1%
2-Causes of the conflicts:

Financial problems	85%
Conflicts with family-in-law	69,2%
Disagreement about child care	51,8%
Jealousy	28,5%
Women's work	26,5%
Sharing housework	23,2%
Sexuality	17,9%

3-Characteristic of the Conflict::

a* Physical aggression is noted in nearly half of the cases



b* Course of the conflict :It is continuous in 20 % of cases

c* The impact of Conflicts on women's work.

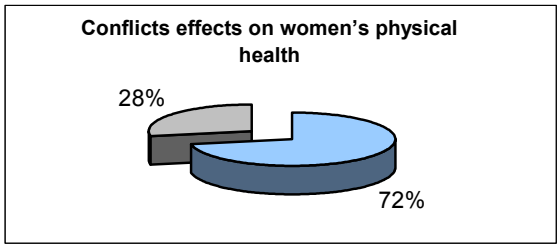
While less than one third of women incriminate work in generating conflicts, three out of four report significant impact on their professional activities.

d* Nature of the consequences of conflicts on women's work:

Decrease of the performances :	56,7 %,
Sick leave :	43,3 %
Abandon work :	29 %

4-Conflicts effects on women's physical health:

There are more somatic disorders among women experiencing marital conflicts (72% vs 28%). The difference is significant p=0,00005.



a* Onset of somatic disease

Among women with marital conflicts, somatic disorders follow marital discord in 95 % of cases.

b* Nature of somatic disorders Psychological impact of marital conflicts

- Depression:

There is a significantly greater / higher rate of depression (BDI score > 03) among women with conjugal conflicts (96% vs 50%) (p =0, 00000001). Women with conjugal conflicts, experience more severe forms of depression, while women without marital conflicts report milder forms

- Anxiety:

There is a higher rate of anxiety among women with marital conflicts 76% vs 24% (p=0,004) . The group with conjugal conflicts experiences slight and moderate anxiety, while the group without marital conflicts reports mainly slight forms

■ DISCUSSION:

1-frequency of marital conflicts

In our study 43, 1 %.

In the literature : it ranges from 25 % to 62 %, depending on :

Assessment tools: (conflict tactic scale, dyadic adjustment scale, marital adjustment test...)

Population: (ethnic and cultural subgroups, urban vs rural settings, socioeconomical status, special populations (at the beginning of marriage, at the birth of children, at the adolescence of the children)).

2-The impact of marital conflicts on women's health involves:

- Worsening of pre-existing disorders
- Triggering diseases
- Causing relapses

a- Physical impact

Our results are consistent with literature: Frequency of dermatological, infectious, gastric and neurological diseases among women with marital conflicts. The mechanisms of the Physical impact involve marital conflicts as stressful events. Allostatic system, hypothalamo-hypophysal system, medullo-suprarenal gland are also involved.

- Cortisol → immuno-suppression → infection
- Catecholamine → High blood pressure
- LDH cholesterol → cardiovascular risks
- Hyperglycemia → diabetes

b- Psychological Impact

In our study: There is a greater frequency of depression, essentially severe and moderate forms.

In the literature: There are greater seeking of care, (higher heath costs), more depression, and anxiety, worsening of preexisting bipolar disorder, higher risk of suicide. There are also more substance abuse, eating and sleep disorders, more psychosis, somatoform disorders and facticious disorders.

c- Mechanisms of Psychological impact

In case of conflicts, the couple loses its:

-Emotional function: empathy, understanding
-Instrumental function : (punctual) help
-Informative function : counceling, coaching
- function of dampening of daily stressors

In case of conflicts, the couple becomes itself a stress factor.

■ CONCLUSION

There is an evident need for appropriate preventive and therapeutic strategies, given the serious consequences of domestic conflicts on women's physical and mental health.

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The Case Of First Wife In Polygamy

Description of an Arab Culture-specific Condition

LOTFY A.M. AL-SHERBINY, PhD , PSYCHIATRIST – Alexandria, Egypt

lotfyaa@yahoo.com

SUMMARY: Polygamy and the case of first wife in Arab culture

Polygamy and the condition of first wife were investigated by study of a sample of 100 women ; half of them were first wives in polygynous marriages and the other half were a control group . Assuming that the first wife reacts to remarriage of the husband in certain pattern which is amenable to investigation and description , the subjects were collected by ' snowball ' technique and studied using brief interview , demographic sheet and the General Health Questionnaire (GHQ) .

The findings of this study revealed the first wives in polygynous marriage tend to have certain demographic characteristics e.g. relatively older age than controls, lower education , higher number of children and mostly being housewives . The initial reactions of the first wives to remarriage of the husband took the form of severe symptoms and sharp actions . Acceptance and adaptation to the new situation gradually takes place after 6 months in the average . Physical , psychological and social consequences continue to manifest for long time in polygynously married first wives . Certain symptoms were either spontaneously reported or observed through GHQ application , the most frequent of them were the somatic complaints e.g. pain , psychological symptoms e.g. anxiety and irritability and mixed e.g. tiredness .

The findings of this study suggested the proposal of an Arab Culture specific condition in women described as ' first wife syndrome ' . This new native category of psychiatric disorders which has no Western equivalent is justified by the almost constant pattern of reaction of Arabic women to polygamy based on findings of this study . Further research in this area and other relevant cultural studies had been recommended.

ملخص: الزواج المتعدد وحالة الزوجة الاولي في الثقافة العربية

يهتم الطب النفسي عبر الثقافي Transcultural بالظواهر النفسية وعلاقتها بالخلفية الثقافية في ثقافات العالم المختلفة ، وفي الثقافة العربية Arab culture كما في غيرها خصوصيات تتميز بها تجعل الحالات النفسية تختلف مظاهرها في المجتمعات العربية عنها في بلاد الشرق والغرب الأخرى ، وكذلك يمتد التباين والاختلاف بين الحالات النفسية من مجتمع عربي محلي الي آخر ، وهنـاك الاضطرابات النفسية التي ترتبط بالثقافة Culture-bound disorders ، وحالات اخرى توصف بأنها مختصة لثقافة معينة Culture-specific ، والحالة المرضية النفسية التي نقوم بوصفها هنا هي نموذج لمثل هذه الحالات التي يمكن ملاحظتها والتعرف عليها في الثقافة العربية دون ان نجد مقابل يماثلها تماماً في النموذج الغربي Western model الذى نجده في المراجع والأدبيات الخاصة بالطب النفسي ، ولذلك فقد تم وصف هذه الحالة المرضية النفسية الجديدة بناء علي دراسة نفسية منهجية في الثقافة العربية ، وتم اقتراح اضافة الحالة المرضية الجديدة التي اطلق عليها " متلازمة الزوجة الأولي " First wife syndrome بعد وصفها في سياق هذه الدراسة .

■ Introduction:

Polygamy seems to be one of the special of interest and a distinguished feature in the study of Arab Culture in relation to psychosocial patterns. Very few serious studies exist about psychiatric implications of polygamy , but a lot of sentimental , picturesque and romantic prose has , in the Arab and Orientalist tradition , been written about polygyny in Islam and Middle East.For the Arabs , a great bulk of "second-hand" information on polygamy is available , however one must be cautious when handling these information .

The importance of the systemic psychiatric study of this subject comes from the fact that polygamy is a well known feature of marriage pattern which is approved by Islamic Sharia laws in Arab Countries.At the same time,there is an impression of the existence of assumed psychiatric,in addition to social,implications on women who are,at any time,married polygynously or involved in polygamy.There is literature that points at the psychiatric and social implications of polygamy in some societies in Africa (Dorjahn 1988),certain Christian groups i.e.Mormen (Logue 1985) , Latin and North America(Smith and Kunz 1976),some Islamic countries e.g.Turkey(Behar 1991),and in Arab Culture in different Arab countries(Huzyyin 1981,El-kholi 1
971,Chamie 1986).

■ **Polygamy In Arab And Islamic Culture :**

Generally, polygamy is a well known and recognized practice from social, legal and religious aspects in most of Arab and Islamic Communities . Most of the Western observers , however , are fascinated by the stories of ' Harem ' and other related mysteries , and in the best of instances , looked upon polygamy as an exciting local curiosity . As to the Arab writers, there are multiple opinions and numerous impressionistic accounts about social and religious aspects of polygamy. Here is a summary of facts and views of the subject in Arab and Islamic Culture.

Marriage with up to four wives is, in principle, permitted by Islamic Sharia Law. According to Islamic Rules, it can be understood from statements of the holy Quraan * that getting married to more than one wife is, inspire of being allowed, justified only if man can manage that on an equal basis between wives . According to the ' Sonna ' (teachings of Prophet Mohammed) , the man who married polygynously have to divide equally his care and time his two , three of four wives , in addition to spending equal amounts of his income on each of them . Some other Islamic Rules regulate the practice of poygyny e.g. man is not allowed to get married to the sister of his present wife, nor to her mother or her aunt. Referring to Islamic Rules , the polygynous man have to spend one night with each of his wives alternatively on equal basis , and in case of traveling he should accompany one of them alternatively (Holy Quraan and ' Sonna ' teachings references) .

In Islamic culture, polygamy should be regarded as a selection which, if appropriately resorted to, may help reducing marital discord and solving conflicts and problems of the involved individuals and families. Following Islamic principles and adhering to the rules regulating polygamy can minimize or completely eliminate the side effects of this practice. Moreover, polygamy , from the Islamic point of view , can be a way of achieving and enjoying a healthy balanced marital life leading to promotion of physical , social , spiritual and mental health (El-Azayem and Hedayat 1994) .

Polygamy in Arab Culture is,contrary to the wide spread opinion,of low incidence,however this low proportion of polygons unions does not,with time,tend to disappear.Although marriage with up to four wives is permitted by Islamic law,the predominant form in most of Arab communities is undoubtedly bigamy(Chamie 1986). There are some reasons to believe that the low incidence of polygamy in Arab communities is far from being a new development.There is quite a lot of circumstantial and qualitative evidence in the form of memories, travelogues, novels and other literary sources to show that the phenomenon of polygamy, although a fundamentally accepted part of the basic marriage pattern, was and still meeting increasing disapproval and strong opposition in many Arab Societies.(Al-Sherbing 1996) .

The official data available estimate the frequency of polygamy in some Arab countries to be still lower than that mentioned in Mormons or in some African communities (Smith and Kunz 1976). Taking the percentage of the polygynously married men , it was 4% in Egypt (1960) , 7.5% in Iraq (1957) , 4.3 % in Syria (1960) , and still supposedly higher figures in Gulf Area where polygamy is more accepted among nomad and rural societies (Chamie 1986) .

When we mention the figure of 4% of men polygynously married in Egypt; this means that around more than 8% of married women are, at one time, involved in polygamy . The predominant form of polygamy in Arab countries is bigamy , relatively few number of men have three wives , and still fewer are those who have four .

