List of abbreviations

*MBU: Mother and baby units.

*WHO: World Health Organization.

*ICD-10: International classification of disease by World Health Organization-Tenth version.

*GHQ: General Health Questionnaire.

*PMDD: Premenstrual Dysphoric Disorder.

*EPQ: Eysenck Personality Questionnaire.

*BDI: Beck Depression Inventory.

*OCD: Obsessive Compulsive Disorder.

*MINI-KID: Mini international neuropsychiatric interview for children.

*OCS: Obsessive Compulsive Symptomes.

*RIA: Radioimunoassay.

*TT3: Total thyroxin 3.

*TT4: thyroxin 4.

*FT3: Free thyroxin 3.

*FT4: Free thyroid 4.

*TSH: Thyroid stimulating hormone.

*E2: Estrogen 2.

*MSI: Marital satisfactory inventory.

*HARS: Hamilton anxiety rating scale.

*HDRS: Hamilton depression rating scale.

*GAS: Guilford aggression scale.

*SCID-I: Structured clinical interview-Axis I.

*SCID-II: Structured clinical interview-Axis II.

*SCID-CV: Structured clinical interview-clinical version.

*MINI-PLUS: Mini international neuropsychiatric interview.

*CIDI: Composite international diagnostic interview.

*PANSS: Positive and negative schizophrenia scale.

*MMPI: Minnesota Multiphasic Personality Inventory.

*PSE: Present state examination.

*SCAN: Schedules of clinical assessment in neuropsychiatry.

*CHS: Clinical history schedule.

*WAIS: Wechsler adult intelligence scale.

*OAS: Overt aggression scale.

*YMRS: Young mania rating scale.

*PSQ : Psychological stress questionnaire.

*DSFI : Derogatis sexuel functionning inventory.

*CSFQ: Changes of sexual functioning questionnaire.

*MSI: Marital satisfaction inventory.

*PAS: Personality assessment scale.

*WISC: Wechsler intelligence scale for children.

*CBCL: Child behavior checklist.

*SCL-90: Symptom checklist-90.

*FAS: Fertility adjustment scale.

*PCASEE: Quality of life questionnaire that looks for impairment in six domains :(physical-cognitive-affective-social-economic-go functioning)

*IQ: Intelligence quotient.

*MSS: Middle sex scale.

*HADS: Hospital anxiety and depression scale.

*FLIC: Functional living index of cancer.

*APA: American psychiatric association.

*PMS: Premenstrual syndrome.

*PPD: Postpartum depression.

*PPP: Postpartum psychosis.

*ECT: Electroconvulsive therapy.

*SAFE: Study of abuse within family environment.

*GAF Scale: Global assessment of functioning scale of DSM IV

*DSM IV: Diagnostic and Statistical Manual of Mental Disorders of American Psychiatric Association -4th version.

*PTSD: Post traumatic stress disorder.

Introduction to women mental health

The need for specific psychiatric services for women has been debated by many practitioners involved in care delivery and management of women with differing degrees of mental health problems. Many authors believe that women, who represent 52% of the population, should not be classified as 'special' but should be regarded as mainstream. Their mental health needs, assessment, treatment and service requirements should receive a mainstream approach. Trying to designate special units and different treatments may lead to 'segregation by specialization'. This may further lead to evidence that women's mental health problems are distinctive and require specialty expertise. Setting women's mental health apart may result in the mistaken belief that clinicians do not need to know about it and should leave everything to the specialist ***(Satel, 1998).***

The response to this argument is that most of women's needs are accepted to be main stream by the majority of practitioners. However, there is evidence that those needs have been neglected. Many issues have not received the attention they deserve, for example: mental illness in pregnancy, motherhood and pre- and postnatal care; comorbidity; care and custody of children whose mothers have mental illness; trauma; domestic violence; child sex abuse; vulnerability; stigma and victimization; and differences in presentation of some mental health disorders. It is clear that there is a need for a gender-sensitive understanding in all generic psychiatric services. Nevertheless, mental health issues that arise from the social psychological ***(Haw, 2000)*** and physiological differences (***Scott, 2000***) between the genders need to be addressed specifically. ***(Holmshaw & Hillier, 2000),***

Gender-focused management is still a new concept and it has not yet entered into wide practice. Proponents of women's issues stress that women have been underrepresented in the decision-making process and in medical and clinical research. Data on the epidemiology of mental health issues, general and specific needs and the present state of generic services will help to establish future philosophy and policies on generic and specific services. ***(Kohen, 2001).***

Epidemiology of different psychiatric disorders in women:

There are established gender differences in the frequency, clinical expression and outcome of psychiatric disorders in women. Women have higher prevalence of depression, dysthymia, seasonal affective disorder, generalized anxiety disorders, panic attacks, phobias and deliberate self-harm .Women show differences in the social concomitants, relapse and outcome of schizophrenia. Perinatal psychiatry is exclusive to women, and women comprise the majority of cases with eating disorders. ***(Meltzer et al, 1995).***

Depression

The lifetime prevalence of major depression in women is almost twice that in men. According to some studies, depression affects over 20% of the female population***).*** Prevalence rates of the mild but chronic forms of depression and dysthymia are considered to be higher in women, although it is accepted that studies on mild depression and dysthymia are difficult to interpret because of differences in definition and problems of reliability. The presence of certain mood abnormalities such as premenstrual dysphoric disorder may contribute to the higher prevalence of depression. ***(Kaplan, Sadock,2004)***

Generalised anxiety disorder

Generalised anxiety disorder is more prevalent in women, and the risk of panic disorders is three times more common in women GAD is around 7% in U.S***).***Women are also more likely to experience posttraumatic stress disorder (1.3% in U.S) ***(Kaplan ,Sadock ,2004)***

Deliberate self-harm

Deliberate self-harm (DSH), which is an index of social deprivation, is closely linked with unemployment, overcrowding, substance misuse, physical and sexual abuse during childhood and domestic violence. There is a higher prevalence of DSH in women of all ages. ***(Hawton et al, 1997).***

Perinatal psychiatric disorders

The prevalence of post-partum psychosis is about 0.2% and that of postnatal depression 10–15% ***(Kaplan ,Sadock , 2004).***It was noticed that low income women were more likely to suffer from postpartum depression***.(IOWA University 2008).***

Eating disorders

These syndromes, predominantly seen in women, show a male-to-female ratio of 1:10 or even more (1:20). In Britain the incidence of anorexia

nervosa is 7 per 100 000 population, which may mean 4000 new cases per year **.** Of individuals suffering from bulimia nervosa, 90% are female, and the incidence in young women is 52 per 100 000 **(Turnbull et al, 1996).** In U.S, prevalence of anorexia nervosa is 0.28% in young females. Bulimia nervosa prevalence is 11.4 per 100.000.) ***(Kaplan,Sadock ,2004)***

Drug and alcohol dependence in women

The British Household Survey **(Thomas et al, 1998)** indicates that there has been a gradual increase in alcohol consumption by British women and that the proportion of women drinking over 14 units per week had increased to 14% in 1996.The Psychiatric Morbidity Survey ***(Meltzer et al, 1995)*** shows that men have a higher prevalence of drug dependence (3%) than women (1.5%).In U.S, 5% of women consume alcohol (either dependence or abuse) ***(Kaplan, Sadock , 2004).***

Schizophrenia

Schizophrenia appears at younger age in men (15-25 year) and perinatal insults to the central nervous system appear to affect more men than women***(Kaplan,Sadock,2004).***

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Difficulties in social and interpersonal interaction, which are associated with higher relapse rates, show a marked difference. Women show lower rates of sensitivity to and lower responses to expressed emotion but higher risk for suicide ***(Kaplan, Sadock , 2004).***

Increase in sickness absence with psychiatric diagnosis:

Psychiatric disorders have always been one of the most common diagnostic groups in sickness absence, and in recent years there has been an increase in cases ***(Alexanderson et al 2004).***

Whether this represents a true increase in the prevalence of psychiatric disorders or an adjustment in sickness absence to the real occurrence of lowered work capacity due to psychiatric disorders has been the subject of discussion ***(Sandanger et al 2000).***

General population-based assessments of cumulative incidence of sickness absence with psychiatric disorders have varied from 2.1% for women and 1.3% for men in Sweden in 1985 to 3.53% and 1.66% in Norway in 1998

(Herrin J et al 2001) .A higher incidence among women has been reported by several studies ***(Hensing G et al 1995).***

In the Whitehall II study on civil servants aged 35–55 years ***, Stansfeld, 1995*** found a social gradient in sickness absence with psychiatric disorders and a higher incidence in widowers, single men and divorced women. In occupational groups that were extremely male or female dominated, the sex in the minority had a higher incidence of sick leave with psychiatric disorders. (***Hensing G et al 1995).***

The economic consequences of sickness absence with psychiatric disorders are important. The total National Insurance expenditure for psychiatric disorders in sickness absence, medical rehabilitation and disability pension in Norway adds up to EUR 2,676 mill. in 2004 which corresponds to 27% ***(National Insurance Administration 2005***) .

Community responses to the female mentally ill:

Attitudes about the mentally ill have been charted in public opinion surveys since the 1950s and dislike and fear have remained high among the attitudes surveyed. Negative attitudes are particularly pronounced among people who are poorly educated and among the elderly; men consistently report more negative attitudes than do women.

The core concerns about persons who are mentally ill revolve around their presumed unpredictability and dangerousness. These concerns have some basis in reality, as patients released from state psychiatric hospitals have comparatively high arrest rates. However, most crimes committed by released patients are property crimes that do not involve violence. Unfortunately, the mass media typically emphasize cases where violent crimes are committed by people with a history of emotional problems, thus exacerbating the problem of public misperception.

Intensely negative attitudes about the mentally ill may be a part of a larger cluster of beliefs, attitudes, and values characterized by an absence of sympathy for people who need help; a deep-seated distrust of people and institutions who are perceived as different; and a rigid outlook on what is right and wrong. Such people's views are not easily swayed by rational arguments. ***.(Kaplan , Sadock , 2004)***

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Maternal deaths

"Maternal deaths" were traditionally defined as occurring any time during pregnancy and up to 42 days postpartum, with additional classification as "direct", "indirect" or "incidental direct deaths result from obstetric complications (e.g., eclampsia). Indirect deaths result from a condition that is not directly related to obstetric causes but is aggravated by the effects of pregnancy (e.g., a cardiac condition***)***. In Australia, before 1997, deaths from psychiatric illness, apart from puerperal psychosis (which was classified as a direct cause), were classified as incidental maternal deaths (conditions occurring during pregnancy but for which the pregnancy is unlikely to have contributed significantly to the death). ***". (WHO 2005 report).***

More recently, the classification of maternal deaths was broadened (ICD-10 coding) to include late maternal deaths — that is, deaths from direct or indirect causes between 43 and 365 days postpartum .Deaths associated with psychiatric illness are increasingly being included in the category of late maternal deaths. ***.(WHO 2005 report).***

It is well recognized that maternal deaths due to psychiatric illness have been under-reported, partly because of misclassification of suicides as incidental deaths, and partly because of under-reporting of late maternal deaths .Late maternal deaths are more difficult to identify, as they often occur after women have ceased to attend maternity services. Researching deaths thereafter is reliant on various data collections (including coroners' reports and state registries of births, deaths and marriages), which in the past have not necessarily identified death in relation to giving birth, thus making them a less reliable source of information. ***.(Hedegaard K, et al 2003-Berg C, et al 2005***).

From the psychiatric perspective, there has also been a conceptual shift. Researchers and clinicians have moved away from focusing solely on postnatal psychiatric disorders to including disorders arising across the perinatal period. In the mental health context, the perinatal period is usually defined as encompassing pregnancy through to the end of the first year postpartum**.(*Austin MP .Arch women Mental Health 2004)***

Innovative psychiatric services for women in the 21 st century

Philosophy

It is important that the philosophy of caring for women with mental health problems is well established. It is also important that all members of the local unit, ranging from senior management to the mental health workers delivering the services, are clear about the objectives of this service. Psychiatric services for women will be successful if there is agreement that they are a way forward to improve quality of life and decrease suffering. Well-funded, accessible, multi-agency, integrated, tiered local services with access to specialist services should be our goal***. (Kohen, 2001)***

Recognition of local needs

Recognition of the specific needs of the local community will lead to a better understanding of the services required. National surveys, publications of the Office of National Statistics, demographic variables about the area, general practice statistics and information from local hospitals and accident and emergency departments offer invaluable data on the specific needs of a locality. Comparison of admission and readmission rates in different areas with the index district will also help build up a picture of the psychiatric needs of women. The number of births per year can be an important Index in the establishment of perinatal psychiatric services. Antenatal obstetric services could be a useful source of information on the number of women who have depression or psychosis. Since many cases of post-partum psychosis and postpartum depression show their first clinical signs while the women are in obstetric clinics, close links with these clinics may help to clarify the local needs. Domestic violence figures from the police, although an under-representation, may give insight into the number of women who will need services.***(Kohen ,2001).***

*Community provisions (***Community psychiatry for women)

The first step is to set up a community psychiatric group within a larger community psychiatric team, which will accept referrals for key-working with women with perinatal psychiatric problems, schizophrenia in pregnancy. This group will study unmet needs and relationships with patients and professionals, and to contribute to future planning of the most

effective services. Family centers that offer daily assessment of the parenting skills of mothers with severe mental health problems can be a good alternative to other mental health facilities. Women with long-term severe mental illness have rehabilitation needs that differ from those of male patients. Mixed-gender rehabilitation teams may not been very attractive to women, who may be shy and unwilling to participate. However, there are occupational therapy indicating reports that when the choice of specific groups with female-designated tasks are offered, vulnerable women perform well***. (Kohen 2001).***

Desjarlais et al 1995 suggested recommendations for Specific Initiatives in Mental Health Services and Training

1. Upgrade the quality of mental health services

   Mainstreaming a gender perspective in the mental health sector -- through educating women at all levels of society about the possibilities of mental health interventions and the potential for services and programs -- is central to the success of mental health program development. The development of community based programs may build upon the engagement of many women to their local communities and their commitment to community and family health. Formal mental health services, including rational drug policies for psychotropic medications and the reliable provision of adequate supplies at reasonable costs (selected generic antidepressants, antipsychotic and anticonvulsant drugs), must be complemented by non-medical support groups, consumer groups and healing institutions that provide crucial care in many communities.

2. Encourage systematic efforts to upgrade the amount and quality of mental health training for workers at all levels, from medical students to graduate physicians, from nurses to community health workers.

   Essential to mental health programs is a small cadre of well-trained mental health professionals: psychiatrists, psychologists, social workers and psychiatric nurses. Specific training in diagnosis and management of psychiatric conditions is required to improve the quality of mental health services offered in primary care.

3. Promote efforts to improve state gender policies, toward interdicting violence against women, and toward empowering women economically, and to make women central in policy planning and implementation of mental health services. Research should evaluate the mental health consequences of these programs for women, for children, and for men.

   Women throughout the world constitute the vast majority of caretakers of first and last resort for chronically disabled family members, including mentally retarded children, demented elderly, and adults suffering a major mental illness. Minimally, it is in a community's long-term social interest to assist with this burden through formal health services..

   4-Collective and interpersonal violence is one of the most pressing problems in the world today. Transnational initiatives to treat trauma may assist in modest but effective ways as well to quickly respond to and aid victims of collective violence. Intervention programs of therapy and triage, which have been shown to have beneficial effects, need to be supported internationally as well as locally given costs and limited services in many parts of the world. Women's organizations have taken major roles in leading such efforts in the past and can be models for future efforts as well.

5-Direct efforts specific to primary prevention of mental disorders, and behavioral, psychosocial and neurological disorders.

Successful prevention programs call for the integration of biological and psychosocial factors, and the active promotion of proven preventive programs. Models taking account of the co-morbidity of many disorders, the clusters of psychiatric disorders and psychosocial distress, must be developed in order to encourage interventions to support individuals who are afflicted with mental illness.

While it is essential that affordable, accessible, appropriate treatments and systems of referral and care are available for people with mental illness in developing country settings (especially women), the promotion of mental health by addressing its determinants is another potential strategy for

reducing the burden of mental illness for individuals and communities in these settings. (***Public health 2007)***

Summary

Both women and men deserve the best of services. The discussion of services for women is intended to draw attention to the specific needs and the physiological, psychological and social concomitants of mental illness in women. Once these needs are recognized and management plans are set, services will be provided not just by a small group of specialists but by all involved in mainstream and generic psychiatry. The next step now should be to conduct wider discussions highlighting women's distinctive needs and raising awareness of them within the profession. Increased awareness usually leads to increased detection, which in turn leads to increased demands for different specific services. Dealing with mental health issues specific to women will require trained professionals and more research on the subject. Adequate research, informing local expertise, will yield the best patient satisfaction. It is hoped that the emerging evidence on gender and physiological, social and psychological aspects of mental health will lead to the establishment of academic departments of women's mental health**.** ***(Kohen , 2001).***

Rationale of the work

As medicine moves to be evidence based, the excess amount of research being published nowdays raises the need for having the criteria for critical appraisal to determine the value of published researches and to decide their applicability to clinical practice.So this work aims to make full use of this effort to identify the missed points in Egyption researches about psychiatric disorders in women to overcome the defects in the future.

METHODOLOGY (PROCEDURES)

In Order to fulfill the aim of the work, a systematic review of all available Egyptian studies on psychiatric disorders in women will be done.

The following databases will be explored:

1- Library of Faculty of Medicine Ain Shams University
2- Library of Faculty of Medicine Al-Azhar University
3- Library of Faculty of Medicine Cairo University
4- Library of Faculty of Medicine Alexandria University
5- Some other journals of Psychiatry for Egyptian studies

The obtained studies from these databases will be categorized according to the following categories:

1- Epidemiology
2- Etiology
3- Clinical description
4- Outcome
5- Management

These studies will be critically appraised and important findings will be discussed. Following these steps recommendations for further studies would be generated.

Systematic review

Understanding the concepts of systematic review helps to know the importance of evidence-based medicine.

Many if not most medical review articles are still written in journalistic form. The term journalistic review refers to an overview of primary studies which have not been identified or analyzed in a systematic way. A systematic way means standardized and objective way. Journalists get paid according to how much they write rather than how much they read or how critically they process it. In contrast a systematic review is an overview of primary studies which contains a statement of objectives, materials&methods that has been conducted according to explicit and reproducible methodolgy***.(Mustafa ,2006)***

In this methodology, the objectives of the review of the primary studies should be stated with determining the eligibility criteria. The methodological quality of each of these studies should be assessed, then search for studies that seem to meet eligibility criteria will be done. the most complete dataset feasible should be assembled with assistance from investigators, if possible. Analysis of the results of eligible studies by using statistical synthesis of data (meta-analysis) is better to be done if appropriate and possible with comparing the alternative analyses. Finally, a critical summary of the reviews, stating aims, describing materials&methods, and reporting results should be presented.***(Greenhalgh, 2001).***

Most research studies are concerned with one or more of the following :

Therapy-Diagnosis-Screening-Prognosis-Etiology

Oxman and Guyatt, 1993 stated that systematic review has the following advantages :-

a) It limits bias in identifying and rejecting studies through following standard and explicit methods and hence conclusions are more reliable and accurate.

b) Through systematic reviews, large amounts of information can be assimilated quickly by health care providers, researchers and policymakers, through these information, the delay between research discoveries and implementation of effective diagnostic and therpeutic strategies is potentially reduced.

c) Results of different studies can be formally compared to establish generalisability of findings and consistency (lack of heterogenecity) of results.

d) Reasons for inconsistency in results can be identified through systematic reviews and so new hypotheses can be generated about particular subgroups.

e) Quantitative systematic reviews (meta-analyses) increase the precision of the overall result.

****Greenhalgh,2001 stated that the standard questions asked to evaluate a systematic review are:***

a) Can you find an important clinical question which the review addressed?

b) Was a thorough search of the appropriate databases done and were other potentially important sources explored?

c) Was the methodological quality assessed and the studies weighted accordingly?

d) Have The numerical results been interpreted with common sense and with regard to the broader aspects of the problems?

d) Have The numerical results been interpreted with common sense and with regard to the broader aspects of the problems?

*In order to fulfill aim of this work, we have to make a systematic review to all Egyptian studies that targeted psychiatric disorders in women.

*In fact, there were plenty of studies targeting different aspects of this problem such as effect of (substance abuse-infertility-hysterectomy-cancer breast-premenstrual dysphoric disorder-obsessive compulsive disorder-depression-schizophrenia-bipolar disorder-burn-crime preparation-domestic violence-sexual dysfunction),While other studies targeted (the response to antidepressants-effect of menstruation on schizophrenic symptoms-spouse role in addiction-psychiatric morbidity in wives of addicts),There were quantitative studies that measured

(serum estrogen in menopausal women and its relation to cognitive impairment-biological markers of female vulnerability to depression).

*It was difficult to review these topics, classify them precisely according to epidimiology, etiology, clinical profile, outcome and management. But we will try to review them systematically in an appropriate way.

*At first, it is important to mention magnitude of the problem in the whole world. As comparative analysis of empirical studies of mental disorders reveals a consistency across diverse societies and social contexts: symptoms of depression and anxiety as well as unspecified psychiatric disorder and psychological distress are more prevalent among women , whereas substance disorders are more prevalent among men. The disability-adjusted life year's data recently tabulated by the World Bank reflect these differences. Depressive disorders account for close to 30 percent of the disability from neuropsychiatric disorders among women, but only 12.6 percent of that among men. Conversely, alcohol and drug dependence accounts for 31 percent of neuropsychiatric disability among men, but accounts for only 7 percent of the disability among women. These patterns for depression and general psychological distress and substance disorders are consistently documented in many quantitative studies carried out in societies across the world. ***(Desjarlais et al. ,1995),*** Explanations proposed for gender differences in psychiatric morbidity in Asia, Africa, the Middle East and Latin America echo established associations among poverty, isolation and psychiatric morbidity for women in Western Europe and the United States ***(Dennerstein et al. 1993).***

Epidemiology of psychiatric disorders in women

Mental disorder epidemiology is the quantitative study of the distribution and causes of mental disorder in human populations. This definition has several important components, including a population focus and a reliance on statistical methods to assess significant differences among population groups in their risk for developing mental disorders.
Epidemiological research focuses on population groups rather than individuals. Although individuals within population groups must be accurately diagnosed, the unique scientific questions addressed by epidemiology begin with descriptions of how mental disorders are distributed across different population subgroups. By providing a scientific method for assessing the relative health status of communities and different population groups, epidemiology serves as the basic science of public health. An observation that disease rates in one population group significantly exceed expected or average rates is the basis for identifying an epidemic within the population. Such assessments require accurate diagnosis of all cases of illness within the population and the use of statistical methods to assess differences in the frequency of disorders in population groups studied. Identifying different rates of illness in population groups is only the first step in epidemiological investigations. Both clinicians and epidemiologists rely on observations that pathological states are differentially associated with physical, biological, social, and temporal characteristics of human beings and their environments. Where causal mechanisms are not yet clearly defined, epidemiologists attempt to identify characteristic factors that define populations with excessively high rates of illness, including mental disorders. By narrowing the range of characteristics associated with a disorder, the ultimate aim is to identify specific correlates or risk factors whose alteration will interrupt the causal network that produces a disorder**.(*Kaplan,Sadok 2004).***

Now, Psychiatric disorders are generally believed to be the outcome of complex interactions between biological, psychological, and social forces, so that the linear one to one model of causality is hardly likely to explain any type of psychiatric disorder successfully. Within the domain of descriptive epidemiology, considerable progress has been made during the last four decades in the direction of delineating the extent and nature of psychiatric morbidity in the community. Community psychiatric surveys are an essential part of psychiatric epidemiology. They inform us about the need for services and whether these are changing, they

allow us to examine disorders without the distortions of the referral process, they permit the identification of high risk groups, and they enable us to examine the influence of important social and cultural factors ***(Ghubash, 2001).***

A basic requirement for understanding any disease is an understanding of the distribution of the illness in the general population and variables that determine that distribution. Epidemiology is the study of variation in the distribution of specific disorders in population and the factors that influence that distribution. Epidemiological studies can generate three types of information about a disorder: states, variations of these states by person, time and place and identification of risk factors which increase the probability of developing the disorder. Such information, pathogenesis, treatment and prevention can provide insights to improve practice and planning for care ***(Okasha, 1998).***

Four studies discussed prevalence of many disorders e.g. substance abuse, obsessive compulsive disorder, post-partum psychological disturbances and premenstrual dysphoric disorder.

1-Substance use disorders amonge females in secondry school students in Cairo:

Hashim studied the extent ,socio-demographic relevance, etiology of substance abuse in secondary school female students in 3 different areas in Cairo. She selected 593 female students distributed among six schools in urban (Heliopolis), semi-urban (Zayton) and rural (EL-Marg) areas in Cairo. For each area, one governmental and one private school were chosen to be studied. From each school, three classes representing the secondary educational levels were randomly studied, Initiated and completed during the educational year 2000-2001.

**** She used the following methods:**

*A self-administered questionnaire for the detection of substance use disorders (Soueif, et al, 1986).

