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From the Editor

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This the second issue this year of the journal. The issue has a number of papers from across the World. It is an excellent start for the journal and we look forward to further success.

A cross sectional study from Kuwait and Egypt looked at prevalence of the metabolic syndrome by five definitions, and its associations among consecutive admissions to an acute admission psychiatric care facility in an Arab setting. Data from admissions at the Psychological Medicine Hospital, Kuwait, over a period of 6 months were analyzed. A total of 153 participants (N = 153; 63.4% men, aged 38.7yrs) fulfilled the study’s inclusion criteria. Using JIS criteria, 56.2%, 21.6%, 61.4%, 15.7%, 18.3% and 30.7%, respectively, had abnormal values for WC, triglycerides, HDL –C, systolic BP, diastolic BP, and fasting blood glucose; 39.9% were obese (BMI > or = 30Kg/m2). The authors concluded that the correlation of MetS with age and duration of illness, and prevalence of additional subjects with two abnormal indices (25.5%), call for cardio-metabolic monitoring. The result of using the Arab WC and the pattern of correlation of WC, supports use of region-specific WC values.

A paper from Jordan looked at Using Cognitive Behavioral Therapy to Manage Insomnia among Patients with Cancer. The authors stressed that insomnia is one of the prominent problems that affects patients with cancer, although, it has received little attention from clinicians or researchers. The author attempts to establish the effectiveness of cognitive behavioral therapy (CBT) as the best practice to manage insomnia among patients with cancer. The author showed that an extensive literature review conducted using major nursing, medical and psychological database between 2005 and 2011, found that in ten studies CBT is proved to be effective in managing insomnia without side effect and better sleep duration among patients with cancer, also, could be used in home, or internet based.

A paper from Saudi Arabia looked at the Psychological relationship between Medical students and their teachers. The study was conducted at College of Medicine, King Saud University, Riyadh, Saudi Arabia. A total of 101 medical students were chosen randomly at different educational levels, and were asked to answer open ended questions about what are the three most important things they like and also the three most important things they dislike in their medical teachers. The analysis showed that the majority of medical students in this study highly appreciate respect to them even more than teaching skills. Medical students like new ways of teaching methods and to be involved in discussions with their teacher and the group.

A paper from India looked at familial suicides. The author outlines that Familial suicide is where the perpetrator kills all family members before committing suicide. Such incidents abound in the media in India but are rarely mentioned in the medical literature. Though this phenomenon has attracted public attention it has rarely been discussed in academic circles. The main motive of the suicide pact is the relief of the environmental stressors. The current paper focuses on a series of suicide pacts involving several members of the same family living together, reported in the media recently and looks into the probable causes so as to help devise strategies for intervention.

A paper from Nigeria attempted to determine the prevalence of the practice of drink-driving among commercial intercity drivers. A total of ninety respondents were enrolled in this study. The driving experience of the respondents revealed that most respondents: 53(58.9%) had more than 20 years driving experience. Few respondents: 29(32.2%) admitted to intake of alcohol at least on one occasion prior to driving in the year preceding this study. There was a significant association between involvement in road traffic accidents and alcohol intake. The authors concluded that few respondents admitted to history of alcohol intake before driving. There is need for aggressive educational efforts to enlighten the population on the risks involved in drink-driving. Availability of alcohol should be reduced. The drivers involved in drink-driving should be penalized so as to serve as a deterrent.

A paper from Libya looked at the silent feminine torture ‘Female genital mutilation’. The author stressed that FGM/C is a dubious practice imposed on young girls’ genitals that cannot be condoned for the sake of personal non-therapeutic reasons. It has been estimated that around 100-130 million women are affected all over the world mainly in Africa. The main reason for such practice is to preserve virginity, chastity and prohibit promiscuity, and it is a traditional rooted behaviour in ancestral traditions. It is a symbolic convention to signify fidelity, exemplify cleanliness, feminity, beauty, and attracting men for marriage in some regions. Major drawbacks can be detrimental and irreversible, besides the psychological consequences. In some countries it is carried out by doctors and nurses and called medicalisation of FGM/C. Human-rights condemn such conduct and it is illegal to have FGM/C in the UK and a fine and persecution will be incurred for the perpetrators. The author concluded that in order to end this practice, educating women is an utmost to fight this practice, and defeat such cultural constraints, as it gives women independence at various levels, like decision-making, self-choice of spouse, working for personal fulfilment, freedom of movement, and moreover education denotes what is called ‘autonomy’.

A descriptive and analytical research from Iran investigated students’ attitude regarding crack abuse side effects. The research population was (n = 906). The results showed the students’ needs attitude assessment towards crack abuse side effects. The results of the present research regarding students’ needs assessment towards short-term and long-term crack abuse side effects revealed that students’ long-term attitude towards crack abuse side effects trends towards negative, their needs assessment is primarily based on the short-term; trends towards unfavorable.
Prevalence of the metabolic syndrome by five definitions, and its associations among consecutive admissions to an acute admission psychiatric care facility in an Arab setting

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Abstract

Background and objectives: Despite reports of high prevalence of metabolic syndrome (MetS) in the Arabian Gulf, there are no reports on acutely ill persons with severe mental disorders from Arabia. We:
(i) highlight the proportion of consecutively admitted subjects with abnormal values for the indices of MetS, based on the Joint Interim Statement (JIS) definition, and the waist circumference (WC) recommendation for Arabs;
(ii) estimate the prevalence of MetS using definitions of the JIS, IDF, NCEP-ATPIII, and AHA ATP-IIIA; and
(iii) assess the association of MetS with socio-demographic and clinical variables.

Settings and design: Data from admissions at the Psychological Medicine Hospital, Kuwait, in a period of 6 months were analyzed in a cross-sectional design.

Patients and methods: Participants (N = 153: 63.4% men, aged 38.7 years) fulfilled the study’s inclusion criteria. The majority had schizophrenia (59.5%) and bipolar disorder (22.2%). Blood was taken for fasting levels of biochemical indices.

Results: Using JIS criteria, 56.2%, 21.6%, 61.4%, 15.7%, 18.3% and 30.7%, respectively, had abnormal values for WC, triglycerides, HDL-C, systolic BP, diastolic BP, and fasting blood glucose; 39.9% were obese (BMI ≥ 30Kg/m2).

A significantly higher proportion of women had abnormal values for WC and HDL-C. The prevalence of MetS was 28.1%, 26.1%, 24.8%, and 18.3%, respectively, by the JIS, IDF, AHA -ATP-IIIA, and NCEP-III definitions; there were no gender differences. Using the Arab WC within the IDF definition resulted in 22.9% prevalence rate. Prevalence was higher with age and duration of illness (P < 0.01). WC was not significantly correlated with HDL-C and triglycerides.

Conclusions: The correlation of MetS with age and duration of illness, and prevalence of additional subjects with two abnormal indices (25.5%), call for cardio-metabolic monitoring. The result of using the Arab WC and the pattern of correlation of WC, supports use of region-specific WC values.

Key words: Metabolic syndrome, psychiatric patients, Arab
Introduction

The Metabolic Syndrome (MetS), a cluster of metabolic risk factors (central obesity, dyslipidemia, raised blood pressure, and fasting blood glucose) for type 2 diabetes mellitus and cardiovascular disease (CVD), is a commonly observed phenomenon in psychiatric practice(1). Once CVD or diabetes develops, the number of components of the syndrome contributes to disease progression and risk(2,3). The prevalence of MetS among general population samples in Arabian Gulf states is 10-15% higher than in most developed countries, with higher prevalence rates for women(4). For men, the prevalence in national population samples in the Arabian Gulf states ranged from 20.7% to 37.2% (by the Third Adult Treatment Panel of the National Cholesterol Education Program: NCEP - ATPIII definition) and from 29.6% to 36.2% (by the International Diabetes Federation - IDF definition); and, for women, from 32.1% to 42.7% (NCEP - ATPIII definition) and from 36.1% to 45.9% (IDF definition). A community-based study from Kuwait(5) indicated that the prevalence of obesity (i.e., BMI > or = 30 Kg/m2), 47.5%, was significantly higher among women, while there was no gender difference in the prevalence of MetS (36.2%) by IDF definition. A follow-up study from the Kingdom of Saudi Arabia(6) found that, using NCEP ATP-III definition, the prevalence of MetS was high (35.3% among 2850 adults). In addition, low HDL cholesterol (HDL - C) was the most prevalent (88.6%) of the indices.

A major problem confronting researchers in this field is the lack of consensus on the cut-off point for the values of the risk factors that define MetS(2). Three popular systems of definition, the NCEP-ATP III, the IDF, and the adapted adult treatment panel of the American Heart Association (AHA ATP-III), differ mainly by the value assigned to the waist circumference. The waist circumference (WC) requirement is mandatory for the IDF (94cm for men and 80cm for women among Europids/ Middle Easterners/ sub-Sahara Africans), but it is not mandatory for the NCEP-ATP III and AHA - ATP IIIA (102cm for men and 88cm for women). The controversy is owing to the fact that the association between WC and MetS, may vary between ethnic groups(7).

Workers in the field have produced a Joint Interim Statement (JIS) to harmonize the definition. It was agreed that there should not be an obligatory component, but that waist measurement would continue to be a useful preliminary screening tool. A single set of cut points would be used for all components except WC. In the interim, national or regional cut points for WC can be used(2). Accordingly, one report from Lebanon has suggested that for Arabs, the cut-off value for WC should be 91cm for women and 99.5cm for men(8). Accordingly, in a comparison of the JIS definition with the other three definitions, using a Greek general population sample, the prevalence of MetS was 45.7%, 43.4%, 24.5% and 26.3%, respectively, for the JIS, IDF, NCEP-III and AHA- ATP IIIA(9).

Reports from the Arab world comparing prevalence estimates by the various definitions of MetS have been based on general population samples(10,11) and clinical populations, such as hypertension(3,12), obesity(13), coronary artery disease(14), pre-diabetes(15), and primary health care attendees(16). There are no such studies for acutely ill subjects with severe mental disorders. One report from Iran indicated that, among consecutively admitted subjects with schizophrenia, the prevalence of MetS by various definitions ranged from 27.4% (ATP-III), through 37.6% (ATP-II), to 38.7% (IDF)(17). A report on inpatients with schizophrenia in Turkey, involving 231 adults, with duration of illness 15.8 years, found that 32% fulfilled IDF criteria for the MetS and the prevalence was significantly higher in women (61.5%) than men (22.4%)(18). But another report from Turkey involving 108 outpatients with schizophrenia and using ATP-III, ATP III-A and IDF criteria found prevalence rates of 21%, 34% and 41%, respectively(19). In a report from Japan of 1186 subjects with schizophrenia aged 54.8 years, the overall prevalence of the MetS was 27.5%, and schizophrenia was an independent risk factor (20). However, in a review of 50 reports on subjects with schizophrenia, mostly from Europe and North America, De Hert et al(21) found that the prevalence of MetS increased from 5.7% among first episode cases, through 17.0% for those who had been ill for 2 years, to 28.5%, 42.5% and 49.4%, respectively, for those who had been ill for less than 10 years, 10 - 20 years, and over 20 years.

About 85% of the western reports had prevalence rates over 31%. For subjects with bipolar disorders, the prevalence rate was 30-40%.

Comparison of the prevalence estimates by different definitions is important because there is the practical consideration of what threshold justifies the expenditure of national medical resources for clinical intervention in contrast to public health intervention(2). Information about the burden of the syndrome using the popular definitions will better inform health planners about the possible magnitude of the problem and an estimate of the size of resources needed for intervention.