Informal polygamy is an atypical family structure which is available, but no reliable stistical figures could be found about its incidence or prevalence in Arab societies . This pattern of marriage was described in other cultures as well (Rivett and Street 1993) .

*** From the Holy Quraan :**

"Marry women of your choice, two, or three , or four , but if you fear that you shall not be able to deal justly (with them) then only one . That will be more suitable to prevent you from doing injustice "Surat An-Nisa " .

■ **Psychosocial Aspects Of Polygamy :**

Areas to be explored in reviewing the social and psychological aspects of polygamy in Arab Culture include the possible reasons for remarriage, determinants of polygamy and its problems, reactions and outcomes in relation to psychosocial life .

The reasons of polygamy being still thriving in some Arab communities,mainly the Gulf and other parts of Arabian Peninsula,are related to the culturally approved function of women as just to get married and produce children(El-Islam 1982,El-Kholi 1982).If we turn,first to women going into polygynous marriages,it seems that unmarried women,spinsters,and those from nomad and farmer cultures are more involved in polygynous unions(Behar 1991,Bates 1973).Two categories of men seem slightly more involved in polygynous unions than the others;men with strong religious connection or having an occupation in religious related area(Sheikh , Motawa ', Mulla or Emam) , and high rank officials of the society (Chamie 1986) . When the first wife is childless or ill, and in special situations such as death of the brother who leaves a widow and children , the second marriage looks justified and more accepted in Arab Culture . Islamic religion and wealth are viewed by some observers to be the main determinants of the incidence of polygyny in Arab and Islamic Culture (Behar 1991). Other observers have the opinion that men should almost always prefer polygyny, and dynamic tension between female and male interest may result in polygamy which emerge because women also prefer it as evidenced by female competition for the more attractive and wealthiest husbands (Gaulin and Boster 1990, Schlegel and Eloul 1987). The surveys which were conducted in the 1970's in some Arab cities (Cairo, Damscus) seem to indicate that education and socio-cultural status are inversely related to multiple marriages (Huzayyin 1981) , but other study points out that the relationship is not as simple (Chamie 1986) .

The results and outcome of polygamy together with the problems which may arise following the husband getting remarried are predicted, together with the anticipatory reactions from the side of the first wife as well. The second marriage represents, in most of the instances, a major crisis mainly affecting the first wife caused by distress which reflect mourning over the death of the relationship or continued anger and hostility toward the partner and the new wife. Emotional reactions , legal issues , economic or financial troubles , disturbed social relationship and series of psychological upsets are among the list of expected troubles , rather than intended solutions , which may arise as a result of resistance of the first wife to the new situation following remarriage of the spouse .(Darwish 1989 , Al-Issa 1990)

Here , in this study , information about the subject of

polygamy in Arab Culture are collected and handled as to explore and investigate the hypothesis of the effects of polygamy on the psychological state of the first wife . The symptoms which are frequently seen in Arabic women when the man gets married to a new wife may be adequate to establish the need of a new diagnosis. Assessment of these symptoms and comparison of their incidence and frequency in controls from the same culture can help identification and description of an Arab Culture-bound psychiatric condition.

Similar reactions indicating stress in first wives described in women in African Societies (Mulder 1992), and in the Arab culture in the Gulf (Darwish 1989), and Algeria (Al-Issa 1990) .

■ Hypothesis :

Field study of special areas of interest in Arab Communities in relation to psychiatry can highlight some aspects in the Arab culture relationship with mental conditions.

Polygamy is a condition which is little known outside the Arab culture. Relevance of demographic data to the phenomenon of polygamy could be confirmed. Systemic psychiatric study of polygamy through concentration on reactions of the first wife can reveal a specific psychiatric condition amenable for investigation and description. This pattern of reaction of first wives which is culture-specific in Arabic women is related to cultural factors and psychiatric implications of polygamy in Arab Culture.

There are special areas of interest in Arab Communities which can be studied in relation to Psychiatry to highlight some aspects of the relationship between Arab Culture and mental conditions. Here is an attempt made to study one of the areas of interest in Arab Culture. Hopefully the findings of this study can illuminate the influence of Arab Culture on Psychiatric conditions and succeed in examining the mentioned hypotheses. Psychiatric implications of Polygamy in Arab Culture through concentration on study of its effects mainly on the first wife (Hypothesis a, b).

■ Methodology:

- **The Sample**:

One hundred Arabic women participated in the study of polygamy were distributed as follows :

- Fifty ladies who are involved in polygynous marriages; each of them being the first wife of a man who remarried to a new wife, are the subjects of the study group.
- Fifty ladies who are monogamously married were selected randomly as a 'control group '.

Recruitment of subjects who were studied as the first wives was by the 'snowball'technique. Personal contact had been used by the help of some local social workers, psychologists and other sources of referral.

Additional participants were identified by these contacts and were invited to be studied.

- **The Instruments**:

1. **General Health Questionnaire (GHQ) :** This is an Arabic version of the scaled version of GHQ , which is a widely used instrument for the screening of psychiatric symptoms in the community and in primary care practice(Goldberg 1979).It has been translated and used in a number of countries including Kuwait where this study has been conducted(El-Islam et al 1986).The 28-Item version of GHQ is composed of 4 scales, each of them contains 7 symptoms covering somatic, anxiety, social dysfunction and depressive symptomatology.Symptoms are scored 0 if never experienced or experienced no more than usual, and as 1 if slightly or definitely experienced by the subject out of keeping with what is usual by her.

2. **The Demographic Data And Information Sheet :** A demographic data sheet was distributed along with the GHQ to the members of the study group of the sample (B) which include the ladies involved in Polygamy.This sheet contained demographic variables which may influence the subject condition such as age,education,occupation etc..Other information such as length of marriage and number of children was also assessed.

The factors relevant to marriage and polygamy were assessed through some simple inquiries added to the demographic data sheet. The main items include the length of marriage prior to remarriage of the husband and the existence of severe marital conflicts during that period. The view of the first wife to the remarriage of here husband, and her explanation of the reason for that, together with her opinion of the husband were asked for. The sheet includes inquiries about the initial reaction of the first wife remarriage of the husband and the reported recent difficulties she faced.

■ The Procedure :

The women who were studied for the influence of polygamy (The 50 ladies who were first wives) were contacted through several means of communication. These ladies who are the subject of the study were identified using the 'snowball' technique (an unfolding process which was defined as the selection of relevant subjects through referrals from other subjects (Babbie 1982). The subjects are then reached personally and the following procedures were carried out :

The nature and purpose of the study were simply and clearly explained to each subject.

The subjects were assured that the obtained data would be handled with confidentiality.

Their consent was essential after they were informed that the process is confidential and risk free , and only the investigator would have access to the data collected (giving the name was optional and it was possible to replace it by a code or a pseudonym e.g. ' Um-Ahmed ' which means ' the mother of Ahmed ').

Standardized psychiatric interview, constructed for the purpose of this study took 15-20 minutes, although it was often prologend by subjects who wanted the opportunity to discuss their problems. Some of the cases were referred for physical and laboratory examinations when needed.

Demographic data sheet which contains personal information and inquiries about marital issues was completed by the subjects after the interview.

Subjects were then asked to complete the Arabic version of the 28 item General Health Questionnaire (GHQ).

The control group which included 50 subjects (monogamously married ladies) were asked to complete the GHQ, and their personal demographic information data were collected as well .

■ Statistical Analysis

The hypothesis concerning the influence of polygamy was tested by comparison of the study group whose subjects are first wives involved in polygynous marriages with the control group of monogamously married ladies on the variables under investigation. Statistical analysis and the differences between the two groups in demographic data and GHQ score were carried out using Chi-square contingency tables and other methods of discriminate analysis.

■ Results

Results of the Study of impact of polygamy on the first wife which was conducted using a sample of the subjects involved in polygynous marriages as the first wife (50 cases) and a control group of ordinary wives in monogamous marriages (N:50) were as follows :

Age: The age of the study group and controls is represented in the following table.

Table (1)

Sample	Age Range	Mean	SD
Study Group	23-52	36.36	7.782
Control Group	18-49	26.34	8.289

Age of study group (first wife , N = 50) , and control group (N = 50) .
- The mean age of the study group is higher than that of the controls.

Marital Status: All cases of the sample were married, either being the first wife in polygamous marriage in the study group , or the only wife in monogamous marriage . The exception was only two cases that were divorced at the time of investigation. Each of these 2 cases was also the first wife and they asked for divorce after few years of remarriage of the spouse.

Education : The level of education in the study group and the control group is shown as follows :

Table (2)

Education	Study	Group	Control	Group
Level	No.	%	No.	%
1. Illiterate	9	18	2	4
2. 1 ry School	12	24	9	18
3. 2 ry School	22	44	10	20
4. University Graduated	7	14	28	56
5. Postgraduate	-	-	1	2
Total	50	100	50	100

Education in the sample members of Study group (50) , and Control group (50) .

- The great majority (more than 80%) of the study group of the first wives in polygamous marriage were noted to have educational levels lower than the University degrees .
- More than half the control group women were University graduated.

Occupation : The occupation of the sample members is distributed as shown in the following table :

Table (3)

Occupation	Study	Group	Control	Group
Level	No.	%	No.	%
Housewife	28	54	11	22
Employed*	22	44	31	62
Student	-	-	8	16
Total	50	100	50	100

Occupation in the sample members of Study group (50), and Control group (50).

- Job includes mainly clerk and official works (Government is the main employer).
- Housewives represent more than half of the Study group (first wife) and less than quarter of the Control group .

Number of Children: The number of children born by wives in the Study group and those of the Control group will represent as follows :

Table (4)

No. of Children	Study	Group	Control	Group
	No.	%	No.	%
1.	3	6	5	10
2.	6	12	8	16
3.	11	22	13	26
4.	9	18	11	22
5.	8	16	7	14
6.	5	10	3	6
7.	3	6	1	2
8.	2	4	1	2
9.	2	4	1	2
10.	1	2	-	-

Frequencies of No. of children of sample members of Study group (50) and Conrol group (50).

- The mean for the Study group is 3.56, and for the Control group is 2.62. This means that women in the study group (first wives) tend to have more children than controls.

Difference in demographic data between Study group (first wife) and Control group concerning some variables is represented in the following table :

Table (5)

Demographic Variables	Study group	Control group	X2	DF	P
	N = 50	N = 50			
Median age	36 .36	26.36	20.80404	1	0.00001
Lower education	43 (86 %)	21 (42 %)	13.21835	1	0.00028
Housewives	28 (54 %)	11 (22 %)	1.42227	1	0.03296
No. of Children (mean)	3.56	2.62	13.39396	1	0.00024

Difference in some demographic variables between Study group (first wife, N= 50), and Control group (N = 50) .

