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Systematic review of Egyptian psychiatric studies on Neurotic Disorders

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Dedication

To my beloved family and friends whose their support
gave me the power to go on...

ABBREVIATIONS

ADHD: Attention Deficit Hyperactivity Disorder

APA: American Psychiatric Association

ASUIP: Ain Shams University, Institute of psychiatry

BD: Body Dysmorphic

BDD: Body Dysmorphic Disorder

BDI: Beck depression inventory

BW: Body weight

CDDG: Clinical Descriptions and Diagnostic Guidelines

CFS: Chronic Fatigue Syndrome

CIDI: Composite International Diagnostic Interview.

COWA: Controlled Oral Word Association

CSF: Cerebro-spinal fluid

DCR: Diagnostic criteria for research

DES: Dissociative Experience Scale

DMP-1: Diagnostic Manual of Psychiatric Disorders

DSM-IV: Diagnostic and statistical manual of mental disorders, 4^{th} edition

ECG: Electrocardiography

ECT: Electroconvulsive therapy

EEG: Electro-encephalography

EPQ: Eysenck personality questionnaire

ER: Emergency Room

FH: Family history

FSH: Follicle stimulating hormone

GAD: Generalized Anxiety disorder

GH: Growth hormone

HAS: Hamilton anxiety scale

ICD-10: International Classification of Diseases, 10^{th} version

LH: Luteinizing hormone

LISRES-A: Life Stressors and Social Resources Inventory- Adult Form

LOI-Ch V: Leyton obsessional inventory- child version

MINI-KID: Mini International Neuropsychiatric Interview for Children

MMSE: Mini-Mental State Examination

OAT: Object Assembly Test

OC: Obsessive compulsive

OCD: Obsessive compulsive disorder

OPC: Out patient clinic

OT: Obsessive traits

PANSS: Positive and Negative Syndrome Scale

PCASEE: P = physical indicators; C = cognitive indicators; A = affective indicators; S = social indicators; E = economic-social stressors or negative life events; and E = ego function or personality problems.

PD: Personality disorder

PH: Past history

PRL: Prolactin

PSE: Present state examination

PTSD: Post traumatic stress disorder

QoL: Quality of life

RIFT: Range of impaired functioning tool

ROS: Religious Orientation Scale

rTMS: repetitive Trans- cranial Magnetic Stimulation

SCID: Structured clinical interview for diagnosis

SCL-90: Symptom check list questionnaire

SCOS: Subthreshold obsessive compulsive syndrome

SPECT: Single Photon Emission Computed Tomography

TSH: Thyroid stimulating hormone

WAIS: Wechsler Adult Intelligence Scale

WCST: Wisconsin Card Sorting Test

WHO: World Health Organization

WMS-R: Wechsler Memory Scale

Y-BOCS: Yale- Brown Obsessive Compulsive Scale

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INTRODUCTION

Neurotic symptoms such as worry, tiredness, and sleepless nights are common in the general population affecting more than half of adults at some time, while as many as one person in seven experiences some form of diagnosable neurotic disorder. The World Health Organization's study of mental disorder in general health care screened over 25 000 people in 14 countries worldwide and assessed 5500 in detail. A quarter had well defined disorders, and a further 9% had sub-threshold conditions. The most common disorders were depression (10%) and generalized anxiety disorder (8%). ***(Craig and Boardman, 1997)***

Neurosis is a chronic or recurrent non psychotic disorder characterized mainly by anxiety which is experienced or expressed directly or is altered through defense mechanisms; it appears as a symptom such as an obsession, a compulsion, a phobia…. In the 3rd edition of DSM a neurotic disorder was defined as follows: a mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing to the individual and is recognized by him or her as

unacceptable and alien (ego dystonic); reality testing is grossly intact. Behavior does not actively violate gross social norms (though it may be quite disabling). The disturbance is relatively enduring or recurrent and is not limited to a transitory reaction to stressors. There is no demonstrable organic etiology or factor. ***(Sadock and Sadock, 2004)***

Neurotic disorders are thought to be caused by an unconscious conflict that generates anxiety; symptoms develop when an individual's defenses can not cope adequately with this anxiety. ***(Toy and Klamen, 2007)***

The term neurosis encompasses a broad range of disorders of various signs and symptoms, as such; it has lost its precision. ***(Sadock and Sadock, 2004).*** However; it is still retained in the ICD10 in the rubric "neurotic, stress related and somatoform disorders". DSM IV has effectively carved up the neuroses into: anxiety disorders, somatoform disorders, dissociative disorders and adjustment disorders. ***(Semple et al., 2005)***

According to the ICD 10 the neurotic disorders are classified as follows:

Neurotic, stress-related and somatoform disorders:

F40 Phobic anxiety disorders

F41 Other anxiety disorders

F42 Obsessive-compulsive disorder

F43 Reaction to severe stress, and adjustment disorders

F44 Dissociative [conversion] disorders

F45 Somatoform disorders

F48 Other neurotic disorders

(ICD 10, 2007)

Patients with neurotic illness become chronically unwell and high users of primary care services**.** ***(Lloyd et al., 1996)***. Neurotic disorders such as acute anxiety or panic disorder can cause chaotic or dangerous behavior. ***(Atakan and Davies, 1997)*** and even associated with raised mortality (the death rate among psychiatric outpatients with neurotic disorders is raised by a factor of 1.5 to 2). Increased deaths have been ascribed to suicide, accidental deaths, or even misdiagnosis of underlying physical conditions. ***(Sims and Prior, 1978)***

Such patients need appropriate physical, psychological, and social effective intervention, particularly those with a more severe illness who do not recover within one year. ***(Lloyd K, Jenkins. 1995)***

As neurotic disorders constitute a major public problem through out the years, many Egyptian studies were done to address this important topic. So, it is time to review these studies with the intent to collect their results and critically appraise the findings. This hopefully will be a step to know where the Egyptian studies on neurotic disorders stand; and what is needed to be done further.

RATIONALE OF THE WORK

As there are many previous researches discussing the topic of neurotic disorders in Egypt from its different aspects; this effort deserves to make use of it. This signifies the importance of having a clear system for reviewing these studies and planning for future researches, in order to have complementary research system. And as medicine moves to be evidence-based; the need for having the criteria for critical appraisal to determine the value of the published researches and to decide their applicability to clinical practice is increasing. So this work was done to make use of this effort to identify the missing points in Egyptian researches to overcome the defects in the future.

AIM OF THE WORK

The aim of this work is:

1- To systematically review & appraise the available Egyptian studies on Neurotic disorders.

2- To generate recommendations for further studies.

3- To provide a summary of clinical M.S.c thesis& M.D, thesis on Neurotic disorders done in Ain-Shams University, Psychiatry Department (these will be included as an Appendix).

METHODOLOGY (PROCEDURES)

In Order to fulfill the aim of the work, a systematic review of all available Egyptian studies on Neurotic disorders 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- 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.

NEUROTIC DISORDERS

Epidemiology

Prevalence of neurotic disorders:

In Egyptian studies the life-time prevalence of anxiety (neurotic) disorders was found to be 15.3%. As the term anxiety disorders encompasses broad range of disorders; it was found that the most prevalent neurotic disorder is specific phobia, followed by panic disorder without agoraphobia, generalized anxiety disorder (GAD), social phobia, panic disorder with agoraphobia, obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), and finally agoraphobia without history of panic (table 1). ***(Mahfouz et al, 2003)***

Table 1: Lifetime Prevalence of the Different Neurotic Disorders

Diagnosis	% in relation to the whole sample (N=900)
Specific Phobia	5.44%
Panic disorder without agoraphobia	5.11%
GAD	4.66%

Social Phobia	2.33%
Panic disorder with agoraphobia	0.77%
OCD	0.77%
PTSD	0.66%
Agoraphobia without history of panic	0.33%

(Mahfouz et al, 2003)

In another community based study ***Soliman et al, 1997*** found that prevalence of anxiety was 18.6% of 325 subjects from a rural area in Minia included in the study.

Anxiety disorders were found in 11.3% of 479 second grade medical students in Al Azhar university represented as; GAD in 2.3%, OCD in 1.7%, specific phobias in 2.6%, social phobia in 1.2%, panic disorder in 2.6%, PTSD in 0.4%, adjustment disorder in 3.3%, somatoform disorder in 1.03%, and acute stress reaction in 0.6%. ***(Ali et al, 2006)***

General medical patients were found to have high rates of anxiety disorders; as among 500 patients general medical inpatients in Kasr El Aini hospital, who were examined by ***El-Gamal et al, 2001*** adjustment disorder was found in 13%, followed by mixed anxiety depression in 9.4% and anxiety not other wise specified in 3.6%. A random sample consisted of

326 patients were selected from a general practice clinic in a nationalized industrial organization in Cairo, in that sample; the prevalence of depressive neurosis was 11.6%, anxiety neurosis 8.8%, and involutional melancholia 0.9%.The total prevalence of the three diagnoses was 21.4%. ***(El-Akabawi& Fekri, 1985)***

Among psychiatric patients; the neurotic disorders represented the commonest diagnostic category as was found by ***Fawzy et al, 1981*** who studied 500 patients attended the psychiatric Outpatient clinic (OPC) in Zagazig university hospital. They were diagnosed according to the Egyptian Diagnostic Manual of Psychiatric Disorders "D.M.P.1" (Egyptian psychiatric association, 1975). Among the neurotic disorders hysterical neurosis was the most frequent neurosis followed by anxiety disorder (table 2).

Table 2: Prevalence of different neurotic disorders among psychiatric patients

Diagnosis	% Number (240)
Hysterical neurosis	33
Conversion type	*17.5*
Dissociative type	*15.5*

Anxiety disorder	28.7
Depressive neurosis	15.5
Hypochondriasis neurosis	10.5
Reactive and situational neurosis	4.1
Phobic neurosis	3.3
OC neurosis	3.3
Neurasthenic neurosis	1.6

(Fawzy et al, 1981)

The prevalence of sub-syndromes of anxiety disorders was also studied in general population and was found to be 23.33% in a sample of 900 adult subjects, living in a rural area in Minya. Sub-syndrome GAD was the most prevalent representing 10.2%; followed by sub-syndrome panic 9%; sub-syndrome social phobia 3.3%; and finally sub-syndrome OCD 18.2%. ***(Mahfouz et al, 2003)***

Age:

The mean age of anxiety neurosis patients was found to be 30.77 years ±15.2. The most common age for presentation is between 20- 29 years old ***(Okasha et al, 1981, El-Akabawi& Fekri, 1985***, ***Abd EL-Mawella et al, 2001***, ***Bayomy et al, 2007***)

The different neurotic disorders were found to have significantly variable mean age of onset as social phobia tends to occur at earlier age followed by Agoraphobia without history of panic, OCD, Panic disorder, GAD and PTSD that have later age of onset (table 3). ***(Mahfouz et al, 2003)***

Table 3: Mean age at onset of different Neurotic disorders

Disorder	Mean age
Social phobia	18.29
Agoraphobia without history of panic	19
OCD	22
Panic disorder without agoraphobia	29.48
Panic disorder with agoraphobia	31.4
GAD	32.5
PTSD	34

(Mahfouz et al, 2003)

Gender:

Mahfouz et al, 2003 studied 900 adult subjects, living in a rural area in Minya and found that neurotic disorders were affecting more female subjects (69%) compared to males (31%). In that study females with neurotic disorders tended to live more in extended families with in-laws, while males with

neurotic disorders tended to be more unemployed than the controls and lived in nuclear families *(table4)*.