The objectives of the study were to: (i) highlight the proportion of consecutively admitted subjects over a period of six months at the acute admission units of the Psychological Medicine Hospital, Kuwait, with above cut-off values for the various indices of the MetS, based on the JIS definition and the WC recommendation from Lebanon(8); (ii) estimate the prevalence of the MetS using the definitions of the JIS, IDF, NTCP-ATP III, and AHA-ATP IIIA, as well as the definition that includes the recommendation of waist circumference for Arabs, within the IDF criteria, in comparison with the international data. In view of the fact that the JIS was based on a consensus among experts in the field, we used it as the gold standard for delineating concordance, false positive and false negative cases, in comparison with the other definitions; and (iii) assess the association of MetS by the JIS definition with socio-
demographic characteristics, duration of illness, psychiatric diagnosis (DSM-IVTR) (22), and scores on the Brief Psychiatric Rating Scale(23).

Method
Participants and study design: This was a cross-sectional study in which all subjects aged 18 years and above, consecutively admitted at the acute admission wards of the Psychological Medicine Hospital, Kuwait, over a period of six months, and who fulfilled the study’s inclusion criteria, were invited to participate. The exclusion criteria were dementia, mental retardation, being currently pregnant or a history of pregnancy in the past six months and, substance use disorder. The study was approved by the hospital’s research and ethical committee. All consenting patients and their families signed written informed consent to participate. Of 175 eligible patients admitted during the period, eleven refused to participate, and another eleven had incomplete data, leaving a total of 153 subjects for this report. There were 97 (63.4%) men and 56 (36.6%) women, aged 38.7 years (SD 11.8; range 31-50). The majority (86 or 56.2%) were aged 31-50 years, had been ill for 6 years to 20 years (79 or 51.6%; mean duration for all: 12.6, SD 9.0; range: 6 months - 40 years), were single (78 or 50.9%); and had no formal employment (131 or 85.6%). While the tendency for the men to be older (40, SD 13.0) than the women (36.4, SD 8.9) did not reach significance (P > 0.05), the men had significantly longer duration of illness (13.7, SD 9.3 vs. 10.7, SD 8.4) (t = 1.99, df = 151 P < 0.05). The majority had schizophrenia (91 or 59.5%) and bipolar disorder (34 or 22.2%); while the remainder had major depressive disorder (11 or 7.2%), schizo-affective disorder (9 or 5.9%) and brief psychotic disorder (8 or 5.2%).

Procedure:
Psychiatric diagnosis was based on the DSM-IVTR(22) as agreed to by the consultant psychiatrist in charge of the case at the ward round held either at discharge or when the patient had been on admission for over eight weeks. As a routine in this hospital, all newly admitted patients have their blood taken the next day for fasting levels of biochemical indices: including blood glucose, triglycerides, and high density lipoprotein cholesterol (HDL - C), which are analyzed at the hospital’s laboratory. Glucose was measured by the oxidative glucose colorimetric method, with dry chemistry readings with reflectometry. The triglycerides were measured by the enzymatic and colorimetric method. HDL- C was measured by homogenic or direct method.

In each ward, a senior nurse (male nurse for men and female nurse for women) was nominated to do the anthropometric measurements. Participants’ height was measured using a wall-mounted stadiometer, and weight was measured using calibrated electronic scales with the patient wearing light clothes. Waist circumference was measured at the midpoint between the upper border of the iliac crest and the lower rib, with a tape measure horizontally circling the body. Blood pressure was measured with the patient seated, after a minimum of 10 minutes’ rest.

Severity of psychopathology was assessed by the Arabic translation of the 24- item version of the Brief Psychiatric Rating Scale (23,24), which has been used in our setting in recent studies, and found to have adequate reliability and validity(25). All clinical psychiatric assessments were done by one of us (RR), an experienced native Arab psychiatrist, after a period of rating with another senior psychiatrist at the preliminary stage of the study.

Data analysis:
Data were analyzed by the SPSS version 15, using frequency counts, chi-square tests and t-tests. The level of significance was set at P < 0.05.

Results
Using the JIS criteria (Table 1, next page), the majority had abnormal values for waist circumference (86 or 56.2%) and HDL (94 or 61.4%). About a fifth had abnormal values for triglycerides (33 or 21.6%); almost a third (47 or 30.7%) had abnormal blood glucose levels, while less than a fifth had abnormal systolic and diastolic blood pressure readings (15.7% and 18.3%, respectively). In addition, about 40% had abnormally high body mass index (BMI) (i.e., > or = 30 Kg/m2) indicating obesity. A significantly higher proportion of women had abnormal values for waist circumference and HDL-C (P < 0.005). However, when the Lebanon cut-off score was used, the tendency for a higher proportion of women to have higher WC just failed to reach significance (P = 0.06).

Table 2 (page 7) shows that the prevalence of MetS was highest by the JIS definition (28.1%) and least by the NCEP-III definition (18.3%). It is noteworthy that using the Lebanon recommendation of WC within the IDF definition resulted in a prevalence rate (22.9%) that was closest to the NCEP-III. The tendency for women to have higher prevalence of the syndrome did not reach significance (P > 0.05). Furthermore, an additional quarter of subjects (39 or 25.5%) had abnormal values for two indices of the syndrome. In line with the prevalence values, agreement (or concordance) between the JIS definition (as gold standard) and the other definitions was highest with the IDF (93.0%) and least with the NCEP-III (65.1%).

While the presence of metabolic syndrome was highly significantly associated with increasing age (P < 0.001) (Table 3, page 8), there was no trend for significant association with level of education and occupational status. The prevalence of the syndrome consistently increased with duration of illness, from 14.3% for those within the first year of illness, to 33.7% for those who had been ill for over a decade; such that, there was a highly significant difference in duration of illness between those who had MetS and those who did not have it (P < 0.01). Although there was a trend for the syndrome to be more prevalent among those with schizophrenia/ schizo-affective and bipolar disorders than those with major depressive disorder and brief psychotic disorder.
In an assessment of the relationship between waist circumference and other indices of the MetS, using Pearson's correlation (7), we found that, WC was significantly correlated with fasting blood glucose ($r = 0.34$, $P < 0.001$); systolic blood pressure ($r = 0.35$, $P < 0.001$); and diastolic blood pressure ($r = 0.27$, $P < 0.001$); but not with triglycerides ($r = 0.12$, $P > 0.05$) and HDL - C ($r = -0.16$, $P = 0.06$).

**Discussion**

In this first report from the Arab world of patients admitted in an acute admission psychiatric care facility, we found that, using four definitions, the prevalence of the MetS was 28.1%, 26.1%, 24.8%, and 18.3%, respectively, by the JIS, IDF, AHA-III, and NCEP-III definitions. When the recommendation to use a different WC for the Arab world was included, the prevalence was 22.9%, resulting in an average of 24.0%.

Using the JIS criteria, 56.2%, 21.6%, 61.4%, 15.7%, 18.3% and 30.7%, respectively, had abnormal scores for WC, triglycerides, HDL-C, systolic BP, diastolic BP, and fasting blood glucose.
With regard to the individual indices of the syndrome, our findings are similar to the trend from Arab/Middle East reports, because the most prevalent abnormalities were for WC and HDL-C, in which women had significantly higher values than the men (6,11,19,26). In support of the recommendation to use WC values that are specific to regions, when the Lebanon cut-off score was used, the tendency for a higher proportion of women to have higher WC failed to reach significance. Furthermore, the correlation of WC with triglycerides and HDL-C was not significant in our sample (7).

Compared with one pooled analysis of general population samples in the Arabian Gulf states, our prevalence rates were lower by IDF definition, and at the lower end of the range for the ATP-III definition (4). Our rates are also lower in comparison with some general population reports from Kuwait (5) and Saudi Arabia (6), as well as studies from our region involving other chronically ill populations (3,12,13-16). However, we note the potential for increased prevalence rate among our subjects because an additional 25.5% were positive for two indices of the syndrome. Compared with psychiatric populations from Iran (17), Turkey (19), and Japan (20) the prevalence rates were rather closer to ours (24.8%) when the ATP-III definition was used. Compared with reports from Europe and North America, although our rates were consistently lower, the trends were similar for associations with age and duration of illness (21). Our finding that the prevalence of MetS among our sample of psychiatric patients was somewhat lower than that in most general population reports from the Arabian Gulf, could be explained by the following observations. First is the influence of age. In the only study from Kuwait (27) involving young adults (aged 20-44 yrs.) with no chronic illness, the prevalence of MetS by the NCEP-ATPIII definition was 18.0%, which is similar to our 18.3%. Second, we note that Kuwait has high levels of obesity (28). However, in an earlier report from Kuwait, comparing psychiatric patients seen in non-psychiatric clinics with patients without mental disorders, it was found that the psychiatric patients were significantly more likely to be single, unskilled, young, less educated and living alone or in an overcrowded household and to report more recent life events than controls (29). For patients with severe symptoms, such as in our study, this could imply a tendency for a level of physical neglect and relatively poor socioeconomic circumstances by many in the group, that would be associated with lower prevalence of MetS (30). Third, while reports of high prevalence of MetS among psychiatric patients have usually concerned chronically ill populations (21), our subjects were acutely ill and recently admitted. Hence, the prevalence of MetS among our subjects who had been ill for over ten years (33.7%) was quite high. Finally, we note that the psychiatric reports with high prevalence of MetS concerned subjects with schizophrenia and bipolar disorder (1,21), whereas the subjects involved in our study had a wider variety of mental disorders.

**Limitations of the study**

Our findings are not generalizable because of the cross-sectional nature of the study. However, we have assessed our patients using a broad set of definitions, thereby making our findings comparable with the international literature.

**Conclusions**

The correlation of MetS with age and duration of illness, and the high prevalence of additional subjects (25.5%) with two abnormal indices of the syndrome, imply the need for cardio-metabolic monitoring (1). The result of using the recommended cut-off value for Arabs supports the view that WC values should be region-specific (2).
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ORIGINAL CONTRIBUTION AND CLINICAL INVESTIGATION

Note: no significant difference in level of education and occupational status between subjects with MetS and those without the syndrome.

Table 3: Association of MetS by JIS definition with age, psychiatric diagnosis, duration of illness and psychopathology (BPRS) score

<table>
<thead>
<tr>
<th>Variable</th>
<th>MetS by JIS</th>
<th>No MetS by JIS</th>
<th>Statistics: tests of significant difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age: Mean (SD)</td>
<td>43.5(11.3)</td>
<td>36.8(11.5)</td>
<td>T = 3.3, df = 151; P &lt; 0.001</td>
</tr>
<tr>
<td>2. Psychiatric diagnosis:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia: N = 91 (%)</td>
<td>24(26.4)</td>
<td>67(73.6)</td>
<td></td>
</tr>
<tr>
<td>Brief psychosis: N = 8 (%)</td>
<td>1(12.5)</td>
<td>7(87)</td>
<td></td>
</tr>
<tr>
<td>Schizo-affective disorder: N = 9 (%)</td>
<td>3(33.3)</td>
<td>6(66.7)</td>
<td></td>
</tr>
<tr>
<td>Major depressive disorder: N = 11 (%)</td>
<td>2(18.2)</td>
<td>9(81.8)</td>
<td></td>
</tr>
<tr>
<td>Bipolar disorder: N = 34 (%)</td>
<td>13(38.2)</td>
<td>21(61.8)</td>
<td></td>
</tr>
<tr>
<td>3. BPRS score: Mean (SD)</td>
<td>54.5(9.5)</td>
<td>53.9(8.4)</td>
<td>X² = 3.5, df = 4; P &gt; 0.05</td>
</tr>
<tr>
<td>4. Duration of illness: Mean (SD) years</td>
<td>15.5(8.7)</td>
<td>11.4(8.9)</td>
<td>T = 2.6, df = 151; P &lt; 0.01</td>
</tr>
<tr>
<td>5. Categories of duration of illness:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5 – 1yr: N = 14 (%)</td>
<td>2(14.3)</td>
<td>12(85.7)</td>
<td></td>
</tr>
<tr>
<td>1.5 – 5yrs: N = 32 (%)</td>
<td>6(18.8)</td>
<td>26(81.3)</td>
<td></td>
</tr>
<tr>
<td>6 – 10yrs: N = 30 (%)</td>
<td>6(20.0)</td>
<td>24(80.0)</td>
<td></td>
</tr>
<tr>
<td>11 – 40yrs: N = 77 (%)</td>
<td>29(37.7)</td>
<td>48(62.3)</td>
<td></td>
</tr>
<tr>
<td>6. BMI: Mean (SD)</td>
<td>32.7(6.0)</td>
<td>27.9(6.9)</td>
<td>T = 3.9, df = 151; P &lt; 0.001</td>
</tr>
</tbody>
</table>

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Psychological relationship between Medical students and their teachers

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Abstract

The aim of this study was to explore the psychological relationship between medical students and their teachers in the aspect of what they like and dislike in their Medical teachers, at College of Medicine, King Saud University, Riyadh, Saudi Arabia.