*A self-administered (General Health questionnaire) for the detection of psychiatric disorders (Goldberg, 1983).

*Any student who reported psychiatric disorder was furtherly and individually assessed by the research diagnostic criteria using the ICD-Symptom Checklist that helps to check the presenting symptoms

****The author found out that** prevalence of substance use disorders was 18.4%. Alcohol was the most common substance used (15.9%) , followed by illicit drugs (3.9%), tobacco smoking (2.5%) and then cannabinoid (0.7%).

****It was concluded that:**
1-causes of continuation were (getting dependent on then & influence of their friends& various social occasions& getting sense of pleasure)
2-causes of abstinence were (fear of dependence & harmful effect of drugs on health & religious factor & social limitations).
3-Tobacco was significantly correlated with being a student in a private school or a member of a club or association. While cannabinoid users had moderately educated father. Alcohol abusers were living in semi-urban residents, having highly educated mothers, being a member in a club and being a student in a private school (***Hashim 2002***).

2-A Psycho-socio-demographic study of premenstrual dysphoric disorder (PMDD) in a sample of Egyptian women.

Zarif studied the prevalence , symptoms of PMDD, its relevance to different personalities and socio-demographic factors in Ain Shams University Hospitals where a sample of Egyptian females (single or married ,in child bearing period) were chosen randomly with inclusion criteria of: (age from 15-45 year, regular menstrual cycles),exclusion criteria of :(presence of medical or gynecological disease, being under any drug therapy).The sample included doctors, nursing students and employees.
****The author used the following methods:**
1- Eysenck Personality Questionnaire. (EPQ).
2-Taylor Manifest Anxiety Scale.
3-Beck Depression Invetory. (BDI)
4-Guilford Scale.
5-Fahmy and El Sherbini (1988).
6-Dealing with illness coping inventory
****The author found out that:**
1-High prevalence in first social class.
2-High prevalence in troublesome homes.
3-Menorragia,dysmenorria,infertility and abortions were higher with PMDD.
4-Prevelance of PMDD in our sample was 6.59% while premenstrual exacerbation was 3.65%.Values for control group was 52.08%. Dropouts of this research were 7.7%.

5-Higher score for neuroticism, criminality, anxiety and depressive symptoms
****It was concluded that:** Symptom profile of PMDD is variable (pain-negative affect-behavioural changes-irritability-mood swings-fatigue-general aches-

preference to stay at home-breast tenderness-bouts of excitement-nausea-vomiting-difficulty in concentrating -palpitation-feeling of suffocation) ***(Zarif 1999).***

3-Post-partum psychological disturbances (Epidemiological view).

Youssef studied prevalence of risk factors of post-partum depression and puerperal psychosis.

****The selected sample consisted of:**

1-Ladies delivering in department of gynecology and obstetrics in El Hussein University Hospital in 50 days chosen randomly.(Group I)

2-Ladies admitted to El Abbassia mental hospital, known to have given birth within 6 months previous to admission. (Group II)

3-Ladies admitted to El Maadi Palace with a history of delivery 6 months prior to admission.(Group III)

****The author used** the psychiatric sheet-mini mental scale and Hildreth Scale for mood as a method of studying post-partum psychological disturbances.

****The author found out that:** Psychiatric symptoms in puerperium are (adjustment disorder with depressed mood 13.2%-maternity blues 7.5%-atypical bipolar disorder 3.8%) while risk factors are (unemployment-positive family history of mental illness-neurotic mood-negative attitude of husband-sex of the baby)

****It was concluded that** negative attitude of the mother towards the baby and negative attitude of father to mother reflects depressive mood***.(Youssef 1985).***

4-Prevelance of obsessive compulsive disorder among female secondary school students in Cairo.

Soltan studied prevalence of OCD in female secondary schools in Cairo and mentioned the most common obsessive compulsive symptoms. So 607 female students were selected from urban, semi urban and rural areas (public and private schools) aged from 14-17 years from Cairo secondary schools.

****The author used the following methods:**

1-Leyton obsessional inventory-child version.

2-Mini International Neuropsychiatric Interview for Children (MINI-KID).

3-Full clinical assessment.

****The results** showed that Prevalence of OCD is 1.2%, while obsessive compulsive symptoms prevalence is 13.01% .The commonest OC symptom was excess conscience (more in rural than urban, more in public than private school).

****So it was concluded that** adolescent OCD is not a rare disorder while subthreshold obsessive compulsive syndrome is widely presented in adolescent population. Culture may Colour the clinical picture but does not affect prevalence. Religion does not affect prevalence of OCD but it is an area where OCD expresses itself***. (Soltan 2002).***

Table (1):Studies discussing epidemiology of psychiatric disorders of women.

Auther	Site	Instruments	Subject	Results
Hashim 2002	Cairo governorate, Ain Shams University Hospitals	*A self-administered questionnaire for the detection of substance use disorders (Soueif, et al, 1986),General Health questionnaire)	593 patients (governmental, Private schools).	Prevalence of substance use disorders in secondary school females in Cairo was 18.4%. Alcohol was the most common substance used (15.9%) , followed by illicit drugs (3.9%), tobacco smoking (2.5%) and then cannabinoid (0.7%).
Zarif 1999	Ain Shams University Hospitals.	1- Personality Questionnaire. (EPQ).Eysenck 2-Taylor Manifest Anxiety Scale. 3-Beck Depression Inventory.(BDI) 4-Guilford	Females (15-45 year).	PMDD prevalence was 6.59% while premenstrual exacerbation was 3.65%.

		Scale. 5-Fahmy and El Sherbini. 6-Dealing with illness coping inventory		
Youssef 1985	El-Hussein University (Cairo).	(psychiatric sheet-mini mental scale-Hildreth Scale for mood)	3 groups of patients in 3 different hospitals.	Psychiatric symptoms in puerperium were (adjustment disorder with depressed mood 13.2%-maternity blues 7.5%-atypical bipolar disorder 3.8%).
Soltan 2002	Ain Shams University Hospitals. (Cairo)	1-Leyton obsessional inventory-child version. 2-Mini International Neuropsychiatric Interview for Children (MINI-KID). 3-Full clinical assessment.	607 patients (14-17 year)	Prevalence of OCD was 1.2%,while Obsessive compulsive symptoms prevalence was 13.01%.

Etiological and risk factors of psychiatric disorders in women

Many researchers studied the etiological factors related to many psychiatric disorders. As regarding etiology, it is a combination of genetic vulnerability and environmental stresses (diathesis stress model).So genetic defect will manifest itself when environmental risk factor is also present *(Craddock, 2005).***

The studies discussing the etiology of psychiatric disorders in women done in Egypt are still deficient in many aspects especially those concerned with the biological factors, this may attributed to lack of technologies and expertise required for such studies. Moreover, the greater importance was given to the epidemiological and sociocultural studies.

The following 10 studies demonstrated that issue.

1-Study of the relationship between serum estrogen level in menopausal women and cognitive functions.

Ibrahim studied the etiological relation between level of serum estrogen and cognitive abilities. So the author selected ninety naturally menopausal women selected randomly from general population ,allocated into three groups according to duration since menopause.

*Group I (30 women) with more than 1 year, less than 2 years from menopause.
*Group II (30 women) with 2-6 year since menopause
*Group III (30 women) with more than 6 year since menopause.
** Exclusion criteria are:(history of psychiatric, medical illness, previous head injury, smoking ,drug abuse, gynecological disorder with hyperestrinism, obese women, women with history of hormonal replacement therapy.

****The author used the following methods:**

1-Full history taking including gynecological history.
2-Thorough general medical examination.
3-Complete mental state examination.
4-Serum estradiol level by RIA (using available kits)
5-Neuropsycological tests of memory functioning using :(mini mental state examination.

****The results** showed **that** there is negative correlation between duration since menopause and serum estradiol levels, also between women age and scores of

cognitive tests. **But** there is positive correlation between serum estradiol levels and cognitive function tests.
****It was concluded that** physiological menopause (estrogen deficiency) has a negative effect selectively on short term verbal memory.***(Ibrahim 1999).***

2-<u>Biological markers of women vulnerability to depression.</u>

Shawer studied biological factors of women vulnerability to depression. The author used 60 patients fulfilling criteria of DSM IV of depression (40patients-20 normal) **.**All members were subjected to:
1-Full clinical psychiatric sheet.
2-Laboratory tests including T3-T4-TSH-Estrogen level.
3-Psychometric study.
****The results** showed that there was a positive correlation between degree of depression and age of the patient, his marital status, his social class. While Level of TT3,TT4,FT3,FT4 ,TSH ,E2 are significantly different between patients and controls. The higher the degree of depression, the lower the level of TT3-TT4-FT3-E2
It was concluded that the higher the E2 level, the higher the TT4 level*(Shawer 2006)*

** No one can deny the role of risk factors in development of psychiatric disorders e.g. (marital discord, inadequate psychosocial support, recent traumatic life events, low socioeconomic status, unwanted pregnancy and domestic violence**) (Evans J, 2001).**So many researchers tried to study the effect these risk factors practically. The following six studies were examples for this**.**

3-<u>Spouse role in the problem of drug abuse.</u>

Emara studied main sources of marital dissatisfaction and conflicts in couples of drug abusing husbands, relation between behaviors and attitudes of wives of addicts and main source of conflicts between them and coping mechanisms of their wives that contributes to the problem. 30 addict patients and their spouses were selected from inpatient psychiatric hospital. Patients were diagnosed according to criteria of DSM IV-TR (2000), the control group was 30 normal male persons and their spouses were matched for same age, educational level and social status.

****Tools used were:**
1-Marital Satisfactory Inventory (MSI)
2-Hamilton Anxiety Rating Scale (HARS)
3-Hamilton Depression Rating Scale (HDRS)
4-Gillford Aggression Scale (GAS)
****The results** showed that wives of addicts prefer traditional roles while husbands of female addicts do not, Wives had higher level of aggression, depression and anxiety. There was no history of family distress.
****It was concluded** that couples of drug abusers have ill communication difficult problem solving, sexual dissatisfaction, and conflict over child rearing, disaggreament over finances and dissatisfaction with children**. *(Emara 2002*).

4-Psychiatric morbidity in wives of substance users in an Egyptian sample.

Afifi studied the impact of substance use on wives of addicts, different types of burden upon them and prevention, management of morbidity detected. The selected sample was 120 wife of substance abusers form outpatient or inpatient unit in Ain Shams University Hospital.
****Tools used were:**
1-General health questionnaire (GHQ Arabic version)
2-Assessing social class using Egyptian Classification of Fahmy ,El-Sherbini 1988.
3-The Structured Clinical Interview for DSM IV AXIS I disorders (SCID II)
4-Mini International Neuropsychiatric Interview (MINI PLUS Arabic version)
5-North Carolina Family Assessment Scale.
6-Social Readjustment Rating Questionnaire.

****Results** showed that addict's wives showed significant higher level of (adjustment-major depressive-anxiety-personality-sexual) disorders.
There were problems in areas of family environment, financial management, domestic violence, low parenting capabilities and bad quality of life.
****It was concluded** that **a**ddicts spouses experience a burden that increases as illness lengthens so negative impact on quality of life is expected which is associated with psychiatric morbidity**. *(Afifi 2007).***

5-<u>Study of domestic violence in a sample of Egyptian female psychiatric patients.</u>

Ezzat studied different conceptual and psychiatric aspects of domestic violence. The study explained issues of domestic violence in married couples with female partner having a psychiatric illness.

****The sample consisted of** 60 married female psychiatric patients put in 3 groups:(20 diagnosed as bipolar affective disorder-20 diagnosed according to ICD 10 to have neurotic disorders-20 as control group).

****The tools used were** :

1-Zung self rating depression scale.
2-Locus of control.
3-Eysenck Personality Questionnaire (EPQ)
4-Special questionnaire used to assess intimacy and abuse according to wives perception of husbands characters

****Results showed that:**

1- Physical abuse is more common than verbal and emotional.
2-Domestic violence has significant relation with history of child abuse.
3-Battered women were more depressed, showed higher scores in middle level of locus of control and higher scores in psychoticism.
4-Abused women said that their husbands are not democratic and reported husband parental troubles.
5-There is an important relation between divorce and domestic violence.

****It was concluded that:**

1-Domestic violence is a general health problem that has psychiatric, medical, social and legal aspects .It is underestimated with insufficient measures to face this problem.
3-Child abuse, husband family troubles, divorces or beating are important risk factors for domestic violence***.(Ezzat 2005)***

*6-<u>**Study of risk factors of post-partum depression (cross cultural perspective).**</u>*

Abdel Latif studied risk factors for development of post partum depression taking cultural aspect into consideration **.**The sample consists of women who gave birth in the last 9 months, Half of the sample is patient and subgroup., the other half is control group.(The sample contains 4 cultural groups e.g. Saudi-Yemeni-Sudanese-Egyptian).The study was done in Dar El Shifa Hospital (Jeddah).

Tools used were: Composite international diagnostic interview (CIDI)-Semi-structured questionnaire for assessment of possible risk factors of postpartum depression.
****Results showed that the** most common causes of postpartum depression are (postpartum blues-polygamy-guardian unemployment-marital problems-undesired infant sex being teenage).However, women in this study were married, muslims, of different educational level and aged between 22-26 year.
(***Abdel Latif 1999)***

*7-**Impact of menstrual cycle on schizophrenia.***

Abdel Razek was studying the following:
1-Comparing schizophrenic symptoms in different phases of the cycle aiming to find any significant difference.
2-Finding a relation between exacerbation and specific phase of the cycle (whether exacerbation increase in late luteal and early follicular or not).
So 40 Saudi female patients were selected with inclusion criteria of (diagnosed as schizophrenic by ICD 10-on a therapeutic dose of antipsychotic drugs-all in child bearing period-all have history of regular menses: at least 3 consecutive cycles).Exclusion criteria were(irregular cycle-pregnancy-intake of oral contraceptive pills-affective symptoms or schizoaffective)
The study was done in Al Amal complex for mental health.
****Tools used were** ICD 10 Symptom Checklist and PANSS (positive, negative schizophrenia scale).
** **Results showed that :**
1-There was statistically significant difference between luteal ,follicular phase of the cycle regarding total score of PANSS ,the highest score in the luteal (premenstrual phase).
2- There were highly significant correlation between date of admission, menstrual and premenstrual phase (Being higher in luteal than menstrual).

****It was concluded that:**
1-Premenstrual exacerbation of symptoms in female schizophrenics may not be a worsening of the core schizophrenic symptoms but a concurrence of a cluster of affective, behavioural, and somatic symptoms which may be related to hormonal changes.
2-Hormonal treatment for schizophrenic is still in research phase***.(Abdel Razek 2006)***

8-Study of violence against women(study of prevelance,psychiatric consequences)

Hussin studied magnitude, prevalence, possible correlates, consequences, different theories explaining violence against women plus reviewing interventions made to prevent future occurrence of the problem.

1158 females were selected with certain inclusion criteria (age from 18-45 year), certain exclusion criteria (other age groups).

They were put in 2 groups:

1-Group I: 620 female from gynecology clinic.

2-Group II: 538 females from psychiatric outpatient clinic.

The study was done in Al-Zahraa Hospital Outpatient Clinic.

****Tools used were:**

1-Standerdized psychiatric assessment. Structured clinical interview for DSM IV axis I disorders.(SCID-CV)clinical version 1997.

2-Structured clinical interview for DSM IV Axis II personality disorder.

3- World SAFE questionnaire (study of abuse within family environment)

4-Clinical psychiatric assessment using Al-Zahraa hospital sheet. The study

****Results** showed that:

1-Types of violence :(slapping-hitting-beating-kicking-insulting-threatening-abandoning)

2-There is interpersonal violence between husbands and wives.

3-Causes reported by women are (refusing sex-withholding money-disobedience-joules-house duties)

4-Bipolar patients are more likely to be abused followed by psychotic patients.

5-Severly abused patients usually attempt suicide.

6-Most common psychiatric disorders related to abuse are (depression-generalized anxiety disorder-somatoform disorder).

7-Types of sexual abuse (street harassment-touching-rubbing-attempt or actual rape-exhibitionism).

****It was concluded that:**

1-Psychiatric patients of group II were more abused than those of group I as follows :(physical, psychological abuse-abuse during pregnancy-sexual abuse-hospitalization as a consequence)

2-Risk factor for abuse in women (illiterate-abused or witnessed abuse in childhood-not working).

3-Risk factors for women who prepare for violence :(illicit drug abuse plus the former factors).

4-Victims are more liable to psychiatric disorders than the non abused persons.

(Hussein 2007).

9-Study of Depression during pregnancy as a risk factor for pre-eclampsia,a prospective study.

Hewedi and Fahmy studied occurrence of preeclampsia in different stages of pregnancy, its relation to depression. So 100 nulliparas women with singleton pregnancies were recruited, with certain inclusion and exclusion criteria, followed up longitudinally from early pregnancy to end of gestation with comprehensive neuropsychiatric assessment. Preeclampsia was defined as elevated blood pressure than 140/100 mmHg and proteinuria (0.3 during 24 hours or more).

****Tools used were:**

1- Beck depression inventory (BDI).
2- Blood pressure measurement.
3- Protein in urine measurement.
4- Semi-structured interview using clinical obstetric data sheet.
5-Revised scale of socioeconomic status of the Egyptian family

****Results** showed that:

Depression was detected in 30% of subjects in early pregnancy while it was detected in 34% of subjects in late pregnancy. Pre-eclampsia occurred more with combined early and late depression than late depression alone.

****It was concluded that:**

Depression in pregnancy is strongly linked with risk for subsequent pre-eclampsia***.(Hewedi, Fahmy 2006)***

10- Violence against Women in Egypt(Psychological and Social Consequences)

Seif El Dawla studied 500 women and 100 men from various locations in Egypt. The inclusion of men in the study had twofold objectives:

1- To draw an insight about men's perceptions regarding violence against women.

2- To compare both male and female perceptions regarding the phenomenon under study.

She wanted to investigate the perception of a sample of Egyptian women and men to the issue of gender violence, the personal experience of women of such violence and the psychological consequences that might follow therefore. She used a cross-sectional observational study.

****Tools used were:** 1- Women were interviewed by means of

- A questionnaire designed to investigate demographic background, personal knowledge and attitude towards violence against women in and outside the family.
- Checklist of personal exposure of domestic violence applied to married

women only.
- ICD- 10 checklist for psychological symptomatology applied to women who themselves had experienced domestic violence.
2- Men were interviewed regarding their demographic background and their attitude towards domestic violence against women.
3- Results were tabulated for descriptive purposes.
4- The definition of violence against women adopted in this study is the definition of the International Declaration against Violence against women adopted by the UN General Assembly on the 20th of December 1993.

**Results showed that: 1- The most commonly reported symptoms were feelings of helplessness (97%), depressive symptoms (92%), lack of self confidence (87%) and a chronic feeling of apprehension ,anticipation of violence (85%). generalized Anxiety disorder (36 cases), adjustment disorder (28 cases), dysthymic disorder (15 cases), and major depressive disorder (1 case).
2-Spouse behavior that women consider violence:
Polygamy 96% -marital rape 93%-preventing wives from going out of the house 83%-withholding children after divorce 77%-enforced obedience 72% Preventing wives from traveling 70%
3. Psychological consequences of violence Psychological reaction %
Feelings of helplessness 97-depressive symptoms, inappropriate sleep and fatigue 92-lack of confidence in others 87-chronic feeling of apprehension and anticipation of violence 85-lack of self confidence 84-bouts of anger 79 Chronic ambiguous feeling of guilt 68-mood swings 50-flashbacks and nightmares of certain violent incidents 12
4-Diagnosis percentage were (PTSD 2 .1%-GAD 36 .19%-Adjustment disorder 28. 15%-Dysthymic disorder 15. 8%-Major depressive disorder 10.5%

****It was concluded that:** gender violence is a considerable phenomenon in Egypt that it constitutes a psychological health problem to women and that it has psychological consequences that deserve special attention and intervention on the part of mental health professionals***. (Seif El Dawla 2001)***

Table (2)Etiology and risk factors of psychiatric disorders in women.

Auther	Site	Instrument	Subject	Results
Ibrahim 1999	Alexandria University Hospitals.	1-Full history taking including gynecological history. 2-Thorough general medical examination. 3-Complete mental state examination. 4-Serum estradiol level by RIA (using available kits) 5-Neuropsycological tests of memory functioning using :(mini mental state examination).	90 menopausal patients	Negative correlation between duration since menopause and serum estradiol levels, also between women age and scores of cognitive tests. Positive correlation between serum estradiol levels and cognitive function tests
Shawer 2006	Police hospital in Cairo. Ain Shams University. .	1-Full clinical psychiatric sheet. 2-Laboratory tests including T3-T4-TSH-Estrogen level. 3-Psychometric study.	60 depressed patients .	Level of TT3, TT4, FT3, FT4, TSH , E2 were significantly different between patients and controls. The higher the degree of depression, the lower the level of TT3-TT4-FT3-E2. the higher the E2 level, the higher the TT4 level. Wives had higher level for aggression, depression, .

Afifi 2007	Ain Shams University Hospital and El Nozha Hospital	1-General health questionnaire (GHQ arabic version) 2-Assessing social class using Egyptian Classification of Fahmy,El-Sherbini 1988. 3-The Structured Clinical Interview for DSM IV AXIS I disorders (SCID II) 4-Mini International Neuropsychiatric Interview (MINI PLUS arabic version) 5-North Carolina Family Assessment Scale. 6-Social Readjustment Rating Questionnaire.	120 couples (inpatient-outpatient)	Wives showed significant higher level of (adjustment-major depressive-anxiety-personality-sexual) disorders. There were problems in areas of family environment, financial management, domestic violence, low parenting capabilities and bad quality of life.
Ezzat 2005	Kasr El Aini Hospitals in Cairo	1-Zung self rating depression scale. 2-Locus of control. 3-Eysenck Personality Questionnaire (EPQ) 4-Special questionnaire used to assess intimacy and abuse according to wives perception of husbands characters.	60 patients	Physical abuse was more common than verbal and emotional. Domestic violence had significant relation with history of child abuse. Battered women were more depressed, showed higher scores in middle level of locus of control and higher scores in psychoticism. There was an important relation between divorce, parental troubles and domestic violence. Domestic violence was a general health problem that had psychiatric ,medical, social and legal aspects .It was underestimated with insufficient measures to face this problem

Hussin 2007	Al-Zahraa Hospital.(Cairo).	-Standardized psychiatric assessment. Structured clinical interview for DSM 1V axis I disorders.(SCID-CV)clinical version 1997. 2-Structured clinical interview for DSM 1V Axis 11 personality disorder. 3- World SAFE questionnaire (study of abuse within family environment) 4-Clinical psychiatric assessment using Al-Zahraa hospital sheet.	1158 patients (18-45 year).	Types of violence were (slapping-hitting-beating-kicking-insulting-threatening-abandoning) .There was interpersonal violence between husbands and wives. Causes reported by women were (refusing sex-withholding money-disobedience-joules-house duties).Bipolar patients were more likely to be abused followed by psychotic patients. Severely abused patients usually attempted suicide. Most common psychiatric disorders related to abuse were (depression-generalized anxiety disorder-somatoform disorder).Types of sexual abuse were (street harassment-touching-rubbing-attempt or actual rape-exhibitionism).Risk factor for abuse in women were (illiterate-abused or witnessed abuse in childhood-not working).Risk factors for women who prepare for violence were (illicit drug abuse plus the former factors).
Abdel Latif 1999.	Dar El Shifa Hospital (Jeddah)	1-Composite international diagnostic interview (CIDI) 2-Semi-structured questionnaire for assessment of possible risk factors of postpartum depression.	Unlimited number of new mothers (22-26 years)	Postpartum depression is the same medically but different culturally according to the following risk factors:(family history of psychiatric illness-cesarean section-guardian unemployment-hormonal contraceptives-marital problems-polygamy-not breast feeding-poor social support-postpartum blues-premenstrual tension syndrome-primipara-teenager-undesired infant sex-unwanted pregnancy)
Abdel Razik	Al Amal	ICD 10 Symptom	40 patients.	1-Premenstrual exacerbation of

2006.	complex for mental health	Checklist.- PANSS(positive, negative schizophrenia scale).		symptoms in female schizophrenics may not be a worsening of the core schizophrenic symptoms but a concurrence of a cluster of affective ,behavioural ,and somatic symptoms which may be related to hormonal changes. 2-Hormonal treatment for schizophrenic is still in research phase.
Emara 2002	(Maadi Nile Sanatorium) Ain Shams University	1-Marital Satisfactory Inventory (MSI) 2-Hamilton Anxiety Rating Scale (HARS) 3-Hamilton Depression Rating Scale(HDRS) 4-Gillford aggression scale(GAS)	60 couples	Couples of drug abusers had ill communication skills, Difficult problem solving, sexual dissatisfaction, conflict upon child rearing, disagreement with finances and dissatisfaction with children
Hewedi, Fahmy 2006	out patient clinic of obstetric and gynacology Ain Shams University	1-Beck depression inventory (BDI). 2-Blood pressure measurement. 3-Protine in urine measurement. 4-Semi-structured interview using clinical obstetric data sheet. 5-Revised scale of socioeconomic status of the Egyptian family.	100 subjects.	depression was detected in 30% of subjects in early pregnancy while it was detected in 34% of subjects in late pregnancy. Pre-eclampsia occurred more with combined early and late depression than late depression alone.
Seif El Dawla 2001	Ain Shams University.	1- Women were interviewed by means of - A questionnaire designed to investigate demographic background, personal knowledge and attitude towards violence against women in and outside the family. - Checklist of personal exposure of domestic	500 women, 100 Men	1- The most commonly reported symptoms were feelings of helplessness (97%), depressive symptoms (92%), lack of self confidence (87%) and a chronic feeling of apprehension ,anticipation of violence (85%). generalized Anxiety disorder (36 cases), adjustment disorder (28 cases), dysthymic disorder (15 cases), and major depressive

		violence applied to married women only. - ICD- 10 checklist for psychological symptomatology applied to women who themselves had experienced domestic violence. 2- Men were interviewed regarding their demographic background and their attitude towards domestic violence against women. 3- Results were tabulated for descriptive purposes. 4- The definition of violence against women adopted in this study is the definition of the International Declaration against Violence against women adopted by the UN General Assembly on the 20th of December 1993.		disorder (1 case). **2-**Spouse behavior that women consider violence : polygamy 96% -marital rape 93%-preventing wives from going out of the house 83%-withholding children after divorce 77%-enforced obedience 72% preventing wives from traveling 70% **3.** Psychological consequences of violence Psychological reaction % feelings of helplessness 97-depressive symptoms, inappropriate sleep and fatigue 92-lack of confidence in others 87-chronic feeling of apprehension and anticipation of violence 85-lack of self confidence 84-bouts of anger 79 chronic ambiguous feeling of guilt 68-mood swings 50-flashbacks and nightmares of certain violent incidents 12 **4-**Diagnosis percentage were PTSD 2 .1%-GAD 36 .19%-Adjustment disorder 28. 15%-Dysthymic disorder 15. 8%-Major depressive disorder 1 0.5%

Clinical profile of psychiatric disorders in women

1-Gender related psychobiological differences in obcessive compulsive disorder patients.