Table 4: Female to male ratio in different Neurotic disorders.

Disorder	F: M ratio
Panic disorder without agoraphobia	2.8 : 1
Panic disorder with Agoraphobia	6 : 1
Agoraphobia without history of panic	3 : 0
Specific phobia	3.9 : 1
Social phobia	1.3 : 1
OCD	0.7 : 1
PTSD	0.2 : 1
GAD	1.4 : 1
Total	**2.2 : 1**

Mahfouz et al, 2003

Education:

Abd El-Mawella et al, 2001 found that 26.7% of 30 patients with neurotic disorder were faculty educated while 16.7% were illiterates.

When compared between illiterates and high school graduates as regards the symptoms; ***Okasha et al, 1981*** found that poor concentration, loss of weight, delayed sleep; anergia, retardation and amnesia were commoner in educated group. On the other hand, the illiterates showed depersonalization, dissociative and conversion symptoms.

Marital Status:

Among anxiety patients single males were more frequent than married males, while on the contrary; the married females outnumbered the single. ***(Okasha et al, 1981)***

Occupation:

El-Akabawi, Fekri, 1985 found no significant difference between the prevalence of anxiety neurosis among patients in production and non production jobs; as in the cases diagnosed as anxiety neurosis (27 patients); numbers of patients in production jobs and non-production jobs were 14 and 13 patients respectively.

Etiology

Family history& precipitating factors:

Patients with anxiety disorders had lower paternal care and higher over protection rates than the controls. ***(Bayomy et al, 2007)***

Life stresses were found more frequently in anxiety patients as death of a close relative occurred in 56.7%, followed by

history of child abuse in 46.7%, then paternal loss in 26.7% and marital problems in 25% of 60 anxiety patients included in the study of ***Bayomy et al, 2007*** .

Positive family history of anxiety disorders was found in 59.7% of 30 cases with anxiety disorders studied by ***Abd El-Mawella et al, 2001***

Clinical Picture

Premorbid personality& past history:

Patients with anxiety disorders had lower self esteem ***(Bayomy et al, 2007)***; and higher rates of alexithymia than controls ***(Draz et al, 2001)***.

Abd El-Mawella et al, 2001 found that patients of anxiety disorders had high dependency & irresponsibility traits. The paranoid personality disorder was found in 16.5% of the 30 patients with anxiety disorders included in the study followed by sociopathic personality disorder in 13.3%, anankastic personality in 10% then hypochondriacal and avoidant personality disorders each in 6.7% of the cases.

Regarding the style of defense mechanisms frequently used by patients with anxiety disorders ***Bayomy et al, 2007*** found that they used neurotic defenses more than controls. Isolation was the more commonly used individual defense mechanism in the anxiety patients group.

As regards the past history 6.67% - 17.7% of anxiety patients had suffered from previous attacks of anxiety disorder, while 6.3% of them had history of substance abuse. ***(Abd El-Mawella et al, 2001, Bayomy et al, 2007)***

Presentation and symptoms:

Among anxiety disorders OCD was found to be the most chronic disorder with the longest duration which is about 45.57 months± 35.09. On the contrary panic disorder without agoraphobia had the shortest duration; 6.8 months± 5.29 (table 5). ***(Mahfouz et al, 2003)***

Table 5: Duration of different Neurotic disorders:

Disorder	Mean duration (in months)	SD
OCD	45.57	35.09
Panic disorder with agoraphobia	38.57	27.6
PTSD	37	15.38

Social phobia	36.4	23.02
Agoraphobia without history of panic	17	16.5
GAD	15.17	7.65
Panic disorder without agoraphobia	6.8	5.29

(Mahfouz et al, 2003)

Okasha et al, 1981 reported that the commonest anxiety symptoms were worrying, irritability, free-floating anxiety; social impairment, depressed mood, tiredness, restlessness, anergia, retardation, hypochondriasis, social withdrawal, delayed sleep, early wakening, ineffective thinking and loss of interest in a sample consisted of 120 patients with neurotic disorders.

As regards the somatic symptoms associated with anxiety disorders; ***Draz et al, 2001*** studied 30 patients with anxiety disorders namely GAD and panic disorder and found that the commonest symptoms were; palpitation in 28% of the patients, chest pain in 25%, shortness of breath in 24%, frequency of micturation in 22% and headache in 18%.

It was noted that somatic symptoms affected more those of lower social class and females. Females had pain in joints, back pain, pain in limbs, dry mouth, vomiting, dizziness,

fainting attacks, paraesthesia and lump in the throat more than males. ***(Draz et al, 2001)***

Comorbidity:

Hamdi et al, 1995 studied 50 subjects presenting with anxiety or depression to a psychiatric OPC, and found that 8% had pure anxiety disorder, and 20% had depressive disorder, while the majority (72%) was diagnosed as mixed anxiety depressive disorders. Conditions starting earlier were considered primary and those starting later were considered secondary. Twice as many cases (42%) started with anxiety, than those that started with depression (19%). Comorbidity is likely to be missed in routine clinical interviews, as the extent of comorbidity described in routine clinical interviews (24%) is much less compared to 72% by the research Structured clinical interview for diagnosis (SCID) ***(Spitzer et al., 1990)***.

Mahfouz et al, 2003 found that comorbidity between different neurotic disorders was 24.5%, and between neurotic disorders and major depressive disorder 46.2%.

Management

Psychotherapy:

Ali et al, 1991 applied transactional analysis principle on neurotic patients in a group psychotherapy (7 patients completed the study) and found that 57.15% showed positive changes in from of decreased degree of neurotic symptoms while the other 42.85% showed negative changes in the form of increase of the degrees of neurotic symptoms.

Outcome

Quality of life:

Quality of life was assessed in patients with anxiety disorders using Range of impaired functioning tool (Life-RIFT) by **Leon et al, (1999)** and results showed that patients with anxiety disorders had moderate to marked general impairment of functioning. PTSD had the greatest impact on the quality of life of individuals with any anxiety disorder followed by OCD and panic disorder. That impairment was mainly in job and satisfaction with life domains. ***(Mahfouz et al, 2003)***

Neurotic Disorders in Special Groups

In Children

Okasha et al, 1999a found anxiety symptoms in 7.9% of 1699 primary school students. The prevalence was significantly higher among public than private school children (10.6% and 6.7% respectively).

Anxiety symptoms were more common among older children, first order of birth and female gender (10.2% of the females had anxiety symptoms compared to 6% of the males). ***(Okasha et al, 1999a)***

A comparison was done by ***Abd Rabo et al, 1995*** between primary school children (10-12 years old) from urban and rural areas as regards anxiety disorders so 157 students were included from each group. It was found that the total prevalence of anxiety disorders was 21%. Also it was found that 32% of urban children and 9.5% of rural children had anxiety disorders. The rate of anxiety affecting females was 40% and 6.6% in urban and rural areas respectively. On the other hand, it affected 28.45% of the males from urban areas

and 12.1% of the males from rural areas. ***(Abd Rabo et al, 1995)***

Familial background:

Children of primary schools with positive anxiety symptoms had larger families than the controls (mean number of members =5.4 and 3.37 respectively). More over, it was found that the prevalence of anxiety symptoms was higher in children with either illiterate or highly educated fathers than among children of fathers with average levels of education ***(Okasha et al, 1999a)***.

High anxiety was more among children experiencing abnormal paternal relationships, either by divorce or death (20.7% and 20% respectively) than among children with normal paternal relationship (8.6%). ***(Okasha et al., 1999a)***

Precipitating factors and premorbidity:

Neurotic traits were more frequently reported by the parents of the children with anxiety than the controls. The most frequent traits were nail biting in 29% of the anxious children compared to 10% of the controls, followed by nervousness in 31% and 9.4% respectively, then enuresis in 22% compared to

8.7%, sleep problems in 19% vs. 4.6%, stuttering in 13% vs. 3.2%, and thumb sucking in 11% compared to 4.6%.(***Okasha et al, 1999a)***

Presentation and symptoms:

Okasha et al, 1999a found that children with anxiety symptoms showed a variety of clinical presentations; 31% of them presented with emotional symptoms, 19% had mental symptoms, 15% had motor symptoms and 4% and 3% had physiological and social symptoms respectively.

Diagnosis:

It was found that 89% of children with positive anxiety symptoms fulfilled criteria for a psychiatric diagnosis and tended to have multiple diagnoses. Behavioral and emotional disorders with onset usually accruing in childhood were the most common diagnoses (95.5%) followed by neurotic, stress related and somatoform disorders (31.6%). Behavior syndromes associated with physiological disturbances, disorders of psychological development and lastly mood disorders. ***(Okasha et al, 1999a)***

In Adolescents

Okasha et al, 1999b studied anxiety disorder in 795 secondary and preparatory school students and found that prevalence of anxiety symptoms among them was 38.4%. Secondary schools students had more rates than preparatory school students (40.8% vs. 32.8% respectively)

Familial background:

Number of adolescents with anxiety symptoms is higher among large families (mean number of family members=6.07 ± 1.6) with higher crowding index and lower family income. Mothers working outside the home were more among adolescents with anxiety. In addition, abnormal paternal relationship, paternal separation and psychiatric illness of one of the parents were associated with presence of anxiety symptoms in adolescents ***(Okasha et al, 1999b).***

Precipitating factors and premorbidity:

Adolescents with anxiety had history of neurotic traits during childhood, the most frequent traits reported were nail biting, night fears, nervousness, nightmares, suckling fingers,

enuresis, stuttering and eating problems. Anxiety positive adolescents had significantly higher neuroticism and psychoticism scores compared to control ***(Okasha et al, 1999b)***.

In addition, it was found that abnormal psychosocial situations were more frequent among adolescents with anxiety. Abnormal quality of up bringing was the most frequent situation followed by abnormal familial relationship; chronic interpersonal stresses in school or work, inadequate or distorted inter familial communications, societal stresses, abnormal immediate environment and acute life events.

The most frequent acute life events were the events resulting in low self esteem, altered pattern of family relationship, loss of love relationship, sexual abuse, removal from home and personal frightening experience. ***(Okasha et al, 1999b)***

Diagnosis:

It was found that 58.4% of the adolescents with anxiety symptoms included in the study by ***Okasha et al, 1999b*** satisfied ICD-10 criteria for one or more psychiatric diagnosis.