- The Study group (first wife) tended to be older in age in comparison with the controls. Level of education was comparatively lower in the Study group. Housewives dominate in the Study group and represented as much as more

than double their existence in Control group. Number of children tended to be significantly higher in subjects of Study group than the controls.

Data about the (first wife) :

The data collected by demographic sheet and the inquiries about polygamy and remarriage are summarized in the following points :

- Length of marriage in the group of 'first wife 'involved in polygamous marriage ranged from 2-36 years (mean - 13.5 years).
- The years of marriage passed before second marriage took place ranged from 2-36 years from the first marriage (mean = 8.7 years). About 50% marriage occurred before completing 7 years of marriage.
- A relatively smaller number of cases (first wife) reported the existence of severe marital conflicts prior to remarriage of the husband, only 14 cases (28%).
- The reasons for remarriage of the husband as viewed and reported by the first wife were :
  * About one third of cases (17 or 34 %) reported that they don't know why the spouse remarried to a new wife.
  * Some explained the remarriage of the husband as being a caprice to search for more sexual satisfaction.
  * Others attributed it to the existing marital conflicts, and the husband wanted to punish the old wife by remarriage.
  * Some wives attributed remarriage of the husband to the influence of his family, mainly mother-in-law who suggest this idea as revenge against the first wife.
  * Fewer cases mentioned that they themselves (the first wives) were responsible for the remarriage of their husbands in some way. Two cases reported that they were childless; one other case reported that she was late to get pregnant; another mentioned that he remarried to have a male child after she had 4 girls, and some others reported that their men remarried to have more children.
- Attitudes of the first wives to their husbands after remarriage to a new wife were generally negative as noted in their responses to inquiry about their opinion of the husband. The great majority described them as selfish, womanly, irresponsible, careless or evasive. Only a few cases mentioned that their husbands are religious and good despite their remarriage.
- The reaction of the first wife to remarriage of the husband as reported by the sample cases can be summarized in the following points :
  * Initially, the wife when informed or discovered for the first time that her husband got married to a new wife, reacted severely to the situation. The initial reaction took the form of surprise, nervous breakdown, outburst of anger, hysterical behaviors or tearful episodes.
  * The action taken by the first wife in the initial phase was frequently leaving the house and going to her family home, asking for immediate divorce, or showing signs of severe illness to be transferred for emergency treatment in the hospital.
  * The serverity and duration of this initial reaction differ from one case to another. Generally, acceptance of the new situation with gradual adaptation took place in the majority of cases after 6 months of the event. Residual effects continued in the form of physical, psychological and social consequences as shown in the study of the sample of first wives.
- The first wives reported the difficulties they faced after remarriage of their husbands. They could be summarized in the following points :
  * Psychological e.g.tension, sleep disorders, low self esteem, lack of satisfaction and feelings of jealousy, injustice and frustration. The commonest spontaneously reported symptoms are mentioned later.
  * Physical problems e.g.multiple persistent somatic complaints such as fatigue (tiredness), headache, Abdominal pain, backache, which poorly responded to treatment, and overconcern with their health.
  * Social and economic difficulties e.g.lack of interest of the husband in the first wife , unfair distribution of the husband's time and income between both wives by giving more to the new one , the burden of care for children in not effectively taken by the father , and repeated problems and conflicts between both wives .

Symptoms: The spontaneously reported symptoms by cases of the study group (first wife) which include somatic, psychological and mixed symptoms were recorded during the interview . The frequency of the commonest symptoms was represented in the following table :

Table (6)

Symptom	N	%
Fatigue (tiredness)	34	68
Headache	28	54
Breathlessness	25	50
Abdominal pain	18	36
Backache	18	36
Anxiety	23	46
Irritability	11	22
Depression	3	6

The frequency of symptoms reported by members of the Study group (first wife).

- The rule was complaining of multiple symptoms and somatic symptoms (e.g.pains) were more common than psychological symptoms (e.g.anxiety) and mixed (e.g.tiredness).

General Health Questionnaire (GHQ) Symptoms: The symptoms reported by the subjects on the GHQ showed difference between the Study group (first wife) and the Control group . This difference is represented in the following table :

Table (7)

Symptom	GHQ SCORE %						
	Study Group		Control Group				P
	High	Lower	High	Lower	X2	DF	(Sig.)
Somatic	70	30	26	74	19.4847	1	0.00001
Anxiety	72	28	8	92	36.967	1	0.00000
Social dysfunction	56	44	38	62	5.47264	1	0.01932
Depression	58	42	38	62	3.34849	1	0.06727
Total	68	32	12	88	16.3185	1	0.00005

Score of sample cases on the GHQ (The lower score is 8 or less on the total; the high is more than 8). Scores on the scales of Somatization and anxiety showed significantly higher symptoms in the study group (first wife) than in control group.

■ Discussion

Reviewing results of this study,and analyzing its findings can highlight the problem of polygamy from the psychiatric point of view.Very few serious studies exist and the surveys which were conducted in Arab Culture are small and not very homogenous,in addition to being not comparable with our data in this study for methodological reasons.Before discussing the findings of this study there are some observations that deserve mentioning.First is that polygamy,although fundamentally accepted part of the basic marriage pattern , is meeting increasing disapproval and even opposition in some Arab Communities . In the law of some Arab countries (e.g.Tunisia) the woman has the right to forbid her husband from taking a second wife. The legislator attempted, probably under strong public opinion pressure, to create obstacles to polygynous unions in some other Arab communities without departing from the basic framework of Islamic Sharia Law. In some Arab Communities, special permission from the judge is requested in order to marry polygynously which seems as if the legislator accepted it half-heartedly in cased of female sterility or chronic illness.

Turning now to data in the results of this research, the socio demographic data of the sample showed discrepancy between the study group (first wife in polygynous marriages) and the control group members who are wives in monogamous marriages. The mean age of the study group tended to be higher than that of the controls. The difference was statistically significant. This finding confirms that of Behar (1989) in Istanbul. This has been explained by the fact that women going into polygynous marriage as wife number two do so at the same time or slightly later than monoganous ones . Men marry their second wives after several years of the first. So, it is expected that age difference exists between the first wife in polygynous marriage who married early and the monogamous women.

Regarding to other demographic variables i.e.education, occupation and number of children, it has been noted that significant differences exist between the study group (first wife) and the controls. The women who are first wives in polygynous marriages were of relatively lower educational levels, most of them housewives and generally had more children than the controls.

These data conform with some studies made in Arab culture which indicate that education and socio-cultural status are inversely related to multiple marriages (Huzayyin 1981). Chamie (1986) , however , pointed out that the relationship is not as simple .

The length of marriage in the study group (first wife) ranged from 2 to 36 years (mean : 13.5) , and the time passed in monogamous before the man married the second wife ranged from 2 to 36 (mean : 8.7) in this study . It has been found that by the end of the 6th year of marrigage more than 50% of the second marriages take place as shown in the results of study of this sample.

These findings confirm those of Behar (1991) in Istanbul. It has been mentioned that polygynous men marry their second wives on the average 8.5 years after the first, by which time these men are around 40, and the age difference with the second wife is much higher than that with the first.

Evident marital discord and conflicts prior to the man remarriage were not reported by the great majority of the first wives in the sample. The areas of trouble in marriage included poor communication between partners , inappropriate ways of solving disputes , different attitudes towards child bearing and child rearing , bad relations with the in-laws and the handling of finances . Although there is impression that sexual dissatisfaction is involved in many cases leading to marital maladjustment, women of our sample never disclose that because of cultural constraints.

The reasons for second marriage as viewed by the first wives in this sample were noted to be mainly attributed to the man's wish to have a new wife , however some ladies reported that they are themselves blamed for remarriage or their husbands , and others claimed that they don't know the reasons .

Reviewing the literature, marital problem is one of 13 conditions listed in DSM III-R and described as states that are the focus of attention or treatment but are not attributable to mental disorder. When a person presents with marital problems, the marital and sexual history are essential for purpose of diagnosis. To discuss and understand the reasons of polygamy in Arab Culture we argue that it sometimes seems as a last resort to solve marital problems which is used by husbands as an alternative to divorce. Polygamy is socially and religiously accepted while divorce is not much desired in Arab Culture. This can be understood in the light of gender roles in most of Arab societies where man has the position of unchallenged authority and women are unassertive.

There are several reasons mentioned in studies of polygamy in different cultures. Ecology , economy , kinship and warfare were mentioned together with further factors as causes for polygamy in cross cultural studies (White and Burton 1988) ,(Naden and Naden 1991). The relationship between polygamy and divorce has been studied as there are similarities between both conditions in some aspects (Gage and Anastasia 1992). The findings of this study may not be enough to tell all the causes of polygamy in Arab Culture as the investigation is directed mainly to the sample of first wives and their views about the reasons of remarriage of their husbands. There could be multiple social, cultural, economic and religious factors working together behind the phenomenon of polygamy in Arab Culture. (Weisfeld 1990)

Reaction of first wife: As far as noted in results of this study, certain pattern of reaction by the first wives had been reported and observed frequently when their husbands marry to new wives . This pattern is described as follows :

- Initial severe reaction of the first wife when informed about new divorce. In polygamy, the situation of remarriage of the husband represents a major crisis and distress tot he first wife. The reaction of the first wife may reflect mourning over the death of previous monogamous marital relationship or continued anger and hostility towards the husband. This reaction may also represent anticipation of difficulties in adapting to a new life style after polygamy being a single head-of-household, losing 'full time 'daily contact with the partner, or living on a substantially reduced income . Studies indicate that the process of recovery from divorce takes about 2 years, while acceptance and adaptation to the situation of polygamy in this study occur within 6 months. Another point of comparison of divorce with polygamy is that the rate of divorce in Arab Societies is much higher, about 10 times as much as the rate of polygamy.

The difficulties reported by first wives in the sample included psychological (e.g.lack of satisfaction , feelings of jealousy and frustration) , physical (multiple somatic complaints) and social together with economic problems .These difficulties and problems are considered to be the outcome of exposure to stress as a result of polygamy . Negative attitudes toward the

husband are noted in this study of first wives, however some of the sample cases show neutral or ambivalent attitudes.

The explanation of psychological effects of polygamy on the first wife in similar in some aspects to that of psychic divorce where love object is given up and grief reaction about the death of the relationship occurs. Physical symptoms are explained as an expression of emotional pressure for manipulation by the first wives to gain emotional and social support. The economic problems arise as a result of division of the property and income between both of the two wives (or more 3 or 4) and their children. The great majority of first wives report lesser interest of the husband in them after remarriage, and unfair distribution of his time and income between the first and new wives. This represents an additional suffering of the first wife which seems to be inevitable. The change in the social network of the first wife after remarriage of the husband, and being practicably in some instances the single parent of children are additional sources of stress in cases of polygamy. (Al-Issa 1990)

Psychiatric symptoms in first Wives: The spontaneously reported symptoms by first wives in the sample of this study include Somatic (e.g. pains and breathlessness), psychological (e.g. Anxiety and irritability) and mixed symptoms (e.g.tiredness) .