Nasr El Den studied gender related demographic, clinical, neuropsychological and biological characteristics that may help better understanding of OCD. Also the study tried to estimate severity of symptoms, it relation to presence of cognitive deficit and gender difference that may help management of OCD patients

****The following tools were used:(**Yale Brown Obsessive Compulsive Scale-Yale Brown Obsessive Compulsive Symptom Checklist-Hamilton Anxiety Scale-Hamilton Depression Scale-Wisconsin Card Sorting test-Controlled oral word association test-Attention tests-Social Readjustment Rating Scale-Selected Subtests from Wechsler Adult Intelligence Scale(Similarities, Block design)-Selected subtests from Wechsler Memory Scale-Revised(figural memory, visual paired associate 1,visual reproduction 1,visual memory span).

****Results** showed that men expressed more religious, sexual obsessions, hopelessness, controlled oral word association and visual memory span. While women expressed more hoarding , other compulsions, failure to maintain serotonin level. Females were slower, less selectively attentive than males, more impaired as language abilities than males.

****It was concluded that**

1-Sex does not determine OCD severity.
2-Females show higher serotonin level especially in chronic illness so serotonin is gender specific marker.
3-Attentional deficit is disease specific rather than gender specific.
4-OCD is not a stress related behavior but it is a maladaptive learnt behavior.
5-OCD is not a progressive disorder as regards cognitive dysfunction***.(Nasr El Din 2001).***

2-Gender Differences in Depressive Disorders in an Egyptian Sample.

Botros studied gender differences in unipolar major depression in adult Egyptian sample. **The selected were** 40 patients diagnosed as unipolar major depression according to DSM 1V criteria (20 male-20 female)

****Patients were subjected to:**

1-Full psychobiogram.

2-General physical and neurological examination.
3-Beck Depression Inventory .
4-MMPI (D) Scale (Arabic version)
****Results** showed that:
1-Males showed low self esteem, indecisiveness, decreased dreams, neglected self hygiene and prevailing depressed mood.
2-Females showed fatigue, crying, dissociative symptoms, negative self perception, tendency to go out, decreased sexual desire, no change in dreams, adequate self hygiene, retardation and impaired judgment.
****The author concluded that** many factors Colour clinical picture, symptomatic expression of depression e.g. level of education, work, gender, socioeconomic state, personality and cultural norms of society. (***Botros 1997).***

3-<u>Gender differences in schizophrenia.</u>

El-Rakhawy studied clinical presentation of schizophrenia in both groups with a stress on the cultural factors affecting such differences.
****The author suggested that** gender has an impact on epidemiology, age of onset,symptoms,coarse and outcome of schizophrenia (neuropsychological and neuroanatomical fields).103 patients were selected with certain inclusion and exclusion criteria.
****The following tools were used:**
1-The Egyptian Classification of Fahmy and El-Sherbini.
2-Present State Examination 10 th(PSE 10) included in Schedules of clinical assessment in Neuropsychiatry(SCAN) Arabic version.
3-Clinical History Schedule (CHS) included in SCAN.
4-MMPI personality test.
5-Wecksler Adult Intelligence Scale (WAIS)
6-Overt Aggression Scale (OAS).
****Results** showed that:
1-Men: have an earlier age of onset, a poorer premorbid history, more negative symptoms, differential neuro cognitive functions, a poorer response to neuroleptics and a lower family risk for schizophrenia.
2-Women: had more decreased motor activity, self neglect, suicidal attempts, higher scores in paranoia scale of MMPI and a tendency to have more positive family history of schizophrenia.
****It was concluded that** gender has little impact on presentation and course of schizophrenia. Assessment should be done in context of sociocultural beliefs***.(El Rakhawy 1998).***

4-Gender differences in bipolar disorder.

Hassan studied gender differences in bipolar disorders in Egyptian sample.
The sample consists of 55 patients (27 males-28 females).The study was done in Kasr El Aini hospital .Diagnosis: according to DSM IV criteria.
**Patients were subjected to:
1-Detailed psychiatric history taking sheet (Kasr El Aini Sheet)
2-Hamilton Depression Rating Scale (HDRS)
3-Young Mania Rating Scale (YMRS)
4-Eysenck Personality Questionnaire (EPQ)
5-Psychological Stress Questionnaire (PSQ)
****Results** showed that gender difference lies in the following:
1-Females :(lower mean age-earlier age of onset-shorter duration of episode-usually divorced-rapid cycling-positive family history of bipolarity-high score in extraversion)
2-Males :(higher mean age-later age of onset-longer duration of episode-being single-depressed and mixed episodes-high score in mania rating scale and in family, economic stresses-high guilt-loss of interest-weight change)
****It was concluded that:**
1-Prevelance rates in women exceed those of men.
2-Gender difference in mood disorders have an important clinical subtypes or symptoms clusters specific to each sex, will help better understanding of pathophysiological mechanisms involved in affective illness***.(Hassan 2002).***

5-Presentation of female sexual dysfunction in medical practice.

Abed studied relative frequency, forms and possible psychological factors of sexual dysfunction. 33 females were selected from gynecology clinic, put into 3 groups:
1-Group I(S group): distressed by sexual problems and choose to go to gynecologist.
2-Group II(D group):distressed by sexual problem, answered positively to general sexual screen and welcome sex therapy.
3-Group III(C group):have sex difficulties, answered negatively to general sexual screen and refuse sex therapy.
****Tools used were:**
1-General sexual screen proposed by Seahan.
2-Semistructured interview tailored to fit the research, diagnose sexual problems according to ICD 10.

3-Marital Satisfaction Inventory (global version) .
4-DSFI (Derogatis sexual functioning inventory).
**Result showed that:
1-Conservative patients :(30 year old-from suburban areas-have more than 3 children-unwanted pregnancy-after 10 years of contraception)
2-Frank cases (20 years old-newly married-no children-liberal-positive self body image-first 3 years of marriage-after any gynecological operation).
****It was concluded that** most common sexual complaints were vaginismus, loss of sexual desire, dyspareunia and anorgasmia***(Abed 1998).***

6-Sexual dysfunction in female psychiatric patients.

El Fangry studied this topic, its relationship with personality characteristics, marital adjustment and sexual hormonal levels.
120 female psychiatric patients were screened, inclusion criteria was having sexual dysfunction, exclusion criteria of having current psychiatric illness or with organic etiology for sexual dysfunction.
****Tools used were**:
1-Sexual history 2-General Health Questionnaire (GHQ)
3-Assessment of sexual function using CSFQ.
4-Assessment of marital adjustment using global version of MSI.
5-Assessment of personality PAS.
6-DSFI modified extracted version.7-Sex hormone level measurement.
****Results** showed that: 1-The most common sexual dysfunctions are desire disorders, orgasmic dysfunction, arousal disorder, dyspareunia and lastly vaginismus.
2-The most common psychiatric disorders in these patients are (mood-anxiety-somatoform-adjustment) disorders.
3-There was high rate of circumcision, manual hymenal perforation in wedding night, discrimination in favor of males, earlier onset of marriage and first information about sex from the family.
4-Psychiatric patients had low (sexual drive, sexual attitude, sexual satisfaction, orgasmic capacity, desire frequency and total sexual functioning) plus more dependent personality disorder than others.
****It was concluded that:**
1-Psychiatric patients show more sexual dysfunction, personality pathology and marital dissatisfaction than others.

2-There is a high rate of overlap between different sexual disorders in the same patients.
3-Testesterone is positively correlated with sexual desire and orgasm. (***El Fangry 2003).***

7-Psychological aspects of sex chromosome disorders with application on turner syndrom.

Gaffer studied psychological aspects of different sex chromosome disorders (impact on cognitive development, personality, behavior and possible related psychological complications)
The author did an assessment of Egyptian Turner Syndrome girls aged between 8-12 year, with the aim of identifying possible psychological characteristic profile of these patients which might help in avoidance of psychological. The study was done in national research centre.
****Patients were subjected to the following**:
1-Wecsler intelligence scale for children (WISC)
2-Bem sex-role Inventory.
3-Child Behavior Checklist(CBCL)
4-Symptom Checklist-90 (SCL-90)
****Results** showed that:
1-The 2 groups were not different as regards somatic features, anthropometry and intelligence tests.
2-Cognitive decline in these patients start since childhood and continue to adulthood
3-Patients had higher femininity score and they can manage appropriately in their homes and they are less symptomatizing than normal girls(due to being defensive in their self reports about symptoms)
****** The author concluded that** early diagnosis, follow up is very important. Overprotection or rejection from parents is forbidden. Early social stimulation and special schooling are necessary. Medical treatment for induction of growth, regular menses must be considered***.(Gaffer 1993).***

8- Pregnancy related obsessive compulsive disorder(A study in Egyptian sample).

Assad T, Kamel K.M. studied 100 pregnant females from those attending antenatal care clinics. Inclusion criteria included any female who accepted to be subjected to detailed psychological evaluation, without specifications related to age, educational level, parity; past or family history standard pattern of randomization or sample selection had been followed). The control group

consisted of similar number of nonpregnant females (preferably, a patient's relative), matched for age and educational level as far as possible with the pregnant group.

****Patients were subjected to the following**:

1- Structured Clinical Interview based on DSM–IV SCID I Clinician version (1997) for clinical psychiatric diagnosis.

2- SCID II (Structured Clinical Interview for DSM IV Axis II Personality Disorders (1997).

3- Yale-Brown-Obsessive-Compulsive Scale for assessment of severity and phenomenology of obsessions, only for those who will fulfill criteria of OCD (Arabic version translated by Okasha et al 1994).

4- The standard gynecologic and obstetric history and examination for pregnant group.

****Results** showed that :

1-The most frequent obsessions encountered were religious thoughts followed by cleanliness thoughts and rituals and then impulses related to harming the foetus.

2-Severity of the disease ranged from moderate to sever.

3-Most of symptoms occurred in the 2 nd trimester.

**** The authers concluded that** positive family history of OCD and the presence of obsessive compulsive personality were the two significant associations. Several explanations can be put foreword to understand such a relation between pregnancy and OCD, including the possible effect of gonadal steroids on serotonergic system. ***(Assad T, Kamel K.M 2001)***

Table (3) Studies discussing clinical profile of psychiatric disorders in women.

Auther	Site	Instrument	Subject	Results
Nasr El Din 2001	Kasr Al Aini Hospital,(Cairo)	(Yale Brown Obcessive Compulsive Scale-Yale Brown Obcessive Compulsive Symptom Checklist-Hamilton Anxiety Scale-Hamilton Dedression Scale-Wisconsin Card Sorting test-Controlled oral word assosiation test-Attention tests-Social Readjustment Rating Scale-Selected Subtests from Wecsler Adult Intellegence Scale(Similarities,Block design)-Selected subtests from Wecsler Memory Scale-Revised(figural memory,visual paired associate 1,visual reproduction 1,visual memory span).	81 persons.	Men expressed more religious, sexual obcessions,hopelessness ,controlled oral word association and visual memory span.While women expressed more hoarding,other compulsions,failure to maintain seritonin level.Femaies were slower,less selectively attentive than males,more impaired as language abilities than males
Botros 1997	Kasr Al Aini Hospital,(Cairo)	1-Full psychobiogram. 2-General physical and neurological examination. 3-Beck Depression Inventory . 4-MMPI (D) Scale (Arabic version	40 patients.	1-Males showed low self esteem,indecisiveness, decreased dreams,neglected self hygien and prevailing depressed mood. 2-Females showed fatigue,crying,dissociative symptoms,negative self perception,tendency to go out,decreased

				sexual desire,no change in dreams,adequate self hygien,retardation and impaired judgment
Hassan 2002	Kasr Al Aini Hospital,(Cairo)	1-Detailed psychiatric history taking sheet (Kasr El Aini Sheet) 2-Hamilton Depression Rating Scale (HDRS) 3-Young Mania Rating Scale (YMRS) 4-Eysenck Personality Questionnaire (EPQ) 5-Psychological Stress Questionnaire (PSQ)	55 patients.	1-Females:(lower mean age-earlier age of onset-shorter duration of episode-usually divorced-rapid cycling-positive family history of bipolarity-high score in extraversion) 2-Males:(higher mean age-later age of onset-longer duration of episode-being single-depressed and mixed episodes-high score in mania rating scale and in family,economic stresses-high guilt-loss of interest-weight change)
El Rakhawy 1998.	Multiple hospitals (Kasr El Aini-El Abbassia-El-Nile Sanatorium-Dar El	1-The Egyptian Classification of Fahmy and El-Sherbini. 2-Present State Examination 10 th(PSE 10) included in Scedules of clinical assessment in Neuropsychiatry(SCAN) Arabic version. 3-Clinical History Schedual (CHS) included in SCAN. 4-MMPI personality test. 5-Wecksler Adult Intellegence Scale (WAIS) 6-Overt Aggression	103 patients.	:1-MEN: have an earlier age of onset,a poorer premorbid history,more negative symptoms,differential neurocognitive functions,a poorer response to neuroleptics and a lower family risk for schizophrenia. 2-WOMEN:had more decreased motor activity,self neglect,suicidal attempts,higher scores in paranoia scale of

	Mokattem).	Scale(OAS).		MMPI and a tendency to have more positive family history of schizophrenia.
El Fangry 2003.	Kasr Al Aini Hospital,(Cairo)	1-Sexual history 2-General Health Questionnaire(GHQ) 3-Assessment of sexual function using CSFQ. 4-Assessment of marital adjustment using global version of MSI. 5-Assessment of personality PAS. 6-DSFI modified extracted version. 7-Sex hormone level measurment	120 patients.	The most common sexual dysfunctions were desire disorders,orgasmic dysfunction,arousal disorder,dyspareunia and lastly vaginismus.The most common psychiatric disorders in these patients were (mood-anxiety-somatoform-adjustment) disorders.There was high rate of circumcision,manual hymenal perforation in wedding night,discrimination in favour of males,earlier onset of marriage and first information about sex from the family.Psychiatric patients had low (sexual drive,sexual attitude,sexual satisfaction,orgasmic capacity,desire frequency and total sexual functioning) plus more dependent personality disorder than others. Psychiatric patients

				showed more sexual dysfunction, personality pathology and marital dissatisfaction than others.There was a high rate of overlap between different sexual disorders in the same patients. Testesterone was positively correlated with sexual desire and orgasm.
Abed 1998	Al-Zahraa outpatient clinic (Cairo)	1-General sexual screen proposed by Seahan. 2-Semistructured interview tailored to fit the research,diagnose sexual problems according to ICD 10. 3-Marital Satisfaction Inventory (global version) . 4-DSFI (Derogatis sexual functioning inventory).	33 patients.	Most common sexual complaints were vaginismus, loss of sexual desire, dyspareunia and anorgasmia.

Gaffar 1993	National Research Center(Cairo)	1-Wecsler intelligence scale for children (WISC) 2-Bem sex-role Inventory. 3-Child Behaviour Checklist(CBCL) 4-Symptom Checklist-90 (SCL-90)	21 patients (8-12year)	Recommendations were (overprotection or rejection from parents is forbidden.Early social stimulation and special schooling are necessary.Medical treatment for induction of growth,regular menses must be considered). Cognitive decline in these patients started since childhood and continue to adulthood. Patients had higher femininity score and they could manage appropiatly in their homes and they were less symptomatizing than normal girls(due to being defensive in their self reports about symptoms).
Asaad ,Kamel 2001	Ain Shams University	1- Structured Clinical Interview based on DSM–IV SCID I Clinician version (1997) for clinical psychiatric diagnosis. 2- SCID II (Structured Clinical Interview for DSM IV Axis II Personality Disorders (1997). 3- Yale-Brown-Obsessive-Compulsive Scale for assessment of severity and phenomenology of	200 subjects.	OCD was significantly higher in pregnant females ($p<0.05$). The most frequent obsessions encountered were religious thoughts followed by cleanliness thoughts and rituals and then impulses related to harming the foetus.

		obsessions, only for those who will fulfill criteria of OCD (Arabic version translated by Okasha et al 1994). 4- The standard gynecologic and obstetric history and examination for pregnant group.		

Out come of psychiatric disorders in women

1- Psychiatric morbidity in infertility in a sample of Egyptian females.

Radwan studied psychiatric morbidity among infertile women,identified its variables,investigated its relationship and highlighted this topic.The auther reviewed medical aspects of infertility and reviewed available treatment of psychiatric difficulties related to infertility.

So 210 women put into 2 groups (patient-control) ,selected in 1 year interval (June 2005- July 2006) The patient group was 110 infertile women (inpatient-outpatient)

*Inclusion criteria:(primary infertility-child bearing period-fulfill diagnosis of infertility)

*Exclusion criteria:(Major general medical disease-Male factor infertility-History of recurrent abortions)

**control group:100 fertile women (no history of infertility,abortions nor hormonal contraception)

The study was done in **d**epartment of obstetrics and gynecology,Ain Shams University Hospitals (Assisted Reproductive Technique Unit).

****Tools used were:**

1-Structured Clinical Interview for DSM IV (SCID I)
2-Structured Clinical Interview for DSM IV axis II (SCID II)
3-Fertility Adjustment Scale (FAS)
4-Beck Depression Inventory.
5-The Manifest Anxiety Scale.
6-PCASEE quality of life questionnaire.
7-Eysenck Personality Questionnaire (E.P.Q)
8- D- scale of Guillford Inventory of Personality factors.
9-Fahmy and El-Sherbini Social Classification Scale .

****Results** showed that :

1- Social phobia is the most encountered ,followed by dysthymia,major depressive disorder,obcessive compulsive disorder,agoraphobia and post traumatic stress disorder.
2-Comorbidity between depression and anxiety is high.
3-High prevelance of personality disorder.

****It was concluded that** women with psychiatric morbidity have difficulty to become pregnant and poorer outcome in general***(Radwan 2007).***

2-<u>Descriptive study of psychotic homicidal females in comparison with psychotic females non-offenders.</u>

Elwan did the following:
a-Reviewd Egyptian ,International litrature about;(Legal definition of homicide ,criminal responsibility- relation between mental illness,violence and criminality-homicidal behaviour committed by mentally ill women).
b- Compared female psychotic homicidal with female psychotic non-homicidal to detect a correlation in the past history,social circumstances and clinical profile associated with homicide.
c-Described crime circumstance
****Global assessment was done** by using psychiatric assessment and history taking according to Ain-Shams semi-structured interview then usage of standardized psychiatric assessment using Structured Clinical Interview for DSM 1V .(SCID I- SCID II).Inclusion criteria were :(female-psychotic).Exclusion criteria were:(organic or epileptic psychotic patients)
****Results** showed that homicidal females scored higher on GAF scale.50% of them were schizophrenics,35% were bipolar.15% were schizoaffective.
****It was concluded that** correlates of homicide in psychotic females were :(younger age of onset of mental illness-diagnosis of schizophrenia then bipolar manic then mood episodes of postpartum onset then schizoaffective-being married with children-history of exposure to domestic violence in childhood-past history of sever violent acts especially attempted homicide). ***(Elwan 2005)***

3-<u>Psychiatric evaluation of Egyptian female mentally diseased criminals.</u>

William tried **t**o find the relationship between crime and various mental disorders. 70 females were selected from El-Abbassia hospital and put in 3 groups:
1-Group I: 20 females mentally-disordered criminals from El-Abbassia mental hospital.
2-Group II: 25 female non-mentally disordered,criminals from El-Kanater prison.
3-Group III: 25 female mentally disordered,non criminals from Abbassia mental hospital

Persons were subjected to:
1-Demographic data and specific factors related to crimes.
2-Psychiatric interviews,complete psychiatric examination.
3-Psychometric assessment for I.Q,Personality and Adaptation.
****Results** showed that :
1-Mean age of committing a crime is around 35 year,with more prevelance in rural areas,mostly amonge married female housewives with low educational level and past history of mental disorder.
2-Family history of criminality and-or mental disorder with absence of father figure as an added factor.
3-Wepons used are either sharp instrument or heavy blunt objects.
4-Victims are usually relatives to patients.(usually husbands).
5-Causes of crimes were (accidental murder-excitement-anger-vendetta-delusion of persecution or infedility-with out cause).
6-Most of patients have intellectual deterioration and social maladjustment.
7-There is high score for criminality,neuroticism,lie score,depression traits,impulsivity and maladaptability scale.
8-Psychiatric disorders mostly occurring are (schizophrenia-bipolar disorder-mental subnormality-sociopathy-addiction).
****It was concluded that** mental hospital criminals are not more criminals (bad) than prison criminals.
*Mental hospital criminals are not more mentally disordered (mad) than patients with no criminal records***.*(William 1986).***

4-<u>Psychiatric assessment of female burn patients during hospitalization.</u>

Abdel Hameed made a psychiatric assessment of female burned patients specially for depression ,anxiety ,deterioration of self concept and fear to face society after discharge as an impact of disfigurment and incapacity.The study was done in Kasr Al Aini Hospital-Ahmad Maher Hospital-Shobra General Hospital-Om El Masreyeen Hospital.
****The selected sample was** 50 females put in 2 groups:
1-30 burnt female aged from 18-40 year ,having third degree burn affecting any part of the body.
2- 20 normal female in the same age group.
****Tools used were :**
1- Patient group were subjected to the following:(psychiatric sheet-Hamilton Depression Rating Scale-Hamilton Anxiety Scale-Self-Concept Questionnaire-Abbreviated Burn Specific Health Scale)
2-Normal controls were subjected to (HDRS-HAS-SCQ)

****Results** showed that 40% reached level of diagnosable psychiatric illness while 60% did not.Most common diagnoses were (depression-acute stress disorder-delirium-mixed anxiety depression) specially with burns of the face.
****It was concluded that** burns significantly affected psychological well being of patients.Specialized psychiatrist should be available to handle these troubles***(Abdel Hameed 1996).***

5-<u>Psychosexual aspects of female circumcision.</u>

Sami studied this phenomena,knew its extent in society.compared between circumcised,uncircumcised females regarding psychological and sexual effects.
80 females (40 circumcised-40 uncircumcised) were selected
from outpatient clinic in Ahmad Maher Hospital(obstetric,gynecology).
****Tools used were**:(Quesstionnaire about attitude of females towards circumcision-Eysneck Personality Inventory-Sexual Inventory modified,extracted from Derogatis Sexual Inventory).
****Results** showed that :
1-The chief motive was religious then inherited customs.
2-Women reported physical and hygienic complications after operation .
3-Most women were illitrate,operated upon by midwives or doctors.
4-Most of circumcised females had high neurotic score and reached orgasm with difficulty.
****It was concluded that** the most important side effects of circumcision were sexual dis-satisfaction and anorgasmia***.(Sami 1995).***

6-<u>Psychological aspects of hysterectomy.</u>

Omar studied **p**sychological problems with hysterectomy specially sexual problems with the husband. 60 patients admitted in Kasr El Aini hospital over 8 months,
(30 inpatient females from gynecology department,to carry out hysterectomy-30 inpatient females from surgry department,to carry out cholcystectomy).
****Tools used were:**
1-Clinical interview,psychiatric diagnosis according to DSM IV.
2-Middle Sex Scale (MSS).
3-Beck Depression Inventory (BDI).
****Results** showed that :

1-Psychiatric diagnosis after hysterectomy were depression,anxiety then sleep disorders.
2-Quality of sexual life after operation improved.
3-Patients below 40 year,without children suffer psychologically more than other women.
4-Good husband,family relationship minimize this stressful situation.
****It was concluded that :**
1-Importance of family relations to women after operation.
2-The expectations of women,premenopausal age and premorbid personality determine sequele after operation***.(Omar 1998).***

7-<u>Psycosocial profile of a sample Egyptian female patients with breast cancer.</u>

El Hennawy aimed at investigating a sample of Egyptian female patients with breast cancer,trying to get a psychosocial profile and to detect risk factors important in tumerogenesis of breast cancer.
****The selected sample was** 60 Egyptian females in 3 groups:

- 20 with breast cancer (group I)
- 20 with benign breast tumers (group II)
- 20 not known to have physical or psychiatric disorders (group III)

****Tools used were** (after taking consent) :
1-Semistructured sociodemographic and clinical interview.
2-Social readjustment rating scale.
3-Eysenk Personality Inventory (EPQ)
4-ICD-10 research diagnostic criteria.
****Results** showed that :
1-High incidence of (loss of libido-persistant somatic complains not responding to symptomatic treatment-retardation-sleep troubles-fears-worries-eating problems-depressed mood-psychiatric disordrs not attributed to any specific disease).
2-No difference between groups regarding (sociodemographic data-stressful life events in year preceding diagnosis).
3-Cancer breast patient consume more fat in diet compared to the rest of the sample.
4-High score in extraversion, low score in neuroticism.
5-Low prevelance of personality disorder in cancer breast patients.
****It was concluded that** high prevelance of psychiatric manifestation in breast cancer patients denots importance of psychiatric and psychological support to improve physical and psychosocial wellbeing***.(El Hennawy 1999).***

8-psychological profile and quality of life(QOL) assessments in cancer breast patients.