The most common psychiatric disorders were depressive episode, GAD, phobic anxiety, social anxiety disorder, dissociative and conversion disorder, sleep disorders, OCD and adjustment disorder.

PHOBIC ANXIETY DISORDERS

Epidemiology

Prevalence:

The prevalence of social phobia was found to be19.6% among 555 secondary school students and 11.3% among 203 university students studied by ***Ragheb et al, 2005***. ***Haggag & El Sheikh, 2003*** also studied 176 university students and found that 45.5% of the studied population were positive for both social phobia and social interaction anxiety. Those were further subdivided into mild social phobia and mild social interaction anxiety representing 29% and 27.3% of cases respectively, then moderate social phobia and social interaction anxiety representing 11.4% and 14.8% respectively, and those with severe social phobia and social interaction anxiety were 5.1% and 3.4% respectively.

Socio-demographic data

As regards the gender differences; prevalence of social phobia and social interaction anxiety was found to be higher in females than males (26.2% vs. 13.7% in secondary school students and 11.9% vs. 8.6% in university students) with a ratio of 1.9:1 in secondary school and 1.3:1 in university females and males respectively. ***(Ragheb et al, 2005, Haggag, El Sheikh, 2003)***

Ibrahim et al, 2000 studied 30 patients with social phobia and found that the prevalence of social phobia was rather equal in both genders (53.3% males and 46.7% females).

Etiology

Family History

Family history of social phobia was positive in 20% of 30 patients with social phobia compared to negative family history in the control group. It was also found that there were higher rates of behavioral inhabitation by the family during childhood in patients groups (40%) compared to controls (16.6%). ***(Ibrahim et al, 2000, El Raey et al, 2001)***

Clinical Picture

Premorbid personality, past history and presentation:

Avoidant personality disorder was the most frequent type of personality disorders found in patients with social phobia representing (63.3%) followed by borderline personality (43.33%) then passive aggressive personality (20%) and dependent personality (13.33%). ***(Ibrahim et al, 2000)***

El Raey et al, 2001 found that there was history of minor depressive and anxiety disorder and psychotropic drug intake in 40 % of the 30 patients with social phobia included in the study compared to control group. Most probably these symptoms and trials of treatments were ushering the social phobia or associated with it.

In ***Ragheb et al, 2005*** study, the most common strong social fears reported were fear of embarrassment, public speech, criticism, others watching, parties and social events, talking to strangers, and people in authority. As for physiological symptoms; the most common were trembling or shaking, sweating, blushing and palpitations.

Quality of Life:

Patients of social phobia showed high rates poor quality of life i.e. dissatisfaction including the health, self esteem, goals, money, work productivity, reactions, people help, romantic relations, friends, relatives, house, neighborhood and community. ***(Ibrahim et al, 2000)***

OTHER ANXIETY DISORDERS

PANIC DISORDER

Epidemiology

Prevalence:

El-Mahdy et al, 2004 studied the prevalence of panic disorder among patients attending the psychiatry, chest and cardiology OPC in EL-Husseen university hospital over a period between January – June 2002. They were 1704 patient and 6.3% of them were found to have panic disorder. Comparing the frequency of panic disorder among patients from the three clinics it was found that panic disorder is more common among the cardiac patients followed by the chest then the psychiatric patients.

Socio-demographic data:

El-Mahdy et al, 2004 found that panic disorder is most prevalent among patients less than 20 years old and those between 40-49years old and least among those more than

50years old. The mean age of panic disorder patients at onset of illness is 26.7± 6.43 years ***(Salim et al, 1992).***

Panic disorder is more prevalent in extended family with large number of members ***(Salim et al, 1992 and El-Mahdy et al, 2004)***

As regards order of birth; ***El-Mahdy et al, 2004*** found that 53.7% of 108 panic patients included in the study had an intermediate birth rank compared to 19.4% were first children and 26.9% were the last in order of birth.

Panic disorder is more common among the married population (>60%) compared to the single or divorced. ***(Salim et al, 1992, Abu EL-Ela, 2000, El-Mahdy et al, 2004)***.

Moreover 20% of 30 panic patients included in ***Salim et al, 1992*** study perceived their marital life as disharmonious, 56% had moderate quarrels and 12% experienced unsatisfactory sexual relation.

El-Mahdy et al, 2004 studied 108 panic patients; among those patients 17.6% were illiterates, 18.6% could only read and write, 6.5% received below intermediate education, 35.2% received intermediate education and 6.5% were highly

educated. Unemployed and those who were not working presented 46.4% followed by production workers who presented 16.7% then those with scientific or artistic jobs presenting 10.3%.

Etiology

Family history and precipitating factors:

As regards intrafamilial relationships and home atmosphere; panic disorder patients were found to have pathological family background compared to normal controls. About 36.7% of 30 patients studied by ***Salim et al, 1992*** had separated parents and they were frequently separated from one of their parents since early childhood. Also, panic disorder patients were found to frequently perceive their mothers negatively describing them as nervous.

In ***Salim et al, 1992*** study; 26.7% of 30 panic disorder patients had positive family history of psychiatric disorders compared to 6.7% of the controls. Regarding types of psychiatric disorders found in the relatives of panic patients; both GAD and depression were equally reported affecting

about 37.5% of the cases. More recently ***El-Mahdy et al, 2004*** found that 57.4% of 108 panic disorder patients had positive family history of psychiatric disorders with 36.1% had Family history of panic disorder.

Death or illness of one of the relatives, followed by stresses at work was the most common precipitating factors among panic disorder patients. They were found in 72.2% of 108 panic patients ***(El-Mahdy et al, 2004).***

Clinical Picture

Premorbid Personality and Past History:

About 50% of panic disorder patients had neurotic symptoms during their childhood. The commonest were stuttering and enuresis followed by nails biting, sleep disorders, thumb sucking and separation anxiety. ***(Salim et al, 1992, El-Mahdy et al, 2004)***

On the other hand, the most frequent personality traits found in patients with panic disorder were dependent traits that were found in 32.4% of 108 patients, followed by avoidant traits in

30.5%, then obsessive traits in 8.3%, and histerionic traits 6.6% of the patients ***(El-Mahdy et al, 2004).***

As regards past history of psychiatric disorders in panic patients; it was also found that 10% of 30 patients had past history of major depression before start of illness, and 6.7% of the patients had phobic disorders, while 3.3% had social phobia and 3.3% had agoraphobia which developed prior to panic disorder. ***(Salim et al, 1992)***

Symptoms and presentations of panic disorder

The mean duration of illness in panic disorder was found to be 4.9 ± 5.4 years and it usually followed episodic course with several attacks. The rate of occurrence of panic attacks might be as frequent as three attacks/ week (in about 12% of studied cases), or two to three times/ week (in 29.7% of cases) or happens once to trice/ month (in 22.2%) or even less than one attack/ month (in 11.1%). Each attack lasts for 21.9 ± 17.2 minutes. In between the attacks the patients had 3.3 ± 1.9 days free. ***(Salim et al, 1992, El-Mahdy et al, 2004)***

Panic disorder presents with somatic and/or psychological symptoms. The most frequent of all symptoms was fear of

death that occur in about 100% of the patients followed by cardiopulmonary symptoms (in 80-90%) as palpitations, chest pain and dyspnea, then dizziness and somatic sensory complaints including tingling, numbness and hot flushes. Although fear of going crazy is considered one of the diagnostic criteria; it was the least reported symptoms by the patients. The most prominent complaint of panic disorder patients was choking sensation followed by chest pain and tachycardia. It is worth mentioning that suicidal thoughts were reported by 8-16% of panic patients. ***(Salim et al, 1992, Abu EL-Ela, 2000 and El-Mahdy et al, 2004)***

Comorbidity

Panic disorder was associated with comorbid psychiatric disorders in 74.1% of 108 panic cases. GAD was the most frequent comorbid psychiatric illness with panic disorder followed by agoraphobia then depression. It was also found that there were comorbid physical illnesses in 71.4% of the patients. The commonest physical illnesses were hypertension and migraine. ***(El-Mahdy et al, 2004)***

Mansour et al, 2003 studied 120 patients with panic disorder. 22% of the patients reported suicidal ideation in the last year, 5% had actual suicidal attempts during the last year. 8.5% of them reported attempting suicide at other times in their lives. Patients who had suicidal attempts reported more previous hospitalizations and treatment for depression than the patients who had never attempted suicide.

Outcome

El-Mahdy et al, 2004 found that there is social and occupational disturbance in 70.4% of the 108 studied cases; 37.9% of the patients suffered from severe disturbance, while 32.5% had moderate disturbance.

Burden of panic disorder on General Hospital Services

It was remarkable that majority of patients with panic disorder (50%-90%) were referred from another specialties; most frequent was from the cardiologists, neurologists and audiologists. Only 10-25% of the panic disorder patients were

self referred to a psychiatrist. ***(Abu EL-Ela, 2000, El-Mahdy et al, 2004)***

Abu EL-Ela, 2000 found that 93.3% of 30 panic disorder patients tried at first their general practitioners, 83.3% consulted a specialist of internal medicine, 66.6% consulted cardiologists, and 26.6% consulted chest specialists. 73% of patients had visited the emergency room (ER), 26.6% were admitted to inpatients wards and 13.3% were admitted to ICU.

Patients with panic disorder excessively utilized various types of investigations especially the cardiac investigations, followed by brain investigations and hormonal assessments ***(Abu EL-Ela, 2000 and El-Mahdy et al, 2004).***

Generalized and Mixed Anxiety Disorders

Epidemiology

Prevalence:

Among medical students; ***Bakr, Elsayed, 2005*** found that 61.9% of 1034 students in different grades suffered anxiety. Most of them were students of first and second grades. GAD was found in 2.3% of the second grade medical students (479 students) in a study by ***Ali et al, 2006*** while mixed anxiety depression was found in 9.4% of 500 medical patients surveyed in a study by ***EL-Gamal et al, 2001*** who also found that anxiety not otherwise specified presented 3.6% of the cases.

EL- Fangary et al, 1994 studied 50 patients diagnosed as depression and/or anxiety and found that pure anxiety represented 8%, pure depression 20%, and mixed anxiety depression were 72% of the cases. Secondary depression represented 28% so it was more common than secondary

anxiety which was 14%. It worth mentioning that anxiety was frequently under diagnosed in favor of depressive disorders in Kasr El-Aini psychiatric clinic where the study was done.

Socio-demographic data:

Anxiety was found to be more frequent among females than males and in single subjects than the married. The first child in order of birth was the most frequently affected with anxiety and GAD. The mean age of onset of GAD was 23.7 ±5.78 years. It was more common in patients who received a relatively high education (mean educational years 12.7 ± 3.38). ***(Salim et al, 1992 & Bakr, El-Sayed, 2005)***

Familial background and family history:

Salim et al, 1992 studied 30 patients with GAD and found that they had negative image about their fathers as they perceived them as temperamental and authoritarians.