Method: This study was conducted during October 2010 at College of Medicine, King Saud University, Riyadh, Saudi Arabia. 101 Medical Students were chosen randomly at different educational levels, and were asked to answer open ended questions about what are the three most important things they like and also the three most important things they dislike in their medical teachers, without mentioning any name either of teacher or student, in the data collection paper. Papers were collected by one of the students, emphasizing that all students should not write their names in the papers, so to be Anonymous, and to not criticize any specific medical teachers, by using their name. All their opinions in the 101 papers returned were read and analyzed one by one. Their opinions have been categorized by frequency tables as in SPSS version 15.5.

Results: The analysis of qualitative data in 101 papers returned from medical students showed that the majority of medical students in this study highly appreciate the respect given to them, even more than teaching skills. Medical students like new ways of teaching methods and to be involved in discussion with their teacher and the group. Also the majority of medical students dislike poor personal communication and rigidity and lack of respect for their time and their needs.

Conclusion and recommendation: The majority of medical students in this study highly appreciate respect shown to them, even more than teaching skills. Medical students like new ways of teaching methods and to be involved in discussions with their teacher and the group. Further studies are recommended to study in depth the psychological relationship between medical teachers and students in different medical schools to improve academic learning environments.

Introduction

A good teacher wants to be a good teacher. Teaching has to be its own reward. While recognition for outstanding teaching is commendable, faculty who are motivated only by formal honors will not achieve teaching excellence. Faculty need to work as hard at teaching as they do at research or clinical practice (1). Teaching is increasingly highlighted as an essential professional role for doctors (2). There is an imperative need to discern what students like/dislike and how they recognize their good teacher (3,4). An effective teacher is one who contributes to a student’s acquisition of knowledge and skill by using a number of techniques associated with the promotion of learning and who displays personal characteristics commonly associated with a positive learning environment (5). The concept of the effective medical teacher may be at variance with many teachers, who feel they function quite effectively. However, one has only to approach students openly to discover that students see many teachers differently from the way they see themselves; in some way the quality of their learning experience is thereby diminished. In the past, medical educators in general have given little thought to teaching methods and whatever thought has been given has focused almost totally on teaching content, to the virtual exclusion of teaching process. Surely this emphasis should be reversed, or at least balanced? (6) It is important in academic medical centers for medical students to be able to evaluate faculty teaching performance. Their evaluation provides a basis for faculty feedback, identification of areas for faculty development, prioritizing resource allocation, and assisting in self improvement processes (7-9).
The aim of this study was to explore the psychological relationship between medical students and their teachers in the aspect of what they like and dislike in their medical teachers, College of Medicine, King Saud University, Riyadh, Saudi Arabia.

Methods
This study was conducted during October 2010 at College of Medicine, King Saud University, Riyadh, Saudi Arabia. 101 Medical Students were chosen randomly at different educational levels, and were asked to answer an open ended questions about what are the three most important things they like and also the three most important things they dislike in their medical teachers, without mentioning any name either of teacher or student in the data collection papers. Papers were collected by one of the students emphasizing that all students should not write their names in the papers, so to remain anonymous, and to not criticize any specific medical teachers. All their opinions in the 101 papers returned were read and analyzed one by one; their opinions have been categorized by frequency tables as in SPSS version 15.5.

Results
The analysis of qualitative data in 101 papers returned from medical students showed that the majority of medical students in this study highly appreciate the respect given to them even more than teaching skills. Medical students like new ways of teaching methods and to be involved in discussion with their teacher and the group. Detail of the positive things they like in their medical teachers has been shown by order in Table 1 (page 12). Also the majority of medical students dislike poor personal communication and rigidity and lack of respect for their time and their needs which has been shown by order in Table 2 (page 13).

Discussion
The qualitative data returned from medical students showed that the majority of medical students in this study highly appreciate good personal communication skills, and respect given to them, even more than teaching skills. Also the majority of medical students in this study dislike poor personal communication and rigidity and lack of respect for their time and their needs. One may question how an academic can consistently resolve this tension and summon temperance, humility and charity in the workplace. One important answer may lie in an improved understanding of the moral necessity of social cooperation, fairness, reciprocity, and respect that is constitutive of the Student-teacher role. Although normative expectations and duties have been outlined in extant codes of ethics and conduct within academic medicine, few training programs currently teach faculty and students about the ethics of appropriate pedagogic and intimate relations between teaching staff and students, interns, residents, researchers, and other trainees (10). Other qualitative studies showed that students also felt that their teachers’ positive attitudes, commitment to them, ability to establish a good supervisory relationship, and good teaching skills were important to learning (11). Medical students in this study like good teaching skills and new ways of teaching methods and to be involved in discussion with their teacher and the group. Medical education currently carries a health warning because of the stress and anxiety caused to students and young graduates; any educational process that promotes enjoyment of learning without loss of basic knowledge and skills must be a good thing. It is therefore imperative for teachers to create an appropriate learning environment where these active learning methods can be effectively implemented (12-18).

In 1985, Harvard Medical School introduced the New Pathway program, a preclinical curriculum that sought to promote a sound knowledge of basic science, and positive attitudes toward active, self-directed learning, and competency in integrating psychosocial and humanistic concepts with biologic principles in patient care. Problem based learning, pioneered at McMaster University, was adopted as the primary pedagogic method to meet these goals, but the new curriculum also included lectures, labs, weekly structured learning experiences focused on humanistic aspects of medicine, and clinical experiences designed to foster humanism and the doctor-patient relationship. All educational activities were coordinated with the tutorial cases to enhance integration, while active, student-directed learning aimed to encourage self-reliance. The whole program took place in a highly social and interactive environment designed to promote humanistic skills and attitudes. The new curriculum was introduced to two consecutive classes as a randomized controlled trial. Program evaluation took place at the end of the students’ second and fourth years of medical education, as well as four years after graduation. At these times, the new pathway and control students demonstrated strong and consistent differences, with new pathway students more positive in the humanistic domain. No significant difference was observed in basic science knowledge or clinical problem solving (19).

Another study was done at Harvard University to evaluate the effect of a radically redesigned curriculum at Harvard Medical School on preclinical students’ knowledge, skills, personal characteristics, approaches to learning, and educational experiences. The results showed that New Pathway students reported that they learned in a more reflective manner and memorized less than their control counterparts in the traditional curriculum during the preclinical years. The New Pathway group preferred active learning and demonstrated greater psychosocial knowledge, better relational skills, and more humanistic attitudes. They felt more challenged, had closer relationships with faculty, and were somewhat more anxious than those in the traditional program. There was no difference in problem-solving skills or biomedical knowledge base (20). This study at college of medicine, King Saud University emphasizes the importance of building and maintaining good relationships and respect between medical teachers.
<table>
<thead>
<tr>
<th>Positive points which the medical students like in their medical teachers</th>
<th>Number of medical students who wrote these positive points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect of students</td>
<td>36</td>
</tr>
<tr>
<td>Come on time to the teaching session</td>
<td>26</td>
</tr>
<tr>
<td>Humility</td>
<td>22</td>
</tr>
<tr>
<td>Good teaching skills</td>
<td>17</td>
</tr>
<tr>
<td>Flexibility</td>
<td>16</td>
</tr>
<tr>
<td>Cooperative</td>
<td>15</td>
</tr>
<tr>
<td>Honest</td>
<td>14</td>
</tr>
<tr>
<td>Talk in simple and understood manner</td>
<td>14</td>
</tr>
<tr>
<td>Smile to the students</td>
<td>13</td>
</tr>
<tr>
<td>Good professionalism</td>
<td>13</td>
</tr>
<tr>
<td>Good medical knowledge</td>
<td>12</td>
</tr>
<tr>
<td>Involve students in discussion</td>
<td>11</td>
</tr>
<tr>
<td>Prepare suitable and easy exam questions from what has been taken in the lecture</td>
<td>7</td>
</tr>
<tr>
<td>Use new ways of teaching methods</td>
<td>5</td>
</tr>
<tr>
<td>Fair with the students</td>
<td>4</td>
</tr>
<tr>
<td>Make fun</td>
<td>4</td>
</tr>
<tr>
<td>Be strict to the core curriculum</td>
<td>4</td>
</tr>
<tr>
<td>Easily approachable outside the class</td>
<td>3</td>
</tr>
<tr>
<td>Audible voice in the class</td>
<td>3</td>
</tr>
<tr>
<td>Controls the student’s behavior in the class</td>
<td>3</td>
</tr>
<tr>
<td>Involves students in decision making</td>
<td>2</td>
</tr>
<tr>
<td>Decide specific and easy reference</td>
<td>2</td>
</tr>
<tr>
<td>Repeat the important information to the students</td>
<td>2</td>
</tr>
<tr>
<td>Involved in social activity with the students</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 1: shows the positive points the medical students like in their medical teachers (most common answer at the top)
Table 2: shows the negative points the medical students dislike in their medical teachers

<table>
<thead>
<tr>
<th>Negative points which the medical students dislike in their medical teachers</th>
<th>Number of medical students who wrote these negative points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of respect to students</td>
<td>43</td>
</tr>
<tr>
<td>Arrive late to teaching session</td>
<td>41</td>
</tr>
<tr>
<td>Rigidity and nervous</td>
<td>25</td>
</tr>
<tr>
<td>Cancel break time and use it for teaching</td>
<td>17</td>
</tr>
<tr>
<td>Not organized</td>
<td>17</td>
</tr>
<tr>
<td>No discussion and no dialogue</td>
<td>10</td>
</tr>
<tr>
<td>Lack professionalism</td>
<td>9</td>
</tr>
<tr>
<td>Prepare difficult exams from outside lectures</td>
<td>8</td>
</tr>
<tr>
<td>Cannot teach simply and difficult to be understood</td>
<td>7</td>
</tr>
<tr>
<td>Lack of reference</td>
<td>6</td>
</tr>
<tr>
<td>Read from slides all the time</td>
<td>5</td>
</tr>
<tr>
<td>Not answer greeting when student meets the teacher in the college</td>
<td>4</td>
</tr>
<tr>
<td>Not answer questions in the class</td>
<td>4</td>
</tr>
<tr>
<td>Lack of knowledge</td>
<td>4</td>
</tr>
<tr>
<td>Unclear content material in the lecture</td>
<td>4</td>
</tr>
<tr>
<td>Use of mobile during teaching session</td>
<td>2</td>
</tr>
<tr>
<td>Lack of fun</td>
<td>2</td>
</tr>
<tr>
<td>Unclear language</td>
<td>2</td>
</tr>
<tr>
<td>Inaudible voice</td>
<td>2</td>
</tr>
<tr>
<td>No examples and illustration</td>
<td>2</td>
</tr>
<tr>
<td>Quick movement of slides</td>
<td>2</td>
</tr>
</tbody>
</table>

and medical students to improve the learning environments, and to be more enjoyable and comfortable. Studies showed that stress management in medical education is an important aspect for the future of medical students. Indeed, some studies indicate that medical students face unique academic challenges that render them more vulnerable to stress and anxiety than students of other disciplines. These challenges of a medical education include the rigours of the educational programme and emotionally tense experiences, such as dealing with illness, disease and dying. (21-26)

In Conclusion: The majority of medical students in this study highly appreciate respect to them even more than teaching skills. Medical students like new ways of teaching methods and to be involved in discussion with their teacher and the group. Further studies are recommended to study in depth the psychological relationship between medical teachers and students in different medical schools to improve academic learning environments.
References

2- Cook V, Fuller J, Evans D. Helping Students Become the Medical Teachers of the Future - The Doctors as Teachers and Educators (DATE) Programme of Barts and the London School of Medicine and Dentistry, London. Education For Health 2010;23(2):1-6
Drink-Driving Among Commercial Drivers in a Nigerian Community

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B.O. Omolase (3)  
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Abstract

Aim: This study aimed at determining the prevalence of the practice of drink-driving among commercial intercity drivers.