Allam highlighted the quantitative,qualitative psychological profile,quality of life changes in lives of those patients to provide intervention stratiges to cover patients suffering.

****The selected sample were** females diagnosed as breast cancer patients with no age limitations to facilitate the recruitment .The auther aimed to have an idea about the distribution of the different changes in psychological profile in the different age groups.

****Tools used were** used:

a-Beck Depression Inventory (BDI)

b-Hospital Anxiety and Depression Scale (HADS)

c- Functional Living Index-Cancer (FLIC)

d-The Structured Clinical Interview for DSM IV Axis I Disorders (SCID-I)

****Results** showed that :

1- case group suffer from depression,anxiety more than control group.

2-patients below 50 years old suffer severe symptoms of anxiety, depression more than those above 50 years old.

3-Quality of life is worse in patients below 50 years.

4-More anxiety is present in patients with lumbectomy(for fear of recurrence).

5-More depression is present in patients with radical mastectomy.

****It was concluded that t**here are cultural issues that need to be assessed in breast-cancer patients so we suggest some questions added to quality of life tools***.(Allam 1999).***

9-psychiatric manifestations in cancer breast patients.

Hussein studied the effect of breast canser upon psychology of women. **The selected sample was put in** two groups :

1-patients group:40 cancer breast patients were chosen from radiotherapy clinic at the main hospital of alexandria university.

2-control group: 20 females suffering from breast abcess were chosen from surgery clinic.

****Both groups were subjected to**:

1-physical and standard psychiatric examination.

2-psychometric test;the arabic version of Beck Depression Inventory(BDI)

****Results** showed that:

-Half of cancer breast patient were in 5^{th} decade.

-No family history of cancer was found in 90% of cases.

-Radiation therapy,mastectomy are definite evidences of cancer.
-Depression was 77% using psychiatric interviewer and Beck Depression Inventory.
-By using Beck Depression Inventory,1/3 of patients were not depressed;1/3was mildly depressed,and1/3 was severely depressed.
-Most common symptoms were somatic preoccupation,sadness,insomnia and body image change while least common symptoms were suicidal ideas and guilt.
-Loss of libido is reported in 755 of cases.
-Anxiety is reported in 50% of cases.
-Fear is reported in52,5%of cases(of death-disability-desease-disfigurment-ans husbands rejection).
-Most common defense mechanisms used are denial,displacement and reaction formation.
-There is no role for stressful like events or prior psychiatric disturbances.
****It was concluded that** cancer breast patients suffered from psychiatric manifestations e.g anxiety , depression, fears .There has to be laison between psychiatry, oncology to help these patients***(Hussin 1986).***

Table (4) studies discussing outcome of psychiatric disorders in women.

Auther	Site	Instrument	Subject	Results
Radwan 2007.	Departmen t of obstetrics and gynecolog y,Ain Shams University Hospitals (Assisted Reproduct ive Technique Unit).	1-Structured Clinical Interview for DSM IV (SCID I) 2-Structured Clinical Interview for DSM IV axis II (SCID II) 3-Fertility Adjustment Scale (FAS) 4-Beck Depression Inventory. 5-The Manifest Anxiety Scale. 6-PCASEE quality of life questionnaire. 7-Eysenck Personality Questionnaire (E.P.Q) 8- D- scale of Guillford Inventory of Personality factors. 9-Fahmy and El-Sherbini Social Classification Scale .	210 patients.	**1** - Social phobia is the most encountered ,followed by dysthymia,major depressive disorder,obcessive compulsive disorder,agoraphobia and post traumatic stress disorder. 2-Comorbidity between depression and anxiety is high. 3-High prevelance of personality disorder. **4**-Women with psychiatric morbidity have difficulty to become pregnant and poorer outcome in general.
Elwan 2005.	Al Abbassia Hospital (Cairo).	by using psychiatric assessment and	40 admitted females.	Comparizon between female psychotic homicidal with female

		history taking according to Ain-Shams semi-structured interview then usage of standardized psychiatric assessment using Structured Clinical Interview for DSM 1V .(SCID I-SCID II).Inclusion criteria were :(female-psychotic).Exclusion criteria were:(organic or epileptic psychotic patients)		psychotic non-homicidal to detect a correlation in the past history,social circumstances and clinical profile associated with homicide. Results showed that homicidal females scored higher on GAF scale.50% of them were schizophrenics,35% were bipolar.15% were schizoaffective**.** **C**orrelates of homicide in psychotic females were :(younger age of onset of mental illness-diagnosis of schizophrenia then bipolar manic then mood episodes of postpartum onset then schizoaffective-being married with children-history of exposure to domestic violence in childhood-past history of sever violent acts especially attempted homicide
William 1986.	Al Abbassia Hospital(Cairo).	1-Demographic data and specific factors related to crimes. 2-Psychiatric interviews,complete psychiatric examination. 3-Psychometric	70 patients.	Mental hospital criminals were not more criminals (bad) than prison criminals.Mental hospital criminals were not more mentally disordered (mad) than patients with no criminal records. Results showed that :

		assessment for I.Q,Personality and Adaptation		1-Mean age of committing a crime was around 35 year,with more prevelance in rural areas,mostly amonge married female housewives with low educational level and past history of mental disorder. 2-Family history of criminality and-or mental disorder with absence of father figure as an added factor. 3-Wepons used were either sharp instrument or heavy blunt objects. 4-Victims were usually relatives to patients.(usually husbands). 5-Causes of crimes were (accidental murder-excitement-anger-vendetta-delusion of persecution or infedility-with out cause). 6-Most of patients have intellectual deterioration and social maladjustment. 7-There was high score for criminality,neuroticism,lie score,depression traits,impulsivity and maladaptability scale. 8-Psychiatric disorders mostly occurring were (schizophrenia-bipolar

				disorder-mental subnormality-sociopathy-addiction).
Abdel Hameed 1996.	Kasr Al Aini Hospital-Ahmad Maher Hospital-Shobra General Hospital-Om El Masreyeen Hospital.	1- Patient group were subjected to the following:(psychiatric sheet-Hamilton Depression Rating Scale-Hamilton Anxiety Scale-Self-Concept Questionnaire-Abbreviated Burn Specific Health Scale) 2-Normal controls were subjected to (HDRS-HAS-SCQ)	50 patients.	40% reached level of diagnosable psychiatric illness while 60% did not.Most common diagnoses were (depression-acute stress disorder-delirium-mixed anxiety depression) specially with burns of the face.So burns significantly affected psychological well being of patients.
Sami 1995.	Outpatient clinic in Ahmad Maher Hospital(obstetric,gynecology) (Cairo).	:(Quesstionnaire about attitude of females towards circumcision-Eysneck Personality Inventory-Sexual Inventory modified,extracted from Derogatis Sexual Inventory).	80 patients.	The chief motive was religious then inherited customs.Women reported physical and hygienic complications after operation .Most women were illitrate,operated upon by midwives or doctors.Most of circumcised females had high neurotic score and reached orgasm with difficulty.The most important side effects of circumcision were sexual

				dis-satisfaction and anorgasmia.
Omar 1998.	Kasr El Aini hospital (gynacology-surgry inpatient unit)	1-Clinical interview,psychiatric diagnosis according to DSM IV. 2-Middle Sex Scale (MSS). 3-Beck Depression Inventory (BDI).	60 patients.	That psychiatric diagnosis after hysterectomy were depression,anxiety then sleep disorders.Quality of sexual life after operation improved.Patients below 40 year,without children suffered psychologically more than other women.Good husband,family relationship minimized this stressful situation.The expectations of women,premenopausal age and premorbid personality determined sequele after operation.
El Hennawy 1999.	Ain Shams University Hospital (Cairo).	1-Semistructured sociodemographic and clinical interview. 2-Social readjustment rating scale. 3-Eysenk Personality Inventory (EPQ) 4-ICD-10 research diagnostic criteria.	60 patients.	,High incidence of (loss of libido-persistant somatic complains not responding to symptomatic treatment-retardation-sleep troubles-fears-worries-eating problems-depressed mood-psychiatric disordrs not attributed to any specific disease).There werev(high score in extraversion, low score in neuroticism low

				prevelance of personality disorder in cancer breast patients.
Allam 1999.	Ain Shams University Hospital (Cairo)	a-Beck Depression Inventory (BDI) b-Hospital Anxiety and Depression Scale (HADS) c- Functional Living Index-Cancer (FLIC) d-The Structured Clinical Interview for DSM 1V Axis I Disorders (SCID-I)	Group of breast cancer patients with no age limitation.	case group suffer from depression,anxiety more than control group. -patients below 50 years old suffer severe symptoms of anxiety, depression more than those above50years old. -Quality of life is worse in patients below 50 years. -More anxiety is present in patients with lumbectomy(for fear of recurrence). -More depression is present in patients with radical mastectomy.
Hussin 1986.	Main Hospital in Alexandria.	1-physical and standard psychiatric examination. 2-psychometric test;the arabic version of Beck Depression Inventory(BDI)	60 persons.	**C**ancer breast patients (above 50 years) suffer from psychiatric manifestations e.g:anxiety (50%),depression(77%),fears and loss of libido(52.5%). No family history of cancer was found in 90% of cases-Most common defense mechanisms used are denial,displacement and

				reaction formation. There is no role for stressful like events or prior psychiatric disturbances.

Management of psychiatric disorders in women

In the last fourty years,there had been a revolution regarding pharmacotherapy.New drugs were introduced into markets.Many antidepressants,antipsychotics and mood stabilizers were used hand in hand with electroconvulsive therapy*.(Nonac 2003).***

The following study tried to study effect of drugs on both genders.

1-A Gender-related study of antidepressant in a sample of Egyptian depressed patients.(Response and side effects profiles).

Abdel Raouf studied importance of gender in vulnerability,presentation of depression,clinical response to antidepressant,through (reviewing available literatures-evaluate symptomatology with respect to gender-evaluate clinical response and adverse effects of antidepressants).The sample consisted of 148 depressed patients (126 continued the study-22 dropouts),and they were put into 3 groups,each group consisted of 20 males,20 females.The first group was treated with Imipramine,the second treated with Maprotiline,the third treated with Sertraline).

****Tools used were**:(clinical interview,examination-IQ testing-Gilford D scale for depressive traits-Zung scale for depressive state-Hamilton rating scale).

****Results** showed that :

1-Females were more vulnerable,more symptomatizing of depression,more adherent to treatment ,While males responded more to antidepressants.

2-All patients on Sertraline suffered from insomnia and headache,while those on Maprotiline,Imipramine suffered from constipation,blurred vision.

****It was concluded that** gender and culture are to be considered on assessing and treating a case of depression,it was found that depressed men are more rapidly responding to antidepressants due to differences in pharmacokinitics and pharmacodynamics of antidepressants resulting in different outcome and adverse effects***.(Abdel Raouf 2001).***

Table (5) studies discussing management of psychiatric disorders in women.

Auther	**Site**	**Instrument**	**Subject**	**Results**
Abdel Raouf 2001.	Military, Abbassia hospital (Cairo).	clinical interview,examination-IQ testing-Gilford D scale for depressive traits-Zung scale for depressive state-Hamilton rating scale)	148 patients.	1-Females were more vulnerable,more symptomatizing of depression,more adherent to treatment ,While males responded more to antidepressants. 2-All patients on Sertraline suffered from insomnia and headache,while those on Maprotiline,Imipramine suffered from constipation, blurred vision

`CRITICAL APPRAISAL OF EGYPTIAN STUDIES ON PSYCHIATRIC DISORDERS IN WOMEN

** Critical appraisal can help us if a paper is likely to be valid or important.The decision to use the published evidence also takes into account our patients preferences and goals.When embarking on the critical appraisal of an article, many people consider this as an invitation to trash the article as vigorously as possible. This approach does little to inform our management of patients and should be replaced with a more considered judgement of validity through asking these questions:-

I- Is the study performed so badly that it can be of no use whatsoever?
II- Is the study flawed and what effects are the flaws likely to have upon the published results?

The critical appraisal of an article addresses two main areas: validity and importance, irrespective of the study type *(Lawrie et al, 2000)***

Usually the critical appraisal is provided by using certain checklist which provide a framework for the approach of papers, they provide a series of question to be asked to published papers, these questions lead toward an informed judgment on the meaning of the findings and their relevance for clinical practice. Many of the criteria of appraisal apply to all methods of researches but others are specific to a single method ***(Crombie, 1997).***

There are several questions which should be asked of all research papers irrespective of the method which has been used.

The standard appraisal questions:

A. Are the aims clearly stated

B. Was the sample size justified?

C. Are the measurements likely to be valid and reliable?

D. Are the statistical methods described?

E. Were the basic data adequately described?

F. Did unwanted events occur during the study?

(Crombie, 1997).

Specific questions (*Crombie, 1997):*

a) Case-control studies:-

1. How were the cases obtained?
2. In the control group appropriate?
3. Were data collected in the same way for cases and controls?
4. Where are the biases?
5. Could there be confounding?

6. How does the results compare with previous reports?

b) Cross-sectional surveys:

1. Who was studied?
2. How was the sample obtained?
3. What was the response rate?
4. Is there a suggestion of haste?
5. How could selection bias arise?
6. Where the findings serendipitous?
7. Can the result be generalized?

c) Cohort studies:

1. Who exactly has been studied?
2. Was a control group used?
3. How adequate was the follow up?
4. Was the exposure or the intervention accurately measured?
5. Were relevant outcome measures ignored?
6. Did the analysis allow for the passage of time?

d) Randomised controlled trials:

Criteria of good randomized controlled trials:

- Allows rigorous evaluation of a single variable (for example, effect of drug treatment versus placebo) in a precisely defined patient group.
- Prospective design (that is, data are collected on events that happen after you decide to do the study).
- Avoid introduction of hidden bias through:-

  1- Imperfect randomisation.

  2- Failure to randomise all eligible patients (clinician offers participation in the trial only to patients he or she considers will respond well to the intervention).

  3- Failure to blind assessors to randomisation status of patients, it should be double blind control studies.

(Mustafa 2006)

Critical appraisal of epidemiological studies of psychiatric disorders in women

1-Substance use disorders amonge females in secondry school students in Cairo: (Hashim 2002)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Hypothesis and rational of the study were mentioned clearly.
*Title of the study was simple and specifying the studied phenomena and the target group.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*The study design was appropriate. Sample size was justified clearly.
*The type of prevalence mentioned was life time prevalence.
*The statistical methods (procedures) used were pilot study then the study proper. The pilot study revealed that using Composite International Diagnostic Interview (CIDI-Arabic) (WHO 1990) was markedly time consuming so General Health Questionnaire (GHQ) (Goldberg, 1983) was used instead for detection of psychiatric disorders. The study proper took a whole educational year. Pilot study was done to detect size of the sample and reliability of used tools.
*The statistical analysis was descriptive and chi-square test. p value determines statistical significance.
*The author used ICD 10 as specific diagnostic criteria.
*There was lack of adequate number of similar researches in our country except for few researches about substance abuse in males.
*The design of the study was appropriate regarding that type of studies.
*Sources of cases were mentioned.
*Mesures to exclude other health problems were not mentioned.
*Size of the sample was justified clearly and in details. It was calculated to meet aim of the study.
*Methods of data collection were clearly identified.
*Validity and reliability of measures were mentioned. Tools used were reliable (inter-rater and test-retest reliability), with accepted validity (GHQ-ICD symptom check list).

*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings was mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were mentioned in the study such as study limitations, problems that faced the author and implications of the study. e.g. (There were a problem in front of the study which was presence f 8.1% defaulters (They were absent from school or being missed during lectures or period of the break).This was a limitation to the study).

2-A Psycho-socio-demographic study of premenstrual dysphoric disorder (PMDD) in a sample of Egyptian women(Zarif 1999).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Type of prevalence was not mentioned clearly.
*Stratified random sample was selected because it was the most appropriate for this type of studies.
*Title of the study was clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were used. Multivariant analysis was beneficial.
*Tools used were reliable.
*The author used specific diagnostic criteria (ICD 10), (DSM IV).
*There was lack of adequate number of similar researches in our country.(There were previous two studies but less specific).
*Study design was appropriate.
*Source of cases was mentioned.
*Measures to exclude health problems were mentioned.
*Pilot study was done, followed by the study proper.
*Size of the sample was justified clearly and in details. It was calculated to meet aim of the study. Pilot study took around 4 months to determine sample size and to assess the used tools. The study proper took a year and a half.
*Pilot study was done to detect size of the sample and reliability of used tools.
*Validity and reliability of measures were not mentioned clearly.

*Way of statistical analysis used descriptive ways plus analytical tests (mentioned in details).
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings was mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations and implications of the study. The author faced some problems regarding symptom categorization and duration across the cycle. Drop outs were about 7.7%
*The author high lightened the cost of the disease upon the patient, his family and the whole community.

3-Post-partum psychological disturbances (Epidemiological view).(Youssef 1985)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Type of prevalence was not mentioned.
*Random sample was used, yet the study design was not mentioned clearly..
*Title of the study was clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM III).
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases was mentioned.
*Measures to exclude health problems were mentioned.(Patties without any obstetric complication)
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning. The selected sample was of unknown number.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.

*Recommendations were mentioned in the end of the study. Clinical importance of findings was mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.
*The author mentioned that he had difficulties in collecting information of his patients (which is a common problem in developing countries).

4-Prevelance of obsessive compulsive disorder among female secondary school students in Cairo.(Soltan 2002).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Type of prevalence was pin-point prevalence.
*Hypothesis of the study was mentioned.
*The sample was representative, randomly selected from 3 areas (rural-semi urban-urban), (public-private schools) with certain inclusion and exclusion criteria.
*Title of the study was clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were used.(Prevalence-chi square test-T test).
*The study was done on 2 stages: screening phase then using MINI-KID.
*Tools used were reliable.(LOI, MINI-KID)
*The author used specific diagnostic criteria (DSM III).
*There were plenty of similar researches in our country and abroad.
*Study design was appropriate.
*Source of cases was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was justified clearly and in details. It was calculated to meet aim of the study.
*Validity and reliability of measures were mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings was mentioned.

*Measurements were mentioned, identified and referenced.
*The sample size was not mentioned.
*Many important points were mentioned in the study such as study limitations , problems that faced the author and implications of the study

Critical appraisal of etiological and risk factors of psychiatric disorders in women

1-Study of the relationship between serum estrogen level in menopausal women and cognitive functions. (Ibrahim 1999).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Random sample was used.
*Hypothesis and rational of the study were not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means.
*Site and timing of the study were clearly mentioned.
*Consent wataken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author did not use any specific diagnostic criteria.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases was mentioned but it was so loose (women from general population, living in their homes, function independently).
*Measures to exclude health problems were mentioned. (Exclusion criteria)
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned (clinical interview could not used as a method of studied this topic).
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings was mentioned.

*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations and problems that faced the author.

2-<u>Biological markers of women vulnerability to depression.(Shawar 2006)</u>

*The aim of study was clearly stated giving an explanation for the purpose of the study.

.*Random sample was used. The selected sample consisted of**:** 40 patients fulfilling criteria of DSM IV with certain inclusion and exclusion criteria**.**
*The way of sample collection was clearly mentioned.
*Hypothesis and rational of the study were not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM IV 1994).
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations and problems that faced the author.

3-Spouse role in the problem of drug abuse.(Emara 2002)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Random sample was used .Specific inclusion and exclusion criteria were mentioned.
*Hypothesis of the study was mentioned.
*Sampling method was mentioned clearly.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned. (Controls were appropriately matched with cases)
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned clearly.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations and problems that faced the author.

4-Psychiatric morbidity in wives of substance users in an Egyptian sample(Afifi 2007).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Hypothesis of the study was mentioned.
*Title of the study was not representing its content clearly. It was so generalizing that it did not specify the target group by any means.

*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*Pilot study was followed by study proper.
*The author used specific diagnostic criteria (DSM IV).
*There was lack of adequate number of similar researches in our country.
*Study design was mentioned.
*Source of cases and controls was mentioned. Controls were matched to cases appropriately.
*Measures to exclude health problems were mentioned.
*Size of the sample was justified clearly as the author made a pilot study at the beginning.
*Validity and reliability of measures were mentioned clearly and assured by previously done pilot study.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were mentioned in the study such as study difficulties and limitations.

5-Study of domestic violence in a sample of Egyptian female psychiatric patients.(Ezzat 2005)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*Hypothesis of the study was not mentioned.
*Title of the study was not clearly representing its content. .It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (ICD 10).
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.

*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

6-Study of risk factors of post-partum depression (cross cultural perspective).(Abdel Latif 1999)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was representative consisted of women who gave birth in the last 9 months, Half of the sample is patient and subgroup., the other half is control group.(The sample contains 4 cultural groups e.g. Saudi-Yemeni-Sudanese-Egyptian).The study was done in Dar El Shifa Hospital (Jeddah).
*The sample was selective and homogenous with clear inclusion and exclusion criteria.
*Hypothesis of the study was not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author mentioned specific diagnostic criteria (ICD 10-DSM IV).
*Pilot study was done followed by study proper.
*There was lack of adequate number of similar researches in our country.
*Study design was mentioned.
*Source of cases and controls was mentioned clearly.
*Measures to exclude health problems were mentioned.
*Size of the sample was justified clearly as the author made a pilot study at the beginning.

*Pilot study aimed to test the tools, determine risk factors, determine statistical methods, test sample size and determine suitable length of the study.
*Validity and reliability of measures were mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests in details.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.
*The author mentioned some problems that faced the study.

*7-**Impact of menstrual cycle on schizophrenia(Abdel Razek 2006)***

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was randomly selected with certain inclusion and exclusion criteria.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*Hypothesis of the study was clearly defined.
*The author used specific diagnostic criteria (ICD 10).
*There was lack of adequate number of similar researches in our country.
*Study design was mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.

*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were mentioned in the study such as study limitations.

8-Study of violence against women(study of prevelance,psychiatric consequences) (Hussin 2007)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was randomly selected with specific inclusion and exclusion criteria.
*Life time prevalence was mentioned clearly in the study.
*Hypothesis and rational of the study were mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*General appearance of the study was satisfactory.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM IV).
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

9-***Study of Depression during pregnancy as a risk factor for pre-eclampsia, a prospective study.(Hewedi D ,Fahmy A 2006)***

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*The sample was randomly selected with certain inclusion and exclusion criteria.

*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means.

*Site and timing of the study were clearly mentioned.

*Consent was taken from all participants.

*Descriptive and analytical statistical analysis were mentioned collectively without any details.

*Hypothesis of the study was not defined.

*The author did not use specific diagnostic criteria.

*There was lack of adequate number of similar researches in our country.

*Study design was mentioned clearly.

*Source of cases and controls was mentioned.

*Measures to exclude health problems were mentioned.

*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.

*Validity and reliability of measures were mentioned.

*Way of statistical analysis used descriptive ways plus analytical tests in an appropriate way.

*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.