5% of the GAD cases perceived their marital life as disharmonious; 80% had moderate quarrels and 10% experienced unsatisfactory sexual life compared to none of the controls ***(Salim et al, 1992).***

As regards family history of psychiatric disorders 23.3% of the patients had positive F.H compared to 6.7% of the controls. Relatives were more frequently affected by GAD (42.8%) and depression 28.6%; 42.3% of the affected relatives were of the first degree ***(Salim et al, 1992)***.

A comparison was done by ***El- Fangary et al, 1994*** between patients with anxiety and those with mixed anxiety depression as regards the FH. It was found that 75% of patients with anxiety had positive FH of psychiatric illness compared to only 30% of those with mixed anxiety depression.

Premorbid personality and past history:

Salim et al, 1992 found that 63.3% of 30 patients with GAD included in the study had neurotic symptoms during their childhood compared to 26.7% of the controls. Nocturnal enuresis was the most frequent symptom followed by nail biting, sleep disorders, stammering and thumb sucking. 67% of the patients suffered panic attacks, while 10% experienced depressive disorder during some period in their lives.

Presentation and symptoms:

Among medical students with anxiety ***Bakr, El-Sayed, 2005*** found that tension (compressed / tired) and intellectual problems (lack of concentration) were the most presenting symptoms, followed by depressed mood, irritability and cardio pulmonary symptoms. 18.8% of anxious medical students (640 students) and 12.1% of total study group (1034 students) suffered moderate to severe anxiety. Medical study was the most annoying cause for anxiety; it was disturbing enough to hold 14.4% to use psychoactive drugs.

In the study of ***Salim et al, 1992*** on 30 patients with GAD around 100% of the patients had worry, free floating anxiety, anxious foreboding, restlessness, social withdrawal and nervous tension, followed by irritability, tiredness, anergia, retardation and depressed mood. The mean duration of illness was found to be 8.4 ±7.3 years.

Quality of life:

Life stressors and resources were assessed through a standardized questionnaire Life Stressors and Social Resources Inventory- Adult Form (LISRES-A) by ***Rudolf, (1994)*** in 45 patients with anxiety disorder. It was found that the patients

had high scores in most of the stressors domain, namely; physical health, finances, spouse, children and extended family. They were affected by both positive and negative life events. Gender differences were observed with males experiencing more stressors than females. ***(Akram et al, 1999)***

OBSESSIVE COMPULSIVE DISORDER

Epidemiology

Prevalence of obsessive compulsive disorder:

Obsessive compulsive symptoms (OCS) were found in 5.07% of 1400 residents of a rural area in Egypt. Among them 3.5% subjects received the diagnosis of OCD according to DSM-IV criteria. According to Yale- Brown Obsessive Compulsive Scale (Y-BOCS); 2.3% were found to be clinical and 1.2% were subclinical subjects with OCD. ***(Haggag et al, 2003)***

Among university students; ***Abu Hegazy et al., 1999*** found that 27.11% of 409 students had psychiatric disorders and 3.01% of them were diagnosed as OCD patients. When the prevalence of OCS and OCD among secondary school students was studied; ***Hmmoda et al, 2000*** found that 18.4% of 1000 students had high scores in the OCS portion of Symptom check list questionnaire (SCL-90) ***(Al-Behairy A, 1984)***. Yet, only 9.1% were fulfilling the DSM-IV criteria for

OCD. However among female secondary school students in Cairo the prevalence of OCD was found to be 1.2%, and the prevalence of sub-threshold obsessive compulsive syndrome (SOCS) was 13.01% among 607 female secondary school students representing urban, sub-urban and rural areas in Cairo. ***(Soltan et al., 2005)***

As regards the prevalence of OCS among psychiatric patients; ***El-Kholy et al., 1997*** studied 372 patients with different psychiatric diagnoses and 308 controls. OCS were significantly higher in the psychiatric population than in the general population representing 62.1% compared to 38% respectively.

Socio-demographic data:

The majority of studied OCD patients had onset of illness at age between 20-29 years old with a mean age of onset of OCD was found to be 22.8± 7.1years. ***(Okasha et al, 1991, Sadek et al, 2001)***

Okasha et al, 1991 studied 54 male and 30 female patients and observed that males start their illness before females. On the other hand, ***Hmmoda et al, 2000***, found that the prevalence

of OCS among females was more than males in the age of 14-15 years. However, the contrary was found in the age intervals 16-17 and 18-19; indicating early female predominance then change to male predominance later on.

The presenting symptoms of OCD were almost similar among both Moslems and Christians; where religious and sexual thoughts were predominant. However, there was a marked difference in rituals which were more frequent in Moslems emphasizing the role of ritualistic Islamic upbringing as compared to Christians in the Egyptian community ***(Okasha et al, 1991). El-Kholy et al, 1997*** found a positive relationship between the prevalence rate of OCS and extrinsic religious orientation in the general population. On the other hand, there was no relationship between the development of OCS and both intrinsic and extrinsic religious orientation in the psychiatric patient group.

El-Nahas, 2000 found that 47.1% of total 51 OCD patients studied came from semiurban areas, 41.2% were from urban areas and 11.7% were of rural regions. On the other hand, there was no difference between the secondary school female

students coming from different areas as regards the prevalence of OCD and SCOS ***(Soltan et al, 2005)***.

Level of education seemed to have no effect on the distribution of OCD as in a study by ***Okasha et al, 1991*** on 84 OCD patients 27% were found to have primary education, 35% had secondary and 32% had university education.

Okasha et al, 1991 found no significant importance of marital status as regards obsessional illness in an Egyptian sample. But it was noted that the majority of cases who have changed into psychosis were single.

Etiology

Risk& precipitating factors:

The precipitating factors varied to a great extent; they might be psychological or physical factors. Both were noticed in about 69% of 84 OCD cases studied by ***Okasha et al, 1991***. Among the psychological precipitating factors is; death of the near relatives, malignant diseases, tuberculosis or surgical interference in one member of the family, the stress of examinations, sometimes marriage and after retirement. The

most important physical ones were childbirth, abortion, menstruation and a few reported the onset after sexual intercourse. Also, some patients regarded triggering of their symptoms to contraceptive pills. The above data point that hormonal imbalance can play a role in precipitating obsessional disorders. In addition, environmental precipitant were found in about 25% of 22 OCD cases ***(Reda et al, 1999).***

Hammoda et al, 2000 found that in about 36.3% of 91 secondary school students diagnosed to have OCD precipitating factors were preceding the onset. The most frequent risk factors detected in that study were; harsh communication inside the family in 56% of the patients, death of one parent in 25.3%, and 11% had physical disease/s. As regards past history of psychiatric disorder; 47.2% of the patients had psychiatric disorder during their childhood.

Family history:

El-Nahas, 2000 found that 19.6% of the 51 OCD patients included in the study had a positive family history of psychiatric disorder. Family history of obsessional illness was positive in approximately 31% of 84 patients included in study

by ***Okasha et al, 1991***, while psychosis in parents and siblings was noticed in 7% of the patients. Other neurotic disorders in the immediate family, mainly of anxiety, were prevalent in 16.6% of the cases. Obsessional personality and traits were common among parents and siblings ranging up to 51%. In another study by ***Okasha et al, 1994;*** 20% of 90 OCD patients had a positive family history for OCD.

Haggag et al, 2003 reported that family history of similar condition was found in 41.7% of 49 OCD patients, while 16.7% had family history of other psychiatric disorder.

As regards the family history of psychiatric disorder in OCD university student patients; ***Abu Hegazy et al, 1999*** found it positive in 80%, while among secondary school students it was positive in 29.7% of the OCD cases ***(Hmmoda et al, 2000)***.

Clinical Picture

Premorbid personality& personality traits/disorders:

Okasha et al, 1991 found that most of the 84 OCD patients included in the study had neurotic traits during their childhood; the most common traits were fears, anxiety, enuresis, irritability, shyness, sleep disturbance. Actual compulsive personality was noticed in 22% of the patients, while anxious, dependent and histrionic personalities were found in 39% and the others showed mixed types with no specificity.

Kamel et al, 2006 studied 60 OCD patients; among them 51.7% had at least one comorbid personality disorder (PD). So, the patients were divided into two groups; A group with comorbid PD (31 patients) and another group without comorbid PD (29 patients). It was found that 23.3% of the subjects in the study had a single PD, while 28.3% had multiple or mixed PDs. Obsessive-compulsive and avoidant PDs were the most frequent types (table 6).

Table 6: frequency of different types of PD among OCD patients

Patients with PD								***Patients with no PD***
Number = 31								**Number = 29**
51.7%								**48.3%**
Cluster-A		Cluster-B		**Cluster-C**		Not otherwise specified		
.Paranoid	8.3	.Histerionic	3.3	**.Avoidant**	**18.3**	.Passive-aggressive	10	
.Schizotypal	3.3	.Narcissistic	6.7	.Dependent	10	**.Depressive**	**13.3**	
.Schizoid	1.7	**.Borderline**	**11.7**	**.Obsessive-Compulsive**	**40**			
		.Antisocial	3.3					

Kamel et al, 2006

Patients with comorbid PD had significantly higher total Y-BOCS severity scoring than those without PD. Cluster-B PDs was the most important cluster affecting the severity of OCS with higher scores in total Y-BOCS; that is due to dramatization of symptoms and the impulsive nature that may drive them to yield easily to compulsions. Although Cluster-C is the most prevalent cluster of PD, it did not significantly affect the severity of the OCS. Regarding the impact of specific types of PDs on OCD severity; dependent PD was the most important PD affecting the total Y-BOCS severity

followed by depressive, avoidant, and borderline PDs. ***(Kamel et al, 2006)***

In ***1999; Abu Hegazy et al.*** found that 40% of the university student with OCD had obsessive-compulsive PD while 20% had avoidant PD.

Presentation of patient with OCD:

Okasha et al, 1991 found that the onset of OCD was found to be sudden in 67% of the 84 cases studied, but followed a gradual progressive course in the remainder, with a mean duration of OCD of 3.2 years. Also, it was found the majority of the studied patients (59%) seek psychiatric help after a period of 1-4 years during which they have tried to resist the compulsion or adopt various social devices to counteract the illness. When obsessive patients seek medical attention, it is because of supervening symptoms on top of their compulsions. These are usually anxiety, depression or the obsessions themselves. Usually these symptoms are mixed together. The main presenting symptoms are anxiety in 84.5%, obsessive symptoms in 29.7%, depression in 9.5% and social incapacity in 14.28%.