The scores on the General Health Questionnaire (GHQ) in the sample are showing significantly higher symptoms (mainly somatization and anxiety) in the first wives than in controls.

In Arab Culture, women tend to express their emotions in terms of physical illness. This explains the preponderance of Somatic Symptoms whether spontaneously reported or as shown in scores of GHQ of the sample. These findings conform with previous studies about Somatization in Arabic women (Racy 1980, El-Islam 1978). Somatization or advertising physical symptoms together with emotional upset may be explained also by the wish of first wives in their hard life experience to manipulate the situation to their best social advantages. (El-Islam 1990 , Mulder 1992)

Somatic and emotional symptoms can also be viewed as means for getting social support and sympathy or others. Furthermore, there is impression that illness behavior of first wives may enable them to challenge the authority of their husbands as the culture accorded them to get married polygynously but they are not supposed to make the wives sick (Krieger 1989).

An unexpected finding has emerged from this study so far. There is constant pattern suggesting response by depression to such stressful life situation as that experienced by first wives in polygamy marriage in Arab Culture. The findings of this study show that depression is rarely spontaneously reported by cases in the sample, and there is no significant difference in the extent to which first wives and controls acknowledge depression on GHQ. Also, social dysfunction is not significantly higher in the sample of first wives than controls. This may point to the fact that Arabic women react to stress of such life experiences by somatization and anxiety more than by other patterns. This conforms in some aspects with some previous studies in Arab Culture (Krieger 1989, El- Islam 1982, Racy 1980). Psychosexual problems are not listed, although there is impression of their existence, because women in Arab culture never report such symptoms and doctors are reluctant to explore this area owing to cultural constraints. (Bhugra and de Silra 1993).

- **Case Study**

First wife in Polygamy : (The case of Um Ahmed)

Um Ahmed (Um Ahmed is a pseudonym , means the mother of Ahmed , her oldest son .) is a 36 year-old , married lady , housewife, educated upto secondary school and have five children . She is the first wife of Abu Ahmed (the father of Ahmed) who works as a merchant and is also her first cousin. She was first seen when she presented in the psychiatric clinic complaining mainly of being 'upset'. Although she did not mention except some somatic symptoms such as headache, chest felt tight, generalized body aches and fatigue, she looked at this time miserable and frustrated. In the first visit she did not talk much about her complaint, but during tearful episodes she expressed her feelings of irritability and oppression (dega). This first visit was not the beginning of the story of Um Ahmed which was collected and followed up over 2 years. It seemed that she first presented during a stormy period in her marriage. She was just informed that her husband got married to a new younger wife after 15 years of marriage. She was seen repeatedly after this initial presentation, and that provided an opportunity for deliberate case study, collecting history information, observation, interviewing, management and follow up.

History taking from Um Ahmed in subsequent interviews revealed that she was married before her 19th birthday. Her marriage was unhappy from the beginning as she reported. The marriage was arranged by her mother, father-in-law and the relatives against her will; although she confessed to her mother her love to another one of their relatives. An informant companion who came with her in the first visit reported that the husband of Um Ahmed was bad and he was the reason of her illness. She reported that she was occasionally exposed to physical violence from her husband who was 8 years older than her.

At the time of marriage he was working as a clerk in a Ministry (Government is the main employer here) , then he moved to be self employed in business with much improvement in his income . She complained that her husband used to be most of the time outside the house , either in his work during the day time or with his friends in 'Diwania ' (the place for gathering of friends) till late at night . She also complained that he used to be 'nervous 'and she tolerated much of his yelling insults and beating her and the children. When I interviewed the husband he looked calm but complained that his wife is spending money in a way he considered extravagant. He expressed being bored with the demands and responsibilities of his wife but she insisted she bought only necessities and mentioned that he was away from the house and did not recognize the needs of the children. It had been noted that was disparity in intelligence and social skills between the spouses ; her husband was not as intelligent as her

Past history of previous medical treatment for occasional joint pain by general doctor was mentioned by Um Ahmed, and she was treated by some analgesics and antirheumatic tablets. Her attitude towards the present complaint was noted to be that she attributed it to emotional reasons causing physical illness. One doctor told her that her illness was originated from emotional stress, and she repeated this statement frequently.

Family history showed that her father who died before she got married was also married to a previous wife before his marriage to her mother i.e. she was the daughter of the second wife. Both wives (her mother and the previous wife) lived in the same house though in a separate place for each of them with her children. As far as she could recall there were some conflicts

between her mother , who got married after the death of her father , and the old wife . She had half siblings from both parents.

Um Ahmed was almost satisfied by her role as a wife and a mother of five children, three of them males and two were females. She was the centre of many social relationships and widely accepted by here relatives and neighbors. She demonstrated admirable skills in fulfilling all aspects of her social role as housewife, mother, relative and friend despite the occasional martial discord which she used not to disclose it. This situation which continued for about 15 years of marriage was suddenly changed when she was informed that her husband got married to a young educated unmarried lady who was one of his work colleagues. She was shocked in the beginning as she never expected that her husband could do that, and when she faced him he did not deny. She decided to leave the house during the initial time of anger, but some of her friends asked her to stay with her children. A reaction in the form of nervous breakdown took place and she was transferred for treatment in the emergency department in the nearest general hospital. This episode tended to recur several times in the following days and finally the general doctors advised that she must be seen by psychiatrist. She resisted at first and argued that she is not 'crazy 'but agreed on request of some of her friends to visit the psychiatric clinic.

Mental state assessment showed signs of high distress in Um Ahmed when seen for the first time as she looked tense, irritable and easily going to tearful episodes. Multiple symptoms were reported, most were physical e.g. headache, chest oppression with chest felt tight (Dega and Katma), joint pains and generalized body aches. Sleep pattern was disturbed with insomnia, and interrupted sleep with nightmares reported. She used to concentrate on being ill and upset together with expression of anger and protest. Mood showed fluctuations with anxiety and depressive coloring, and ideas of preoccupation with her health, children and future were frequently expressed.

In subsequent interviews during the follow up over two years, the condition of Um Ahmed showed change in the main features. She complained only of multiple Somatic Symptoms and talked much about investigations and medical treatment. She looked as if accepting the new situation after only a few months of remarriage of her husband to the new wife. Instead of anger which was expressed in quarrels with the husband and the new wife, she started to ask only for her share in his income to care for her children. After one year she looked more adapted to the situation .However, she continued to mention bodily complaints and attribute it to emotional upset and the difficulties in relationship with her husband because he was discriminating between her and the new wife as she reported. During the course of follow up of Um Ahmed over two years, she was physically examined several times and too many investigations performed, most of it to satisfy her as no significant medical problem existed.

■ Comment :

The case of Um Ahmed can be taken as a representative case of the influence of polygamy as a stressful event on the first wife initiating a psychological reaction. This case is far from being marginal to the local Arab Culture in the Gulf State of Kuwait. From 1982 to 1995 I have been in the Gulf region for intervals of time which allowed me to contact with local Arab Cultures there, to note the changes, and to interview a lot of cases over these periods. Coming from another Arab Culture in Egypt which has the same language and background , this helped me understand and deal with people in different Arab Societies . Although changes in people's life and culture have taken place, such as luxury in oil Gulf countries, many facets of life endured. Among these were habits and beliefs about marriage and polygamy.

This case can illustrate some psychosocial aspects of marriage, gender role and polygamy in Arab Culture. In this case the subject married against her will when she was 19 , which reflects that early arranged marriage is the rule , and cousin marriage is an ordinarily preference pattern in this culture . Polygamy, though recognized by Islamic religion and socially accepted, is usually considered a difficult life experience which causes psychological reaction in the first wife. The reaction of first wife to polygamy is initially severe with acute psychological features which disappear by time passage to be replaced by acceptance within only a few months as in this case. (Mulder 1992)

In this case, the subject expressed the emotional pressure mostly by physical symptoms to gain emotional and social support. Advertising her physical symptoms are an illness behavior which enabled her to regain some of here self esteem after being affected by remarriage of the husband to a new wife. Somatization helped her also manipulate the situation of polygamy by challenging the authority accorded by the culture to the husband. This case represents the uses of being upset by Arabic women, in the situation of being involved in polygamy as a first wife, to manipulate this stress to their best social and psychological advantage.

■ Limitations of the Study :

The present investigation suffers from some limitations, which pertain to the instrumentation or to the subject pool. The instruments and diagnostic tools are mostly developed in the complex Western Societies and their feasibility and applicability when used in the simple third world societies (as in Arab Culture) is open to question . Another problem may arise due to lack of standardized methods to estimate cultural influences and to explain the information available when we try to correlate between social, psychological and cultural observations.

Subjects selected in this study limited the research because the samples were not representative of the entire Arab Culture. Many differences exist between local Arab communities as subjects in Egypt are expected to show specific features differ from those in the Gulf and from Arabs in the North Africa.

In spite of these limitations, such cultural studies are justified by the need to highlight the importance of broader understanding of the local belief systems and cultural differences of Arab Culture from the Western Model. The data analysis and results of the investigation suggest further research in different Arab Societies using suitable culturally sensitive instruments and appropriate samples.

■ Conclusion

The Case of First Wife
Description of an Arab Culture-specific Condition

Reviewing results of this study together with analysis and discussion of the findings, we can present here an account of a specific Arabic culture-bound condition or a 'first wife syndrome ' . This suggested psychiatric entity description is justified by the almost constant pattern of reaction of the first wife in polygamous marriages to the situation of remarriage of the husband to a new wife. The 'Scenario 'of consequence of events in cases of polygamy, and reactions of the first wives usually take the same

pattern in every occasion in Arab culture. Although generalization in such phenomenon is not absolute, the variations in reactions of first wives as observed in this study are only in some details.

Here is a summarized brief account on the main items of the suggested 'first wife syndrome ' ; the description of a cultural-specific psychiatric entity related to Arab culture which has not been previously specified :

- This condition occurs in Arabic women involved in polygynous marriages as the first wives following remarriage of the husband to a new wife. These women tend to have certain demographic characteristics e.g. relatively older age, lower education, more children and mostly housewife.
- The initial reaction of the first wife which immediately follows her being informed of remarriage of the husband is severe in the form of nervous breakdown, emotional upset or outbursts of anger. The duration and severity of this initial reaction differ from one case to another in the way people differ in their reaction to stress.
- The actions taken by the first wife in response to this situation, in addition to manifesting signs of emotional and physical upset, include leaving the husband's house asking for immediate divorce and calling for emergency treatment. Negative attitude toward the husband and hostility toward the new wife always exist.
- After a lapse of time (average 6 months) , gradual adaptation usually takes place due to acceptance of the new situation . Residual effects continue to manifest in the form of physical, psychological and / or social consequences.