*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.

*Measurements were mentioned, identified and referenced.

*Many important points were mentioned in the study such as study limitations.

10- Study of violence against Women in Egypt(Psychological and Social Consequences)(Seif El Dawla A 2001)

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*The sample was randomly selected with certain inclusion and exclusion criteria.

*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means.
*Site and timing of the study were not clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*Hypothesis of the study was not defined.
*The author did not use specific diagnostic criteria.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was not mentioned clearly.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests in an appropriate way.
*Results were put in tables .Results were consistent, this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were mentioned in the study such as study limitations.

Critical appraisal of clinical profile of psychiatric disorders in women

1-Gender related psychobiological differences in obcessive compulsive disorder patients.(Nasr El Din 2001)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was randomly selected with specific inclusion and exclusion criteria.
**Hypothesis and rational of the study were not mentioned.

*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (ICD 10-DSM IV).
*There was lack of adequate number of similar researches in our country.
*Study design was mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.

*Many important points were mentioned in the study such as study limitations and pitfalls.

2-Gender Differences in Depressive Disorders in an Egyptian Sample.(Botros 1997).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The selected sample was randomly selected and with specific inclusion and exclusion criteria.
*Way of sample selection was not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM IV, APA 1994).

*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.

*Many important points were not mentioned in the study such as study limitations and problems that faced the study.

3-Gender differences in schizophrenia.(El Rakhawy 1998).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was randomly selected with specific inclusion and exclusion criteria.
*Title of the study was not clearly representing its content. . It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM III R 1987).
*There was lack of adequate number of similar researches in our country.
*Hypothesis of the study was mentioned.
*Study design was mentioned.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.

*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were mentioned in the study such as study limitations and problems that faced the study such as difficulty of obtaining information and limited number of admitted female patients.

4-Gender differences in bipolar disorder.(Hassan 2002).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was representative with specific inclusion and exclusion criteria.
*The study was retrospective survey followed by a comparative study.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM IV).
*Hypothesis and rational were not mentioned.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.

*Many important points were not mentioned in the study such as study limitations

5-Presentation of female sexual dysfunction in medical practice.(Abed 1998).

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*The sample was randomly selected with certain inclusion and exclusion criteria.

*Hypothesis and rational were not mentioned.

*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means

*Site and timing of the study were clearly mentioned.

*Consent was taken from all participants.

*Descriptive and analytical statistical analysis were mentioned collectively without any details.

*The author used specific diagnostic criteria (ICD 10).

*There was lack of adequate number of similar researches in our country.

*Study design was not mentioned clearly.

*Source of cases and controls was mentioned.

*Measures to exclude health problems were not mentioned.

*Size of the sample was justified clearly as the author made a pilot study at the beginning.

*Validity and reliability of measures were not mentioned.

*Way of statistical analysis used descriptive ways plus analytical tests.

*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.

*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.

*Measurements were mentioned, identified and referenced.

*Many important points were not mentioned in the study such as study limitations

6-Sexual dysfunction in female psychiatric patients.(El Fangry 2003).

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*Hypothesis of the study was mentioned clearly.
*The sample was representative with certain inclusion and exclusion criteria.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*General appearance of the study was satisfactory.
*Descriptive and analytical statistical analysis were mentioned clearly
*The author used specific diagnostic criteria (ICD 10).
*There was lack of adequate number of similar researches in our country.
*Study design was mentioned clearly.(screening part followed by depth study).
*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations

7-Psychological aspects of sex chromosome disorders with application on turner syndrom.(Gaffer 1993).

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*The sample was continent and well selected with specific inclusion and exclusion criteria.

*Hypothesis of the study was not mentioned clearly.

*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned in details.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.*Many important points were not mentioned in the study such as study limitations

8- Pregnancy related obsessive compulsive disorder(A study in Egyptian sample(Assad T , Kamel K.M)

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*The sample was randomly selected with specific inclusion and exclusion criteria..

*Hypothesis of the study was not mentioned clearly.

*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site of the study was clearly mentioned.
*Consent was taken from all participants.
*General appearance of the study was satisfactory.
*Descriptive and analytical statistical analysis were mentioned in details.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.

*Validity and reliability of measures were not mentioned.
*Results were not put in tables or figures.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were not mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

Critical appraisal of outcome of psychiatric disorders in women

1- Psychiatric morbidity in infertility in a sample of Egyptian females.(Radwan 2007).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*A stratified random sample of 210 patients put in 2 groups with specific inclusion and exclusion criteria.
*Hypothesis and rational of the study were mentioned.
*Title of the study was not clearly representing its content. It needed more specification.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*General appearance of the study was satisfactory.
*Descriptive and analytical statistical analysis were mentioned in details.
*The author used specific diagnostic criteria (DSM IV).
*There was lack of adequate number of similar researches in our country.
*Study design was mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was justified clearly as the author made a pilot study at the beginning.
*Validity and reliability of measures were mentioned.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.

*Measurements were mentioned, identified and referenced.
*Many important points were mentioned in the study such as study limitations.

2-Descriptive study of psychotic homicidal females in comparison with psychotic females non-offenders.(Elwan 2005)

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*Rational of the study was mentioned clearly.
*The sample was representative with certain inclusion and exclusion criteria.
*Title of the study was not clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*General appearance of the study was satisfactory.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM IV).
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

3-Psychiatric evaluation of Egyptian female mentally diseased criminals.(William 1986)

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was representative and randomly selected.

*Hypothesis and rational of the study were not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author did not mention any specific diagnostic criteria for diagnosis.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

4-Psychiatric assessment of female burn patients during hospitalization.(Abdel Hameed 1996).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The selected sample was representative with specific inclusion and exclusion criteria.
*Hypothesis and rational of the study were not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned clearly.
*The author used specific diagnostic criteria (DSM IV).
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.

*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

5-Psychosexual aspects of female circumcision.(Sami 1995).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was representative with specific inclusion and exclusion criteria.
*Hypothesis and rational of the study were not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned at the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.

*Many important points were not mentioned in the study such as study limitations.
*The author mentioned a problem that faced the study; it was that patients did not want to talk about any sexual experience such as circumcision and masturbation.

6-<u>Psychological aspects of hysterectomy.(Omar 1998).</u>

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was randomly selected with certain inclusion and exclusion criteria.
*Hypothesis and rational of the study were not mentioned.
*Title of the study was not clearly representing its content. It was so generalizing that it did not specify the target group by any means
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*General appearance of the study was satisfactory.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (DSM IV).
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used only P value.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

7-Psycosocial profile of a sample Egyptian female patients with breast cancer.(El Hennawy 1999).

*The aim of study was clearly stated giving an explanation for the purpose of the study.

* The selected sample was 60 Egyptian females in 3 groups:

- 20 with breast cancer (group I)
- 20 with benign breast tumors (group II)
- 20 not known to have physical or psychiatric disorders (group III)

*The sample was randomly selected without mentioning its source with specific inclusion and exclusion criteria..
*Hypothesis and rational of the study were not mentioned.
*Title of the study was not clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned in details.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was not mentioned.
*Measures to exclude health problems were mentioned as exclusion criteria.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

8-psychological profile and quality of life(QOL) assessments in cancer breast patients.(Allam 1999).

*The aim of study was clearly stated giving an explanation for the purpose of the study.

*The selected sample were females diagnosed as breast cancer patients with no age limitations to facilitate the recruitment .So the sample was random
*Hypothesis of the work was mentioned.

*Title of the study was not clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was not mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

9-psychiatric manifestations in cancer breast patients.(Hussin 1986).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was randomly selected without mentioning any inclusion and exclusion criteria.
*Hypothesis of the work was not mentioned.
*Title of the study was not clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned in details.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned clearly.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were not mentioned.
*Size of the sample was not justified clearly as the author did not make a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.
*Way of statistical analysis used descriptive ways plus analytical tests.

*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and referenced.
*Many important points were not mentioned in the study such as study limitations.

Critical appraisal of management of psychiatric disorders in women

1-A Gender-related study of antidepressant in a sample of Egyptian depressed patients.(Response and side effects profiles).(Abdel Raouf 2001).

*The aim of study was clearly stated giving an explanation for the purpose of the study.
*The sample was representative.148 depressed patients were studied.22 patients were drop outs,8 of them were non responders.
*Title of the study was not clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*Descriptive and analytical statistical analysis were mentioned collectively without any details.
*The author used specific diagnostic criteria (ICD 10).
*Title of the study was clearly representing its content.
*Site and timing of the study were clearly mentioned.
*Consent was taken from all participants.
*General appearance of the study was satisfactory.
*Hypothesis and rational of the study were not mentioned.
*Pilot study was done, followed by study proper.
*There was lack of adequate number of similar researches in our country.
*Study design was not mentioned.
*Source of cases and controls was mentioned.
*Measures to exclude health problems were mentioned.
*Size of the sample was justified clearly as the author made a pilot study at the beginning.
*Validity and reliability of measures were not mentioned.

*Way of statistical analysis used descriptive ways plus analytical tests.
*Results were put in tables and figures. Results were consistent; this gave a higher weight to these results.
*Recommendations were mentioned in the end of the study. Clinical importance of findings were mentioned.
*Measurements were mentioned, identified and but not referenced.

*Many important points were mentioned in the study such as study limitations

DISCUSSION

Any research or review should not be an end point, but it must open the door for new researches and studies and their conclusions must direct the clinical practice. That is why it is important to have a research strategy aiming from time to time to revise the researches done, trying to make use of their efforts and detecting the missed points in these areas, looking at the end for a complementary work system.

It is prudent to review these studies with the intent of evaluating their results and critically appraising the findings. This will enable to know where Egyptian studies stand on psychiatric disorders in women and what needed to be done further. .

This work was conducted in order to systematically review and appraise the Egyptian studies on psychiatric disorders in women, so it is possible to generate recommendations for further studies. In order to fulfill this aim, several studies discussing different aspects of the topic of psychiatric disorders in women were collected from different databases.

Then the important findings of these studies were presented in a simple way. Lastly, critical appraisal of these studies was done to find out the missed points and how to avoid them in further research projects.

Preliminary work:

In this study several databases were explored in the period from November 2007to March 2008 to collect Egyptian studies on psychiatric disorders in women. The databases searched were those of libraries of faculty of medicine Ain Shams University since 1963, faculty of medicine Al-Azhar University since 1977, faculty of medicine Cairo University since 1990,faculty of medicine Alexandria University since 1990, as well as Egyptian journal of psychiatry since 1979, and current psychiatry since 1999. All the databases were searched till the time of data collection.

During data collection it was noticed that most of the libraries especially in the faculties of medicine lack the computer databases that organize and keep soft copies of the studies. Although, the optimistic start in the central library of Al-Azhar University, it is still a starting project that needs more effort in order to collect all the studies conducted in Al-Azhar University taking into consideration it has several branches in different governorates. Cairo University has a new central library that was under construction during data collection, so can not be judged. Nowadays, the Egyptian universities ask the researchers to provide soft copies of their studies in order to construct computer databases. The old researches need a great effort to be organized and collected in these databases.

The available data were categorized into data related to epidemiology, etiology, clinical description, management, and outcome as far as possible.

All the studies included in the review were done by Egyptian researchers on different samples of the Egyptian population, as the review was meant to highlight the characteristics of psychiatric disorders in women in the Egyptian community. Some Egyptian researchers conducted there research in other Arab countries and included samples of different nationalities .Only one study was done in this way.

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General aspects:-

As regard the studies discussing the topic of psychiatric disorders in women, Epidemiological studies are still deficient in many areas of Egypt. The type of prevalence addressed by these studies was not identified in most of surveys. The case - control design was the rule in most of these studies. In many cases, this design was not appropriate to the aim. The details of calculation of the sample size in relation to the aim of the work were not justified in most of these studies. Also few studies were concerned with evaluating the reliability and validity of their measures. Sources of bias and how they were eliminated were not described in most of these studies. Absence of multicentric co-operation in Egyptian researches was a common missed point. Randomized controlled trial as a method for assessment of the efficacy of antidepressants in treatment of depression was not used. Also the role of pharmacotherapy and psychotherapy in management of psychiatric disorders in women wasn't discussed in details in these studies. It was

observed that most of the studies had raised questions for further research work and recommended many items to complete these researches, so there is still a need for a well planned system of designing the research work.

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Systematic review:

a) Epidemiology of psychiatric disorders in women:

Epidemiology is the study of variations in the distribution of specific disorder in population and the factors that influence that distribution. Such study can provide insight to improve practice, treatment; prevention and planning for care.

Studying the epidemiology of any disorder is an important step to know the actual size of the problem, so that a proper planning for health services can be carried out. This will result also in better screening, proper referral and suitable management. Moreover, this will cut down the cost of these disorders. .

For ideal epidemiological study, it should give an idea about the prevalence of a disorder in the general population. It should illustrate the effect of different socioeconomic factors on the distribution of the illness. Through epidemiological studies, the different risk factors and how they contribute to the development of the illness will be explored. Results should be presented in clear way with description of the statistical methods used and compared with those of previous studies giving explanation for the differences. Finally, the actual size of the problem will be known for better and suitable management.

Actually, Egyptian studies discussing the topic of epidemiology of these disorders were defective in many aspects. The studies mentioned here discussed few topics e.g. substance abuse, OCD, PMDD and postpartum psychological disturbances.

Most of these studies did not define the specific type of prevalence addressed by the study and hence so, there is marked discrepancy between the prevalence rates of different types of these disorders in these

studies.

The use of different psychiatric tools in these studies may contribute to these differences.

There is lack of such large surveys that involve many geographical areas in Egypt to assess the epidemiology of these disorders. The studies discussing the specific epidemiological characteristics of these disorders when occurring in special age groups are still deficient.

There were 2 studies targeting female secondary school students, the first discussed prevalence of substance abuse in 3 different areas in Cairo in governmental and private schools**.** ***Hashim(2002)*** found out that alcohol was the most prevalent source of addiction, followed by illicit drugs, tobacco and cannabinoid. The author mentioned causes of continuation and abstinence.

The second study discussed prevalence of OCD in 3 different areas in Cairo. ***Soltan (2002)*** found out that prevalence of OC symptoms was 4 times more than OCD as a disorder. Also it was found that adolescent OCD is not a rare disorder while subthreshold obsessive compulsive syndrome is widely presented in adolescent population. Culture may Colour the clinical picture but does not affect prevalence. Religion does not affect prevalence of OCD but it is an area where OCD expresses itself**.**

A study discussing PMDD was done by ***Zarif (1999)*** that studied prevalence, symptoms and socio-demographic factors related to PMDD High prevalence rate (about 6.6%) was in first social class and with those with troublesome homes. PMDD symptom profile was variable.

Another study discussed postpartum depression and puerperal psychosis, was made by ***Youssef (1985)*** who described many disorders e.g. postpartum blues, depression, adjustment and atypical bipolar disorders.

b) <u>Etiology of psychiatric disorders in women:</u>

Generally, the studies discussing the etiology of these disorders done in Egypt are still deficient in many aspects especially those concerned with the biological factors, this may be attributed to lack of technologies and

expertise required for such studies. Moreover, the greater importance was given to the epidemiological and sociocultural studies.

To discuss the etiology of these disorders, the etiological studies have to cover all aspects of the etiology. The role of different types of biochemical and hormonal factors should be investigated. Also the interaction between these factors and the psychosocial factors should be declared. These studies have to explain the way by which the different bioactive substances contribute to the development of these disorders. Also through discussing the genetic aspects of such disorders, identification of the different genes responsible for inheritance of such disorders may be possible. The role of different brain areas in the development of these disorders should be investigated through studies using recent neuroimaging techniques. Also, it is prudent to identify the social stressors implicated in the development of such disorders.

Ibrahim(1999)studied the relationship between serum estrogen level and cognitive functions in menopausal women. There is negative correlation between duration since menopause and serum estradiol levels, also between women age and scores of cognitive tests. But there is positive correlation between serum estradiol levels and cognitive function tests. Physiological menopause (estrogen deficiency) has a negative effect selectively on short term verbal memory**.**

Shawer (2006), studied biological factors of women vulnerability to depression. There was a positive correlation between degree of depression and age of the patient, his marital status, his social class. While level of TT3, TT4, FT3, FT4, TSH, E2 are significantly different between patients and controls. The higher the degree of depression , the lower the level of TT3-TT4-FT3-E2. The higher the E2 level, the higher the TT4 level**.**

There were 2 studies concerning role of wives in the problem of substance abuse. ***Emara (2002)*** studied spouse role in the problem of drug abuse where sources of marital dissatisfaction and conflicts between couples were important factors. **C**ouples of drug abusers have higher scores in conventionalization global distress, ill communication, depression, anxiety, aggression, difficult problem solving, sexual dissatisfaction, conflict over child rearing, disagreement over finances and dissatisfaction with children**.**

Afifi (2007) found out that there was multiple interpersonal conflicts e.g. disturbed family environment, financial problems, low parenting capability and bad quality of life. Addicts spouses experience a burden that increases as illness lengthens so negative impact on quality of life is expected which is associated with psychiatric morbidity**.**

There were 3 studies discussing violence against women. ***Ezzat (2005)*** studied effect of domestic violence on women regarding comorbid psychiatric illness, interpersonal conflicts with their husbands. It had been shown that domestic violence in female psychiatric patient is not higher than normal that indicates the value of traditions, religion and culture in tolerating mental illness. Many types of abuse were mentioned with its impact on troublesome home atmosphere. While ***Hussein (2007)*** studied magnitude, prevalence, possible correlates, consequences, different theories explaining violence against women plus reviewing interventions made to prevent future occurrence of the problem. Most important factors were mentioned.

Bipolar disorder patients were the most frequently abused followed by psychotics. Severely abused patients attempted suicide. Risk factors for abused, abuser women were discussed.

Seif El Dawla (2001) studied violence against women in Egypt. She wanted to investigate the perception of a sample of Egyptian women and men to the issue of gender violence, the personal experience of women of such violence and the psychological consequences that might follow therefore. She concluded that gender violence is a considerable phenomenon in Egypt that it constitutes a psychological health problem to women and that it has psychological consequences that deserve special attention and intervention on the part of mental health professionals

Abdel Razek(2006) discussed menstrual cycle in schizophrenia. It was noticed that premenstrual exacerbation of symptoms in female schizophrenics may not be a worsening of the core schizophrenic symptoms but a concurrence of a cluster of affective, behavioural, and somatic symptoms which may be related to hormonal changes.

There were 2 studies discussing the relation between pregnancy and depression. ***Hewedi,Fahmy (2006)*** studied occurrence of preeclampsia in different stages of pregnancy ,its relation to depression. So 100 nulliparas women with singleton pregnancies were recruited, with certain inclusion and

exclusion criteria, followed up longitudinally from early pregnancy to end of gestation with comprehensive neuropsychiatric assessment. Preeclampsia was defined as elevated blood pressure than 140/100 mmHg and proteinuria (0.3 during 24 hours or more). Results showed that:
depression was detected in 30% of subjects in early pregnancy while it was detected in 34% of subjects in late pregnancy. Pre-eclampsia occurred more with combined early and late depression than late depression alone

Abdel latif (1999) studied risk factors for development of post partum depression taking cultural aspect into consideration .The most common causes of postpartum depression were (postpartum blues-polygamy-guardian unemployment-marital problems-undesired infant sex being teenage).

c) Clinical profile of psychiatric disorders in women:

Egyptian studies discussed the clinical description of these disorders from the following aspects:

Gender difference in many psychiatric disorders e.g. schizophrenia, bipolar disorder, and OCD and depression .Also, sexual dysfunctions in female psychiatric patients. A single study was done on sex chromosome disorders e.g. Turner syndrome.

Nasr El Den (2001) studied gender difference in OCD. It showed that men expressed more religious, sexual obsessions, hopelessness, controlled oral word association and visual memory span. While women expressed more hoarding, other compulsions , failure to maintain serotonin level. Females were slower, less selectively attentive than males, more impaired as language abilities than males. In fact, Sex does not determine OCD severity.

Females show higher serotonin level especially in chronic illness so serotonin is gender specific marker. Attentional deficit is disease specific rather than gender specific. OCD is not a stress related behavior but it is a maladaptive learnt behavior. OCD is not a progressive disorder as regards cognitive dysfunction**.**

A study was done discussing gender difference in unipolar depression. It was done by ***Botros (1997)*** who found out that many factors Colour

clinical picture, symptomatic expression of depression e.g. level of education, work, gender, socioeconomic state, personality and cultural norms of society**.**

Gender difference is shown as the following:
1-Males showed low self esteem, indecisiveness, decreased dreams, neglected self hygiene and prevailing depressed mood.
2-Females showed fatigue, crying, dissociative symptoms, negative self perception, tendency to go out, decreased sexual desire, no change in dreams, adequate self hygiene, retardation and impaired judgment.

Another study discussed gender difference in schizophrenia. It was done by ***El Rakhawy (1998)*** who found out that gender had little impact presentation and course of schizophrenia. Gender difference was demonstrated as the following:
1-Men: have an earlier age of onset, a poorer premorbid history, more negative symptoms, differential neuro cognitive functions, a poorer response to neuroleptics and a lower family risk for schizophrenia.
2-Women: had more decreased motor activity, self neglect, suicidal attempts, higher scores in paranoia scale of MMPI and a tendency to have more positive family history of schizophrenia.

On the other hand, A study was done by ***Hassan (2002)*** who studied gender difference in bipolar disorder, found out that prevalence rates in women exceed those of men. In fact, gender difference in mood disorders have an important clinical subtypes or symptoms clusters specific to each sex, will help better understanding of pathophysiological mechanisms involved in affective illness

Results showed that gender difference lies in the following:
1-Females :(lower mean age-earlier age of onset-shorter duration of episode-usually divorced-rapid cycling-positive family history of bipolarity-high score in extraversion)
2-Males :(higher mean age-later age of onset-longer duration of episode-being single-depressed and mixed episodes-high score in mania rating scale and in family, economic stresses-high guilt-loss of interest-weight changes.

Assad T, Kamel K.M 2001 studied OCD in pregnancy. They found out that the most frequent obsessions encountered were religious thoughts followed by cleanliness thoughts and rituals and then impulses related to harming the foetus. Severity of the disease ranged from moderate to sever. Most of symptoms occurred in the 2 nd trimester. The authors concluded that positive family history of OCD and the presence of obsessive compulsive personality were the two significant associations. Several explanations can be put foreword to understand such a relation between pregnancy and OCD, including the possible effect of gonadal steroids on serotonergic system. ***(Assad T, Kamel K.M 2001)***

Two studies targeting sexual dysfunction in women ***Abed (1998)*** found out those most common sexual complaints were vaginismus, loss of sexual desire, dyspareunia and anorgasmia**.** While ***El Fangry(2003)*** studied a broader part of the same topic. Results showed that:

1-The most common sexual dysfunctions are desire disorders, orgasmic dysfunction, arousal disorder, dyspareunia and lastly vaginismus.

2-The most common psychiatric disorders in these patients are (mood-anxiety-somatoform-adjustment) disorders.

3-There was high rate of circumcision ,manual hymenal perforation in wedding night, discrimination in favor of males, earlier onset of marriage and first information about sex from the family.

4-Psychiatric patients had low (sexual drive, sexual attitude, sexual satisfaction, orgasmic capacity, desire frequency and total sexual functioning) plus more dependent personality disorder than others.

5-Psychiatric patients show more sexual dysfunction, personality pathology and marital dissatisfaction than others.

6-There is a high rate of overlap between different sexual disorders in the same patients.

7-Testesterone is positively correlated with sexual desire and orgasm.

A unique study done on turner syndrome patients showed that early diagnosis, follow up is very important. Overprotection or rejection from parents is forbidden. Early social stimulation and special schooling are necessary .Medical treatment for induction of growth, regular menses must be considered**.**

d) Outcome of psychiatric disorders in women:

Ideal study discussing the outcome of a disorder should give information about the course of the illness. The risk of either relapse or recurrence and their causes should be estimated. Also, predictors of outcome should be discussed in details whether related to the illness or the patient. Through good studying of the outcome of such disorders, it will be possible to identify the residual symptoms in between the attacks; also the functional disability of the patients with these disorders can be determined. Through this, the economic burden of these disorders can be nearly calculated.

Generally, the Egyptian studies performed to determine the outcome of psychiatric disorders related to women are few and unsatisfactory. Also the main factors affecting this outcome aren't discussed in details in these studies.

There are many studies discussing different circumstances that happen to women and affect their psychological wellbeing e.g. cancer breast, different types of crimes, burn, circumcision, hysterectomy and infertility. The outcome of these events is discussed here in details.

Radwan (2007) studied psychiatric morbidity among infertile women, identified its variables, investigated its relationship and highlighted this topic. The author reviewed medical aspects of infertility and reviewed available treatment of psychiatric difficulties related to infertility. It was found out that:

1- Social phobia is the most encountered, followed by dysthymia, major depressive disorder, obsessive compulsive disorder, agoraphobia and post traumatic stress disorder.

2-Comorbidity between depression and anxiety is high.

3-High prevalence of personality disorder.