El-Nahas et al, 1996, Kamel et al, 2006 found that about half of OCD patients presented with mixed obsessions and compulsions. The remaining group showed that the predominantly obsessive type was slightly more than double the predominantly compulsive type. ***Reda at al, 1999*** found also that 59% of 22 OCD patients presented with mixed symptoms while 23% had compulsion and the rest 18% had obsessions. Out of 90 OCD patients included in a study by ***Okasha et al, 1994;*** 40% of the patients presented with a mixture of obsessions and compulsions, whereas 29% presented with obsessions and 31% with compulsions.

OC Symptoms:

The commonest symptoms in OCD patients are ruminations then fears and rituals. The content of the obsessions are mainly about religion, followed by filth, harm, and sex, while the most common compulsion is checking compulsions ***(Okasha et al, 1991, El-Nahas, 2000).***

The most commonly occurring obsessions were religious and contamination obsessions in 60% of 90 OCD patients and somatic obsessions in 49%, and the most commonly occurring

compulsions were repeating rituals representing 68%, cleaning and washing compulsions 63%, and checking compulsions 58%. 71% of patients were rated severe on the Y-BOCS, all of them had impaired insight with 9% were insightless ***(Okasha et al, 1994)***.

El-Kholy et al., 1997 studied 308 normal subjects; among them the commonest OCS were obsession with need for symmetry (16.6%), cleaning/ washing obsessions (16.2%) and contamination obsessions (14.3%).

A comparison was done by ***Haggag et al., 2003*** between outpatient OCD subjects (24 patients) and subjects with OCD detected through population screening regarding presenting obsessions and compulsions(49 subjects). Outpatient subjects with OCD reported significantly more sexual obsessions, repeating, counting and miscellaneous compulsions than the community subjects with OCD (table 7). Also, symptoms of OCD were significantly more severe in outpatient subjects with OCD in comparison with community subjects. 81.6% of the community group were in the category of subclinical and mild OCD, while 83.3% of the outpatient subjects with OCD were in the category of moderate/ severe/ extreme.

Table 7: Comparison of obsessive and compulsive symptoms in outpatient and community groups.

	Outpatients		Community	
	No.	%	No.	%
Sexual obsessions:	11	45.8	10	20.4
Repeating Compulsions	11	45.8	11	22.4
Counting Compulsions	14	58.3	10	20.4
Miscellaneous Compulsions	18	75.0	10	20.4

Haggag et al., 2003

Sadek, 2001 found some difference in course of OCD among males (21 patients) compared to females (20 patients), as the continuous stationary course presented in 47.62% of males followed by continuous with exacerbation and partial remission. On the other hand, in females the majority were continuous with exacerbation and partial remission (45%) and continuous stationary course (30%). It was also found that sexual and religious obsessions are higher in males than females while most of types of compulsions are higher in females (75%) than males (57.14%). (Table 8)

Table 8: Comparison between the commonest OCS among male and female OCD patients.

	Males (21 patients)	Females (20 patients)
Sexual obsessions	57.14%	15%
Religious obsessions	90.48%	65%
Hoarding compulsion	28.57%	60%
Other compulsions	57.14%	75%

Sadek, 2001

Okasha et al, 1991 compared between urban and rural areas as regard the commonest presentation of OC patients; it was found that ruminations then fears were commoner in urban population while rituals and impulses predominating in patients from countryside. Also, found that patients from rural areas used to seek psychiatric help earlier than those from urban places as they became panicky from these compulsive phenomena and thought immediate native help and when it failed they came for psychiatric advice.

Soltan et al., 2005 studied the commonest OC symptoms, and compared there distribution among urban, semiurban and rural areas among female secondary school students in Cairo. It was found that the commonest OC symptom in the three

areas was excess conscience. In **urban** areas, the second common was worry about being clean enough, then orderliness, repeated thoughts or words, hate dirt/ contamination and indecision (37.7%). In **semiurban** areas, the second common was repeated words or thoughts, followed by orderliness, Indecision and checking. While in **rural** areas the second common was repeated words or thoughts, followed by orderliness, then indecision, and lake of confidence (repetition). Also, a comparison was done between public and private schools. The commonest OC symptom found in both public and private schools was excess conscience. Followed by; orderliness in **public** schools. In **private** schools the second commonest symptom was repeated words or thoughts.

As regards type of OC symptoms and its relation to the level of education; Ideas, images and ruminations were commoner among the university educated patients while rituals and impulses prevailed among those of low education Certain types of obsessions or compulsions were found to be significantly correlated to higher educational level; these include somatic obsessions, body checking for somatic

symptoms, compulsive list making, non aggressive obsessional images, sexual thoughts images and impulses, harm avoiding rituals and ruminations in abstract religious concepts ***(Okasha et al, 1991)***.

Cognitive functions of OCD patients:

OCD patients have pre-existing cognitive style which makes them vulnerable for the occurrence of the disorder ***(Aly et al, 2007)***

El-Nahas et al., 1996 applied Wechsler Adult Intelligence Scale (WAIS) ***(Wechsler, 1981)*** and Wechsler Memory Scale (WMS) ***(Wechsler, 1987)*** on 30 OCD patient comparing them with 30 normal control subjects and found that lower score of OCD patients on Object Assembly Test (OAT) (10.7± 2.5 SD) compared to controls (12.4± 1.5 SD). It was also found that the duration of illness correlates negatively with the OAT scores, but correlates positively with failure to maintain set, the deterioration in performance is more evident when the duration exceeds 5 years. Yet there was no significant difference found between patients and controls in vocabulary, similarities, digit span, and immediate or delayed memory

subsets of the WMS. Moreover, when applied Wisconsin Card Sorting Test (WCST) ***(Heaton et al., 1993)*** there was highly impaired functioning in patients compared to controls. ***Sadek et al., 2001*** found that OCD patients have poor attention than the control group. Also OCD patients had lower score in the similarity subset of WAIS, WMS and WCST than the controls.

Findings of ***Asaad et al, 2002*** do confirm the presence of negative and dysfunctional cognitive styles in patients with OCD. ***Aly et al, 2007*** compared between 52 OCD patients and the same number of controls and found that OCD patients have predominance of negative thoughts over positive thoughts with more dysfunctional attitudes than controls. Also, the cognitive style of the OCD patents was characterized by being more analytic and less synthetic.

Comorbidity:

58.8% of the OCD patients included in a study by ***El-Nahas, 2000*** had another one or more axis I disorders. The most common comorbid disorders detected among 51 patients were; non OCD anxiety disorders (35.3%), mood disorders (21.6%) and/ or personality disorders (17.6%). In a study by

Okasha et al, 1994 one third of 90 OCD patients had a comorbid depressive disorder.

Sadek et al., 2001 found that 58% of the 41 OCD patients included in the study had current comorbidity. The highest comorbidity rates were with depression and anxiety disorders. (Table 9)

Table 9: Comparison between males and females as regards comorbidity with OCD

	Males (21 patients)	Females (20 patients)
Secondary depression	9.52%	35%
Major depression	19.04%	15%
Panic	9.52%	15%
Anxiety	14.28%	30%
Phobia	4.76%	10%

Sadek et al., 2001

Haggag et al., 2003 compared between outpatient OCD subjects and subjects with OCD detected through population screening as regards comorbid psychiatric diagnosis, and found that 24 OCD outpatients had psychiatric comorbidity more than the 49 subjects in the community group (45.8% and 16.3% respectively). Major depression was the most frequent

comorbid psychiatric diagnosis in both the outpatient (33.3%) and the community groups (12.2%).

Hmmoda et al, 2000 found that the rate of comorbidity with OCD in secondary school students (91 students diagnosed as OCD patients) was 43%. The most prevalent comorbid condition was major depression (15.5%) followed by dysthymia (9.9%), then anxiety disorder (8.9%). On the other hand, ***Soltan et al., 2005*** found that comorbidity frequency in female secondary school student OCD cases was 100% and that the comorbidity pattern of OCD is similar to that of SOCS. The anxiety disorders including agoraphobia, social phobia, separation anxiety and mood disorders including dysthymia and depression are the most commonly encountered disorders.

Investigations:

Reda et al, 1999 compared 22 OCD patients to 12 normal control subjects as regards Brain Single Photon Emission Computed Tomography (SPECT). The comparison revealed that there is perfusion difference between patients of OCD and control group. The most significant finding were the global

hypo-perfusion, the significant difference in the relation of right side to left side perfusion with left side hypo-perfusion more than the right. Also when severity of symptoms by Y-BOCS was correlated with perfusion deficit in certain areas in the brain the results showed that there is a difference between moderate and severe patients in the right frontal region as the perfusion is less in the severe symptoms. There was also difference between obsessive and compulsive patients regarding basal ganglia perfusion and other brain areas; as there was positive correlation between severity of compulsions and blood perfusion in the right occipital lobe while there was no correlation between severity of obsessions and blood perfusion in different areas of the brain.

In ***2000, Saadani et al***, found no CSF hormonal differences between OCD patients and control subjects relating to FSH, LH, GH, PRL and TSH levels in CSF. That study was done on 10 OCD patients and 10 psychologically stable control subjects. Cortisol was not detected in the CSF of both groups.

Serum serotonin level in OCD patients was studied by ***Sadek et al, 2001*** and compared it to normal control subjects with no significant difference was found between both groups.

Management

El-Nahas, 2000 studied 51 OCD patients who were subdivided into three groups; **Group I**: 28 patients assigned for an anti-obsessional (Clomipramine, Fluoxetine, or Fluvoxamine) and behavioral therapy, **group II:** 12 patients given only an anti-obsessional drug, and **Group III:** 11 patients given an adjustment therapy (Electroconvulsive therapy (ECT), anti-psychotics, Buspiron, Clonazepam, or another Serotonin reuptake inhibitor) together with anti-obsessional. After 27 months it was observed that 57.4% improved on therapy while treatment resistance was detected in 42.6%. In 55.6% of group I, 50% of group II and 70% of group III a good response was detected. In that study 80.9% of the patients were compliant to therapy, while 19.1 were not. Only 21.3% needed a hospital admission during the period of follow up.

In ***2003, El-Nahas*** conducted another study and found that right sided prefrontal repetitive Trans- cranial Magnetic Stimulation (rTMS) has a noticeable effect on the OC symptoms. That study was done on 15 OCD patients. The

patients received 7-10 rTMS sessions and were followed up after the 3rd, 6th, final sessions and at 24 weeks post-therapeutic. The most remarkable findings were the improvement of compulsions as compared to obsessions, improvement of control over obsessions, a remarkable early amelioration of anxiety symptoms, and an elevation of mood. It was also found that rTMS had a lasting effect which extended over a period of 24 weeks after application.