Methods: The study was conducted in Owo, South West Nigeria among commercial intercity drivers between June and September, 2009. Ethical clearance was obtained from the Ethical Review Committee of Federal Medical Centre, Owo, Ondo State, Nigeria prior to commencement of this study. The permission of the leadership of Road Transport Workers’ Union was also sought and obtained. Informed consent was obtained from each of the respondents. The data obtained was collated and analyzed with SPSS 15.0.1 statistical software version.

Results: Ninety respondents were enrolled in this study. The driving experience of the respondents as detailed in Table 1 revealed that most respondents, 53 (58.9%) had more than 20 years driving experience. Few respondents, 29 (32.2%) admitted to intake of alcohol at least on one occasion prior to driving in the year preceding this study. There was significant association between involvement in road traffic accidents and alcohol intake.

Conclusion: Few respondents admitted to history of alcohol intake before driving. There is need for aggressive educational efforts to enlighten the populace on the risks involved in drink-driving. Availability of alcohol should be reduced. The drivers involved in drink-driving should be penalized so as to serve as a deterrent.

Key words: Commercial drivers, drink-driving, RTA, Nigeria

Introduction

Driving is the primary mode of travel in many countries. (1) It facilitates the performance of routine daily activities and it is thus integrated with the concept of quality of life. (2) The road transport system in Africa is the dominant form of inland transportation and carries more than 95% of passenger traffic. (3) In Africa driving a car is still considered a privilege, an enviable option not a risky task with inherent responsibilities. (3) However, globally road traffic fatalities and injuries rank high among the major public health problems. Annually 1.2 million people die and about 50 million people are injured in road traffic accidents, thus every day more than three thousand die from road traffic injuries globally. (4) It has been predicted that road traffic accidents are likely to be the fifth leading cause of death in 2030, while they were the ninth leading cause of death in 2004. (5) Though it is a widespread problem, road traffic fatality is a major challenge especially in developing countries. There is a disproportionate higher number of deaths occurring from road traffic injuries in developing countries compared with developed countries. (6, 7) The increase in the number of vehicles is a major factor responsible for this in developing countries. (8) Road traffic fatalities have been projected to increase significantly in developing countries by 2020. (4, 9)

Driving is a psychomotor activity that requires a combination of concentration as well as good visual and auditory functions. (10) Several factors can affect driving including the use of alcohol. (10) Alcohol is a major risk factor for road traffic accidents in that it impairs judgement and increases the possibility of involvement in other high risk behaviours like violating traffic regulations. (11) In close association with rapid motorization, there has been an increase in alcohol
production advertising distribution and consumption.\(^{11}\) Alcohol affects vision, prevents prompt identification of risky situations in the road environment, causes inappropriate coordination for manoeuvring the vehicle, diminishes reflexes and delays reaction time to light and hearing.\(^{12,13}\) Intake of alcohol is accompanied by psychosocial changes like increase in vulnerability to severe injury.\(^{14}\) Alcohol has been reported as the eighth leading risk factor for deterioration of health status of the population \(^{15}\) Drink-driving, also referred to as driving under the influence of alcohol, is dangerous, hazardous and antisocial. The maximum allowable blood alcohol concentration level when driving a vehicle is a tool for enforcement and prevention of road traffic accidents.\(^{11}\) The legally acceptable blood alcohol concentration level varies from 0-100 mg/100ml from country to country. The generally acceptable value is 50mg/100ml in most countries.\(^{15}\) Drivers who indulge in taking alcohol before driving constitute a risk to themselves as well as other road users. It has been reported that there is a clear association between alcohol consumption and road traffic injury within six hours of consumption of alcohol.\(^{16,17}\) Odero reported that 1/5 to 1/3 of crashes occur in the night and most of them were the result of alcohol consumption in combination with other factors like poor visibility, greater traffic densities and limited health care facilities.\(^{18}\) A Kenyan study also established the major role alcohol plays in road crashes.\(^{19}\) Studies done in Nigeria also reported the risk associated with drink-driving.\(^{20,21}\)

In view of the adverse effect of drink-driving on road safety, this study was conducted to assess the practice of drink-driving and its role in causing road traffic accidents among inter-city commercial drivers in Owo, South-West Nigeria. It is hoped that policy implications drawn from this study shall guide the relevant agencies to evolve strategies to curtail drink-driving in Nigeria.

### Methods

This descriptive cross-sectional study was conducted over three months between June and September, 2009. Ethical clearance was obtained from the Ethical Review Committee of Federal Medical Centre, Owo, Ondo State, Nigeria prior to commencement of this study. The permission of the leadership of Road Transport Workers’ Union in the community was sought and obtained before data collection. Ninety intercity commercial drivers out of the estimated one hundred and sixty intercity commercial drivers in the community were enrolled in this study. Informed consent was obtained from all the respondents. They were interviewed with the aid of a semi-structured questionnaire by the authors and two research assistants. The research assistants were trained in administration of the questionnaire. The respondents were interviewed at the Secretariat of Road transport workers’ union and at six different parks in the community. The information obtained from the respondents with the aid of the study instrument (questionnaire) included their bio-data, duration of driving, license status of the population \(^{15}\) Drink-driving on road safety, this study was led to evolve strategies to curtail drink-driving in Nigeria.

### Results

Ninety respondents participated in this study. Their ages ranged between 22 and 70 years with a mean age of 45.2 years ± 10.7 years. The respondents were all males. The majority of the respondents were married, 86\(^{95.6\%}\), 3\(^{3.3\%}\) were single and the remaining 1\(^{1.1\%}\) was divorced. Most respondents were Yorubas, 87\(^{96.7\%}\) and the remaining 3\(^{3.3\%}\) were of the other ethnic groups. Half of the respondents, 45\(^{50\%}\) had secondary education, 31\(^{34.4\%}\) had primary education, 11\(^{12.2\%}\) had no formal education while the remaining 3\(^{3.3\%}\) had tertiary education. The respondents were predominantly Christians, 68\(^{75.6\%}\) while 22\(^{24.4\%}\) were Muslims. The duration of driving experience of the respondents as detailed in Table 1 revealed that the majority of the respondents, 53\(^{58.9\%}\) had more than 20 years driving experience.

#### Involvement in Road Traffic Accident:

Few respondents, 18\(^{20\%}\) had a history of involvement in road traffic accident while driving and the remaining 72\(^{80\%}\) had not been involved in a road traffic accident. Most respondents, 74\(^{82.2\%}\) had a drivers’ license while the remaining 16\(^{17.8\%}\) did not have a drivers’ license.

Few respondents, 29\(^{32.2\%}\) admitted to intake of alcohol on at least one occasion before driving in the year preceding this study while the remaining 61\(^{67.8\%}\) did not. The age of the respondents significantly affected intake of alcohol before driving with a p value of 0.042. As shown in Table 2, alcohol intake was significantly associated with involvement in a road traffic accident with a p value of 0.018. The intake of alcohol did not significantly affect compliance with seat belt with a p value of 0.452.

### Discussion

The fact that most of the respondents were Yorubas is not surprising in view of the fact that the study community is a Yoruba community in South-West, Nigeria. Christianity been the predominant religion among the study population is in keeping with the predominant religion in the community. All our respondents were males and this...
Table 1: Duration of driving experience

<table>
<thead>
<tr>
<th>Duration (Years)</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5 years</td>
<td>7</td>
<td>7.8</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>16 - 20 years</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>&gt; 20 years</td>
<td>53</td>
<td>58.9</td>
</tr>
<tr>
<td>Total</td>
<td>90</td>
<td>100</td>
</tr>
</tbody>
</table>

P value = 0.018

Table 2: Cross tabulation of alcohol intake versus involvement in Road Traffic Accident (RTA)

<table>
<thead>
<tr>
<th>Alcohol intake</th>
<th>Involvement in RTA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>53</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>72</td>
</tr>
</tbody>
</table>

Finding is expected in view of the fact that the commercial inter-city driving is an exclusive preserve of males in Nigeria. The mean age of 45 years is in tandem with an active workforce that the respondents belong to as commercial driving is a demanding occupation. The importance of relatively young age in safe driving cannot be overemphasized. With increasing age there is a decline in sensory cognitive function. It has been reported that older drivers have more accidents per mile than their younger counterparts. (22) Furthermore if an older driver is involved in a road traffic accident, it is more likely to be fatal.(23) After the age of 50 years, there is rapid decline in sensory vision resulting in reduction in visual acuity, contrast sensitivity, stereo acuity and visual field sensitivity.(24) Good understanding of how functional changes with age affect driving ability is likely to improve road safety.(25) Some of our respondents did not have a valid drivers’ license; this is not a good development and it behoves on the Federal Road Safety Corps to arrest this trend. Few respondents admitted to intake of alcohol prior to driving in the year preceding this study. The drivers involved in drink-driving were apparently oblivious of the risk associated with the practice. Many drivers overestimate their ability to drive safely, even after taking alcoholic drinks. There is a commonly held belief that a small amount of alcohol will not impair driving ability.(26) Many people drive after drinking alcohol do so not because driving is the only option but because they believe they are fit to drive. (27) In this study intake of alcohol was significantly associated with involvement in road traffic accident. This finding is in keeping with that of some previous studies. The role of intake of alcohol in involvement of road traffic accidents was reported in the findings of a study by Sindelar in which 5-50% of patients presenting to Emergency Departments on account of trauma were linked to consumption of alcohol. (28) In South East Asia, 30-40% of road crashes occur at night and a significant number were due to consumption of alcohol. (29) A study done in Kenya revealed that alcohol not only plays a major role in road crashes involving 4-wheeled vehicles but also plays a significant role for 2-wheeled vehicles and pedestrians. (19) A study done in New Dehli reported that 7% of patients involved in road traffic accident had consumed alcohol. (30) Another study reported that 29% of two wheeler accident victims had been under the influence of alcohol. (31) It has been observed that severe brain injuries and mortality rates are higher in the alcohol group compared with the non-alcohol group. (32) Age was significantly associated with drink-driving in this study. This finding is consistent with that of previous studies which identified age and gender as the most important risk factors for drink-driving. (26,33,34)

The main limitation of this study was the self reported nature, thus introduction of bias cannot be completely eliminated. It is advised that further studies of this nature in Nigeria should be based on breath testing for alcohol and laboratory estimation of blood alcohol concentration in drivers involved in road traffic accidents. The authors are not aware of the routine conduct of these tests at Accident and Emergency departments in Nigeria at the time of this study.