It was concluded that women with psychiatric morbidity have difficulty to become pregnant and poorer outcome in general**.**

There are 2 studies discussing criminality issues. The first was done to compare psychotic homicidal females with psychotic females non offenders. ***Elwan (2005)*** did the following:

a- Reviewed Egyptian, International literature about ;(Legal definition of homicide, criminal responsibility- relation between mental illness , violence and criminality-homicidal behavior committed by mentally ill women).
b- Compared female psychotic homicidal with female psychotic non-homicidal to detect a correlation in the past history, social circumstances and clinical profile associated with homicide.
c-Described crime circumstance.
*Results showed that homicidal females scored higher on GAF scale.50% of them were schizophrenics, 35% were bipolar.15% were schizoaffective.
*It was concluded that correlates of homicide in psychotic females were :(younger age of onset of mental illness-diagnosis of schizophrenia then bipolar manic then mood episodes of postpartum onset then schizoaffective-being married with children-history of exposure to domestic violence in childhood-past history of sever violent acts especially attempted homicide).

William (1986) tried **t**o find the relationship between crime and various mental disorders.
*Results showed that:
1-Mean age of committing a crime is around 35 year, with more prevalence in rural areas, mostly among married female housewives with low educational level and past history of mental disorder.
2-Family history of criminality and-or mental disorder with absence of father figure as an added factor.
3-Wepons used are either sharp instrument or heavy blunt objects.

4-Victims are usually relatives to patients. (Usually husbands).
5-Causes of crimes were (accidental murder-excitement-anger-vendetta-delusion of persecution or infidelity-without cause).
6-Most of patients have intellectual deterioration and social maladjustment.
7-There is high score for criminality, neuroticism, lie score, depression traits, impulsivity and mal adaptability scale.
8-Psychiatric disorders mostly occurring are (schizophrenia-bipolar disorder-mental subnormality-sociopathy-addiction).

*It was concluded that mental hospital criminals are not more criminals (bad) than prison criminals.
*Mental hospital criminals are not more mentally disordered (mad) than patients with no criminal records**.**

A study discussed effect of burn upon patients during hospitalization. ***Abdel Hemed (1996)*** made a psychiatric assessment of female burned patients especially for depression, anxiety, deterioration of self concept and fear to face society after discharge as an impact of disfigurement and incapacity.
*****Results showed that 40% reached level of diagnosable psychiatric illness while 60% did not. Most common diagnoses were (depression-acute stress disorder-delirium-mixed anxiety depression) especially with burns of the face.
*****It was found out that burns significantly affected psychological well being of patients. Specialized psychiatrist should be available to handle these troubles**.**

Unique study discussing psychosexual aspects of circumcision. It was done by ***Sami (1995)*** who studied these phenomena, knew its extent in society. Compared between circumcised, uncircumcised females regarding psychological and sexual effects.
*****Results showed that :
1-The chief motive was religious then inherited customs.
2-Women reported physical and hygienic complications after operation .
3-Most women were illiterate, operated upon by midwives or doctors.
4-Most of circumcised females had high neurotic score and reached orgasm with difficulty.
*****It was found out that the most important side effects of circumcision were sexual dissatisfaction and anorgasmia**.**

An important study about effect of hysterectomy on psychological aspect of women**.** ***Omar (1998)*** studied psychological problems with hysterectomy especially sexual problems with the husband.

*Results showed that:
1-Psychiatric diagnosis after hysterectomy was depression, anxiety then sleep disorders.
2-Quality of sexual life after operation improved.

3-Patients below 40 year, without children suffer psychologically more than other women.
4-Good husband, family relationship minimizes this stressful situation.
*****It was concluded that:
1-Importance of family relations to women after operation.
2-The expectations of women, premenopausal age and premorbid personality determine sequelae after operation**.**

Three studies discussing effect of breast cancer on psychological wellbeing of women ***El Hennawy (1999)*** aimed at investigating a sample of Egyptian female patients with breast cancer, trying to get a psychosocial profile and to detect risk factors important in tumorigenesis of breast cancer.

There was high incidence of (loss of libido-persistent somatic complains not responding to symptomatic treatment-retardation-sleep troubles-fears-worries-eating problems-depressed mood-psychiatric disorders not attributed to any specific disease).

It was found that high prevalence of psychiatric manifestation in breast cancer patients denotes importance of psychiatric and psychological support to improve physical and psychosocial wellbeing

Allam (1999) highlighted the quantitative, qualitative psychological profile, quality of life changes in lives of those patients to provide intervention strategies to cover patients suffering. Quality of life is worse in patients below 50 years. More anxiety is present in patients with lumpectomy (for fear of recurrence). More depression is present in patients with radical mastectomy. While ***Hussein (1986)*** confirmed the same results as the previous studies. He mentioned the most common defense mechanisms were denial, reaction formation and displacement. There is no role for stressful like events or prior psychiatric disturbances.

e) Management of psychiatric disorders in women

The management of patients with these disorders must be directed towards several goals. First, the patient's safety must be guaranteed. Second, a complete diagnostic evaluation of the patient must be carried out. Third, a treatment plan that addresses not only the immediate symptoms but also the patient's prospective well-being must be initiated. The psychiatrist must advise the patient and the family about future treatment strategies ***(Kaplan and Sadock, 2004)***

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Generally, the Egyptian studies performed to determine the management of psychiatric disorders in women are few and unsatisfactory. Also the main factors affecting this management plan aren't discussed in details in these studies.

Abdel Raouf (2001) studied gender difference in response and side effects to antidepressant. It was found that gender and culture are to be considered on assessing and treating a case of depression, it was found that depressed men are more rapidly responding to antidepressants due to differences in pharmacokinetics and pharmacodynamics of antidepressants resulting in different outcome and adverse effects**.**
Results showed that :
1-Females were more vulnerable, symptomatizing of depression, more adherent to treatment, while males responded more to antidepressants.
2-All patients on Sertraline suffered from insomnia and headache, while those on Maprotiline, Imipramine suffered from constipation, blurred vision.

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Ideal studies discussing the management of a disorder should address different approaches of management with estimation of both the effectiveness and the side effects of each approach. Also comparison between these different approaches should be done illustrating the advantages and the disadvantages of each approach. Randomized double blind controlled trial is the preferred study design used to test the efficacy of a new modality of therapy. The study should be double blind to avoid the introduction of expectation bias. The groups under the study should be followed up for a specified time period and analyzed in terms of specific outcome. The compliance of patients should be taken in consideration when testing the efficacy of a new modality of treatment.

Critical appraisal:

After the review of available Egyptian literature, critical appraisal of the studies included in the review was done. General observations were collected during appraisal and they apply to most of the studies appraised, these observations were:

- Most of the studies' titles included generalization that was not justified during conduction of the research as there was no specification of the sample included in the study or the exact aspects of the disorder to be studied.
- The aim of the study was clearly stated in the majority of the studies. In most of the cases there was more than one aim those were fulfilled by the end of the studies.
- Only few studies had a clearly stated research question or study hypothesis, while the majority did not. A clearly stated specific research question and study hypothesis are important to choose a suitable study design and to select proper sample with suitable sample size.
- The study designs used were frequently not mentioned clearly, described or rationalized. Not clarifying the study design raises questions about the results reached.
- Places of the studies and sampling populations were not rationalized in most of the studies. They were frequently selected according to the university where the study was registered. That is because they are more feasible and time saving; that made the sampling populations not representative for the target populations of most of the studies and decreased the external validity of the sampling population (the ability to generalize from the study results to the target population) with increased sampling bias. Moreover, that deprived several places in Egypt of being studied as they are away from the research centers.

- It was noticed that most of the studies used observational designs mainly cross-sectional and case-control designs. These designs are characterized by being simple, easy and low cost designs compared to other designs. Interventional studies and prospective cohort design were rare in Egyptian research. That might be due to the limited time for the studies and the limited budget of the research as most of the studies are M Sc. or MD theses. Also, the difficulties in following up the patients for long times and increased possibility of dropouts may be contributing factors
- Non probability sampling was more commonly used than probability sampling, with rare randomization. Non probability samples are easier to collect and more simple than probability samples but with increased possibility of sampling bias, which hinders the chances for generalization of the results of the study to the population.

- The assessment tools were usually explained in details with proper referencing, but in some studies the translated tools were not properly tested for reliability and validity before applying them.
- Details of calculation of samples size were not mentioned except in few studies. Suitable sample size is mandatory to give on accurate picture of what is going on in the target population
- Pilot studies were sometimes conducted and their results were used to adjust and improve the study proper.
- The statistical methods used for data analysis were mentioned in most of the studies and referenced.
- The results were usually presented in details mentioning both positive and negative data. The results were usually illustrated in tables and some times in graphs. But in some studies the tables contained data unnecessarily repeated in the text.
- The majority of the studies contained detailed discussions of the results and comparisons with other related studies. But it was noticed in most of the study that the results were incorrectly generalized.
- Recommendations were suggested by the end of most of the studies.
- In some studies limitations and difficulties met were clarified and that added weight to the study by clarifying the possible sources of bias. Yet limitations were not mentioned most of the studies.

Limitations of The Work

- Due to the wide scope of the topic of the study as it included all psychiatric disorders in women, it was hard to collect all the Egyptian studies conducted in that field putting into consideration the limited time of the study and difficult access to the Egyptian literature. So, the studies were searched only in the libraries of the four large Egyptian universities located in Cairo ,Alexandria and two main Egyptian journals of psychiatry that makes the review missing the studies published else where.
- In the libraries searched there were no available computer data bases what made it difficult to collect all studies on psychiatric disorders in women especially the old ones. The difficulties met the search and data collection in the different data bases were:

1. In Ain Shams University:

- Library of Faculty of Medicine Ain Shams University: All studies done in the field of neuro-psychiatry were listed in a chronological order since 1963. The studies were available with easy access to them. Yet, the presence of a computer data base would have made it easier to find the needed studies.

Also, Library of ASUIP was searched. That library included sporadic studies done in the neuro-psychiatry department of Ain Shams University and other universities. Some of the studies done in Ain Shams university were missing from the index of the library and others were not available although were listed in the index of the library.

2. In Al-Azhar University:

- The central library of Al-Azhar University: It has a computer system that was supposed to contain the titles of the studies included in all faculties of Al-Azhar University but it was complicated and still not containing all the studies. That made it easier to search for the studies on-shelf. The library itself contains very little number of studies in the branch of psychiatry; most of them were done in the last 5 years. So, libraries of faculties of medicine, Al-Azhar University in Cairo were visited

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3. In Cairo University:

The library of faculty of medicine: The studies in the field of neuro-psychiatry were collected and organized in chronological order since 1990. These studies were accessible easily. Studies before 1990 are hard to reach as they need reclassification and organization.

- There was an attempt to look for the earlier studies in the central library of Cairo University but at time of data collection they were moving the contents of the library to new place so it was hard search there.

4.In Alexandria University:

The library of faculty of medicine: The studies in the field of neuro-psychiatry were not collected or organized in chronological order. These studies were not accessible easily.

5. Egyptian journals of psychiatry:

- Current psychiatry: Only volumes of the journal since 1999 were accessible easily in ASUIP.

- Egyptian journal of psychiatry: There was available CD containing all volume of the journal since 1979 till 2003. Volumes after 2003 were searched in the library of ASUIP, most of them were available.

Despite these limitations, this work may be considered the first systematic review done in Egypt trying to throw a light on the major work done in the field of psychiatric disorders in women.

RECOMMENDATIONS

1. Establishing a national register system for all Egyptian researches and studies is an essential need. Presence of such system will allow recording of all Egyptian studies and so obtaining of these studies will be easier.

2. There is a need for further systematic reviews addressing different psychiatric disorders in women, it is better to be with narrower scope of research to discuss only one specific aspect of psychiatric disorders.

3. A more comprehensive national Egyptian survey involving all Egyptian governorates is needed to assess the prevalence of different psychiatric disorders in women.

4. Further studies are needed to explore the genetic and the neuro anatomical considerations implicated in the etiology of different disorders affecting women. These studies should depend on recent tools such as those of neuroimaging and genetic assessment.

5. There is still a need for additional studies exploring the relation between psychiatric disorders and other medical disorders in women.

6. There is a need for further studies to assess the different types of outcome of psychiatric disorders better through using prospective cohort design identifying the main factors determining them.

7- It is hoped that clinicians and researchers will be well informed in different classificatory systems and accumulate

clinical and research data to help modify and enrich the present classification of psychiatric disorders in the cultural context.

8- Increase family involvement in treatment of the patients

9- Family psychoeducational programs are very important to reach better prognosis.

10- More work is obviously needed in the area of classification of psychiatric disorders in Egypt.

11- Systematic review of Arabic studies on different psychiatric disorders in women is highly recommended in future research.

12- Psycho-educational approach to the patient and her family may be mandatory to reduce the financial burden imposed by relapse.

13- In order to reduce the stigma and discrimination because of psychiatric illness, it is necessary to change people's attitude to increase the knowledge of mental illness and appropriate treatments through educational and outreach programs. Also it is helpful to collaborate with local social advocacy groups.

14- Improving the quality of life of persons with any mental illness is becoming an important treatment goal.

SUMMARY

Medical literature is vast and rapidly expanding. As clinical practice becomes busier and time for reading and reflection becomes even more precious, the ability effectively to peruse the medical literature and, in the future, to become familiar with a knowledge of best practice from modern communication systems will be essential skills for doctors. This explains the importance of understanding of the concept of "evidence-based medicine".

Evidence-based medicine" is the enhancement of a clinician's traditional skills in diagnosis, treatment, prevention and related areas through the systematic framing of relevant and answerable questions and the use of mathematical estimates of probability and risk.

As psychiatric disorders in women constitute a major public health problem, many Egyptian studies were interested in discussing these disorders from many different aspects. These studies must open the door for new researches and their conclusions must direct our clinical practice.

This work was conducted in order to systematically review and appraise the Egyptian studies on these disorders and hence recommendations for further studies are generated.

In order to fulfill that aim several databases were explored in the period from November 2007 to March 2008 to collect Egyptian studies on psychiatric disorders in women. The databases searched were library of faculty of medicine Ain Shams University, library of faculty of medicine Al-Azhar University, library of faculty of medicine Alexandria University, library of faculty of medicine Cairo University, Egyptian journal of psychiatry, and current psychiatry

After collection of the available Egyptian studies on psychiatric disorders in women (32 studies), a literature review was done. In that review, The available data were categorized into data related to epidemiology, etiology, clinical description, management, and outcome as far as possible.

Critical appraisal of the Egyptian studies on those disorders was included and the systematic review was done.

A general idea about the concepts of systematic review and critical appraisal were given with describing the standard appraisal questions that should be answered for proper evaluation of researches. A list of the most commonly used research methods in practice was presented; the specific appraisal questions asked to evaluate each method were discussed in details in this chapter.

We discussed 32 studies concerning epidimiology, etiology, clinical profile, management and outcome of psychiatric disorders in women.

In fact, there were 4 studies targeting prevalence of substance abuse, OCD, PMDD and postpartum psychological disturbances.

Hashim 2002 found out that prevalence of substance use disorders in secondary school females in Cairo was 18.4%. Alcohol was the most common substance used (15.9%) , followed by illicit drugs (3.9%), tobacco smoking (2.5%) and then cannabinoid (0.7%). She mentioned causes of continuation and abstinence in details. While ***Zarif 1999*** found out that PMDD prevalence was 6.59% while premenstrual exacerbation was 3.65%.Symptom profile of PMDD was variable (pain-negative affect-behavioural changes-irritability-mood swings-fatigue-general aches-preference to stay at home-breast tenderness-bouts of excitement-nausea-vomiting-difficulty in concentrating -palpitation-feeling of suffocation) **.** While studying post partum psychological disturbances**, Youssef *1985*** found out that psychiatric symptoms in puerperium were (adjustment disorder with depressed mood 13.2%-maternity blues 7.5%-atypical bipolar disorder 3.8%) while risk factors were (unemployment-positive family history of mental illness-neurotic mood-negative attitude of husband-sex of the baby). ***Soltan 2002*** studied prevalence of OCD in female secondary schools in Cairo. Prevalence of OCD was 1.2%, while obsessive compulsive symptoms prevalence was 13.01% .The commonest OC symptom was excess conscience (more in rural than urban, more in public than private school).Adolescent OCD was not a rare disorder while subthreshold obsessive compulsive syndrome was widely presented in adolescent population. Culture might Colour the clinical picture but did not affect

prevalence. Religion did not affect prevalence of OCD but it was an area where OCD expressed itself**.**

Many researchers studied the etiological factors related to many psychiatric disorders. Two studies discussed this issue; the first was done by ***Ibrahim 1999*** who studied the etiological relation between level of serum estrogen and cognitive abilities. There was negative correlation between duration since menopause and serum estradiol levels, also between women age and scores of cognitive tests. But there was positive correlation between serum estradiol levels and cognitive function tests. So physiological menopause (estrogen deficiency) had a negative effect selectively on short term verbal memory**.**

Shawer 2006 studied biological factors of women vulnerability to depression. There was a positive correlation between degree of depression and age of the patient, his marital status, his social class. While Level of TT3, TT4, FT3, FT4, TSH, and E2 were significantly different between patients and controls. The higher the degree of depression, the lower the level of TT3-TT4-FT3-E2. The higher the E2 level, the higher the TT4 level.

There were two studies discussing spouse role in addiction and psychiatric morbidity among wives of addicts.

Emara 2002 found out that wives of addicts preferred traditional roles while husbands of female addicts did not, Wives had higher level of aggression, depression and anxiety. Couples of drug abusers had ill communication difficult problem solving, sexual dissatisfaction , conflict over child rearing, disagreement over finances and dissatisfaction with children**.** While ***Afifi 2007***found out that addicts wives showed significant higher level of (adjustment-major depressive-anxiety-personality-sexual) disorders.
There were problems in areas of family environment, financial management, domestic violence, low parenting capabilities and bad quality of life.

Three studies discussed different types of violence against women. ***Ezzat 2005*** found out that physical abuse was more common than verbal and emotional. Domestic violence had significant relation with history of child abuse. Battered women were more depressed, showed higher scores in

middle level of locus of control and higher scores in psychoticism. There was an important relation between divorce, parental troubles and domestic violence. Domestic violence was a general health problem that had psychiatric, medical, social and legal aspects .It was underestimated with insufficient measures to face this problem .While ***Hussein 2007*** found out more detailed problems e.g. Types of violence were (slapping-hitting-beating-kicking-insulting-threatening-abandoning) .There was interpersonal violence between husbands and wives. Causes reported by women were (refusing sex-withholding money-disobedience-joules-house duties).Bipolar patients were more likely to be abused followed by psychotic patients .Severely abused patients usually attempted suicide. Most common psychiatric disorders related to abuse were (depression-generalized anxiety disorder-somatoform disorder).Types of sexual abuse were (street harassment-touching-rubbing-attempt or actual rape-exhibitionism).Risk factor for abuse in women were (illiterate-abused or witnessed abuse in childhood-not working).Risk factors for women who prepare for violence were (illicit drug abuse plus the former factors).

Seif El Dawla 2001 found out that The most commonly reported symptoms were feelings of helplessness, depressive symptoms , lack of self confidence and a chronic feeling of apprehension ,anticipation of violence ,generalized Anxiety disorder , adjustment disorder ,dysthymic disorder ,and major depressive disorder

2-Spouse behavior that women consider violence:

Polygamy -marital rape -preventing wives from going out of the house -withholding children after divorce -enforced obedience

3. Psychological conséquences of violence Psychological réaction

Feelings of helplessness -depressive symptoms, inappropriate sleep and fatigue -lack of confidence in others -chronic feeling of apprehension and anticipation of violence -lack of self confidence -bouts of anger -chronic ambiguous feeling of guilt 68-mood swings 50-flashbacks and nightmares of certain violent incidents

4-Diagnoses were:

(PTSD – Generalized anxiety disorder. - Adjustment disorder - Dysthymic disorder - Major depressive disorder).

Two studies targeted pregnancy related depression. ***Hewedi ,Fahmy 2006*** found out that depression was detected in 30% of subjects in early pregnancy while it was detected in 34% of subjects in late pregnancy. Pre-

eclampsia occurred more with combined early and late depression than late depression alone While ***Abdel Latif 1999*** found out that postpartum depression is the same medically but different culturally according to the following risk factors:(family history of psychiatric illness-cesarean section-guardian unemployment-hormonal contraceptives-marital problems-polygamy-not breast feeding-poor social support-postpartum blues-premenstrual tension syndrome-primipara-teenager-undesired infant sex-unwanted pregnancy

A unique study discussing the effect of antidepressants response and side effects on both genders was done by ***Abdel Raouf 2001*** who found out that females were more vulnerable, more symptomatizing of depression, more adherent to treatment, while males responded more to antidepressants. ,it was found that depressed men were more rapidly responding to antidepressants due to differences in pharmacokinetics and pharmacodynamics of antidepressants resulting in different outcome and adverse effects.

Four studies discussed gender differences in many psychiatric diseases e.g. schizophrenia, bipolar disorder, OCD and depression.

As for OCD, ***Nasr El Den 2001*** found out that men expressed more religious, sexual obsessions, hopelessness, controlled oral word association and visual memory span. While women expressed more hoarding, other compulsions, failure to maintain serotonin level. Females were slower, less selectively attentive than males, more impaired as language abilities than males. So sex did not determine OCD severity. Females showed higher serotonin level especially in chronic illness so serotonin was gender specific marker .Attentional deficit was disease specific rather than gender specific. OCD was not a stress related behavior but it was a maladaptive learnt behavior .OCD was not a progressive disorder as regards cognitive dysfunction .While ***Asaad, Kamel 2001*** found out that pregnancy related OCD had a different criteria .The most frequent obsessions encountered were religious thoughts followed by cleanliness thoughts and rituals and then impulses related to harming the foetus .Severity of the disease ranged from moderate to sever .Most of symptoms occurred in the 2 nd trimester.

When discussing depression ,***Botros 1997*** found out that males showed low self esteem ,indecisiveness , decreased dreams ,neglected self hygiene and prevailing depressed mood ,while females showed fatigue ,crying, dissociative symptoms ,negative self perception ,tendency to go out, decreased sexual desire ,no change in dreams ,adequate self hygiene ,retardation and impaired judgment. Many factors colored clinical picture, symptomatic expression of depression e.g. level of education, work, gender, socioeconomic state, personality and cultural norms of society.

When studying schizophrenia by ***El Rakhawy 1998,*** it was found out that gender had little impact on presentation and course of schizophrenia. Assessment should be done in context of sociocultural beliefs
Gender difference was demonstrated as the following**:**
1-Men: had an earlier age of onset, a poorer premorbid history, more negative symptoms, differential neuro cognitive functions, a poorer response to neuroleptics and a lower family risk for schizophrenia.
2-Women: had more decreased motor activity, self neglect, suicidal attempts, higher scores in paranoia scale of MMPI and a tendency to have more positive family history of schizophrenia

Prevalence rates in women exceeded those of men. Gender difference in mood disorders had an important clinical subtypes or symptoms clusters specific to each sex.

Two studies discussed female sexual dysfunction.***Abed 1998*** concluded that most common sexual complaints were vaginismus, loss of sexual desire, dyspareunia and anorgasmia. While ***El Fangry 2003*** found out that the most common sexual dysfunctions were desire disorders, orgasmic dysfunction, arousal disorder, dyspareunia and lastly vaginismus. The most common psychiatric disorders in these patients were (mood-anxiety-somatoform-adjustment) disorders. There was high rate of circumcision, manual hymenal perforation in wedding night, discrimination in favor of males, earlier onset of marriage and first information about sex from the family. Psychiatric patients had low (sexual drive, sexual attitude, sexual satisfaction, orgasmic capacity, desire frequency and total sexual functioning) plus more dependent personality disorder than others. Psychiatric patients showed more sexual dysfunction, personality pathology and marital dissatisfaction than others. There was a high rate of overlap between different sexual disorders in the same patients. Testosterone was positively correlated with sexual desire and orgasm.

A study about sex chromosome disorders e.g. turner syndrome was done by ***Gaffer 1993*** who concluded that early diagnosis, follow up was very important. Recommendations were (overprotection or rejection from parents is forbidden. Early social stimulation and special schooling are necessary. Medical treatment for induction of growth, regular menses must be considered). Cognitive decline in these patients started since childhood and continue to adulthood. Patients had higher femininity score and they could manage appropriately in their homes and they were less symptomatizing than normal girls (due to being defensive in their self reports about symptoms).

When studying outcome of many psychological disturbances, we find important results e.g. ***Radwan 2007*** found out that:
Social phobia was the most encountered, followed by dysthymia, major depressive disorder, obsessive compulsive disorder, agoraphobia and post traumatic stress disorder. There was high prevalence of personality disorder. Comorbidity between depression and anxiety was high. Women with psychiatric morbidity had difficulty to become pregnant and poorer outcome in general.