Outcome

Okasha et al, 1991 followed up 84 OCD patients for 5 years. The patients were given nonspecific management namely supportive psychotherapy, Imipramine, Amitriptyline and small doses of Neuroleptics. Few cases received gradual desensitization and ECT. Only two patients had leucotomy. The outcome was 15% symptom free, 50% improved with interrupted exacerbation and 29% unchanged. The disease followed various courses with remissions and exacerbations in the majority of cases with seasonal incidence. Some patients ran a progressive course leading to their social incapacity. There also have been cases with a sudden spontaneous

recovery after a long period of management. 8% of the cases developed psychosis of a non-schizophrenic nature. It was associated with obsessive ideas and ruminations rather than with phobias and rituals. Anxiety and depression accompanying the obsessions used to disappear when psychosis developed.

Following up of 47 OCD patients; ***El-Nahas, 2000*** found that 83.36% still had or occasionally experienced OC symptoms to a variable degree after a period of 27 months. 21.27% had no relapses, 42.55% had one relapse and 36.2% had several relapses. After 27 months of follow up the comorbid mood disorders were significantly less, while 12.8% developed psychiatric disorder.

Kamel et al, 2006 studied the relation between the presence of comorbid PD in the OCD patients and prognosis of the illness and found that 70% of patients with PDs (31 patients) had continuous or progressive course (poor prognosis), while only 30% had episodic or improving course. OCD patients with Comorbid PD were found to have longer overall duration and longer mean time delay for seeking psychiatric treatment.

It was also found that 76.5% of the non compliant patients had PD compared to 23.5% with no PD OCD patients. Continuous, progressive course of the illness with poor prognosis, more non compliance rates were associated with low self directedness personality trait, low self esteem and those with external locus of control.

Quality of life:

Nasreldin, et al. 2004 applied PCASEE ***(Bech, 1997)*** on 40 OCD patients and 20 normal persons as a control group and found that there was affective impairment in the OCD patients in the form of increase feeling anxious item. Also they had economic impairment shown mainly regarding the ability to make ends meet and financial assistance items. There was no statistically significant difference between OCD patients and control group regarding the physical problems, Ego problems or social impairment items. In another study by ***Kamel et al., 2006***; it was found that OCD patients with comorbid PD were significantly less functioning with worse Quality of life scale (QoL) ***(Beck et al., 1993)*** scores than those without comorbid PD.

Relation between different personality traits and OCD was also studied by ***Kamel et al, 2006***, who found that high harm avoidance temperament, low self directedness personality trait, low self esteem and those with external locus of control had greater severity of OCS, longer overall duration of the illness, less functioning and worse quality of life.

Impacts on the persons living with the OCD patients:

Saad& Nazeef, 1999 studied 40 OCD patients (20 males and 20 females) and their 99 children. 35 patients with chronic diabetes mellitus were selected as a control group. The children were examined to detect the psychiatric morbidity among them (table 10). Among the 99 children; 7 children were diagnosed as having OCD, 29 had high OCS, and 28 had moderate OCS.

Table 10: Prevalence of psychiatric symptoms among children of OCD patients compared to those of diabetics:

	% in children of OCD patients		% in children of Chronic diabetics	
	Males	Females	Males	Females
Depressive symptoms	40	60	20	10

Anxiety symptoms	50	70	30	20
Obsessive rituals	30	20	0	0
Obsessive ruminations	50	50	0	0
Major depression	20	30	0	10
GAD	10	10	10	20

Saad& Nazeef, 1999

Abou Zeid et al., 2005 compared between schizophrenic patients and OCD patients as regards the caregiver burden and found that the caregiver's burden imposed by OCD patients is either excess or nearly comparable to that of schizophrenia.

OC Phenomena in Special Groups

Children:

In a study done by ***Abdel Aziz et al., 1998*** among primary and preparatory school students (age between 9-12 years); it was found that 0.64% of 1093 children had OCD. Regarding the demographic data; it was found that among 9-12 years old children; OCD was prevalent at age of 10-12 years. There was no significant difference between males and females, or between Moslem and Christian children in occurrence of OCD and OCS. There was a positive family history of psychiatric disorder in 71.4% of the child cases of OCD (28.6% had depression and 28.6% had psychosis). While in the control group, only 11.4% had a family history of psychiatric disorder. In the same research, the obsessive traits in the parents of the children were studied. It was found that 42.9% of parents of OCD children had OT.

Abdel Aziz et al., 1998 studied also abnormal psychosocial situations in children with OCD and OCS, as well as in control group. These situations were considered as childhood traumas

which appear to be crucial etiological factors in the development of a number of serious disorders both in childhood and in adulthood. And it was found that 57.1% of children with OCD experienced one or more abnormal psychosocial situations; compared to 28.6% of control group. When the past history of physical illness in the children was studied; 57.1% of the children with OCD were found to have history of physical illness. The most common physical illnesses are significant fever and chest diseases. Neurotic traits were highly prevalent among the children with OCD, and OCS. The most common traits in children with OCD are night mares and nail biting. Children with high OCS had nocturnal enuresis, night mares, and nervousness. When personality traits were assessed in the same study it was found that 71.5% of OCD children had neurotic traits, 42.9% had extraversion, 42.9% had psychotic traits, and 14.3% had high lie traits.

There was cognitive function impairment in 71.4% of studied child cases of OCD, while, there was cognitive impairment in only 17.1% of the control group. Significant academic deterioration was found in students of primary and preparatory schools suffering from OCD (57.1% had academic

deterioration) compared to14.3% of the control group ***(Abdel Aziz et al., 1998)***

Although the small number of OCD children of the OCD patients (7 OCD children of 99 children) included in a study by ***Saad, Nazeef, 1999*** they reported that 5 children had cognitive function impairment presenting 71.4%. That was compared to 44.8% of 28 children with high OCS, 50% of those 28 with moderate OCS, and only 17.1% of the 35 children with low OCS.

Rakhawy et al., 2002 compared a group of 95 psychiatric patients with another group of 99 controls whose ages ranged from 6 to 13. It was found the there was no significant difference in OC features between the 2 groups. There was a negative correlation between OC features and parents' levels of education and occupation in both groups. For the control group, OC manifestations or symptoms were negatively correlated with children's education, a positive correlation was found as regards the child's relation with his siblings, and freedom in thinking and criticizing. While for the patient group, OC manifestations or symptoms were negatively

correlated with punishments, and with education of children, there is positive correlation between OC features and family history of psychiatric disorders, problems between fathers and mothers, and freedom in thinking and criticizing. The IQ level in OCD children or children with OCS were relatively higher than those with low OC symptoms in both patient and control groups.

As regards children with different psychiatric disorders; OCS were found frequently in children having nocturnal enuresis, followed by those having attention deficit hyper-activity disorder (ADHD), then conduct disorder, developmental disorders, anxiety disorders, dissociation disorder and finally, psychotic disorder ***(Rakhawy et al., 2002)***.

Pregnant females:

Asaad, Esmail, 2001 studied one hundred pregnant females (attending ante-natal care clinics), in addition to a similar group of non–pregnant females matched for age and educational level. It was found that OCD was significantly higher in pregnant females (9 females), compared to only 2

females form the control group. Out of the 9 OCD pregnants; 7 had the onset of their symptoms in the first trimester, while the remaining two had their onset in the second trimester. Concerning parity; 5 of the 9 OCD patients were multipara and 4 were primigravida, compared to 52 were multipara and 34 were primigravida of the other pregnant females without OCD.

In the same study; positive family history of OCD was found in 4 out of the 9 OCD patients and one patient had positive family history of depression, while 4 had negative psychiatric family history. Family history of OCD was found in only 3 out of the 91 pregnant females without OCD. As regards the past history of psychiatric illness; past history of OCD was found in only 3 out of the 9 OCD patients, one patients had past history of major depression and 5 patients had negative psychiatric past history. Obsessive-compulsive personality disorder was found in 4 out of the 9 OCD pregnant female compared to only two out of the 91 pregnant females without OCD.

It was found that the most frequent obsessions encountered were religious thoughts (4 patients), followed by cleanliness

thoughts and rituals (3 patients), and then impulses related to harming the foetus (2 patients) ***(Asaad, Esmail, 2001).***

OC phenomena in other psychiatric disorders

El-Kholy, 2003 studied OC phenomenon in 135 substance abuse patients and found that OCS were significantly higher in them (15.6%) than in the control group (2.8%). This was not the case with OC traits, as there was no statistically significant difference between both groups. As regards the nature of OCS in the substance abuse patients; 52.4% were found to have compulsions, 23.8% had obsessions, and 23.8 had mixed compulsions and obsessions. On the other hand, 48.7% of patients with OC traits (39 patients) had mixed obsessions and compulsions, 33.3% had obsessions and 17.9% had compulsions. The commonest obsession in the group of patients with OCS were aggressive obsessions, while in the group of patients with OC traits it was obsessions with need for symmetry.

In another study ***El-Kholy et al., 1997*** studied OCS in 372 psychiatric patients. The prevalence of OCS was 62.4% (table 11).

Table 11: OCS prevalence in different categories of psychotic patients

Psychiatric disorder	No. of patients	OCS prevalence
Schizophrenia, schizotypal and delusional disorders	147	47.6%
Mood (affective) disorders	108	61.1%
Neurotic, stress related and somatoform disorders	105	83.8%

El-Kholy et al., 1997

The commonest OCS in each group were found to be:

- Schizophrenia, schizotypal and delusional disorders patients (147): somatic obsessions were present in 19.7%, followed by aggressive obsessions (18.4%) then repeating rituals (10.9%).

- Mood disorders patients (108): somatic obsessions were the commonest (36.1%), contamination obsessions (32.4%), aggressive obsessions (30.6%) and checking compulsions (25%).

- Neurotic, stress related and somatoform disorders patients (105): miscellaneous obsessions were the commonest (52.4%); followed by checking compulsions (48.6%),

contamination obsessions (47.6%), aggressive obsessions (35.2%) and miscellaneous compulsions (35.2%).

Trans-cultural comparison

Okasha et al, 1991 compared between obsessive thoughts in Egypt, India, Jerusalem and England. Later; ***Mostafa et al., 2001*** added Saudi patients to the comparison (table 12).

Table 12: Common themes of obsessions in Egypt, India, Jerusalem, England and Saudi.

	Number of patients	filth	Harm	sex	religion	others
Egypt (Okasha, 1991)	84	43%	22%	18%	56%	12%
India (akhtar,1975)	82	46%	29%	10%	11%	27%
Jerusalem (Greenberg, 1984)	10	40%	20%	10%	50%	10%
England (Stern, 1978)	45	38%	23%	9%	--	11%
Saudi (Mostafa,2001)	47	72%	70%	28%	70%	55%

RELATION TO SEVERE STRESS AND ADJUSTMENT DISORDERS

POSTTRAUMATIC STRESS DISORDER

Abdel Hamid et al, 1996 studied two groups of PTSD patients each consisted of 20 patients. **The first** group included non-crippled (those without physical injury) and **the second** included crippled patients (with apparent physical injury). It was found that severe depression was more common in the crippled (60%) than the non-crippled (25%). The crippled had also shown more frequent interpersonal sensitivity, hostility, paranoid ideation and psychoticism implying impairment in adaptive functioning. On the other hand; severe anxiety was more common in the non-crippled (60%) than the crippled (35%). The non-crippled had also shown somatization and phobias pointing to severe maladjustment and psychological distress. 50% of both groups showed that they can not live independently and they need

help from others. PTSD affected individuals continue to suffer years after the initial trauma whether they suffer from concurrent physical disabilities or not.