In view of the risk associated with drink-driving, its reduction should be integrated with other road safety
interventions like enforcement of seat belt compliance to obtain noticeable results in low and middle income countries.(35) Though the Federal Road Safety Corps vigorously campaigns against alcohol intake before diving, there is need for the Nigerian Government to state the legally acceptable blood alcohol concentration in the country.

Conclusion
Few respondents admitted to drink-driving in the year preceding this study. There was significant association between drink-driving and involvement in road traffic accidents. Age of the respondents significantly affected drink-driving.

Recommendation
1) There should be aggressive educational efforts geared towards providing information on the risks associated with drink-driving. This is likely to lead to a reduction in the practice of drink-driving through behavioural change.
2) There should be reduction in availability of alcohol. This can be achieved through increasing the price of alcoholic drinks, limiting the number of outlets, and times and conditions under which alcohol can be sold.
3) Drivers involved in drink-driving should be penalized.

Acknowledgement
We glorify God for a successful completion of this work. The support of the Management of the Federal Medical Centre, Owo is hereby acknowledged. We are also grateful to the respondents for graciously accepting to participate in this study. The cooperation of Road Transport Workers' Union, Owo branch is appreciated. The authors are also indebted to Mr A.K.Bamidele and Mr.P.U.Oparaku for their contribution to this study.

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3) Lugarde E. Road traffic injury is an escalating proportionate research efforts. Plos Med 2007;4(6).
Using Cognitive Behavioral Therapy to Manage Insomnia among Patients with Cancer

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Abstract

Insomnia is one of the prominent problems that confronts patients with cancer, although, it has received little attention from clinicians or researchers. In this paper the author’s purpose was to establish the effectiveness of cognitive behavioral therapy (CBT) as the best practice to manage insomnia among patients with cancer. An extensive literature review was conducted using major nursing, medical and psychological databases between 2005 and 2011, found that in ten studies CBT is proven to be effective in managing insomnia without side effects, and better sleep duration among patients with cancer; also, it could be used in the home, or be internet based.

Introduction

Insomnia is a prominent type of sleep disturbance and refers to a variety of sleep-related symptoms. Symptoms include: difficulty in falling and staying asleep; early morning wakening with inability to resume sleep and non-restorative sleep (Kvale, & Shuster, 2006). Also, insomnia is a common occurrence and an underestimated problem in patients with cancer, where the prevalence of insomnia in patients with cancer is estimated between 30% and 50%, which is higher than the general population, which is up to 20% (Dirksen, Epstein, & Hoyt, 2009; Price et al. 2009).

Also, insomnia in the cancer population has received little attention from clinicians or researchers (Chena, Yub, & Yang, 2008). Based on that, and in the context of cancer insomnia extra concern is needed for it to be managed effectively. To achieve that there are pharmacological and non-pharmacological methods to manage insomnia associated with cancer. The non-pharmacological management is superior to pharmacological strategies in absence of side effects and there are no drug reactions. It includes: relaxation, stimulus control, sleep restriction, paradoxical intention and Cognitive Behavior Therapy (CBT) (Kvale, & Shuster, 2006).

On other hand, patients with cancer experience insomnia during stressful times related to being diagnosed with cancer, during treatment, and persistently after discharge after anticancer therapy (Espie, Fleming, Cassidy, Samuel, Taylor, & White, 2008).

Cognitive behavior therapy combines several modes, including relaxation, stimulus control, sleep restriction, cognitive restructuring, and good sleep hygiene (Price et al. 2009). The purpose of this paper was to establish the effectiveness of cognitive behavioral therapy as the best practice to manage insomnia among patients with cancer.

Method

Design

A systematic review was conducted, using existing literature related to topic of interest; ten articles were included to be reviewed after an extensive search.

Search strategy

A systematic search was conducted on the electronic databases MEDLINE, CINAHL, Science direct, Psychology and Behavioral Sciences Collection and SociINDEX, for articles published between January 2005 and 2011. Additionally, to access as much relevant literature as possible the reference lists of included articles were checked (snowball method).

A broad range of search key words were used beside ‘Cancer Patient’, and were divided into three groups; ‘Cognitive Behavior Therapy’, ‘Nonpharmacological management’, and ‘Complementary Alternative Medicine (CAM)’ which comprised the group concerning treatment regimen. ‘Cancer’, ‘Neoplasm’ and ‘Oncology’ reflect comorbidity. ‘Insomnia’ and ‘Sleep disturbance’ formed the change in bodily functions associated with cancer. All key words were used both alone and in combination.
<table>
<thead>
<tr>
<th>First Author</th>
<th>Design</th>
<th>Purpose</th>
<th>Sample/Setting</th>
<th>Data Analysis</th>
<th>Findings</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arving et al.</td>
<td>Prospective, randomized study</td>
<td>To compare if individual psychosocial support to breast cancer patients was there differences in QoL, anxiety, depression, and posttraumatic stress between patients who received support by a nurse (INS), a psychologist (IPPS), or standard care (SC).</td>
<td>N=179 / the Department of Oncology, Uppsala University Hospital.</td>
<td>The SPSS analysis of variance with repeated measure.</td>
<td>Psychosocial support by specially trained nurses using techniques derived from cognitive behavioral therapy is beneficial for breast cancer patients and may be a realistic alternative in routine cancer care.</td>
<td>2</td>
</tr>
<tr>
<td>Berger et al.</td>
<td>Randomized controlled clinical trial</td>
<td>To determine whether sleep quality and fatigue associated with breast cancer adjuvant chemotherapy treatments can be improved with behavioral therapy (BT).</td>
<td>Behavior Therapy (n:113) or healthy eating control (n:106)/10 community oncology clinics.</td>
<td>The SPSS used, Descriptive and t-tests and chi-square test.</td>
<td>The BT group showed improved sleep quality over time and better sleep.</td>
<td>2</td>
</tr>
<tr>
<td>Davidson et al.</td>
<td>Qualitative Phenomenology</td>
<td>To identify how to make Non-pharmacologic interventions available to cancer patients.</td>
<td>Twenty-six cancer patients who had sleep difficulty.</td>
<td>Analytical induction (Not clearly written).</td>
<td>Participants recommended that the assessment and treatment of sleep difficulty be integrated into the health care system.</td>
<td>6</td>
</tr>
<tr>
<td>Epstein et al.</td>
<td>Randomized controlled trial</td>
<td>To determine the efficacy of a cognitive-behavioral intervention for treating insomnia in breast cancer survivors.</td>
<td>N= 72 women/University and medical center settings.</td>
<td>One-way analysis of variance (ANOVA), Pearson chi-square, Fisher's exact test, and independent t test.</td>
<td>A nonpharmacologic intervention is effective in the treatment of insomnia in breast cancer survivors.</td>
<td>2</td>
</tr>
<tr>
<td>Espie et al.</td>
<td>Randomized controlled study</td>
<td>To investigate the clinical effectiveness of protocol-driven cognitive behavior therapy (CBT) for insomnia, delivered by oncology nurses.</td>
<td>N= 150 patients/clinics at the Beatson Oncology Centre, Glasgow or Anchor Unit, Aberdeen Royal Infirmary.</td>
<td>The SPSS used, Spearman’s rank correlation coefficient, and Hochberg procedure.</td>
<td>CBT for insomnia may be both clinically effective and feasible to deliver in real world practice.</td>
<td>2</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Objective</td>
<td>Participants</td>
<td>Statistical Analysis</td>
<td>Findings</td>
<td></td>
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<tr>
<td>Fiorentino et al. (2010)</td>
<td>Randomized controlled crossover pilot study</td>
<td>Study the effects of individual cognitive behavioral therapy for insomnia (IND-CBT-I) on sleep in breast cancer survivors.</td>
<td>Fourteen participants from San Diego UCSD Cancer Center and other various sources</td>
<td>Mann–Whitney U nonparametric independent sample tests</td>
<td>The pooled pre–post-IND-CBT-I analyses revealed improvements in self-rated insomnia, sleep quality, and objective measures of sleep.</td>
<td></td>
</tr>
<tr>
<td>Fouladbakhsh et al. (2010)</td>
<td>Secondary analysis of the 2002 National Health Interview Survey (NHIS).</td>
<td>To identify relationships among gender, physical and psychological symptoms (pain, insomnia, fatigue, and depression), and use of specific complementary and alternative medicine (CAM) practices among survivors in the U.S. cancer population.</td>
<td>2,262 adults (aged 18 years and older) diagnosed with cancer United States.</td>
<td>Stata® 9.2 software for population estimation. Binary logistic regression, the primary statistical model employed in the analysis.</td>
<td>Pain, depression, and insomnia were strong predictors of practice use, Symptom experience influences likelihood of use.</td>
<td></td>
</tr>
<tr>
<td>Hunter et al. (2009)</td>
<td>Quasi-experiment, longitudinal.</td>
<td>To evaluate a group cognitive behavioural intervention to alleviate menopausal symptoms in women who have had treatment for breast cancer.</td>
<td>N= 17 women/two London breast units.</td>
<td>The SPSS used, Paired t-tests and non-parametric statistics.</td>
<td>There was a significant reduction in negative beliefs about hot flushes (HF), night sweats (NS) and sleep following CBT.</td>
<td></td>
</tr>
<tr>
<td>Savard et al. (2005)</td>
<td>Randomized controlled study.</td>
<td>To evaluate the effect of CBT on sleep among patients with cancer.</td>
<td>Fifty-seven women/participant invited by fliers and pamphlets, ads placed in the local newspapers, and by physician referrals.</td>
<td>Descriptive and inferential statistics were completed using SAS 8.2 statistical software.</td>
<td>This study supports the efficacy of CBT for insomnia secondary to breast cancer.</td>
<td></td>
</tr>
<tr>
<td>Savard et al. (2005)</td>
<td>Randomized controlled study.</td>
<td>To assess the effect of an 8-week cognitive behavioral therapy (CBT) for chronic insomnia on immune functioning of breast cancer survivors.</td>
<td>Fifty-seven women/participant invited by fliers and pamphlets, ads placed in the local newspapers, and by physician referrals.</td>
<td>Descriptive and inferential statistics were completed using SAS 8.2 statistical software.</td>
<td>This study provides some support to the hypothesis of a causal relationship between clinical insomnia and immune functioning.</td>
<td></td>
</tr>
</tbody>
</table>
Inclusion criteria
The titles and abstracts of candidate articles were reviewed, and articles were included only if they met the following criteria: (1) explicitly addressed Cognitive Behavior Therapy; (2) were available in full-text research; (3) were published in English; (4) described the results of empirical research; (5) reflected at least one of the cancer related sleep disturbances.

Findings
In this paper the author did an extensive review on clinical and evidence based practice regarding using CBT as a best practice. To achieve this objective the researcher constructed a table depicting the major themes, (Table 1 - preceding pages).

In the context of breast cancer CBT reveals effective results in managing insomnia, also, there is reduction in negative beliefs about hot flushes, night sweats and sleep following CBT that result in enhancement in immune function. These results were exhibited in seven randomized controlled studies where the samples sizes were satisfactory and random assignment met in all of these studies (Berger et al. 2009; Epstein, & Dirksen, 2007; Fiorentino et al. 2010; Savad, Simard, Ivers, & Morin, 2005a; Savad, Simard, Ivers, & Morin, 2005b; Arving et al. 2007; Hunter, Coventry, Hamed, Fentiman, & Dirksen, 2007; Fiorentino et al. 2008).