Two studies discussed criminality among female psychiatric patients. ***Elwan 2005*** Compared female psychotic homicidal with female psychotic non-homicidal to detect a correlation in the past history, social circumstances and clinical profile associated with homicide. Results showed that homicidal females scored higher on GAF scale.50% of them were schizophrenics, 35% were bipolar.15% were schizoaffective**. C**orrelates of homicide in psychotic females were :(younger age of onset of mental illness-diagnosis of schizophrenia then bipolar manic then mood episodes of postpartum onset then schizoaffective-being married with children-history of exposure to domestic violence in childhood-past history of sever violent acts especially attempted homicide).While ***William 1986*** found out that mental hospital criminals were not more criminals (bad) than prison criminals .Mental hospital criminals were not more mentally disordered (mad) than patients with no criminal records. Results showed that:
1-Mean age of committing a crime was around 35 year, with more prevalence in rural areas; mostly among married female housewives with low educational level and past history of mental disorder.
2-Family history of criminality and-or mental disorder with absence of father figure as an added factor.

3-Wepons used were either sharp instrument or heavy blunt objects.
4-Victims were usually relatives to patients.(usually husbands).
5-Causes of crimes were (accidental murder-excitement-anger-vendetta-delusion of persecution or infidelity-with out cause).
6-Most of patients have intellectual deterioration and social maladjustment.
7-There was high score for criminality, neuroticism, lie score, depression traits, impulsivity and mal adaptability scale.
8-Psychiatric disorders mostly occurring were (schizophrenia-bipolar disorder-mental subnormality-sociopathy-addiction).

Abdel Hamid 1996 discussed the impact of burn upon females. Results showed that 40% reached level of diagnosable psychiatric illness while 60% did not .Most common diagnoses were (depression-acute stress disorder-delirium-mixed anxiety depression) especially with burns of the face. So burns significantly affected psychological well being of patients.

A study discussing psychosexual aspects of female circumcision was done by ***Sami 1995***, who found out that the chief motive was religious then inherited customs. Women reported physical and hygienic complications after operation .Most women were illiterate, operated upon by midwives or doctors .Most of circumcised females had high neurotic score and reached orgasm with difficulty .The most important side effects of circumcision were sexual dis-satisfaction and anorgasmia.

A study discussed the effect of hysterectomy upon psychological wellbeing of women ***.Omar 1998*** found out that psychiatric diagnosis after hysterectomy were depression ,anxiety then sleep disorders .Quality of sexual life after operation improved .Patients below 40 year ,without children suffered psychologically more than other women .Good husband ,family relationship minimized this stressful situation .The expectations of women ,premenopausal age and premorbid personality determined sequela after operation.

Three studies discussed the effect of breast cancer upon psychological wellbeing of women .***El Hennawy 1999*** found out that there was high incidence of (loss of libido-persistent somatic complains not responding to symptomatic treatment-retardation-sleep troubles-fears-worries-eating problems-depressed mood-psychiatric disorders not attributed to any specific disease).There were (high score in extraversion, low score in neuroticism

,low prevalence of personality disorder in cancer breast patients).While ***Allam 1999*** found out that patients below 50 years old suffered severe symptoms of anxiety ,depression more than those above 50 years old .Quality of life was worse in patients below 50 years .More anxiety was present in patients with lumpectomy(for fear of recurrence).More depression was present in patients with radical mastectomy ***.Hussein 1986*** found out that cancer breast patients suffered from psychiatric manifestations e.g. anxiety , depression, fears and loss of libido. Most common defense mechanisms used were denial, displacement and reaction formation.

Conclusion

Many Egyptian studies discussed the topic of psychiatric disorders in women from its different aspects, however these studies are still defective and deficient. Common missed points were found in these studies such as good description of the study design, evaluation of the reliability and validity of their measures and justification of the sample size to meet their aims. Describing the statistical methods used, discussing the unwanted events occurred during the study and how they were dealt with, sources of bias and how they were eliminated were also common missed points in many Egyptian researches. There is a need for further studies discussing this important topic.

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Appendix

1-Subject: Substance use disorder among female secondary school students in Cairo.

Author: Nivert Zaki Mahmoud Hashim**.**

Document: M .D Thesis.

Site: Secondary schools in Heliopolis, Zayton,El-Marg.

Year: 2002

Background: 593 female students distributed among six schools in urban (Heliopolis), semi-urban (Zayton) and rural (EL-Marg) areas in Cairo. For each area, one governmental and one private school were chosen to be studied. From each school, three classes representing the secondary educational levels were randomly studied, Initiated and completed during the educational year 2000-2001

Aim: provide factual answers to:

a-The extent of psychoactive substance among female students.

b-The socio-demographic relevance use.

c-The etiology of such use among those female .

d-Comparing these results with other results done in our country and other countries.

Design: cross sectional epidemiologic study.

Methods:

*A self-administered questionnaire for the detection of substance use disorders (Soueif, et al, 1986).

*A self-administered (General Health questionnaire) for the detection of psychiatric disorders (Goldberg, 1983).

*Any student who reported psychiatric disorder was furtherly and individually assessed by the research diagnostic criteria using the ICD-Symptom Checklist that helps to check the presenting symptoms

Result: prevalence of substance use disorders was 18.4%. Alcohol was the most common substance used (15.9%) , followed by illicit drugs (3.9%), tobacco smoking (2.5%) and then cannabinoid (0.7%).

Conclusion:

1-causes of continuation (getting dependent on then & influence of their friends& various social occasions& getting sense of pleasure)

2-causes of abstinence (fear of dependence & harmful effect of drugs on health & religious factor & social limitations).

2-Subject:psychiatric manifestations in cancer breast patients.

Author: Hussein el-said mahmoud Hussein.
Document: M.Sc Thesis .
Year:1986
Background: Two groups are studied:
1-patients group: 40 cancer breast patients were chosen from radiotherapy clinic at the main hospital of Alexandria university.
2-control group: 20 females suffering from breast abscess were chosen from surgery clinic.
Methods: Both groups were subjected to:
1- Physical and standard psychiatric examination.
2- Psychometric test; the Arabic version of Beck Depression Inventory (BDI)
Design: case control study
Site: Main Hospital of Alexandria University.
Results:
-Half of cancer breast patient were in 5^{th} decade.
-No family history of cancer was found in 90% of cases.
-Radiation therapy, mastectomy are definite evidences of cancer.
-Depression was 77% using psychiatric interviewer and Beck Depression Inventory.
-By using Beck Depression Inventory, 1/3 of patients were not depressed; 1/3was mildly depressed, and1/3 was severely depressed.
-Most common symptoms were somatic preoccupation, sadness, insomnia and body image change while least common symptoms were suicidal ideas and guilt.
-Loss of libido is reported in 75.5% of cases.
-Anxiety is reported in 50% of cases.
-Fear is reported in52, 5%of cases (of death-disability-disease-disfigurement-and husband's rejection).
-Most common defense mechanisms used are denial, displacement and reaction formation.
-There is no role for stressful like events or prior psychiatric disturbances.

Conclusion: cancer breast patients suffer from psychiatric manifestations e.g.: anxiety , depression, fears other has to be liaison between psychiatry, oncology to help these patients.

3-Subject:psychological profile and quality of life(QOL) assessments in cancer breast patients.

Author: Mohamed Ahmed Allam.

Year:1999

Document: M.D Thesis**.**

Site: Ain Shams University Hospital.

Background: Females diagnosed as breast cancer patients with no age limitations facilitate the recruitment and to have and idea about the distribution of the different changes in psychological profile in the different age groups.

Aim: To highlight the quantitative, qualitative psychological profile, quality of life changes in lives of those patients to provide intervention strategies to cover patients suffering.

Design: case control study.

Methods: we used:

a-Beck Depression Inventory (BDI)
b-Hospital Anxiety and Depression Scale (HADS)
c- Functional Living Index-Cancer (FLIC)
d-The Structured Clinical Interview for DSM 1V Axis I Disorders (SCID-I)

Results:-case group suffer from depression, anxiety more than control group.
-patients below 50 years old suffer severe symptoms of anxiety, Depression more than those above50years old.
-Quality of life is worse in patients below 50 years.
-More anxiety is present in patients with lumpectomy (for fear of recurrence).
-More depression is present in patients with radical mastectomy.

Conclusion: There are cultural issues that need to be assessed in breast-cancer patients so we suggest some questions added to quality of life tools.

4-Subject:Descriptive study of psychotic homicidal females in comparison with psychotic females non-offenders.

Author: Tamer Mohamed Elwan.

Document :M.D Thesis.

Site :El-Abbassia Mental Hospital.

Year:2004

Background :A selected twenty psychotic homicidal non-guilty by reason of insanity females in acquit tees ward in El-Abbassia Hospital compared to a group of selected twenty psychotic non-homicidal female patients from other words in the same hospital as a control sample (with the same DSM IV Axis I diagnosis and duration of admission as the first group.

Aim: a-Review Egyptian , International literature about;(Legal definition of homicide ,criminal responsibility- relation between mental illness ,violence and criminality-homicidal behavior committed by mentally ill women).

b-To compare female psychotic homicidal with female psychotic non-homicidal to detect a correlation in the past history ,social circumstances and clinical profile associated with homicide.

c-Describe crime circumstance

Design: case-control study

Methods :by using psychiatric assessment and history taking according to Ain-Shams semi-structured interview then usage of standardized psychiatric assessment using Structured Clinical Interview for DSM 1V .(SCID I- SCID II).Inclusion criteria were :(female-psychotic).Exclusion criteria were:(organic or epileptic psychotic patients)

Results: Homicidal females scored higher on GAF scale.50% of them were schizophrenics, 35% were bipolar.15% were schizoaffective.

Conclusion: Correlates of homicide in psychotic females are:(younger age of onset of mental illness-diagnosis of schizophrenia then bipolar manic then mood episodes of postpartum onset then schizoaffective-being married with children-history of exposure to domestic violence in childhood-past history of sever violent acts especially attempted homicide).

5-Subject:Study of the relationship between serum estrogen level in menopausal women and cognitive functions.

Author :Naglaa Abdel Monem Ibrahim.

Document: M. Sc Thesis.

Site: Alexandria University Hospitals.

Year: 1999

Background :Ninety naturally menopausal women selected randomly from general population ,allocated into three groups according to duration since menopause.

*Group I (30 women) with more than 1 year, less than 2 years from menopause.

*Group II (30 women) with 2-6 year since menopause

*Group III (30 women) with more than 6 year since menopause.

** Exclusion criteria are:(history of psychiatric, medical illness, previous head injury, smoking, drug abuse, gynecological disorder with hyperestrinism, obese women, women with history of hormonal replacement therapy)

Design: case control study**.**

Aim: 1-Study cognitive functions in menopausal women.

2-Study the relationship between estrogen level in menopausal women and cognitive functions.

Methods: patients were subjected to :

1- Full history taking including gynecological history.

2- Thorough general medical examination.

3- Complete mental state examination.

4- Serum estradiol level by RIA (using available kits)

5- Neuropsychological tests of memory functioning using:(mini mental state examination).

Results:

1- There is negative correlation between duration since menopause and serum estradiol levels, also between women age and scores of cognitive tests.

2-There is positive correlation between serum estradiol levels and cognitive function tests.

Conclusion: Physiological menopause (estrogen deficiency) has a negative effect selectively on short term verbal memory.

6-Subject:Psychiatric morbidity in infertility in a sample of Egyptian females.

Document: M.D Thesis.

Author: Doaa Nader Radwan.

Site: Department of obstetrics and gynecology, Ain Shams University Hospitals (Assisted Reproductive Technique Unit).

Year;2007

Background: 210 women put into 2 groups (patient-control) ,selected in 1 year interval (June 2005- July 2006) The patient group was 110 infertile women (inpatient-outpatient)

*Inclusion criteria :(primary infertility-child bearing period-fulfill diagnosis of infertility)

*Exclusion criteria :(Major general medical disease-Male factor infertility-History of recurrent abortions)

**control group: 100 fertile women (no history of infertility, abortions nor hormonal contraception)

Aim: 1-Estimate psychiatric morbidity among infertile women identifies its variables, investigate its relationship and highlight this topic.

2-Infertile women need psychiatric help.

3-Review medical aspects of infertility and review available treatment of psychiatric difficulties related to infertility.

Design: Cross sectional, case control, observational study

Methods: we used:

1-Structured Clinical Interview for DSM IV (SCID I)

2-Structured Clinical Interview for DSM IV axis II (SCID II)

3-Fertility Adjustment Scale (FAS)

4-Beck Depression Inventory.

5-The Manifest Anxiety Scale.

6-PCASEE quality of life questionnaire.

7-Eysenck Personality Questionnaire (E.P.Q)

8- D- scale of Guilford Inventory of Personality factors.

9-Fahmy and El-Sherbini Social Classification Scale .

Results:1- Social phobia is the most encountered ,followed by dysthymia, major depressive disorder, obsessive compulsive disorder, agoraphobia and post traumatic stress disorder.

2-Comorbidity between depression and anxiety is high.

3-High prevalence of personality disorder.

Conclusion: 1-Women with psychiatric morbidity have difficulty to become pregnant and poorer outcome in general.

7-Subject:A Psycho-socio-demographic study of premenstrual dysphoric disorder (PMDD) in a sample of Egyptian women.

Document: M.D.Thesis.

Author :Nashwa Zarif.

Site :at the Faculty of Medicine, Ain Shams University Hospitals.

Year: 1999

Background: A sample of Egyptian females (single or married, in child bearing period) were chosen randomly with inclusion criteria of: (age from 15-45 year, regular menstrual cycles),exclusion criteria of :(presence of medical or gynecological disease, being under any drug therapy)
* Equal number of students was taken from different educational years.

Aim:1-To estimate prevalence of PMDD in a sample of Egyptian women.
2-To explore symptom profile of this disorder in that sample.
3-To search for any relationship between PMDD regarding occurrence and severity with different personality and socio demographic factors.
4-To discuss establishing a public education, prevention and early intervention programs.

Design: Cross sectional study.

Methods: Patients were subjected to :
1- Eysenck personality Questionnaire. (EPQ).
2-Taylor Manifest Anxiety Scale.
3-Beck Depression Inventory. (BDI)
4-Guilford Scale.
5-Fahmy and El Sherbini.
6-Dealing with illness coping inventory.

Results:1-High prevalence in first social class.
2-High prevalence in troublesome homes.
3-Menorragia,dysmenorria,infertility and abortions were higher with PMDD.
4-Higher score for neuroticism, criminality, anxiety and depressive symptoms.

Conclusion: Symptom profile of PMDD is variable (pain-negative affect-behavioural changes-irritability-mood swings-fatigue-general aches-preference to stay at home-breast tenderness-bouts of excitement-nausea-vomiting-difficulty in concentrating palpitation-feeling of suffocation)

8-Suject:Psycosocial profile of a sample Egyptian female patients with breast cancer.

Author :Heshim Salah El Hennawy.

Document :M.Sc Thesis.

Year: 1999

Site :Ain Shams University Hospital.

Background:60 Egyptian females in 3 groups:

- 20 with breast cancer (group I)
- 20 with benign breast tumors (group II)
- 20 not known to have physical or psychiatric disorders (group III)

Aim: Investigation of a sample of Egyptian female patients with breast cancer ,trying to get a psychosocial profile and to detect risk factors important in tumorigenesis of breast cancer.

Design: case control study.

Methods: Tools used are (after taking consent) :

1-Semistructured socio-demographic and clinical interview.
2-Social readjustment rating scale.
3-Eysenk Personality Inventory (EPQ)
4-ICD-10 research diagnostic criteria.

Results:1-High incidence of (loss of libido-persistent somatic complains not responding to symptomatic treatment-retardation-sleep troubles-fears-worries-eating problems-depressed mood-psychiatric disorders not attributed to any specific disease).
2-No difference between groups regarding (socio-demographic data-stressful life events in year preceding diagnosis).
3-Cancer breast patient consume more fat in diet compared to the rest of the sample.
4-High score in extraversion, low score in neuroticism.
5-Low prevalence of personality disorder in cancer breast patients.

Conclusion: High prevalence of psychiatric manifestation in breast cancer patients denotes importance of psychiatric and psychological support to improve physical and psychosocial wellbeing.

9-Subject:A Gender-related study of antidepressant in a sample of Egyptian depressed patients.(Response and side effects profiles).

Author :Mohamed Reda Abdel Raouf.

Document :M.D Thesis.

Year:2001.

Site :Outpatient clinics of psychiatric military hospital and departments of Abbassia mental hospital.(

Background:148 depressed patients (126 continued the study-22 dropouts),and they were put into 3 groups, each group consisted of 20 males,20 females. The first group was treated with Imipramine, the second treated with Maprotiline ,the third treated with Sertraline).

Aim:1-To explore importance of gender in vulnerability ,presentation of depression, clinical response to antidepressant, through (reviewing available literatures-evaluate symptomatology with respect to gender-evaluate clinical response and adverse effects of antidepressants).

Design: case-control study.

Methods: Tools used were:(clinical interview ,examination-IQ testing-Gilford D scale for depressive traits-Zung scale for depressive state-Hamilton rating scale)

Results:1-Females were more vulnerable ,more symptomatizing of depression ,more adherent to treatment ,While males responded more to antidepressants.

2-All patients on Sertraline suffered from insomnia and headache, while those on Maprotiline, Imipramine suffered from constipation ,blurred vision.

Conclusion: Gender and culture are to be considered on assessing and treating a case of depression, it was found that depressed men are more rapidly responding to antidepressants due to differences in pharmacokinetics and pharmacodynamics of antidepressants resulting in different outcome and adverse effects.

10-Subject:Post-partum psychological disturbances (Epidemiological view).

Author :Ismail Mohamed Youssef.

Document :M.D Thesis.

Year:1985

Site: EL-Hussein University.

Background:1-Ladies delivering in department of gynecology and obstetrics in El Hussein University Hospital in 50 days chosen randomly.(Group I)
2-Ladies admitted to El Abbassia mental hospital, known to have given birth within 6 months previous to admission.(Group II)
3-Ladies admitted to El Maadi Palace with a history of delivery 6 months prior to admission.(Group III)

Aim:1-To determine prevalence of, delineate risk factors of post-partum psychiatric disturbances
2-To assess puerperal psychosis.
3-To study similarities , differences between our findings among developed and developing countries.

Design : Retrospective survey study (cross sectional study).

Methods: using:
(Psychiatric sheet-mini mental scale-Hildreth Scale for mood)

Results:1-Psychiatric symptoms in puerperium are (adjustment disorder with depressed mood-maternity blues-atypical bipolar disorder) while risk factors are (unemployment-positive family history of mental illness-neurotic mood-negative attitude of husband-sex of the baby)

Conclusion : Negative attitude of the mother towards the baby ,negative attitude of father to mother reflects depressive mood.

11-Subject: Spouse role in the problem of drug abuse.

Document :M.Sc Thesis.

Author :Enas Kamel Emara.

Year: 2002.

Site :Inpatient psychiatric hospital (Maadi Nile Sanatorium).

Background: 30 addict patients and their spouses were selected from inpatient psychiatric hospital. Patients were diagnosed according to criteria of DSM IV-TR (2000), the control group was 30 normal male persons and their spouses were matched for same age, educational level and social status.

Aim:1-To know main sources of marital dissatisfaction and conflicts in couples of drug abusing husbands.
2- To know relation between behaviors and attitudes of wives of addicts and main source of conflicts between them.
3-To know coping mechanisms of their wives that contributes to the problem.

Design: Case control study.
Method : Tools used were:
1-Marital Satisfactory Inventory (MSI)
2-Hamilton Anxiety Rating Scale (HARS)
3-Hamilton Depression Rating Scale(HDRS)
4-Gillford Aggression Scale(GAS)
Results:1-Wives of addicts prefer traditional roles while husbands of female addicts do not.
2-Wives of addicts had higher level of aggression, depression and anxiety-3-No history of family distress.
Conclusion: Couples of drug abusers have higher scores in conventionalization global distress, ill communication, difficult problem solving, sexual dissatisfaction, conflict over child rearing, disagreement over finances and dissatisfaction with children.

12-Subject:Gender related psychobiological differences in obcessive compulsive disorder patients.

Document: M.D Thesis.
Author: Mohamed Naser El Den.
Year:2001
Site:?
Background:41 OCD patients fulfilling certain inclusion and exclusion criteria were selected ,divided into 2 groups .The first is 21males,the other is 20 females.
Aim:1-To find out gender related demographic ,clinical, neuropsychological and biological characteristics that may help better understanding of OCD.
2-To estimate severity of symptoms, it relation to presence of cognitive deficit and gender difference that may help management of OCD patients
Design : Outpatient comparative survey of male and female OCD patients.
Methods :The following tools were used:(Yale Brown Obsessive Compulsive Scale-Yale Brown Obsessive Compulsive Symptom Checklist-Hamilton Anxiety Scale-Hamilton Depression Scale-Wisconsin Card Sorting test-Controlled oral word association test-Attention tests-Social Readjustment Rating Scale-Selected Subtests from Wechsler Adult Intelligence Scale(Similarities, Block design)-Selected subtests from

Wechsler Memory Scale-Revised(figural memory, visual paired associate 1,visual reproduction 1,visual memory span).

Results: Men expressed more religious, sexual obsessions , hopelessness ,controlled oral word association and visual memory span .While women expressed more hoarding, other compulsions, failure to maintain serotonin level. Females were slower , less selectively attentive than males ,more impaired as language abilities than males.

Conclusion:1-Sex does not determine OCD severity.
2-Females show higher serotonin level especially in chronic illness so serotonin is gender specific marker.
3-Attentional deficit is disease specific rather than gender specific.
4-OCD is not a stress related behavior but it is a maladaptive learnt behavior.
5-OCD is not a progressive disorder as regards cognitive dysfunction.

13-Subject:Gender Differences in Depressive Disorders in an Egyptian Sample.

Document :M.Sc Thesis.

Author :Manal Khairy Botros.

Year:1997.

Site :Kaser El Aini out patient psychiatric clinic.

Background:40 patients diagnosed as unipolar major depression according to DSM 1V criteria(20 male-20 female)

Aim :To review the literature ,to find out gender differences in unipolar major depression in adult Egyptian sample.

Design :case-control study.

Method :patients were subjected to :
1-Full psychobiogram.
2-General physical and neurological examination.
3-Beck Depression Inventory .
4-MMPI (D) Scale (Arabic version)

Results:1-Males showed low self esteem, indecisiveness, decreased dreams ,neglected self hygiene and prevailing depressed mood.
2-Females showed fatigue, crying, dissociative symptoms ,negative self perception, tendency to go out, decreased sexual desire ,no change in dreams, adequate self hygiene, retardation and impaired judgment.

Conclusion :Many factors Colour clinical picture ,symptomatic expression of depression e.g . level of education, work, gender, socioeconomic state ,personality and cultural norms of society.

14-Subject:Study of domestic violence in a sample of Egyptian female psychiatric patients.

Document :M.Sc Thesis.

Author :Ahmad Abdel Aziz Ezzat.

Year:2005

Site :Kaser El Aini Hospital.

Background:60 married female psychiatric patients are put in 3 groups:(20 diagnosed as bipolar affective disorder-20 diagnosed according to ICD 10 to have neurotic disorders-20 as control group)

Aim:1-Introduce different conceptual and psychiatric aspects of domestic violence.

2-Explain issues of domestic violence in married couples with female partner having a psychiatric illness.

Design :case-control study.

Methods :All patients and their husbands were assessed using:

1-Zung self rating depression scale.

2-Locus of control.

3-Eysenck Personality Questionnaire (EPQ)

4-Special questionnaire used to assess intimacy and abuse according to wives perception of husbands characters.

Results:1-In patient group :physical abuse is more common than verbal and emotional. In control group :verbal abuse is more common than physical and emotional.

2-Domestic violence has significant relation with history of child abuse.

3-Battered women were more depressed ,showed higher scores in middle level of locus of control and higher scores in psychoticism.

4-Abused women said that their husbands are not democratic ,reported husband parental troubles.

5-There is an important relation between divorce and domestic violence.

Conclusion:1-Domestic violence is a general health problem that has psychiatric, medical ,social and legal aspects .It is underestimated with insufficient measures to face this problem.

2-Domestic violence in female psychiatric patient is not higher than normal that indicates the value of traditions ,religion and culture in tolerating mental illness.
3-Child abuse ,husband family troubles ,divorces or beating are important risk factors for domestic violence.

15-Subject:Psychological aspects of sex chromosome disorders with application on turner syndrom.

Document :M.Sc Thesis.
Auther :Yehia Mohamed Gaffer.
Year:1993
Site :National Research Center.
Background :A sample of 21 patients with clinical manifestation of Turner Syndrome aged from 8-12 year were put into 2 groups according to karyotyping results:
1-Group A: 10 patients(6 patients with 45x kariotypy,1 patient with 64xx q karyotype ,3 patients with 45x i(xq) karyotype.
2-Group B (11 patients with 46xx normal female karyotype)
Aim:1-To know psychological aspects of different sex chromosome disorders(impact on cognitive development, personality ,behavior and possible related psychological complications)
2-Assesment of Egyptian Turner Syndrome girls aged between 8-12 year, with the aim of identifying possible psychological characteristic profile of these patients which might help in avoidance of psychological complications.
Design :case-control study.
Methods :Patients were subjected to the following:
1-Wecsler intelligence scale for children (WISC)
2-Bem sex-role Inventory.
3-Child Behavior Checklist(CBCL)
4-Symptom Checklist-90 (SCL-90)
Results:1-The 2 groups were not different as regards somatic features , anthropometry and intelligence tests.
2-Cognitive decline in these patients start since childhood and continue to adulthood.