DISSOCIATIVE DISORDERS

Epidemiology

Prevalence:

Haggag, 2002 studied 48 patients collected from OPC of university hospital in Esmailia compared to normal controls and found that 58.3% of patients obtained high dissociation scores in The Arabic Version ***(Abd-El Salam et al., 1992)*** of the Dissociative Experience Scale (DES) ***(Bernstein, Putnam, 1986)*** compared to only 6.3% of controls. 35.4% of the patients received the diagnosis of dissociative disorders and 22.9% were found to be conversion disorder.

Awed Alla et al, 1999 found that 4.3% of 423 military personnel presented to Manshiet Elbakry hospital were diagnosed to have conversion and dissociative disorders.

Socio-demographic data:

Dissociative disorders are most common at age between 20-30 yr ***(Awed Alla et al, 1999)***. ***Abdol-Karim et al, 1988*** found

that females had conversion disorder more than males with a ratio of 2.3: 1 respectively.

As regards the level of education; 30% of 20 patients studied were illiterate and none of them received university education ***(Abdol-Karim et al, 1988)***

It was also realized that marital status plays role in occurrence of dissociative symptoms as among 20 patients with conversion and dissociative disorders studied by ***Abdol-Karim et al, 1988***; 55% were single, 10% were divorced while only 35% were married.

Regarding the occupation and work records; 70% of the dissociative patients were not working ***(Abdol-Karim et al, 1988).*** And even those who were working had impaired job. ***Bishay et al, 1973*** studied hysterical fits in 50 military personnel and found that most of patients with hysterical fits were unfit for military service in fighting units; as they had lower intelligence. Also, 90% of those who attended combats got hysterical fits during combat and 34% were reported as not productive by their leaders. So the placement of those patients in non-fighting units guarantee proper placement.

Etiology

Family history:

Abdol-karim et al, 1988 found positive family history of dissociative disorder in 15% of 20 cases of conversion.

Family instability as manifested by disturbed inter-parent relations, temporary separations and divorce, together with exposure to paternal cruelty were found more commonly in the families of hysterical patients than control group. While a positive family history of epilepsy was present in 20% cases with hysterical convulsions compared to 5% of control group. ***(Bishay et al, 1973)***

Clinical Picture

Premorbid personality and past history:

Neurotic traits during the childhood are more in hysterical patients. The commonest traits in their order of frequency are fears, somnambulism, sleep talking, thumb sucking, foot fads,

and nocturnal enuresis. During their development the hysterical patients were described model children**. *(Bishay et al, 1973)***

As regards the psycho-sexual life of the hysterical patients; it was found that they had tendency to homosexuality than controls (30% vs. 0% respectively). This may be due to identification with the father. ***(Bishay et al, 1973)***

Hysterical personality disorder was diagnosed in 20% of the 20 patients with conversion disorder with 30% of the patients had past history of vague undiagnosed illness. ***(Abdol-Karim et al, 1988)***

Haggag, 2002 found that childhood physical abuse was related to high dissociation scores in the DES, yet childhood sexual abuse was significantly associated with the diagnosis of dissociative disorders.

Presentation and symptoms:

As regards the course of the disorder ***Fawzi et al, 1981*** had selected 50 hysterical patients from 500 patients presented to OPC of Zagazig university hospital; the patients were

clinically assessed and followed up one year after treatment. It was found that the course of hysterical symptoms was variable, but fell into two groups; the episodic hysteria group (38% of the patients) and the sustained hysteria group (62%). The Episodic hysteria referred to a bout of hysterical symptoms which recovered in less than one month, while sustained hysteria referred to a more lasting illness in which the same original symptoms or some other different hysterical symptoms were found at the follow up. 82% of 50 hysterical patients had poly- rather than mono-symptomatic presentations. Symptoms included various forms of motor disturbances, sensory disorders, mental symptoms and sleep disorders.

The most frequent motor symptoms were head nodding, sneezing, tics, tremors and fits representing 84% of the symptoms, followed by weakness, paralysis, torticollis and lock jaw representing 78%, movement disorders 50%, then convulsions 25%, curious gaits 16% and Speech disturbances 14%. On the other hand, the commonest sensory symptoms were paraesthesia representing 56%, pain 34% and anesthesia 28%. The mental symptoms reported were mainly irritability

and nervousness representing 54%, apprehension and fears 44%, fainting, dizziness and in ability to concentrate 40%, amnesia 16%, and fugues 10%. ***(Fawzi et al, 1981, Abdo-Karim et al, 1988)***

Comorbidity:

It was found that 47.1% of patients with dissociative disorders showed comorbid psychiatric diagnosis. The commonly reported comorbid diagnoses were phobia in 30% of the patients, anxiety in 10% and depression in 20%. ***(Abdo-Karim et al, 1988, Haggag, 2002)***

SOMATOFORM DISORDERS

Epidemiology

Prevalence

Roshdy et al, 2000 who studied 1852 patients presented to the OPC of general medicine in Zagazig University hospital, found that; 19.7% of them did not show genuine physical disorder. Of those 37.4% fulfilled Composite International Diagnostic Interview (CIDI) ***(WHO, 1993)*** criteria for somatoform disorders, while 62.6% had less severe form of somatoform disorders. Somatoform disorders presented as pain disorder (2.7%), Hypochondriasis (2%), conversion disorder (1.89%) and somatization disorder (0.76%) of the total population of the out patients (Total 7.35%). On the other hand, according to DSM-IV ***(APA, 1994)*** somatization disorders represented 0.6% of the total out patients.

Socio-demographic data

Haggag et al, 2000 found that among 74 patients studied; females had unexplained physical complaints more frequently than males (60.81% and 39.19% respectively).

Clinical Picture

Premorbid personality and past history:

Haggag et al, 2000 found that all the 74 patients with unexplained physical complaints had alexithymia in significantly higher rates than the controls. And they were defective in cognitive processing and regulation of emotions. They were also found to have less self confidence and relies emotionally more on others; especially the females.

In the same study patients reported more life event stressors than controls. Those stressors included death of a loved one, illness, injuries and legal or financial problems. They had pathological vulnerability to stress. Moreover, 22.34% of patients with unexplained somatic complaints had PD. Dependent; Histerionic and Anankastic personalities were the most frequent PD found especially in females. ***(Haggag et al, 2000)***

Symptoms and presentation:

The most common representing symptoms in patients with somatization were pains including headache, limb, back, chest and abdominal pains followed by palpitations, dryness of mouth, nausea, fainting attacks, flushing and hotness of the face, difficulty in swallowing, excessive sweating, movement disorders, difficulty in urination, amnesia and lastly sexual problems. ***(Roshdy et al, 2000)***

Psychiatric morbidities:

Patients with unexplained physical symptoms received the following diagnosis.

1- Neurotic syndromes (98.94%)

a- Somatoform disorder (36.49%)

b- Panic Disorder (21.62%)

c- GAD (13.51%)

d- Mixed and other anxiety (13.51%)

e- Dissociative disorders (13.51%)

2- Major Depression (24.47%)

3- Personality disorders (22.34%)

4- Behavioral syndromes (9.96%) (non-organic sexual dysfunction & sleep disorders). ***(Haggag et al, 2000)***

Somatoform disorders are considered an economic burden on the patients and the medical service. It was found that direct laboratory and other investigation costs in the patients with unexplained physical symptoms reached up to 2000 and 15000 Egyptian pounds in male & female patients respectively. ***(Haggag et al, 2000)***

BODY DYSMORPHIC DISORDER

Epidemiology

Prevalence:

The rate of Body Dysmorphic Disorder (BDD) was 3.98% among 503 student Egyptian university and college students studied by ***Guemei et al., 2005***. In addition 3.18% were found to have subthreshold BDD, 79.52% were simply dissatisfied or more precisely non-BDD dissatisfied with their appearance, and only 13.32% were found satisfied with their appearance.

While among psychiatric patients ***El-Sheshai et al, 1999*** found that the prevalence of body dysmorphic (BD) symptoms was 1.6% of 1200 psychiatric patients included in the study.

Socio-demographic data*:*

There was no correlation found between incidence of BDD and age, gender, type of study or order of birth. Yet, in the same study ***Guemei et al, 2005*** found that males and older group of students (20-23yr old) were concerned with higher number of body areas than females and younger group (17-

20yr old). Regarding the gender difference in the most dissatisfying body parts; males were found to be dissatisfied more by waist / abdomen, chest, facial hair, entire arm, all upper body, hands, chin & ears. While females were dissatisfied by head hair, nose, breasts, whole body, feet, all lower body, back of arm, cheeks & mouth.

Etiology and Clinical Picture

Family history and familial background:

BDD and dissatisfaction with appearance was found more likely to be present among those having professional & university graduated mothers and lower numbers of brothers and sisters. On the contrary, satisfaction with appearance was found to be more frequent among those living in rural areas, having illiterate mothers, semiprofessional fathers & mothers and high numbers of brothers & sisters. ***(Guemei et al, 2005)***

Presentation and symptoms

The university students who were diagnosed to have BDD reported more than one body area of concern, 50% of them reported at least 5 areas. Furthermore, 93.75% of those who

have subthreshold BDD reported more than one area of concern. ***(Guemei et al, 2005)***

The most frequently reported areas of dissatisfaction were:

- **In university students** (503 students); 70% were dissatisfied with one or more areas related to their head or face especially head hair and nose. This was followed by thighs, buttocks, all lower body and abdomen, then calves, hips, breasts and whole body ***(Guemei et al, 2005).***

- **In Psychiatric patients** (20 patients found to have body dysmorphic symptoms out of 1200 patients with different psychiatric illnesses); Most of the patients had an imagined defect in more than one area of the body. The main areas were in the face 80%, then the genitalia 10%, followed by the breasts 5%. The different parts of the face included in the complaints of the patients were hair of face in 55%, skin of face in 50%, the nose in 45%, eyes in 30%, lips in 15%, ears in 15%, teeth also in 15%, and fore head in 5%. ***(El-Sheshai et al, 1999)***

There were thought disorders related to the body dysmorphic symptoms in the form of obsessive thought disorder in 60% of cases and delusional thought disorder in 40%. There were also thought disorders associated with body dysmorphic symptoms in the form of ideas of reference in 60% of cases and delusion of reference in 40% of the cases. Most of the patients with BD symptoms had associated compulsive behaviors; the most frequent compulsions were frequent mirror checking in 75% of cases, while 25% had avoidance of mirror checking. 40% had repeated questioning of others. ***(El-Sheshai et al, 1999)***

As regards the reaction of the patients and subjects to their BD symptoms ***Guemei et al , 2005*** found that 70% of BDD subjects tried remedies and 50% of them tried more than one method to improve appearance of the most dissatisfying body parts. Regarding types of remedies tried to improve the dissatisfying body parts; specific diet followed by specific exercise were the most common remedies tried. Subjects with BDD were more likely than those with subthreshold BDD to try cosmetic surgery & hair transplant.