Davidson, Stewart, Brennenstuhl, and Ram (2007) suggest that patients with cancer prefer to be assessed and involved in treatment of sleep difficulty including CBT, to be integrated into the health care system at admission, but this assumption needs extra validation where the study relied on a low level of confidence (level sex) and the data analysis was not clear.

Insomnia was a strong predictor of practice using CAM therapy including CBT; also, female patients use CAM more than males. These results were exhibited in a systematic review paper built on randomized control studies where the sample size is large, 2262 adult patients in the USA (Fouladbaksh, & Stommel, 2010). Moreover, in a randomized controlled study where the sample size was 150 patients, it is estimated that 55 minutes mean reductions in wakefulness per night was associated with CBT in comparison with usual treatment (Espie et al., 2008).

Conclusion
Patients with cancer experience insomnia during stressful times relating to being diagnosed with cancer, during treatment, and persistently after discharge after anticancer therapy. CBT is proved to be effective in managing insomnia without side effects, also, it could be used in the home, or be internet based. It is a shared responsibility between oncology nurse and other healthcare providers to start implementation of CBT to manage insomnia in the context of cancer.

References
Familial Suicides in India: An analysis

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Abstract

Familicide-suicide is where the perpetrator kills all family members before committing suicide. Such incidents abound in the media in our country but are rarely mentioned in the medical literature. Though this phenomenon has attracted public attention it has rarely been discussed in academic circles. The main motive of the suicide pact is the relief of the environmental stressors. The current paper focuses on a series of suicide pacts involving several members of the same family living together reported in the media recently and looks into the probable causes so as to help devise strategies for intervention.

Key words: Family suicides; familicide; suicide pacts; financial constraints; family strife/disputes

Introduction

Suicide pacts between two or more persons to end their lives at the same time generate interest in the popular media out of proportion to their frequency, yet they are rarely discussed in the medical literature. They represent 0.6-4.0% of all suicides (1-3), the vast majority being double suicides. Typically, they are composed of married couples, aged 50 to 60, who are socially isolated and mentally or medically ill (1,4,5).

According to the descriptive typology proposed by Nock and Marzuck (1999) (6) murder-suicide falls into four main categories: spousal/consortial murder-suicide, filicide-suicide, familicide-suicide, and extrafamilial murder-suicide. This paper will focus on familicide-suicide, in which the perpetrator kills all family members before committing suicide. Family suicide is defined as the dominant person in the family killing the others before doing away with themselves. Sometimes, it features a suicide pact among family members.

In India, Kerala region ranks as the first in the rate of family suicides. In the year 1999, about 60 families committed suicide. Kerala research programme on local development sponsored a study of family suicides in Kerala by Praveenlal et al (2001) (7). Within a period of 12 months, 31 incidents of family suicide happened in 3 districts of Kerala with 97 persons involved in the act in which 82 died. 73.2% were below the age of 39 years. 69.1% involved in the act were victims of poisoning. Out of 31 family suicides, in 5 cases one of the involved persons had psychiatric illness. In 16 incidents, warning signals were given prior to the attempt. Decision-making was mother (10), father (4), and both (17). Only in 2 instances there was a decline in socio-economic status, but 13 families were leading a life style higher than could be afforded. Financial crisis (35.5%), family problems (25.8%) and psychiatric illnesses (16.1%) were the major identified causes.

This phenomenon has attracted public attention in Kerala as a result of the rise in family suicides in which often husband and wife commit or attempt suicide after killing their children.

We present a series of suicide pacts involving several members of the same family living together reported in the media recently. Such incidents abound in the daily papers in our country but are rarely mentioned in the medical literature. In such reports of course first hand information might be lacking as there are rarely any survivors. However substantial details are collected by the police and the crime branch from the other relatives and neighbors, of the probable circumstances surrounding the incident.

Case 1

Five members of a family in Hyderabad Mr.Y, 46 years, a worker at a sweet shop, his wife Mrs. P, 40 years, sons Mr. S 11 years, Mr. R, 9 and daughter Ms. G 6, ended their lives in a shocking suicide pact that came to light almost two days after it happened when there was a bad smell around their house which was discovered by the neighbors. Mr.Y was found hanging from the ceiling and his wife and three children lying dead on the floor. Police suspect that ceaseless financial problems drove the family to take such a drastic step.
Case 2
In Ahmedabad in an odd suicide pact, four of a family and the man’s paramour, attempted suicide in a Honda City car on the outskirts of the city. 35-year-old Mr. RP was married to Ms. S for the past 10 years and they had two sons 8, and 3 respectively. Mr. RP had an extra-marital affair with a 22-year-old girl from his neighborhood. The affair was carried on for two years ignoring the protests from both the families. The girl’s father insisted on taking her away to his village to get her married. The girl sneaked out and told Mr. RP about the plan, who picked her up and then his family in his car around 2.30 pm. The five were found in Mr. R P’s car on the highway around 12.30 am the next day. The five had consumed poison in an attempt to commit suicide and the couple’s three-year-old son died on the way to hospital while the rest were in a comatose condition for sometime before succumbing to their act. The police suspect it was the pressure of handling the extra-marital affair that drove the family to suicide.

Case 3
A woman and her six children, including four girls, took their lives by consuming poison in the eastern Indian state. The woman’s husband also attempted suicide but he is now in a local hospital in a critical state. A preliminary probe has revealed that the family took the extreme step due to acute poverty.

Case 4
A couple aged 55 and 45 years and their married son 22 years old hanged themselves at their home town around Mysore. A suicide note left by the son held his wife and her parents and brother-in-law responsible for their suicides. The victims had quarreled with the accused and it was conjectured that the humiliation led to the suicides.

Case 5
Three members of an Indian family allegedly committed suicide by hanging themselves in their apartment, in what appeared to be a family pact. Somehow, the father survived the attempt. The three, a 38-year-old woman, her 22-year-old son from an earlier marriage and her 20-year-old sister died in their house. But her husband who also tried to hang himself, escaped with minor injuries. Financial problems were cited as the reason for the mass suicide, in a note left behind in the house. The man survived the attempt to kill himself as his rope came loose and later, he himself alerted the police. This was reported from the UAE and a senior Police official ruled out any criminal intent behind the collective suicide, saying it was a pact motivated by the husband.

Discussion
Brown et al. (1995)(1) has suggested that the main motives of suicide pacts are the relief of mental disorders, relief of medical disorders and reasons related to mental disorder. However, the role of mental disorders in suicide pacts cannot be ascertained without an extensive psychological autopsy of the decedents.

From the available information in all the cases cited above we may argue that the main motive of the suicide pact is the relief of the environmental stressors, such as financial constraints, loss of face and humiliation in the family. Family conflict is an important factor to be considered when studying suicidal behaviors.

In many Asian cultures, family is a pivotal force providing their main source of strength and support; there is great emphasis on harmony and family integration but when things go wrong, it may lead to great anguish. Though so many Asian cultures hold family relationships in high regard, those problems that originate within the family can be the most difficult to solve. Unable to turn to their families for help and reluctant to seek mental health care, troubled people often attempt to work problems out on their own, adding pressure to an already strained situation filled with feelings of shame or guilt.

Blair (2009) (8) a sociologist in his analysis of family murder-suicide, has observed in the West that though now relatively an uncommon phenomenon, it is expected to increase in the next few years because ‘economic strain on families are likely to provoke depression and desperation’. He further observed that “the economic situation also portends a significant increase in other forms of family violence, including spousal and child abuse, child neglect and other forms of dysfunctional behavior like substance abuse”. Researchers have long noted the negative impact of financial and job stress on families and individuals and can negatively impact the quality of family relationships. From the individual’s point of view, the loss of a job is certainly devastating but it can become much worse when it coincides with a loss of savings and investments, the loss of the family home and all family assets.

Parents who choose to end their child’s life often also suffer from emotional problems such as depression, and tend to be socially isolated, making it more difficult for them to get help. Shame also keeps parents from seeking financial or medical assistance. Others do not want to burden their relatives with raising their children hence resort to such drastic decisions of killing their children before killing themselves.

Cultural factors are also behind the disturbing trend, for instance in Asian cultures, parents think their children are their property and hence parents have the right to determine a child’s life.

Finally, despite the fact that suicide pacts share a lot of characteristics with individual suicides and are a rare phenomenon, health practitioners believe that education programs on suicide prevention should incorporate information on suicide pacts and guidelines for preventing suicide pact behaviors.

Conclusion
Suicide is a complex human behaviour that includes multiple unconscious processes and needs to be interpreted multidimensionally from a biopsychosocial perspective.
Suicides should not be interpreted from a psychiatric or a cultural perspective alone but by an integrated view of these variables. This report may be a significant contribution in the direction of planning prevention to avert the suicides and suicide attempts which represent an important public health issue in our country as there is a paucity of reports related to family suicides.

References

References continued from page 18
Drink-Driving Among Commercial Drivers in a Nigerian Community

Students’ attitude of crack abuse side effects

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(2) Medical Doctor, Semmelweis University, Budapest, Hungary

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Abstract

Introduction: Addiction has caused many social problems in Iran. Attitude is a mental position with regard to a fact or state; a feeling or emotion toward a fact or state or attitude assessment. Addiction is considered as one of the three leading health care dilemmas in Iran of which the main victims are adolescents and the young people. The present research was aimed at determining students’ attitude assessment towards crack abuse side effects in Islamic Azad University, Islamshahr Branch.

Materials & Methods: The present descriptive and analytical research investigated students' attitude of crack abuse side effects; indicating a student needs education if he/she scores 50% or less in each area. The research population was 906 (n = 906); and the data was analyzed using the T-test, Chi-square and ANOVA tests and the Pearson' correlation coefficient.

Results: The results showed the students’ needs attitude assessment towards crack abuse side effects at the attitude revealed. A statistically significant correlation was also revealed between the mean short-term (73.57) and long-term (64.19) attitude (p < 0.000; t = 17.35; df = 892).

Also those students ’attitude abuse side effects that were 55.5% had a negative attitude, and students ‘attitude abuse side effects that were 44.5% had a positive attitude.

Discussion & Conclusion: The results of the present research regarding students' needs assessment towards short-term and long-term crack abuse side effects revealed that students' long-term attitude towards crack abuse side effects trends towards negative; their needs assessment is primarily based on short-term trends towards unfavorable.

Key words: knowledge, side effects, crack abuse

Introduction
Crack abuse is nowadays considered the leading cause of consulting withdrawal institutions, which reveals the increasing addiction rate with this high-risk substance in Iran (1). Addiction has also caused many social problems in Iran. Several important socio-economic events such as a petroleum-related economy, the 8-year war against Iraq, population overgrowth, expanding global communicative technology, increased expectations of the young generation, the trend of industrial development and the related complications such as immigration and unemployment, are all issues that make the Iranian society more vulnerable to addiction (2). Therefore, addiction is considered as one of the three leading health care dilemmas in Iran (the two others being poverty and unemployment); the main victims of which are adolescents and the young (3). Recently, individuals are attracted towards substance abuse at a lower age, and the import of chemical and industrial psychoactive drugs has caused a novel trend in the addiction dilemma. The main characteristics and the main reasons for widespread substance abuse (4), especially stimulating substances such as crack are as follows: Cocaine is a highly addictive drug because of its powerful stimulant effects which create an immediate euphoric sensation.(5) Cocaine is processed to form a rock crystal called crack. This form of cocaine is called crack because of the crackling sound it makes when burned (6). When heated, crack releases vapors that are inhaled, producing an intense though brief high. The US National Institute on Drug Abuse reports that 1.7 percent of 18 to 25 year olds use cocaine. (7)

The long term effects of crack abuse begin with the very first dose and steadily worsen from there. After the initial high has worn off, users are left feeling depressed, tired and sad.
Additionally, users will also experience physical effects, such as increased heart rate and blood pressure, as well as intense sweating and dilatation of their pupils. Other effects which may take longer to manifest can include stroke, extreme weight loss, heart attack and even death, either from overdose or from prolonged stress on the body from crack usage. (8)

The short-term physiological effects of cocaine include constricted blood vessels; dilated pupils; and increased temperature, heart rate, and blood pressure. Large amounts (several hundred milligrams or more) intensify the user’s high, but may also lead to bizarre, erratic, and violent behavior. These users may experience tremors, vertigo, muscle twitches, paranoia, or, with repeated doses, a toxic reaction closely resembling amphetamine poisoning (9).