Psychopathology in first wives in Arab culture is characterized by preponderance of somatization which can be explained as an expression of emotional stress of the situation of polygamy in terms of bodily complaints. Multiple physical symptoms manifest together with psychological symptoms, mainly anxiety, and mixed symptoms e.g. tiredness. These symptoms are either spontaneously reported or admitted in response to inquiry, and usually tend be long-term. The psychiatric symptoms in first wives are likely to be maintained and perpetuated by the problems and difficulties faced by them in form of psychological, economic and social pressure.

The previous items, which are based on the findings of this study, constitute the basic description of a native category of psychiatric disorders in Arab culture which has no Western equivalent. This condition which we suggested to label as 'first wife syndrome 'can be considered an Arab Culture-specific psychiatric condition.

Other psychological aspects of polygamy in terms of concept of adding a wife, husband-wife and wife-wife relations, and adjustment to and by a new wife, living arrangements in plural families are amenable area recommended for further psychological study.

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حالـــة الزوجـــة الأولـــى فـــي الـــزواج المتعـــدد

دراسـة نفسـية لحالـة خاصـة فـي الثقافـة العربيـة

د. لطفـــى الشربينـــى – الطـب النفســـي – الاسكندريـة، مصـــر

lotfyaa@yahoo.com

ملخص الدراسة : تم إجراء هذه الدراسة النفسية بهدف إلقاء الضوء علي منطقة خاصة في الثقافة العربية لم تكن موضع اهتمام بالنسبة للدراسات النفسية في السابق هي ، ونعني بها الجوانب النفسية في تعدد الزوجات ، فقد اهتمت هذه الدراسة بالتركيز علي الحالة النفسية للزوجة الأولي ، وفي المقدمة تم عرض للأدبيات القليلة المتوفرة حول تعدد الزوجات في العالم العربي ، ثم استعراض للخلفية الاجتماعية والنفسية الدينية لمسألة تعدد الزوجات ، وبعض الإحصائيات عن انتشار هذه الممارسة في الثقافة العربية ، والعودة إلى المراجع التي تتحدث عن الأسباب والدوافع المحتملة ، ورد الفعل النفسي لدى الزوجة الأولي .

وفي الدراسة العملية تم إجراء البحث علي عينة تضم 100 من السيدات في مجموعتين تتكون الأولي من 50 سيدة هن مجموعة الدراسة حيث أن كل منهن هي الزوجة الأولي في زواج متعدد ، ومجموعة ضابطة من 50 سيدة متزوجة ، وقد استخدمت أدوات للدراسة والقياس تم تطبيقها علي الحالات التي تم جمعها ، وبعد ذلك تم تحليل النتائج إحصائيا .

وقد أظهرت النتائج بعض الفروق في الخصائص الديموجرافية لمجموعة الدراسة مقارنة بالمجموعة الضابطة حيث كانت الزوجة الأولي في الغالب أكبر سنا وأقل تعليماً ولديها عدد أكبر من الأبناء ، وفيما يتعلق بنمط رد الفعل للزوجة الأولي عقب الزواج الثاني للزوج فقد تم رصد المراحل التي تحدث بداية من الرفض والاحتجاج إلى الاستسلام للوضع الجديد في مدة زمنية محددة، كما تم تحديد الأعراض النفسية عن طريق المقابلة الإكلينيكية واستبيان الصحة العامة حيث تبين الشكاوى الجسدية والقلق تحدث بصورة تفوق الاكتئاب وسوء التوافق.

وقد تم وصف هذا النمط من رد الفعل المشترك للزوجة الأولي والأعراض التي تحدث وتشترك فيها السيدات عقب الزواج الثاني بما يمثل حالة مرضية نفسية خاصة قمنا بوصفها في هذه الدراسة و أطلقنا عليها " حالة (متلازمة) الزوجة الأولي " يمكن طرحها كحالة مرضية مستقلة مرتبطة بالثقافة العربية ، وفي نهاية الدراسة تم وضع الاستنتاج والتوصيات باستمرار البحث في الجوانب النفسية المختلفة لموضوع الدراسة

SUMMARY *:Polygamy and the condition of first wife were investigated by study of a sample of 100 women; half of them were first wives in polygynous marriages and the other half were a control group . Assuming that the first wife reacts to remarriage of the husband in certain pattern which is amenable to investigation and description, the subjects were collected by 'snowball' technique and studied using brief interview, demographic sheet and the General Health Questionnaire (GHQ).*

The findings of this study revealed the first wives in polygynous marriage tend to have certain demographic characteristics e.g. relatively older age than controls, lower education, higher number of children and mostly being housewives. The initial reactions of the first wives to remarriage of the husband took the form of severe symptoms and sharp actions. Acceptance and adaptation to the new situation gradually takes place after 6 months in the average. Physical, psychological and social consequences continue to manifest for long time in polygynously married first wives. Certain symptoms were either spontaneously reported or observed through GHQ application, the most frequent of them were the somatic complaints e.g. pain, psychological symptoms e.g. anxiety and irritability and mixed e.g. tiredness.

The findings of this study suggested the proposal of an Arab Culture specific condition in women described as 'first wife syndrome'. This new native category of psychiatric disorders which has no Western equivalent is justified by the almost constant pattern of reaction of Arabic women to polygamy based on findings of this study. Further research in this area and other relevant cultural studies had been recommended.

يهتم الطب النفسي عبر الثقافي Transcultural بالظواهر النفسية وعلاقتها بالخلفية الثقافية في ثقافات العالم المختلفة، وفي الثقافة العربية Arab culture كما في غيرها خصوصيات تتميز بها يجعل الحالات النفسية تختلف مظاهرها في المجتمعات العربية عنها في بلاد الشرق والغرب الأخرى، وكذلك يمتد التباين والاختلاف بين الحالات النفسية من مجتمع عربي محلي إلى آخر، وهناك الاضطرابات النفسية التي ترتبط بالثقافة Cultrue-bound disorders، وحالات أخرى توصف بأنها متخصصة لثقافة معينة Culture-specific، والحالة المرضية النفسية التي نقوم بوصفها هنا هي نموذج لمثل هذه الحالات التي يمكن ملاحظتها والتعرف عليها في الثقافة العربية دون أن نجد مقابلا يماثلها تماماً في النموذج الغربي Western model الذي نجده في المراجع والأدبيات الخاصة بالطب النفسي، ولذلك فقد تم وصف هذه الحالة المرضية النفسية الجديدة بناء على دراسة نفسية منهجية في الثقافة العربية، وتم اقتراح إضافة الحالة المرضية الجديدة التي أطلق عليها " متلازمة الزوجة الأولى" First wife syndrome بعد وصفها في سياق هذه الدراسة.

مقدمـــــة

يعتبر الزواج المتعدد Polygamy إحدى الظواهر الهامة التي تتميز بها الثقافة العربية فيما يتعلق بالأنماط النفسية الاجتماعية Psychosocial patterns في المجتمعات العربية، وهناك عدد قليل من الدراسات حول الجوانب النفسية للزواج المتعدد بينما يوجد الكثير من الكتابات الأدبية وغير العلمية في التراث العربي والشرقي، وبالنسبة للعرب فقد يتوفر قدر كبير من المعلومات من مصادر غير أصلية لكن هذه المعلومات يجب تناولها بحرص قبل التسليم بمحتواها، ومن هنا تأتي أهمية الدراسة النفسية المنهجية لظاهرة الزواج المتعدد.

والزواج المتعدد Polygamy الذي يعني زواج الرجل بأكثر من امرأة في نفس الوقت يتفق مع تعاليم الشريعة الإسلامية في ظل ضوابط محددة، ومن المفترض أن لهذا الزواج آثار نفسية بالإضافة إلى جوانبه الاجتماعية خصوصاً فيما يتعلق بالمرأة التي تخوض في أي فترة من حياتها هذه التجربة حين تكون زوجة أولى أو ثانية في زواج متعدد، وهناك من الأدبيات ما يشير إلى الجوانب النفسية والاجتماعية للزواج المتعدد في أفريقيا (Dorjahin1988)، وفي بعض الطوائف المسيحية مثل المورمون Mormon (Logue 1985)، وفي بعض مجتمعات أمريكا اللاتينية وأمريكا الشمالية المحلية (Smith, Kunz 1976)، وفي البلدان الإسلامية غير العربية مثل تركيا (Behar 1991) وفي الثقافة العربية الإسلامية في مختلف مناطق الوطن العربي (Huzayyin 1981, El Kholi 1971, Chamie 1989).

الـــزواج المتعـــــدد في الثقافـة العربيـــة والإسلامية
Polygamy in Arab and Islamic Culture

يعتبر الزواج المتعدد من الممارسات المعروفة في المجتمعات العربية والإسلامية في ظل ضوابط اجتماعية وقانونية ودينية، ورغم ذلك فإن الكثير من المراقبين في الغرب يركزون على جوانب خيالية يحيطها الغموض في هذا الموضوع مثل الروايات حول"الحريم" وما يحيط بذلك من الإثارة، وبالنسبة للكتاب العرب فقد تم طرح الكثير من الآراء والكتابات التي تستند إلى الانطباعات دون اتباع للمنهج العلمي في دراسة هذه الظاهرة في كثير من الأحوال.

وتسمح قواعد الشريعة الإسلامية بالزواج المتعدد حتى أربع من الزوجات للرجل الواحد في نفس الوقت، غير أنه بناء على فهم القواعد التي تنظم ذلك في نصوص القرآن والسنة فإن هذه الممارسة تخضع لشروط قدرة الرجل على إقامة العدل بين زوجاته، ويشمل العدل توزيع الوقت والاهتمام والموارد بصورة متساوية بين الزوجات دون انحياز، وفي الثقافة الإسلامية يمكن أن ينظر إلى الزواج المتعدد على أنه اختيار يتم اللجوء إليه كحل للمشكلات الزوجية بما يساعد الفرد والأسرة على أسلوب للتوافق والخروج من مأزق الصراعات الزوجية رغم ما يبدو من بعض الآثار الجانبية لهذه الممارسة فإن الالتزام بضوابطها وشروطها يحول دون حدوث أي آثار غير مرغوبة للزواج المتعدد لكل أطرافه، وعلاوة على ذلك فإن الزواج المتعدد - من المنظور الإسلامي - يمكن أن يكون وسيلة لتحقيق توازن صحي في الحياة الزوجية يؤدى إلى آثار إيجابية من النواحي الاجتماعية والصحية والروحية والنفسية (El Azayem, Hedayat 1994).