3-Patients had higher femininity score and they can manage appropriately in their homes and they are less symptomatizing than normal girls(due to being defensive in their self reports about symptoms)

Conclusion: Early diagnosis, follow up is very important. Overprotection or rejection from parents is forbidden. Early social stimulation and special schooling are necessary. Medical treatment for induction of growth, regular menses must be considered.

16-Subject:Gender differences in schizophrenia.

Document :M.D Thesis.

Author :Mona Yehia El-Rakhawy.

Year:1998

Site :Multiple hospitals (Kasr El Aini-El Abbassia-El-Nile Sanatorium-Dar El Mokattem).

Background: Gender has an impact on epidemiology, age of onset symptoms, coarse and outcome of schizophrenia (neuropsychological and neuro anatomical fields).103 patients were selected with certain inclusion and exclusion criteria.

Aim :To elaborate the clinical presentation of schizophrenia in both groups with a stress on the cultural factors affecting such differences.

Design :Inpatient ,outpatient comparative survey of males and females matched as regards age and social class.(case-control study).

Method :The sample consisted of :51 male,52 female patients examined by SCAN (present state examination ,clinical history schedule),other neuropsychological studies.

*The following tools were used:

1-The Egyptian Classification of Fahmy and El-Sherbini.

2-Present State Examination 10 th(PSE 10) included in Schedules of clinical assessment in Neuropsychiatry(SCAN) Arabic version.

3-Clinical History Schedule (CHS) included in SCAN.

4-MMPI personality test.

5-Wecksler Adult Intelligence Scale (WAIS)

6-Overt Aggression Scale(OAS).

Results:1-men: have an earlier age of onset, a poorer premorbid history ,more negative symptoms ,differential neuro cognitive functions, a poorer response to neuroleptics and a lower family risk for schizophrenia.

2-women:had more decreased motor activity, self neglect ,suicidal attempts ,higher scores in paranoia scale of MMPI and a tendency to have more positive family history of schizophrenia.

Conclusion :Gender has little impact on presentation and course of schizophrenia. Assessment should be done in context of sociocultural beliefs.

17-Subject:Psychiatric evaluation of Egyptian female mentally diseased criminals.

Document :M.Sc Thesis.

Year:1986

Author :Nabil William Botros.

Site :El-Abbassia Hospital.

Background:70 females were selected and put in 3 groups:
1-Group I: 20 females mentally-disordered criminals from El-Abbassia mental hospital.
2-Group II: 25 female non-mentally disordered, criminals from El-Kanater prison.
3-Group III: 25 female mentally disordered, non criminals from Abbassia mental hospital.

Aim: To find the relationship between crime and various mental disorders.

Design: case control study.

Methods: Persons were subjected to:
1-Demographic data and specific factors related to crimes.
2-Psychiatric interviews, complete psychiatric examination.
3-Psychometric assessment for I.Q ,Personality and Adaptation.

Results:1-Mean age of committing a crime is around 35 year, with more prevalence in rural areas, mostly among married female housewives with low educational level and past history of mental disorder.
2-Family history of criminality and-or mental disorder with absence of father figure as an added factor.
3-Wepons used are either sharp instrument or heavy blunt objects.
4-Victims are usually relatives to patients.(usually husbands).
5-Causes of crimes were (accidental murder-excitement-anger-vendetta-delusion of persecution or infidelity-with out cause).
6-Most of patients have intellectual deterioration and social maladjustment.

7-There is high score for criminality ,neuroticism, lie score, depression traits, impulsivity and mal adaptability scale.
8-Psychiatric disorders mostly occurring are (schizophrenia-bipolar disorder-mental subnormality-sociopathy-addiction).

Conclusion:*Mental hospital criminals are not more criminals (bad) than prison criminals.
*Mental hospital criminals are not more mentally disordered (mad) than patients with no criminal records.

18-Subject:Study of risk factors of post-partum depression (cross cultural perspective)

Document:M.D Thesis.

Year:1999

Auther :Mohamed Abdel latif Mahmoud.

Site :Dar El Shifa Hospital (Jeddah)

Background: The sample consists of women who gave birth in the last 9 months, Half of the sample is patient and subgroup., the other half is control group.(The sample contains 4 cultural groups e.g. Saudi-Yemeni-Sudanese-Egyptian)

Aim :To identify risk factors for development of post partum depression taking cultural aspect into consideration.

Design :case control (cross-cultural study)

Method :Tools used were:
1-Composite international diagnostic interview (CIDI)
2-Semi-structured questionnaire for assessment of possible risk factors of postpartum depression.

Results:1-Women in this study were married ,Muslims, of different educational level and aged between 22-26 year.
2-Most common causes of postpartum depression are (postpartum blues-polygamy-guardian unemployment-marital problems-undesired infant sex being teenage)

Conclusion :Postpartum depression is the same medically but different culturally according to the following risk factors:(family history of psychiatric illness-cesarean section-guardian unemployment-hormonal contraceptives-marital problems-polygamy-not breast feeding-poor social support-postpartum blues-premenstrual tension syndrome-primipara-teenager-undesired infant sex-unwanted pregnancy)

19-Subject:Psychiatric morbidity in wives of substance users in an Egyptian sample.

Document :M.D Thesis.

Author :Maissa Eid Afifi.

Year:2007.

Site :Institute of Psychiatry Ain Shams University Hospital and Psychological Medicine Hospital at El Nozha Hospital.

Background:120 of wives of substance users (inpatient-outpatient)with certain inclusion and exclusion criteria).

Aim:1-Examine impact of substance use on wives of addicts.
2-Detect different types of burden upon them .
3-prevention,management of morbidity detected.

Design :case-control study.

Methods :Tools used were:
1-General health questionnaire (GHQ arabic version)
2-Assessing social class using Egyptian Classification of Fahmy ,El-Sherbini 1988.
3-The Structured Clinical Interview for DSM IV AXIS I disorders (SCID II)
4-Mini International Neuropsychiatric Interview (MINI PLUS arabic version)
5-North Carolina Family Assessment Scale.
6-Social Readjustment Rating Questionnaire.

Results:1-Addicts wives showed significant higher level of (adjustment-major depressive-anxiety-personality-sexual) disorders.
2-There are problems in areas of family environment ,financial management, domestic violence ,low parenting capabilities and bad quality of life.

Conclusion: Addicts spouses experience a burden that increases as illness lengthens so negative impact on quality of life is expected which is associated with psychiatric morbidity.

20-Subject:Psychiatric assessment of female burn patients during hospitalization.

Document:M.Sc Thesis.

Author :Wael Lotfy Abdel-Hameed.

Year:1996.

Site:Kasr Al Aini Hospital-Ahmad Maher Hospital-Shobra General Hospital-Om El Masreyeen Hospital.

Background:50 females put in 2 groups:
1-30 burnt female aged from 18-40 year ,having third degree burn affecting any part of the body.
2- 20 normal female in the same age group.

Aim: Psychiatric assessment of female burned patients specially for depression ,anxiety ,deterioration of self concept and fear to face society after discharge as an impact of disfigurement and incapacity.

Design: case-control study.

Methods:1- Patient group were subjected to the following:(psychiatric sheet-Hamilton Depression Rating Scale-Hamilton Anxiety Scale-Self-Concept Questionnaire-Abbreviated Burn Specific Health Scale)
2-Normal controls were subjected to (HDRS-HAS-SCQ)

Results: 40% reached level of diagnosable psychiatric illness while 60% did not. Most common diagnoses were (depression-acute stress disorder-delirium-mixed anxiety depression) specially with burns of the face.

Conclusion: Burns significantly affected psychological well being of patients. Specialized psychiatrist should be available to handle these troubles.

21-Subject:Psychosexual aspects of female circumcision.

Document :M.ScThesis.

Author :Shahira Sami Ibrahim.

Year:1995

Site: Outpatient clinic in Ahmad Maher Hospital(obstetric, gynecology)

Background: 80 females (40 circumcised-40 uncircumcised) were selected.

Aim: To study this phenomena, know its extent in society. compare between circumcised, uncircumcised females regarding psychological and sexual effects.

Design: case control study.

Methods :Tools used were:(Questionnaire about attitude of females towards circumcision-Eysenck Personality Inventory-Sexual Inventory modified, extracted from Derogates Sexual Inventory).

Results:1-The chief motive was religious then inherited customs.
2-Women reported physical and hygienic complications after operation .
3-Most women were illiterate, operated upon by midwives or doctors.
4-Most of circumcised females had high neurotic score and reached orgasm with difficulty.

Conclusion: The most important side effects of circumcision were sexual dis-satisfaction and anorgasmia.

22-Subject:Gender differences in bipolar disorder.

Document:M.Sc Thesis.

Year:2002

Site:Kasr El Aini out patient psychiatric clinic.

Background :The sample consists of 55 patients(27 males-28 females).Diagnosis :according to DSM IV criteria.

Design :Retrospective survey study then comparative study.

Aim :Review the literature and find out gender differences in bipolar disorders in Egyptian sample.

Methods: Patients were subjected to :
1-Detailed psychiatric history taking sheet (Kasr El Aini Sheet)
2-Hamilton Depression Rating Scale (HDRS)
3-Young Mania Rating Scale (YMRS)
4-Eysenck Personality Questionnaire (EPQ)
5-Psychological Stress Questionnaire (PSQ)

Results :Gender difference lies in the following:
1-Females:(lower mean age-earlier age of onset-shorter duration of episode-usually divorced-rapid cycling-positive family history of bipolarity-high score in extraversion)
2-Males:(higher mean age-later age of onset-longer duration of episode-being single-depressed and mixed episodes-high score in mania rating scale and in family ,economic stresses-high guilt-loss of interest-weight change)

Conclusion:1-Prevelance rates in women exceed those of men.
2-Gender difference in mood disorders have an important clinical subtypes or symptoms clusters specific to each sex, will help better understanding of pathophysiological mechanisms involved in affective illness.

23-Subject:Biological markers of women vulnerability to depression.

Document :M.Sc Thesis.
Year:2006
Author :Dalia Mohamed Shawer.
Site :Outpatient clinic in police hospital.
Background: 60 patients fulfilling criteria of DSM IV of depression (40patients-20 normal)
Aim :To investigate biological factors of women vulnerability to depression.
Design :case-control study.
Methods :All members were subjected to :
1-Full clinical psychiatric sheet.
2-Laboratory tests including T3-T4-TSH-Estrogen level.
3-Psychometric study.
Results:1-There was a positive correlation between degree of depression and age of the patient, his marital status, his social class.
2-Level of TT3,TT4,FT3,FT4,TSH ,E2 are significantly different between patients and controls. The higher the degree of depression, the lower the level of TT3-TT4-FT3-E2.
Conclusion: The higher the E2 level, the higher the TT4 level.

24-Subject:Study of violence against women(study of prevelance,psychiatric consequences)

Document:M.D Thesis.
Auther:Rania Hussein Mohamed.
Year:2007
Site :Al-Zahraa Hospital Outpatient Clinic.
Background: 1158 females were selected with certain inclusion criteria(age from 18-45 year),certain exclusion criteria(other age groups). They were put in 2 groups :
1-Group 1: 620 female from gynecology clinic.
2-Group 11:538 females from psychiatric outpatient clinic.

Aim:1-Review general scope, magnitude, consequences, different theories explaining violence against women.
2-Review interventions made to prevent future occurrence of the problem.
3-To study prevalence, possible correlates and psychiatric consequences of violence against women.

Design :case-control study.

Methods :Tools used were:
1-Standerdized psychiatric assessment. Structured clinical interview for DSM 1V axis I disorders.(SCID-CV)clinical version 1997.
2-Structured clinical interview for DSM 1V Axis II personality disorder.
3- World SAFE questionnaire (study of abuse within family environment)
4-Clinical psychiatric assessment using Al-Zahraa hospital sheet.

Results:1-Types of violence:(slapping-hitting-beating-kicking-insulting-threatening-abandoning)
2-There is interpersonal violence between husbands and wives.
3-Causes reported by women are (refusing sex-withholding money-disobedience-jeoulsy-house duties)
4-Bipolar patients are more likely to be abused followed by psychotic patients.
5-Severly abused patients usually attempt suicide.
6-Most common psychiatric disorders related to abuse are (depression-generalized anxiety disorder-somatoform disorder).
7-Types of sexual abuse(street harassment-touching-rubbing-attempt or actual rape-exhibitionism).

Conclusion:1-Psychiatric patients of group II were more abused than those of group 1 as follows:(physical, psychological abuse-abuse during pregnancy-sexual abuse-hospitalization as a consequence)
2-Risk factor for abuse in women (illiterate-abused or witnessed abuse in childhood-not working).
3-Risk factors for women who prepare for violence:(illicit drug abuse plus the former factors).
4-Victims are more liable to psychiatric disorders than the non abused persons.

25-Subject:Presentation of female sexual dysfunction in medical practice.

Document:M.D Thesis.

Year:1998

Author :Manal Gamal El Den Abed.

Site:Al-Zahraa outpatient clinic.

Background:33 females were selected from gynecology clinic put into 3 groups:
1-Group I(S group):distressed by sexual problems and choose to go to gynecologist.
2-Group II(D group):distressed by sexual problem, answered positively to general sexual screen and welcome sex therapy.
3-Group III(C group):have sex difficulties, answered negatively to general sexual screen and refuse sex therapy.

Aim:1-To detect relative frequency, forms and possible psychological factors of sexual dysfunction.

Design: case-control study (comparative study)

Methods: Tools used were:
1-General sexual screen proposed by Sheehan.
2-Semistructured interview tailored to fit the research, diagnose sexual problems according to ICD 10.
3-Marital Satisfaction Inventory (global version) .
4-DSFI (Derogates sexual functioning inventory).

Result:1-Conservative patients:(30 year old-from suburban areas-have more than 3 children-unwanted pregnancy-after 10 years of contraception)
2-Frank cases (20 years old-newly married-no children-libral-positive self body image-first 3 years of marriage-after any gynecological operation).

Conclusion: Most common sexual complaints were vaginismus, loss of sexual desire, dyspareunia and anorgasmia.

26-Subject:Psychological aspects of hysterectomy.

Document :M.Sc Thesis.

Year:1998

Author :Hayat Salem Omar.

Site:Kasr El Aini hospital (gynecology -surgery inpatient unit).

Background:60 patients admitted in Kasr El Aini hospital over 8 months, (30 inpatient females from gynecology department, to carry out hysterectomy-30 inpatient females from surgery department, to carry out cholecystectomy).

Aim: Psychological problems with hysterectomy specially sexual problems with the husband.

Design: case-control study.

Methods: tools used were:

1-Clinical interview, psychiatric diagnosis according to DSM IV.
2-Middle Sex Scale (MSS).
3-Beck Depression Inventory (BDI).

Results:1-Psychiatric diagnosis after hysterectomy were depression, anxiety then sleep disorders.
2-Quality of sexual life after operation improved.
3-Patients below 40 year, without children suffer psychologically more than other women.
4-Good husband, family relationship minimize this stressful situation.

Conclusion:1-Importance of family relations to women after operation.
2-The expectations of women, premenopausal age and premorbid personality determine sequela after operation.

27-Subject:Sexual dysfunction in female psychiatric patients.

Document :M.D Thesis.

Auther:Nadia Mohamed El Fangary.

Year:2003

Background: 120 female psychiatric patients were screened ,inclusion criteria was having sexual dysfunction, exclusion criteria of having current psychiatric illness or with organic etiology for sexual dysfunction.

Site :Psychiatric ,gynecologic outpatient clinic in Kasr El Aini Hospital.

Aim: To explore this topic, its relationship with personality characteristics, marital adjustment and sexual hormonal levels.

Design: case-control study (comparative study).

Methods: Tools used were:

1-Sexual history 2-General Health Questionnaire(GHQ)
3-Assessment of sexual function using CSFQ.
4-Assessment of marital adjustment using global version of MSI.
5-Assessment of personality PAS.
6-DSFI modified extracted version.7-Sex hormone level measurement.

Results:1-The most common sexual dysfunctions are desire disorders, orgasmic dysfunction, arousal disorder, dyspareunia and lastly vaginismus.

2-The most common psychiatric disorders in these patients are (mood-anxiety-somatoform-adjustment) disorders.
3-There was high rate of circumcision, manual hymenal perforation in wedding night, discrimination in favor of males, earlier onset of marriage and first information about sex from the family.
4-Psychiatric patients had low (sexual drive, sexual attitude, sexual satisfaction, orgasmic capacity, desire frequency and total sexual functioning) plus more dependent personality disorder than others.

Conclusion:1-Psychiatric patients show more sexual dysfunction, personality pathology and marital dissatisfaction than others.
2-There is a high rate of overlap between different sexual disorders in the same patients.
3-Testesterone is positively correlated with sexual desire and orgasm.

28-Subject:Prevelance ofobcessive compulsive disorder among female secondary school students in Cairo.

Document :M.D Thesis.

Author :Marwa Abdel-Rahman Soltan.

Year:2002

Background: 607 female students were selected from urban, semi urban and rural areas(public and private schools) aged from 14-17 years.

Site :Cairo secondary schools.

Aim:1-Evaluate prevalence of OCD in female secondary schools in Cairo.
2-Estimate prevalence of OC symptoms, the most common ones in our culture.

Design: Cross sectional survey study.

Methods:1-Leyton obsessional inventory-child version.
2-Mini International Neuropsychiatric Interview for Children (MINI-KID).
3-Full clinical assessment.

Results: Prevalence of OCD is 1.2%,while obsessive compulsive symptoms prevalence is 13.01% .The commonest OC symptom was excess conscience(more in rural than urban, more in public than private school).

Conclusion :Adolescent OCD is not a rare disorder while subthreshold obsessive compulsive syndrome is widely presented in adolescent population. Culture may Colour the clinical picture but does not affect prevalence. Religion does not affect prevalence of OCD but it is an area where OCD expresses itself..

29-Subject:Impact of menstrual cycle on schizophrenia.

Document :Egyptian Journal of Psychiatry June 2006,Vol 25 No.2.

Year:2006.

Author :Abdel Razek Ghada,Refaat G.,Abdel Razek Y and Eissa A.

Background: 40 Saudi female patients were selected with inclusion criteria of (diagnosed as schizophrenic by ICD 10-on a therapeutic dose of antipsychotic drugs-all in child bearing period-all have history of regular menses: at least 3 consecutive cycles).Exclusion criteria were(irregular cycle-pregnancy-intake of oral contraceptive pills-affective symptoms or schizoaffective)

Site :Al Aml complex for mental health.

Aim:1-Comparing schizophrenic symptoms in different phases of the cycle aiming to find any significant difference.

2-Finding a relation between exacerbation and specific phase of the cycle (whether exacerbation increase in late luteal and early follicular or not).

Design: cross sectional, cohort study.

Methods: Tools used were:

1- ICD 10 Symptom Checklist.
2- PANSS(positive, negative schizophrenia scale).

Results:1-There was statistically significant difference between luteal ,follicular phase of the cycle regarding total score of PANSS ,the highest score in the luteal (premenstrual phase).

2- There were highly significant correlation between date of admission, menstrual and premenstrual phase (Being higher in luteal than menstrual).

Conclusion:1-Premenstrual exacerbation of symptoms in female schizophrenics may not be a worsening of the core schizophrenic symptoms but a concurrence of a cluster of affective ,behavioural, and somatic symptoms which may be related to hormonal changes.

2-Hormonal treatment for schizophrenic is still in research phase.

30-Subject:Depression during pregnancy as a risk factor for pre-eclampsia,a prospective study.

Document: Egyptian Journal of Psychiatry June 2006,Vol 25 No.2.

Year:2006

Author :Hewedi D , Fahmy A.

Background:100 nulliparas women with singleton pregnancies were recruited ,followed up longitudinally from early pregnancy to end of gestation with comprehensive neuropsychiatric assessment.

Site :out patient clinic of obstetric and gynecology Ain Shams University**,**

Aim :To examine if depression occurring early and late during pregnancy is associated with pre-eclampsia I a sample of healthy pregnant females.

Design :prospective observational study.

Methods :tools used were :

1- Beck depression inventory (BDI).
2- Blood pressure measurement.
3- Protein in urine measurement**.**
4- Semi-structured interview using clinical obstetric data sheet.
5- Revised scale of socioeconomic status of the Egyptian family.

Results :depression was detected in 30% of subjects in early pregnancy while it was detected in 34% of subjects in late pregnancy. Pre-eclampsia occurred more with combined early and late depression than late depression alone.

Conclusion :depression in pregnancy is strongly linked with risk for subsequent pre-eclampsia.

31-Subject:Pregnancy related obsessive compulsive disorder(A study in Egyptian sample).

Document: Current Psychiatry November 2001,Vol 8 No.8.

Year:2001

Author :Assad T, Kamel K.M.

Background:100 pregnant females were included from those attending antenatal care clinics, in addition to a similar group of non–pregnant females matched for age and educational level. Certain inclusion and exclusion criteria were selected.

Site :out patient clinic of obstetric and gynecology Ain Shams University and private clinics**.**

Aim: to highlight such an area about the association between pregnancy and obsessive compulsive disorder in an Egyptian sample, trying to explore the prevalence, nature or characteristics and the possible explanations for this association, if present.

Design :Case control study.
Methods :tools used were:
1- Structured Clinical Interview based on DSM–IV SCID I Clinician version (1997) for clinical psychiatric diagnosis.
2- SCID II (Structured Clinical Interview for DSM IV Axis II Personality Disorders (1997).
3- Yale-Brown-Obsessive-Compulsive Scale for assessment of severity and phenomenology of obsessions, only for those who will fulfill criteria of OCD (Arabic version translated by Okasha et.al 1994).
4- The standard gynecologic and obstetric history and examination for pregnant group.

Results: OCD was significantly higher in pregnant females ($p<0.05$). The most frequent obsessions encountered were religious thoughts followed by cleanliness thoughts and rituals and then impulses related to harming the foetus.
Conclusion: . Positive family history of OCD and the presence of obsessive compulsive personality were the two significant associations. Several explanations can be put foreword to understand such a relation between pregnancy and OCD, including the possible effect of gonadal steroids on serotonergic system.

32-Subject: Violence against Women in Egypt (Psychological and Social Consequences)

Document: Current Psychiatry March 2001,Vol 8 No.1.
Year:2001
Author : Seif El Dawla, A.
Background: Subjects included 500 women and 100 men from various locations in Egypt. The inclusion of men in the study had a twofold. objective:
1- To draw an insight about men's perceptions regarding violence against women.
2- To compare both male and female perceptions regarding the phenomenon under study.
Site: Ain Shams University.
Aim:. is to investigate the perception of a sample of Egyptian women and men to the issue of gender violence, the personal experience of women of

such violence and the psychological consequences that might follow therefore.

Design: Cross-sectional observational study.

Methods:

1- Women were interviewed by means of :
- A questionnaire designed to investigate demographic background, personal knowledge and attitude towards violence against women in and outside the family.
- Checklist of personal exposure of domestic violence applied to married women only.
- ICD- 10 checklist for psychological symptomatology applied to women who themselves had experienced domestic violence.

2- Men were interviewed regarding their demographic background and their attitude towards domestic violence against women.
3- Results were tabulated for descriptive purposes.
4- The definition of violence against women adopted in this study is the definition of the International Declaration against Violence against women adopted by the UN General Assembly on the 20th of December 1993.

Results: 1- The most commonly reported symptoms were feelings of helplessness (97%), depressive symptoms (92%), lack of self confidence (87%) and a chronic feeling of apprehension ,anticipation of violence (85%). generalized Anxiety disorder (36 cases), adjustment disorder (28 cases), dysthymic disorder (15 cases), and major depressive disorder (1 case).
2-Spouse behavior that women consider violence :
polygamy 96% -marital rape 93%-preventing wives from going out of the house 83%-withholding children after divorce 77%-enforced obedience 72% preventing wives from traveling 70%
3. Psychological conséquences of violence(Psychological réaction % feelings of helplessness 97-depressive symptoms, inappropriate sleep and fatigue 92-lack of confidence in others 87-chronic feeling of apprehension and anticipation of violence 85-lack of self confidence 84-bouts of anger 79 chronic ambiguous feeling of guilt 68-mood swings 50-flashbacks and nightmares of certain violent incidents 12)
4-Diagnosis were:
PTSD 2 .1%-GAD 36 .19%-Adjustment disorder 28. 15%-Dysthymic disorder 15. 8%-Major depressive disorder 10.5%

Conclusion: gender violence is a considerable phenomenon in Egypt, that it constitutes a psychological health problem to women and that it has psychological consequences that deserve special attention and intervention on the part of mental health professionals.