Nearly 11% of the young substance abusers in Iran don’t believe these substances cause addiction (10). Attitude is a mental position with regard to a fact or state; a feeling or emotion toward a fact or state. Another way to think of attitude is a mental habit that filters how you perceive the world around you and also the actions and behaviors you take in response (11).

The most effective approach for determining an appropriate educational content is attitude-analysis. The Researcher believes that in order to change these beliefs we need to review and determine the consequences of taking crack as determines their attitude. Thus, the researchers aimed at determining students’ needs assessment towards crack abuse side effects in order to provide a perspective of the current situation for authorities in the area of addiction and to take a step forward in decreasing the tendency of the Iranian young population towards this internecine disaster.

Materials and Methods
The present descriptive and analytical research investigated students’ attitudes towards crack abuse side effects and attitude, therefore if the student scores 50% or less in each area. The research environment consisted of all the faculties of Islamic Azad University. The sample size (at a 95% confidence interval and a maximum estimated error of 0.05) using the formula: N = F/N was estimated to be 906 subjects. Descriptive statistical methods (including statistical indices, formulating frequency distribution tables, and drawing related diagrams), analytical statistical methods (including discussing point estimates and interval estimates for mean and ratio, the t-test, the Chi-square test, the ANOVAs test, and the Psion correlation coefficient), and the SPSS software (version 14) were used in order to meet the research objectives.

Results
In this study 40.2% of samples were female and 542 were male. 33.1, 33.9, 11.5, 10.7, and 10.5 percent of the subjects were selected from the Humanities & Management faculty, the Engineering faculty, the Basic Sciences faculty, the Physical Education faculty, and the Arts faculty, respectively. More than (30.8%) of them were the first child of their parents, and most (55.8%) of them had 4 other family members. More than (44.2%) of their fathers and most (44%) of their mothers had not completed high school. Most (85.9%) of their parents lived together and (24.7%) of whom smoked on liaisons and persistently, respectively; 6.1% of them also stated that they smoked for over 5 years. 8.8% of the students stated they had family members with substance abuse or who performed doping, most of whom (32.6%) were opium abusers. Data related to the measurement of the students’ attitude, regarding the short-term and long-term crack abuse side effects are shown in Tables 1, 2 and 3 (next pages).

The results obtained revealed that students’ attitude about abuse side effects were 55.5% had a negative attitude, and the data obtained revealed that students’ attitude on abuse side effects that were 44.5%, had a positive attitude.

Questions 1, 6, 10 and 15 are related to short-term side effects and Questions 8 and 9 and 12 relate to long-term side effects.

Discussion
The findings regarding assessment of crack abuse side effects and the pertinent faculty, revealed a statistically significant correlation in the areas of attitude, such that the students of the Engineering faculty and the Physical Education faculty had the least and the students of the Engineering faculty and the Humanities faculty had the most attitude levels (means = 67.18 and 73.38, respectively). The variance analysis test showed a statistically significant correlation between age and attitude with the highest attitude revealing a mean of 80.5. The results of a research performed by Shafigh revealed that male gender is considered a risk factor for substance abuse among the medical students in Pakistan (12). Angermeyer showed the general public is often skeptical and negative in their attitudes to anti-psychotic drugs. They believe the risks of such drugs outweigh the possible benefits (13).

In addition, the 26-28 year olds and the 20-22 year old subjects had the best and the worst function levels (means = 84.7 and 73.84, respectively); students under 20 years of age revealed the lowest attitude level (mean = 71.52). The most negative attitude, was observed among the bachelor students (means = 38.29, 68.1, and 74.16, respectively).

In other words, the results obtained regarding students’ needs assessment towards crack abuse side effects at the attitude revealed a statistically significant correlation and also revealed the same between the mean short-term (73.57) and long-term (64.19) attitude (p < 0.000; t = 17.35; df = 892).

Conclusion
The results of the present research regarding students’ needs assessment towards short-term
Table 1: Frequency distribution of students’ attitude of long term and short term crack abuse side effects in Islamic Azad University, Islamshahr branch

<table>
<thead>
<tr>
<th>Related questions with measuring attitude</th>
<th>Disagree</th>
<th>No comment</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>numbers</td>
<td>percent</td>
<td>numbers</td>
</tr>
<tr>
<td>1- Adolescents and young people are at high risk and biased toward crack.</td>
<td>531</td>
<td>5/9</td>
<td>102</td>
</tr>
<tr>
<td>6 - Religious use of crack is forbidden.</td>
<td>164</td>
<td>18/4</td>
<td>372</td>
</tr>
<tr>
<td>8 - Those consuming crack have a chronic disease of addiction.</td>
<td>99</td>
<td>11/1</td>
<td>159</td>
</tr>
<tr>
<td>9 - Crack causes fragility and premature aging of skin</td>
<td>539</td>
<td>60/4</td>
<td>208</td>
</tr>
<tr>
<td>10 - Crack consumption causes seizures and death</td>
<td>78</td>
<td>8/8</td>
<td>242</td>
</tr>
<tr>
<td>12 - Crack can cause limbs to be corrupted.</td>
<td>77</td>
<td>8/6</td>
<td>180</td>
</tr>
<tr>
<td>15 - Even taking crack once can cause addiction in a person.</td>
<td>136</td>
<td>15/4</td>
<td>337</td>
</tr>
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References
<table>
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<tr>
<th>Related questions measuring attitudes</th>
<th>Disagree</th>
<th></th>
<th>No comment</th>
<th></th>
<th>Agree</th>
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<tr>
<td></td>
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<td>percent</td>
<td>numbers</td>
<td>percent</td>
<td>numbers</td>
<td>percent</td>
</tr>
<tr>
<td>2 - Taking crack injection is the first phase of euphoria.</td>
<td>203</td>
<td>22/9</td>
<td>188</td>
<td>21/2</td>
<td>497</td>
<td>55/9</td>
</tr>
<tr>
<td>3- One way of controlling anger is taking crack</td>
<td>64</td>
<td>7/2</td>
<td>226</td>
<td>25/4</td>
<td>599</td>
<td>67/4</td>
</tr>
<tr>
<td>4- If crack is used occasionally or when fancied it is harmless</td>
<td>62</td>
<td>7</td>
<td>135</td>
<td>15/3</td>
<td>684</td>
<td>77/6</td>
</tr>
<tr>
<td>5 – If crack is consumed you will have a good social life.</td>
<td>318</td>
<td>35/8</td>
<td>285</td>
<td>32/1</td>
<td>286</td>
<td>32/2</td>
</tr>
<tr>
<td>7 – A crack-dependent person is able to easily stop use of this substance.</td>
<td>104</td>
<td>11/7</td>
<td>213</td>
<td>24</td>
<td>571</td>
<td>64/3</td>
</tr>
<tr>
<td>11 - Unlike other substances crack does not cause depression</td>
<td>94</td>
<td>10/6</td>
<td>335</td>
<td>37/7</td>
<td>459</td>
<td>51/7</td>
</tr>
<tr>
<td>13-Bodies who are taking crack worm lays</td>
<td>193</td>
<td>21/7</td>
<td>372</td>
<td>30/6</td>
<td>424</td>
<td>47/7</td>
</tr>
<tr>
<td>14 - Side effects from taking crack are fewer than taking other addictive substances.</td>
<td>211</td>
<td>24</td>
<td>328</td>
<td>37/2</td>
<td>342</td>
<td>38/8</td>
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<tr>
<td>16-Unlike ecstasy, crack does not create the illusion of feeling completely safe.</td>
<td>92</td>
<td>10/4</td>
<td>292</td>
<td>32/9</td>
<td>504</td>
<td>56/8</td>
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Table 2: Frequency distribution of students’ attitude of long term and short term crack abuse side effects in Islamic Azad University, Islamshahr branch
Table 3: Comparison of mean and standard deviation of students’ attitude towards crack abuse side effects in Islamic Azad University; Islamshahr Branch, related to use of doping drugs and doping athletes

<table>
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<tr>
<th></th>
<th>70/5±13/7</th>
<th>62/8±14/8</th>
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<tbody>
<tr>
<td>P value</td>
<td>&lt;000</td>
<td></td>
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</tr>
</tbody>
</table>


7- What Are the Side Effects of Crack Cocaine; http://LIVESTRONG.COM.htm

8- Cocaine and Crack short and long term effects; www.thecyn.com/.../long-term-effects-crack-addiction.html


The silent feminine torture: ‘Female genital mutilation’

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Abstract

This review will highlight the issues around Female Genital Mutilation/Cutting (FGM/C) and its practice, history, reasons, prevalence, types, religion and cultural beliefs, legality and western law, and some points in the hope to combat it. FGM/C is a dubious practice imposed on young girls’ genitals that cannot be consented to, and it is done for non-therapeutic reasons. It has been estimated that around 100-130 million women are affected all over the world, mainly in Africa. There are main four types of FGM/C, with the extreme, type III.

The main reason for such practice is to preserve virginity, chastity and prohibit promiscuity, and it is a traditional rooted behaviour in ancestral traditions. It is a symbolic convention to signify fidelity, exemplify cleanliness, femininity, beauty, and attracting men for marriage in some regions. Even those girls who undergo FGM/C and to whom are promised a boy for marriage will have both circumcised the same day (Smith 2008). Moreover some have linked FGM/C to more satisfaction and more sexual enjoyment for women (Smith 2008). Some had underpinned this rite to Islam and religion and it is in fact an assault to Islam itself as there is no backup for such in the Holy Quran.

Major drawbacks can be detrimental and irreversible, besides the psychological consequences. In some countries it is carried out by doctors and nurses and called medicalisation of FGM/C. Human-rights condemn such conduct and it is illegal to have FGM/C in the UK and a fine and prosecution will be incurred for the perpetuators.

In order to end this practice, educating women is an utmost to fight this practice, and defeat such cultural constraints, as it gives women independence at various levels, like decision-making, self-choice of spouse, work for personal fulfilment, freedom of movement, and moreover education denotes what is called ‘autonomy’.

Key words: FGM/C, circumcision, genital cosmetic surgery, female, religion and FGM/C.

Definition

FGM/C or female circumcision (known as ‘Khitan’ in Arabic) is a destructive traditional procedure dating back centuries, conducted on young girls usually between the ages of 4-10 years old, by a traditional birth attendants (TBA), or midwives, in non-sterile conditions without anaesthetic, for non-therapeutic reasons, on the belief to protect virginity and prohibit promiscuity, whilst in the west a modification has been devised to shape the body literally through surgery under the name of vaginal rejuvenation (labioplasty, piercing, pricking, cauterisation and scarping) for mainly cosmetic as well as psychological reasons (Ball 2008, Tag-Eldin, Gadallah et al, 2008). The standing argument is whether part of the body is surgically removed or altered irrespective of the drive.