ورغم الرأي السائد حول انتشار الزواج المتعدد في الثقافة العربية فإنه يقع بنسبة ضئيلة غير أن هذه النسبة لا تقل أو تختفي مع مرور الوقت، وإذا كان الزواج المتعدد للرجل من أربع مسموح به بمقتضى تعاليم الشريعة الإسلامية فإن النمط السائد للزواج المتعدد في المجتمعات العربية هو الزواج الثنائي Bigamy (Chami 1986)، وهناك ما يدل على أن ممارسة تعدد الزوجات في الثقافة العربية يعود إلى عصور ماضية كما ورد في الكتابات التي تصف هذه الظاهرة، ورغم أنها مقبولة كواحد من أنماط الزواج إلا أنها تظل تلقى الكثير من الرفض والمعارضة في كثير من المجتمعات العربية (Al sherbiny 1995).

وتشير الأرقام الرسمية عن الزواج المتعدد في البلاد العربية إلى أن نسبة حدوثه تظل أقل من النسبة التي تذكرها المراجع في مجتمعات المورمون Mormons وبعض المجتمعات الإفريقية (Smith, Kunz 1976) وفي مصر تبلغ نسبة الرجال المتزوجون من أكثر من امرأة واحدة 4%، وفي سوريا 4.3% من خلال إحصائيات في عقد الثمانينات، وهناك انطباع بأن النسبة قد تزيد على ذلك في منطقة الخليج (Chamie 1986)، وحين نذكر أن 4% من الرجال متزوج كل منهم أكثر من واحدة فهذا يعني أن 8% على الأقل من السيدات المتزوجات في نفس الوقت هن الزوجة الأولى أو الثانية في زواج متعدد، وحسب الإحصائيات الرسمية فإن النمط السائد من الزواج المتعدد هو الزواج الثنائي Bigamy بينما الزواج من ثلاث أو أربع تظل نسبته أقل بكثير، أما الزواج غير الرسمي informal marriage والذي لا يتم تسجيله رسمياً فلا تتوفر أرقام دقيقة عن مدى انتشاره، لكن يظل هذا النوع من الزواج موجوداً في الدول العربية كما انه يوجد في ثقافات أخرى مختلفة (Rivett , Street 1993)، وهناك بعض العوائق تم وضعها لتحول دون انتشار الزواج المتعدد في بعض التشريعات المحلية مثل ضرورة موافقة الزوجة على ذلك أو ضرورة الحصول علي تراخيص من السلطات حين تكون الزوجة مريضة أو لا تنجب، وهذه القيود موجودة في بعض المجتمعات العربيـ ـة في شمـ ـال إفريقيـ ـا (Al Issa1990).

الجوانـــب النفسيـــة لتعـــدد الزوجـــات
Psychological Aspects of Polygamy

من الجوانب النفسية الرئيسية عند دراسة الزواج المتعدد الاهتمام بالأسباب المحتملة التي تدفع إلى الزواج المتعدد، والعوامل النفسية التي تهيئ لذلك، والمشكلات وردود الفعل والنتائج التي تحيط بالزواج المتعدد وآثاره علي الصحة النفسية، أما الأسباب التي يعود إليها استمرار حدوث الزواج المتعدد في المجتمعات العربية فإنها تعود إلى دور المرأة الذي تحدده الثقافة العربية والذي ينحصر بصفة رئيسية في الزواج وانجاب الأطفال (El Islam 1982, El Kholi 1982)، وإذا نظرنا في البداية إلى المرأة في الزواج المتعدد، نجد أن السيدات اللاتي لم يسبق لهن الزواج وتجاوزن السن المتعارف عليه للزواج بالنسبة للفتيات، واللاتي ينحدرن من اصل ريفي أو من مجتمـع بدوي هن الأكثر عدداً في حالات الزواج

المتعدد (Behar 1991, Bates1973)، وبالنسبة للرجال فإن فئات متعددة تقدم على الزواج المتعدد تضم أشخاصا ينتمون إلى مختلف الطبقات الاجتماعية (Chamie 1986)، وحين تكون الزوجة الأولي لديها ما يمنع الإنجاب أو تعاني من اعتلال صحي أو عجز فإن الزواج المتعدد يكون له ما يبرره، ومن الأسباب الأخرى للزواج المتعدد بعض الأوضاع الأسرية التي يبدو فيها مقبولاً مثل وفاة الزوج وتركه لأرملة وأبناء فيكون ذلك مبرراً لزواج أحد أشقائه بأرملته في هذه الحالة (Behar 1991).

ومن وجهة النظر النفسية فإن هناك ميل لدى الرجال إلى تعدد الزوجات، وفي نفس الوقت فإن المرأة تفضل الارتباط بالرجل الذي تتوفر لديه بعض المميزات مثل اللياقة البدنية أو النفوذ أو الثروة (Gaulin, Boster 1990 , Schlegel 1987)، ويشير مسح إحصائي في السبعينيات تم في بعض المدن العربية (القاهرة ودمشق) إلى أن مستوى التعليم وارتفاع المستوى الثقافي والاجتماعي تتناسب عكسياً مع حدوث الزواج المتعدد (Huzayyin 1981)، غير أن دراسة أخرى تؤكد أن الارتباط بين هذه العوامل المختلفة والزواج المتعدد ليست خاضعة لهذه العلاقة البسيطة بل هي أكثر تشابكاً (Chamie 1986).

وبالنسبة للنتائج التي تترتب على الزواج المتعدد والمشكلات التي تعقب إقدام الزوج على الزواج الثاني خصوصاً ما يتعلق برد فعل الزوجة الأولي فإنه من المتوقع أن يوجد بعض الآثار النفسية التي تحدث نتيجة للتغيير المفاجئ في العلاقة الزواجية السابقة بين الزوج والزوجة بعد إضافة الزوجة الجديدة، والحزن المسبق على ما ينتظر هذه العلاقة بالإضافة إلى مشاعر الغضب والعداء التي تتملك الزوجة الأولى نحو الزوج والزوجة الجديدة، وتسهم هذه الانفعالات السلبية للزوجة الأولى في إصابتها بالاضطراب النفسي خصوصاً إذا أضيف إلى ذلك بعض الصعوبات المالية والاجتماعية والمسائل القانونية من خلال مقاومة الزوجة الأولى للوضع الجديد عقب الزواج الثاني (Al Issa 1990).

وتوجد دراسات حول رد الفعل النفسي لدى الزوجة الأولى للزواج التالي للزوج من أخرى في بعض المجتمعات الإفريقية (Mulder 1992)، وفي الثقافة العربيـة في الخليـج (Darwish 1989)، وفـي الجزائـر (Al Issa 1990)، وفي دراسة للتأثير النفسي للزواج المتعدد على الزوجة الأولى في الثقافة العربية تم إجراء بحث لرصد الأعراض وردود الفعل التي تعقب الزواج التالي للزوج والتعرف عليها ووصفها كحالة مرضية متميزة ترتبط بالثقافة العربية (Al Sherbiny 1996)، وسوف نقوم بتقديم عرض لهذه الدراسة.

فـــروض البحـــــث / Hypothesis

يتناول هذا البحث منطقة خاصة في الثقافة العربية بما يلقي الضوء على العلاقة المفترضة بين الخلفية الثقافية والاجتماعية العربية وبين الطب النفسي الظواهر المتعلقة بالطب النفسي ، وفروض هذا البحث هي:

- الزواج المتعدد Polygamy ظاهرة توجد بصورة رئيسية في الثقافة العربية وبعض المجتمعات المحلية الأخرى لكنها غير معروفة في الثقافات الغربية، ومن الممكن إخضاع هذا الموضوع إلى بحث نفسي منهجي Systemtic psychiatric study.

- يمكن عن طريق الدراسة النفسية لمسألة تعدد الزوجات عند التركيز على الحالة النفسية للزوجة الأولي أن نجد حالة نفسية متميزة قابلة للبحث و الوصف للنمط الذي يتم به رد فعل الزوجة الأولى للزواج المتعدد بما يؤدى إلى التوصل إلى التعرف على حالة مرضية خاصة بالثقافة العربية لم يتم وصفها من قبل.

- يمكن أن تؤدى نتائج الدراسة النفسية للزوجة الأولى بعد تحليلها إلى تأكيد لتأثير الثقافة العربية على الظواهر النفسية، والعلاقة بين الثقافة و الطب النفسي في الثقافة العربية.

أسلـــوب الدراســـة / Methodology

▪ العينـــــة / The sample

تضم عينة الدراسة 100 من السيدات العربيات في أحد المجتمعات العربية(الكويت)، وتضم العينة ما يلي:

- 50 سيدة متزوجة هن الزوجة الأولى في زواج متعدد ويشكلن مجموعة الدراسة Study group.

- 50 سيدة متزوجة زواج واحد monogamy ويشكلن المجموعة الضابطة Control group.

وقد تم جمع حالات الزوجة الأولى في زواج متعدد باستخـدام أسلوب " كرة الجليد " Snowball technique عن طريق أشخاص يعرفون مثل هذه الحالات التي يتم استدعاؤها للدراسة.

▪ الأدوات / The instruments

1. استبيان الصحة العامة General Helth Questionnaire GHQ (استخدمت الترجمة العربية لهذا المقياس الذي يتكون من 28 بندا تغطي الشكاوى الجسدية Somatic 2.5، والقلق Anxiety، والصعوبات الاجتماعية Social dysfunction، والأعراض الاكتئابية depressive symptomatology والذي يتم وضعه بواسطة جولدبرج Goldberg 1979 وقد سبق تطبيق هذا المقياس في دراسات في البيئة العربية (El Islam 1986).

2. استمارة البيانات الديموغرافية Demographic data sheet وتضم البيانات الديموجرافية للحالة، وأسئلة حول بعض المعلومات حول الزواج، والاتجاهات نحو الزوج ورد الفعل لزواجه من أخرى، والصعوبات التي نشأت عن وضع الزواج المتعدد.

الخطـــــوات / The procedure

بعد جمع الحالات من مجموعة الدراسة بالعينة والمجموعة الضابطة تم إجراء الخطوات التالية:

1. يتم شرح طبيعة وغرض الدراسة بأسلوب مبسط للحالات.
2. يتم التأكيد على سرية المعلومات قبل الإدلاء بها لبث الاطمئنان لدى الحالات.
3. موافقة المفحوصين أساسية مع استخدام أرقام رمزية Code No بدلاً من الأسماء.
4. إجراء مقابلة نفسية مقننة Standardized interview مع كل حالة.
5. استكمال استمارة البيانات الديمواغرافية.
6. استكمال استبيان الصحة العامة (GHQ-28) بواسطة الحالة.

التحليـــل الإحصائـــي / Statistical analysis

تحت مقارنة مجموعة الدراسة مع المجموعة الضابطة باستخدام الوسائـل الإحصائيـة المناسبة مثل طريقـة كا^2 Chi square والتحليل التفريقي discriminant analysis.

النتائـــــج / Results

تم تسجيل نتائج البحث علي مجموعة الدراسة Study group المكونة من 50 سيدة هن الزوجة الأولى في زواج متعدد، والمجموعة الضابطة Control group وجاءت النتائج كالتالي:

- العمر Age: كان متوسط عمر مجموعة الدراسة (36.6 ys) أكبر من المجموعة الضابطة (26.3 ys).
- الحـالة الزواجيـة Marital status: كل أفراد العينـة مـن المتزوجات غير أن 2 منهن كن من المطلقات حيث حدث الطلاق بعد زواج أزواجهن للمرة الثانية.
- التعليم Education: الغالبية العظمي (80%)من مجموعـة الدراسة كان مستوى التعليم اقل من الجامعي.
- مستوى التعليم كان أعلى في المجموعة الضابطة (أكثر من 50% جامعيات).
- المهنة Occupation:كانت الغالبية من مجموعة الدراسة(54%) من ربات البيوت housewives، وذلك مقابل 22% فقط من المجموعة الضابطة، والبقية من السيدات العاملات employed.
- عدد الأبنـاء Number of children كان أكثـر من مجموعة الدراسة (متوسط 3.6 لكل سيدة) مقارنة بالمجموعة الضابطة (2.6 لكل سيدة في المتوسط).

ومن خلال مراجعة نتائج البيانات الديموجرافية يتبين أن مجموعة الدراسة من فئة الزوجة الأولى هن أكبر سناً وأكثر في عدد الأبناء ومعظمهن من ربات البيوت ومن مستوى تعليمي أقل مقارنة بالمجموعة الضابطة.

بيانـــات أخرى عن مجموعـــة الدراســـة (الزوجـــة الأولـــى)

- طول مدة الزواج قبل حدوث الزواج الثانـي يتراوح بين 2 - 36 سنة (بمتوسط 13.5 ys).
- حدث الزواج الثاني قبل مرور 7 سنوات من الزواج الأول في نسبة 50% من الحالات.
- الأسباب التي أدت إلى الزواج الثاني من وجهة نظر الزوجة الأولى كانت كالتالي:
  - في ما يقرب من ثلث الحالات (34%) أجابت الزوجة الأولى أنها لا تعرف السبب وراء الزواج الثاني لزوجها.
  - فسرت البعض من فئة الزوجة الأولى الزواج الثاني للزوج بأنه نزوة مؤقتة للزوج.
  - والبعض الآخر ذكرن أن الزوج فعل ذلك تحت ضغط من أسرته خصوصاً الحماة mother-in-low.
  - وعدد قليل من فئة الزوجة الأولى اعترفن بأن الأسلوب الذي تعاملن به من الزوج كان وراء إقدامه على الزواج من أخرى، ومن هذه الحالات اثنتين لم ينجبا أطفالا، واثنتين تأخرن في الحمل لعدة سنوات، وأخرى كانت تنجب البنات فقط فأراد الزوج أن يتزوج بأخرى لينجب الولد.
- كانت اتجاهات مجموعـة الزوجة الأولى سلبيـة negative attitudes نحو الأزواج ونحو الزوجة الجديدة بصفة عامة، إلا أن عدداً قليلاً منهم وصف الزوج بأنه طيب ومتدين رغم الزواج الثاني.
- رد فعل الزوجة الأولى للزواج الثاني في مجموعة الدراسة من أفراد العينة يمكن تلخيصه كالتالي:
  - بداية يكون رد فعل الزوجة الأولى حاداً عقب علمها بزواج الزوج من أخرى ويتميز بالصدمة التي تؤدى إلى انهيار عصبي nervous breakdown، ونوبة غضب outburst of anger، وسلوك هستيري hysterical behaviour.
  - الفعل المبدئي الذي تقوم به الزوجة الأولى هو مغادرة منزل الزوج إلى منزل أسرتها أو الإصرار على طلب الطلاق، أو إظهار أعراض مرضية تتطلب نقلها للإسعاف الطبي الطارئ.
  - تتباين ردود الفعل المبدئية initial reaction من حيث حدتها وطول فترتها، غيران قبول الموقف بصفة عامة يتم في خلال 6 شهور في غالبية الحالات مع بقاء بعض الأعراض البدنية والنفسية لمدة أطول من ذلك.
- الصعوبات التي تواجه الزوجة الأولى بعد الزواج الثاني للزوج يمكن تلخيصها من خلال استجابات أفراد عينة الدراسة في هذه النقاط:
  - صعوبات نفسية: منها على سبيل المثال التوتر tension، واضطرابات النوم disorders sleep، وانخفاض تقدير الذات low self-esteem، والإحباط frustration.
  - مشكلات جسدية: منها على سبيل المثال أعراض وشكاوى متعددة ومستمرة maltiple persistant somatic complaints كالشعور بالإجهاد fatigne، والصداع ألم البطن وآلام الظهر، ولا تستجيب هذه الأعراض للعلاج إلى جانب زيادة الانشغال بالصحة overconcern with health.
  - صعوبات اجتماعية واقتصادية تنشأ عن عدم اهتمام الزوج بالزوجة الأولى وغياب العدالة في توزيع الدخل بينها وبين الزوجة الجديدة، بالإضافة إلى عبء عناية الزوجة بأبنائها وصراعها المستمر مع الزوجة الجديدة.

الأعراض المرضيـــة فـي الزوجـــة الأولـــى

- هناك مجموعة من الأعراض منها ما يتم الإبلاغ عنها تلقائياً symtoms spontaneously-reported، وهي حسب تتابع حدوثها شعور الإجهـاد Fatigne، الصداع headache، وصعوبـة التنفـس breath lessness، وألم الظهر backache، وسرعة الاستثارة irritability ويلاحظ أن قائمة الأعراض تضم شكاوى جسدية ونفسية، كما يلاحظ أن الشكاوى تتعدد في الحالة الواحدة.
- استبيان الصحة العامة (GHQ) اظهر وجود فروق دالة احصائيا Statistically signficant بين مجموعة الدراسة والمجموعة الضابطة من حيث زيادة الأعراض الجسدية Somatization، والقلق anxiety في مجموعة الدراسة (الزوجة الأولى)، وذلك بنسبة أكبر من الفروق بين المجموعتين في الاضطراب الوظيفي الاجتماعي Social dysfunction والاكتئاب depressionعند المقارنة مع المجموعة الضابطة.

تحليـــــل النتـائـــــج

إن تحليل نتائج هذه الدراسة يلقي الضوء على الجانب النفسي لحالة الزوجة الأولى في الزواج المتعدد، وحين ننظر إلى نتائج هذه الدراسة نجد أنها لا تختلف عن الدراسات القليلة السابقة التي تناولت بعضاً من جوانب هذا الموضوع خصوصـاً فيما يتعلق بالخصائص الديموجرافيـة للزوجة

الأولى خصوصاً الدراسات التي أجريت في الثقافات المحلية العربية والإسلامية(Behar 1991, Chamie 1986, Huzayyin 1981, Darwish 1989)، وبالنسبة لأسباب الزواج الثاني كما وردت في نتائج هذه الدراسة من وجهة نظر الزوجة الأولى فإنها تتفق مع دراسات أجريت في ثقافات أخرى حيث كانت أسباب تعدد الزوجات تنحصر في عوامل تتعلق بالبيئة ecology، أو الاقتصاد economy، أو المصاهرة Kinship، أو الصراع Warfare، وذلك من خلال دراسات عبر ثقافية Cross cultural (White , Burton 1988, Gage, Anastasia 1992, Weisfeld 1990, Naden, Naden 1991).

أما رد فعل الزوجة الأولى للزواج المتعدد فإن بعض الدراسات تعقد المقارنة بين الآثار النفسية للزواج المتعدد على الزوجة الأولى وبين تأثير الطلاق العاطفي Psychic divorecc، نتيجة للاضطراب الشديد في العلاقة الزوجية عقب الزواج الثاني غير أن الوضع في كثير من المجتمعات العربية يختلف عن ذلك حيث يتم التوافق سريعاً مع وضع الزواج الثاني من جانب الزوجة الأولى في فترة تتراوح بين 6 شهور إلى عامين، وبالنسبة للأعراض المرضية التي تضم قائمة من الشكاوى الجسدية والنفسية والتي تبديها السيدات من فئة الزوجة الأولى فإن التعبير عن الانفعالات بمثل هذه الأعراض وسيادة الشكاوى الجسدية كتعبير عن المشكلات النفسية قد تم رصده في دراسات سابقة في الثقافة العربية (Mulder 1992, Racy 1980, El Islam 1978) وهذا يفسر سلسلة المظاهر المرضية التي تحدث عقب تعرض الزوجة الأولى لخبرة الزواج التالي للزوج على النحو الذي يبدو في نتائج هذه الدراسة والذي تؤيده الدراسات الأخرى التي تصف التعبير الانفعالي للمرأة في المجتمع العربي عند تعرضها للمواقف المشابهة التي تتضمن ضغوطاً انفعالية (Krieger 1989, Bhugra, de Silva 1993).

الاستنتـــــاج

وبمراجعة نتائج هذه الدراسة والخلفية النظرية لموضوعها فإن بالإمكان أن نضع إطارا شاملاً لحالة مرضية نفسية جديدة ترتبط بالثقافة العربية، ولا يوجد مقابل لها يماثلها تماماً في النموذج الغربي يمكن أن نطلق عليها " متلازمة الزوجة الأولى " Fiear wife syndrome، وهذه الحالة المرضية المقترح إضافتها إلى قائمة الاضطرابات النفسية تم وضعها بناء على دراسة رد الفعل المشترك للمرأة العربية عقب الزواج التالي للزوج، والمراحل التي يمر بها، والسمات المشتركة التي تنطبق في مجملها على الحالات في هذا النمط من التفاعل النفسي باستثناء اختلاف طفيف في بعض التفاصيل.

وفي النهاية نقدم هنا عرضاً موجزاً لهذه الحالة المرضية الجديدة المقترحة حيث توصف هذه الحالة بأنها حالة خاصة بالثقافة Culture-specific ترتبط بالثقافة العربية تحدث للزوجة الأولة في الزواج المتعدد، وتبدأ برد الفعل المبدئي Initial reaction عند زواج الزوج من امرأة أخرى حيث يكون جاداً في البداية ويتجه إلى القبول بالوضع الجديد في مدة زمنية محدودة، وهناك خصائص ديموجرافية تميز الزوجة الأولى أمكن تحديدها في هذه الدراسة، والأعراض المرضية Symptomatology التي ترتبط بهذه الحالة تضم قائمة من الشكاوى النفسية والجسدية تم ترتيبها حسب تتابع حدوثها بما يشكل الصورة الكاملة للحالة المرضية التي تم وصفها وإطلاق تسمية " متلازمة الزوجة الأولى " First wife syndrome، واقتراح إضافتها كإحدى الحالات الخاصة بالثقافة العربية والتي لا يوجد مقابل لها في أدبيات الطب النفسي في الغرب.