The term mutilation can be misleading and can carry an offence and stigmatisation, and thus has been replaced by the word cut or circumcision which has increasingly been used for better comprehension (Billing & Kentenich 2008).

This procedure involves cutting some parts of the genitalia, such as clitoris, labia, and sometimes creating a tiny tunnel (infibulation) for menstruation and urine passage.

History of FGM/C

The history is dated back to ancient Egypt in the 5th century BC as a distinction for royal families’ females; however some others hypothesize its origin to ancient Greece and it certainly pre-dates both Islam and Christianity (Kennedy 2009). The reasons beyond that remain unclear, however in that era it was believed to be conducted for hysteria, melancholy, epilepsy, lesbianism, and controlling sexual desire including masturbation (Ball, Billing & Kentenich 2008, Tag-Eldin, Gadallah et al, 2008, Kennedy 2009). Some other myths include if FGM/C was not conducted, then the clitoris will grow up like a penis and
if it touches a penis the man will die (Smith 2008).

Prevalence of FGM/C and geographical distribution
The WHO (2008) had estimated that about 100-140 million women have undergone FGM/C worldwide, with 3 million incidences annually.

Female genital mutilation 'FGM', or cutting, is a widespread practice in some parts of the world, mainly in 28 African countries, mostly in sub-Saharan Africa. It includes namely Egypt, Sudan, Somalia, Nigeria, Gambia, Mali, Djibouti, Eritrea, Ethiopia, Rwanda, Kenya, Burkina Faso, Ghana, Democratic Republic of Congo (former Zaire), Zimbabwe, Tanzania, Togo, Ivory Coast, Guinea, Senegal, Uganda, and some of the Middle East and Southeast Asian countries like Yemen, Oman, United Arab Emirates, India, Indonesia, and Malaysia (Morris 2006). The Demographic Health Survey in 2000 (DHS) in Egypt revealed that about 97% of married women had undergone FGM/C (Tag-Eldin, Gadallah et al, 2008). Additionally according to a cross-sectional study conducted by Tag-Eldin, Gadallah et al, 2008, the prevalence of FGM/C in school girls was 50.3% with highest rates in rural areas compared with urban.

The prevalence of FGM/C is mostly high in most African countries. For instance, in Nigeria, the estimated prevalence in 2004 was 23.3 - 45.2%. However the highest rates were seen in Egypt, Sudan, Djibouti, Eritrea, Mali and Somalia, consecutively of more than 90% (Tag-Eldin, Gadallah et al, 2008).

Classifications of FGM/C
There are four main classifications for FGM/C according to WHO: type I where it involves excision of prepuce (equivalent to male foreskin), and with or without partial or complete cut of clitoris, whereas type II is type I in addition to cutting the labia minora with or without an extension to labia majora. Type III is called infibulation and is considered to be the extreme type where the vagina is narrowed by cutting and suturing both labia together by thorns or stitches to create a tiny tunnel. (Tag-Eldin, Gadallah et al 2008). Finally type IV is all other procedures as it is unclassified, but includes cosmetic genital surgery (designer vaginas), such as labioplasty, vaginoplasty, piercing, prickling, cauterisation and scarping and introducing herbs inside vagina to tighten it (Bikoo 2007).

Type I and II account for 80%, while type III accounts for only 10-15% (Leye, Ysebaert et al 2008).

FGM/C Drawbacks
This procedure can carry some types of complication whether in the short term or the long term. Such drawbacks include immediate severe pain, bleeding, shock, infection, HIV, hepatitis B and C infection, painful coitus, overgrowth scars resulting in cysts and keloid, infertility, postpartum haemorrhage, obstructed labour with foetal complications incurred as a consequences of prolonged labour, fistulae with devastating impacts on women's domestic lives, and even death in some cases; all of which are hard to overcome.

One study has found an association between depressed desperate women who undergo FGM/C and abuse to her children in the public stadium as a sign of cry for help (Afifi and Bothmer 2007).

Culture and religion
Various reasons have been proposed for the practice of FGM/C. In some regions, the cultural belief that young girls should undergo such a procedure, so they can be symbolic of ‘cleanliness’ and thus would promote the transition to womanhood and marriage aptitude, (social acceptance with higher dowry). Not only that, some mothers in some cultures assimilated that FGM/C is a ceremony performed 40 days from the end of the postpartum phase of a girl’s life after birth; however it can be delayed to age of 10 (Smith 2008). Also in Sudanese society, such acts would distinguish between decent women and prostitutes.

In the Egyptian society, religious, traditional and social pressure are the main factors for FGM/C (Tag-Eldin, Gadallah et al, 2008). Also to date, a study by Afifi and Bothmer 2007 has shown that a substantial number of medical students in the Egyptian community favour FGM/C continuation, by shifting from the traditional performance by a trained female layperson to more professional conduct through physicians and hence named it ‘medicalisation’.

All of this would only suggest that people are detainees of their traditions, and it is simply passed down without reflection (Gruenbaum 2005).

This rite is ethically unacceptable as it is a misuse of paternal authority over their dependent daughters (Cook, 2008). It depicts a victim to family violence and barbarity, and social stigma (Catania and Abdulcadir et al 2007).

In some cultures it is considered to be a ritual for puberty, and sometimes publicly celebrated (Smith 2008). Some have accorded this custom to religions like Islam, and associate it with religious purifications to enable women to pray in mosque, marry and have children (Smith 2008).

There is no proof for its religious foundation. There is no Islamic nor Christian justification or ground for such a procedure as there are no quotes for FGM/C in the Quran nor in the Bible; however FGM/C is a deeply rooted heritage mainly for cultural and traditional beliefs (Billing & Kentenich 2008). The broad conceptual division for FGM/C can fall between the following categories: socio-cultural, psycho-sexual, hygienic, aesthetic and religious.

FGM/C canonical and the UK
It is illegal and it carries a prosecution to carry out such potentially traumatic procedures on girls, and even to close it back when they become
In the developed countries the immigrants tend to ask doctors originally from their own countries to circumcise their girls illegally (Tag-Eldin, Gadallah et al, 2008). It is a violation of human-rights by all means against human bodies (Ball 2008). Also the UK is aware of those immigrants and has given warning signs to a child at risk, who might go with their parents on a special holiday to be circumcised. FGM/C is considered as child abuse. The UK has suggested examining a child’s genitals prior to departure and on return to protect young girls against their paternal violations.

The genital mutilation of young girls in foreign countries must be avoided. It is important to educate about such procedures and its drawbacks. A heated debate came up about designer vaginas, and how this phenomenon would fit with law against FGM/C, as it is as well a permanent change to the genitals; and as such action is mostly seen in teens and minors (Essen and Johnsdotter 2004).

### Combat and preclude FGM

We need to make things happen by targeting the communities firstly, as such conducts are done on young minors who cannot defend themselves. We need to sensitize the community on FGM through community educational programs, and publications about the severe consequences of FGM/C to mature adults after having birth (defibulation and re-infibulation). In the developed countries the immigrants tend to ask doctors originally from their own countries to circumcise their girls illegally (Tag-Eldin, Gadallah et al, 2008).

<table>
<thead>
<tr>
<th>FGM/C</th>
<th>Cosmetics/plastic genital surgery (labioplasty and laser vaginoplasty)</th>
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<tbody>
<tr>
<td>Depicts 'Mutilation'</td>
<td>Depicts 'Beautification'</td>
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<tr>
<td>No autonomy (victims of oppressive patriarchal rituals)</td>
<td>Autonomy and self-directed to reclaim identity and self-confidence</td>
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<tr>
<td>Perceived as natural and ideal practise</td>
<td>Perceived as enhancing beauty and wellbeing</td>
</tr>
<tr>
<td>Young girls who have no choice, nor understand the procedure itself</td>
<td>Conducted on adult mature women who asked for it, and gave consent for</td>
</tr>
<tr>
<td>Ablative/ destructive</td>
<td>Rejuvenative/ restorative (remove redundant skin)</td>
</tr>
<tr>
<td>Performed in all girls in the communities</td>
<td>Performed in selected females by their choices</td>
</tr>
<tr>
<td>Abolish the sexual pleasure and create a bad sexual experience</td>
<td>Aims to increase size of sexual sensitive areas and G-spot</td>
</tr>
<tr>
<td>Women in developing countries are defeated, oppressed and violated. Such girls grow-up alienated with the idea that their genital is normal like that as they don’t have that normal knowledge about the normal genital physical appearance</td>
<td>Women in the west are liberal and free</td>
</tr>
<tr>
<td>Reasons are mainly traditional and cultural</td>
<td>Reasons claimed mainly are mental and physical wellbeing</td>
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Difference between ‘FGM/C’ and cosmetics/‘designer vaginas’ as Cunningham B a plastic surgeon described it (Morris 2006)
emphasise its drawbacks (Grover 2009).

Any cultural change should come from within to make things happen. The decision to abandon such procedures must come from the communities and should be grounded on a firm human-rights foundation. We need to aim to change communities’ belief and attitudes as there is no religious back up for FGM/C.

It is unethical to destroy and damage the healthy organ under the name of culture and traditions. All human beings are born free with rights and any violations will be considered seriously as an offence and a forbidden conduct. FGM/C is considered as a violation to human-rights under the international conventions and declarations.

You cannot change the whole world but you might change someone’s world, somewhere, somehow. Discourage the mothers and grandmothers from having their daughters excised, as mothers are always the main decision-makers for the procedures as fathers played minor roles in decisions (Leye, Ysebaert et al 2008). Call for harm reducing strategies, for instance the performance of symbolic incisions or the medicalization of FGM (Leye, Ysebaert et al 2008)

Presently the WHO, UNICEF, and UNFPA are working on a revised common statement on FGM/C to bring up-to-date research and understanding and a scheme forward to condemn such acts. It is vital to secure female human-rights and abandon FGM/C. This also can be enforced by law and notifications. The WHO emphasised the importance of knowledge and how to enact the law.

Role of women and ‘harm reduction’
The procedure is mainly carried out by old, non-educated women using non-sterile conditions such as a broken glass, razors, rusted knives, tin lids or sharp stones taken straight from the ground. To witness a single-drop of blood is an indication for the success of the procedure. Additionally the procedure in some other regions; is increasingly done mainly by doctors, nurses under medical conditions, and so called as ‘medicalisation of FGM/C’.

Consequently the role of a woman is vital to combat and oppose any attempt to such an act, from which the concept of ‘Do No Harm’ is raised and adopted by physicians who undertake FGM/C (Afifi 2009). Thus, it mandates stopping such acts by fighting against such conductors, by raising awareness and education and gaining a piece of knowledge. It is very vital to empower women by encouraging literacy, to sense their confidence in deciding the way to live, and develop their own approach, and setting their own priorities, which can enable ending of FGM/C. Additionally this could be achieved by posting a picture which can explain itself, as a picture is worth a thousand words, by informing them and notifying of such unaccepted acts as well as enforcing a law against such acts.

Conclusion
FGM/C is a deeply inherited custom that is practised by some regions. It is a violation by all means against women’s physical and psychological integrity and a woman’s rights regarding her body and an abuse to women’s health. It carries lifelong health consequences. We need to fight against this rite, and the belief of it as an act to promote marriageability which it certainly is not. In order to combat and end the practice of FGM/C, efforts should be made by society to protect young girls from FGM/C. We need a collaborative, coordinated and multidiscipline approach involving health professionals, researchers, religious leaders, community leaders, educationalists and non-governmental organizations (NGOs) to make things happen and impose changes by raising awareness and to offer guidance, advice and clinical with holistic services in a culturally sensitive manner. Each woman has the right to have a healthy sexual and pleasurable life for the fullest psychological and physical well-being.

References
Summary Signpost

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