وفي ختام هذه الدراسة فإن الأمل أن تكون هذه بداية تخدم إلقاء الضوء على نواحي مختلفة في الحياة والظواهر في الثقافة العربية مثل مسألة الزواج المتعدد موضوع هذه الدراسة، والباب مفتوح لمزيد من البحث والتحليل في موضوعات متعددة في الثقافة العربية، وبناء على ما تقدم نضع بعض التوصيات:

- الحاجة إلى مزيد من الدراسة للعلاقة بين الثقافة العربية والطب النفسي بما يؤدى إلى فهم اعمق للمشكلات والظواهر النفسية والاجتماعية في العالم العربي.

- التنبيه إلى أهمية الدراسة المنهجية للظواهر النفسية مع المقارنة لأوجه الشبه والاختلاف مع الثقافات الأخرى بما يعطي الفرصة لاكتساب خبرات مشتركة.

- المتخصصون في المجالات النفسية في الثقافة العربية عليهم مسؤولية دراسة الظواهر المحلية ويجب تشجيعهم على ذلك.

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البقـــاء للـــه وحـــده

الأستاذ الدكتور محمـد غربـــال فـي ذمـة اللـه

"يا أيتها النفس المطمئنة ارجعي إلى ربك راضية مرضية فادخلي في عبادي وادخلي جنتي"

فجعت الأسرة الطبنفسية التونسية يوم 6 ديسمبر 2005 بوفاة المغفور له :الأستاذ الدكتور محمد غربال (أستـاذ الطـب النفسي بجامعـة تونس).

بهذه المناسبة الأليمة،تتقدم أسرة شبكة العلوم النفسية العربية بأحر التعازي والمواساة إلى زوجته وأبنائه وكافة أفراد عائلته، سائلا الله العلي القدير أن يتغمده برحمته الواسعة وأن يسكنه فراديس جناته.

إن المصاب جلل، وبغيابه فقد التحليل النفسي في تونس علما من أعلامه، و فقد الطب النفسي أستاذا عمل جاهدا لتمكين هذا الاختصاص في وطنه، تخرج على يديه نخبة من أبرز الأطباء النفسانيين الشبان.

إنا للـه وإنـا إليـه راجعـون

شبكة العلوم النفسية العربية

قـــواعد النشـــر بمجلـــة شبكـــة العلـــوم النفسيـــة العربيـــة

تعمل "مجلة شبكة العلوم النفسية العربية" على الإحاطة بمستجدات الاختصاص في كافة فروع العلوم النفسية، محاولين بذلك الاستجابة لحاجات المختصين والمهتمين خصوصا بعد تداخل تطبيقات الاختصاص مع مختلف فروع العلوم الإنسانية. وذلك من خلال اطلاع المتصفح على اتجاهات البحوث العالمية وتعريفه بأخبار ومستجدات هذه البحوث عبر بعض الترجمات للأبحاث الأصيلة. أمّا بالنسبة للبحوث العربية فإن المجلّة تسعى لتقديم الدراسات والبحوث الرصينة المسايرة للمستجدات وللحاجات الفعلية لمجتمعنا العربي.

تقبل للنشر الأبحاث بإحدى اللغات الثلاث العربية، الفرنسية أو الإنكليزية.

1- الأبحاث الميدانية والتجريبية
2- الأبحاث والدراسات العلمية النظرية
3- عرض أو مراجعة الكتب الجديدة
4- التقارير العلمية عن المؤتمرات المعنية بدراسات الطفولة
5- المقالات العامة المتخصصة

المجلة مفتوحة أمام كل الباحثين العرب من أطباء نفسانيين و أساتذة علم النفس داخل الوطن العربي و خارجه، وهي ترحب بكل المساهمات الملتزمة بشروط النشر التي حددتها الهيئة العلمية للموقع على الشكل التالي:

■ قواعد عامة

- الالتزام بالقواعد العلمية في كتابة البحث.
- الجودة في الفكرة والأسلوب والمنهج، والتوثيق العلمي، والخلو من الأخطاء اللغوية والنحوية
- إرسال البحث بالبريد الإلكتروني APNjournal@arabpsynet.com أو بواسطة قرص مرن (لا تقبل الأبحاث الورقية).
- إرسال السيرة العلمية المختصرة بالنسبة للكتاب الذين لم يسبق لهم النشر في مجلة الشبكة.

■ قواعد خاصة

1- كتابة عنوان البحث واسم الباحث ولقبه العلمي والجهة التي يعمل لديها مع الملخصات و الكلمات المفتاحية باللغات الثلاث العربية، الفرنسية أو الإنكليزية.
2- يراعي في إعداد **قائمة المراجع** ما يلي: تسجيل أسماء المؤلفين والمترجمين متبوعة بسنة النشر بين قوسين ثم بعنوان المصدر ثم مكان النشر ثم اسم الناشر.
3- استيفاء البحث لمتطلبات البحوث الميدانية والتجريبية بما يتضمنه من مقدمة والإطار النظري والدراسات السابقة ومشكلة البحث وأهدافه وفروضه وتعريف مصطلحاته.
4- يراعى الباحث توضيح أسلوب اختيار العينة، وأدوات الدراسة وخصائصها السيكومترية وخطوات إجراء الدراسة
5- يقوم الباحث بعرض النتائج بوضوح مستعينا بالجداول الإحصائية أو الرسومات البيانية متى كانت هناك حاجة لذلك
6- تخضع الأعمال الطبنفسية المعروضة للنشر لتحكيم اللجنة الاستشارية الطبنفسية للمجلة، كما تخضع الأعمال العلمنفسية لتحكيم اللجنة الاستشارية العلمنفسية و ذلك وفقا للنظام المعتمد في المجلة ويبلغ الباحث في حال اقتراحات تعديل من قبل المحكّمين.
7- توجّه جميع المراسلات الخاصة بالنشر إلى رئيس الموقع على العنوان الإلكتروني للمجلة.
8- الآراء الواردة في المجلة تعبّر عن رأي كاتبها ووجهات نظرهم.
9- لا تعاد الأبحاث المرفوضة لأصحابها.
10- لا تدفع مكافآت مالية عن البحوث التي تنشر.

قواعـد التوثيق:

عند الإشارة إلى المراجع في نص البحث يذكر الاسم الأخير (فقط) للمؤلف أو الباحث وسنة النشر بين قوسين مثل (عكاشة، 1985) أو (Sartorius, 1981) وإذا كان عدد الباحثين من اثنين إلى خمسة تذكر أسماء الباحثين جميعهم للمرة الأولى مثل (دسوقي، النابلسي، شاهين، المصري، 1995)، وإذا تكررت الاستعانة بنفس المرجع يذكر الاسم الأخير للباحث الأول وآخرون مثل (دسوقي و آخرون، 1999) أو (Sartorius etal., 1981) وإذا كان عدد الباحثين ستة فأكثر يذكر الاسم الأخير للباحث الأول و آخرون مثل (الدمرداش، و آخرون، 1999) أو (Skinner, etal., 1965)، وعند الاقتباس يوضع النص المقتبس بين قوسين صغيرين " " وتذكر أرقام الصفحات المقتبس منها مثل: (أبو حطب، 1990 : 43)

وجود قائمة المراجع في نهاية البحث يذكر فيها **جميع المراجع** التي أشير إليها في متن البحث وترتب ترتيبا أبجديا . دون ترقيم مسلسل. حسب الاسم الأخير للمؤلف أو الباحث وتأتي المراجع العربية أولا ثم المراجع الأجنبية بعدها وتذكر بيانات كل مرجع على النحو الآتي:

-عندما يكون المرجع كتاباً:

اسم المؤلف (سنة النشر) عنوان الكتاب (الطبعة أو المجلد) اسم البلد: اسم الناشر، مثال: مراد، صلاح أحمد، (2001) الأساليب الإحصائية في العلوم النفسية والتربوية والاجتماعية، القاهرة: الأنجلو المصرية

-عندما يكون المرجع بحثا في مجلة:

اسم الباحث (سنة النشر) عنوان البحث، اسم المجلة، المجلد الصفحات، مثل: القطامي، نايفة (2002) . تعليم التفكير للطفل الخليجي، مجلة الطفولة العربية، 12، 87 - 114

ج- عندما يكون المرجع بحثا في كتاب:

اسم الباحث (سنة النشر) عنوان البحث، اسم معد الكتاب، عنوان الكتاب، اسم البلد: الناشر، الصفحات التي يشغلها البحث

1- الإشارة إلى الهوامش بأرقام متسلسلة في متن البحث ووضعها مرقمة على حسب التسلسل في أسفل النص التي وردت بها مع مراعاة اختصار الهوامش إلى أقصى قدر ممكن، وتذكر المعلومات الخاصة بمصدر الهوامش في نهاية البحث قبل الجزء الخاص بالمصادر والمراجع

2- وضع الملاحق في نهاية البحث بعد قائمة المراجع

- **الدراسات والمقالات العلمية النظرية:**

تقبل الدراسات والمقالات النظرية للنشر إذا لمست من المراجعة الأولية أن الدراسة أو المقالة تعالج قضية من قضايا الطب النفسي أو علم النفس بمنهج فكري واضح يتضمن المقدمة وأهداف الدراسة ومناقشة القضية ورؤية الكاتب فيها، هذا بالإضافة إلى التزامه بالأصول العلمية في الكتابة وتوثيق المراجع وكتابة الهوامش التي وردت في قواعد التوثيق

- **عرض الكتب الجديدة ومراجعتها:**

تنشر المجلة مراجعات الباحثين للكتب الجديدة ونقدها إذا توافرت الشروط الآتية:

1- الكتاب حديث النشر، ويعالج قضية تخص أحد مجالات الطب النفسي، علم النفس، العلاج النفسي أو التحليل النفسي

2- استعراض المراجع لمحتويات الكتاب وأهم الأفكار التي يطرحها وإيجابياته وسلبياته

3- محتوى العرض على اسم المؤلف وعنوان الكتاب والبلد التي نشر فيها واسم الناشر، وسنة النشر، وعدد صفحات الكتاب.

كتابة تقرير المراجعة بأسلوب جيد

- **التقارير العلمية عن الندوات والمؤتمرات:**

تنشر المجلة التقارير العلمية عن المؤتمرات والندوات والحلقات الدراسية في مجال علم النفس و الطب النفسي التي تعقد في البلاد العربية أو غير العربية بشرط أن يغطى التقرير بشكل كامل ومنظم أخبار المؤتمر أو الندوة أو الحلقة الدراسية وتصنيف الأبحاث المقدمة ونتائجها وأهم القرارات والتوصيات

كما تنشر المجلة محاضر الحوار في الندوات التي تشارك فيها لمناقشة قضايا تتعلق بالاختصاص.