Comorbidity:

BD symptoms had more comorbidity with non psychotic illnesses (60%) than psychotic illnesses (40%). The non psychotic illnesses were further subdivided into OCD in 30% of the patients; social phobia in 20%, panic disorder 5% and psychoactive substance abuse disorder 5%. Whereas the psychotic disorders were subdivided into delusional disorder 5%, and schizophrenia 35%. ***(El-Sheshai et al, 1999)***

Impact of BDD:

Deterioration in the academic level is higher in BDD and Subthreshold BDD subjects than in simply dissatisfied and satisfied groups studied by ***Guemei et al, 2005***.

PERSISTENT SOMATOFORM PAIN DISORDER

One hundred randomized patients with chronic headache lacking an obvious organic basis were compared with 100 subjects, 50 with headache of a known organic cause and 50 seemingly healthy persons. Somatoform pain disorder was diagnosed in 43% of the non-organic and 20% of the organic headache group ***(Ali et al, 1994)***.

Moussa et al, 2005 studied 100 patients with chronic back pain. The patients were divided into two groups; the first included patients with no organic etiology; consisted of 58 patients (psychiatric group). The second group included patients with positive organic findings; they were 42 patients (organic group). Psychiatric patients were found to have more insidious onset of pain, more stationary course, and higher intensity with significantly longer duration of pain than organic group. As regards the past history, it was found that 31% of the psychiatric group had past history of sexual abuse compared to 11.9% in the organic group.

The rate of comorbidity between persistent somatic pain disorder and other psychiatric disorders was 100% in psychiatric group and 73.8% in organic group. In psychiatric group mood disorders was highly frequent (58.7%), followed by anxiety disorders (31%), while higher percentage of adjustment disorder was found in organic group (33.3%). Moreover, 50% of psychiatric group were alexithymics compared to 33.3% in the organic group. Psychiatric group also showed higher scores in Hamilton Rating Scale – anxiety and Hamilton Rating Scale – Depression ***(Sadock and Sadock, 2000)*** than organic group ***(Moussa et al, 2005)***.

On the other hand 9% of 100 patients with non organic chronic headache had major depression, 16% had dysthymia, and 8% had both**.** 77% of the patients in the non-organic headache group had personality disorders, mostly of the mixed and multiple types, compared with 24% of the organic headache patients. The study sample had more alexithymia than the other groups (in 65% of subjects) and had a culturally influenced locus of control and a pain profile characterized by dramatization, vagueness, lower pain threshold, and lower pain

tolerance. The non-organic chronic headache patients showed a high prevalence of somatoform, depressive, and other forms of psychiatric disorders ***(Ali et al, 1994)***.

OTHER NEUROTIC DISORDERS

NEURASTHENIA

Zyada et al, 2007 studied 40 children and adolescents between 4-16 years old with chronic fatigue syndrome **(**CFS) in comparison to 30 subjects with organic disease (collagen disease), and 35 healthy controls. CFS was found to be more prevalent at age group of 7-13 years old (72.5%) especially females and those with last rank in order of birth. 47.5% of CFS patients were of low social class and were even socially adjusted lower than organic and control groups. History of consanguinity among parents was positive in 20% of the cases.

There was positive family history of similar condition in 22.5% of the patients followed by history of other psychiatric disorders in 17.5%. Premorbidly 14.3% showed obsessive traits. 12.5% were physically abused and 5% were emotionally abused. They had good relations with their teachers although their poor educational achievement

70% of the cases with CFS showed severe anxiety, 17.5% had moderate anxiety and 12.5% had mild anxiety.

Cognitive behavioral psycho-therapy improved children with CFS as regards fatigue, anxiety, depressive symptoms especially after 3 months of regular follow up.

Critical Appraisal of the Egyptian Studies on Neurotic Disorders that has been included in the current review

1. ***A study of hysterical fits among adult males under the stress of military service.*** ***(Bishay et al,1973)***

- ***The title*** is stated in a simple way specifying the phenomenon to be studied and the target group.
- ***The introduction*** clarified the size of the problem in Egypt and the observations that rationalized the choice of the study group.
- ***The rationale and aims*** of the work were mentioned in details explaining how they would be fulfilled.
- The study is a case- control study which is a suitable design to reach the aims. Yet the ***study design*** was not clarified.
- The study included three groups; one for hysterical fits patients, the second included the epileptic patients and the third included normal subjects. All subjects were selected according to certain inclusion and exclusion criteria that were explained in details but the ***sampling method*** and the ***sample size*** calculation were not clear. it was mentioned that the subjects of the hysterical fits were reported by their military units and the normal

group was selected by the leaders of the units but it was not mention which units were selected or how they were chosen, also it was not mentioned from where the subjects of the epileptic group were selected.

- ***The assessment tools*** were mentioned and described in details clarifying how they will be applied.
- ***The statistical methods*** used for data analysis were also explained in details showing their application methods.
- ***The results*** were listed in tables that most of them were self explanatory, with brief comment. Some of the tables contained abbreviations without clarifying what they stand for. Also, some of them were hard to understand and needed more detailed comments.
- ***The discussion*** of results contained analysis, possible explanations of the results with comparison with other studies.
- ***Recommendations:*** The study ended up with several practical and clinical suggestions together with recommendations for research.
- ***The limitations*** of the work were not mentioned.

2. • ***Anxiety and Hysteria; an Egyptian Clinical study.*** ***(Fawzi et al, 1981)***

• ***The title is*** clarifying that the study was done on Egyptian sample. That is considered generalization as the sample was only chosen from OPC of Zagazig hospital. Also, it is not specifying what would be studied about anxiety and hysteria.

• ***The introduction*** was brief stressing the relation between anxiety and hysteria, clarifying that there are cultural differences and justifying the need for the study. And ***the aim*** of the study was clearly stated by the end of the introduction.

• ***The study was designed*** as a cross-sectional study. The study design was not mentioned.

• ***Sampling method and sample size:*** The sampling population was all outpatients of psychiatric clinic of Zagazig university hospital for one year. Among them the first 50 received the diagnosis of hysterical neurosis were selected. That makes it non probability convenient sample and decreases the chances for generalization of the results. Moreover, the bases of calculation of the

sample size were not clear.

- ***Tools of assessment and diagnosis*** were just named without any explanation of their use or method of application.
- ***The statistical methods*** used for data analysis were not clarified.
- ***The results*** were presented only in text. The use of tables or graphs would have been better as it makes it easier to present and organize data.
- ***The discussion*** included analysis of the result with possible explanation. The results were compared with several studies. It was realized the results were generalized to the whole population of Sharkeyah governorate, which is not justified by the sample of the study.
- ***Limitations of the study and recommendations*** were not mentioned.

3. ***Psycho-demographic study of anxiety in Egypt. (The first application of PSE in its Arabic version)*** ***(Okasha et al, 1981)***

- ***The title*** is generalizing the study to Egypt although the sample selection did not represent the whole Egyptian population.

- ***The introduction*** was brief including the description of the original present state examination (PSE) and the need for its translation. The introduction also included the rationale of the study.

- ***The aim*** of the study was not mentioned.

- ***The study design*** is descriptive cross-sectional, but that was not clearly mentioned.

- ***The time of the study and the sampling population*** were clarified but they were divided into patients of low social class; from the OPC of Ain Shams university hospital, and patients of high social class; attending the private clinics of the authors. The criteria used for such classification were not clarified and only seeking advice in the hospital or a private clinic can not be the only factor to determine the social class.

- ***The sampling method*** was haphazard sample increasing the chance of bias. Also the ***sample size*** calculation was not justified.
- ***The methods of assessment and diagnosis*** were specified and briefly explained.
- ***The statistical methods*** used for data analysis were not mentioned.
- ***The results*** were presented, discussed and explained in details. They were illustrated with tables and a graph that were informative especially the graph that summarized the symptoms assessed by the PSE. The results were not compared with other studies using the same tool in other cultures. Also, they were not compared with studies using other scale of tested validity and reliability. ***The discussion*** was integrated in the presentation of results.
- ***Limitations*** of the work and future ***recommendations*** were not mentioned.

4. • ***Anxiety and depressive disorders among users of a general practice clinic in an industrial community in Cairo.*** ***(El-Akabawi, Fekri, 1985)***

• ***In the title*** the target population was clear but it did not specify which industrial community to be studied with generalization.

• There was no ***introduction*** to the work.

• ***The aim*** was not clear. All what mentioned was just a notice describing that the study presents prevalence rates for anxiety and depressive disorders among users of general health clinic in an industrial community, and socio-demographic profile for those patients.

• ***Study design*** was cross sectional descriptive yet that was not mentioned.

• ***The sample*** was collected randomly from the patients attending the clinics. Randomization according to days of the week and numbers attending on selected days was done using randomization tables. The total number of the sampling population was not clear and the place from which the sample was selected was not specified. Also sample size calculation was not rationalized.

- ***The methods of assessment and diagnosis*** were briefly mentioned and referenced.
- ***Statistical tests*** used for data analysis were not mentioned.
- ***The results*** were briefly presented and were not illustrated with tables or graphs.
- ***The discussion*** included analysis of data and comparison with other studies.
- Several ***recommendations*** were suggested by the end of the study.
- ***Limitations*** of the work were not mentioned.

5. • ***Descriptive analytic study of conversion disorder in specimen of Egyptian patients.*** ***(Abdol-Karim et al, 1988)***

• ***The research was written in Arabic with an English summary.***

• ***The title*** is limiting the results to the studied sample, clarifying the study design but it was not specific in describing the target population. The word "specimen" was used instead of "sample" in the English translation.

• ***The introduction*** was simple and clarified the rational of the work with clear definition of some terms used in the study.

• ***The aim of work*** was detailed identifying the target population and the purpose of the study.

• Three ***hypotheses*** were stated to be tested. The hypotheses of the study were simple, specific and one tailed.

• ***Study design:*** It was mentioned that the study is descriptive analytical study.

• One study group and two control groups were selected according to certain inclusion and exclusion criteria. ***The sampling method*** and the way the ***sample size*** was

calculated were not clear hindering the generalization of the results.

- ***The assessment tools*** used were listed, described in details, and referenced with clarification of following the copyrights regulation by taking the permission of the original authors and the method of translation but the tests done to examine the reliability and validity of the tool after translation were not described in details enough to judge the results.
- ***The statistical tools*** used to analyze the results were not mentioned.
- ***The results*** were illustrated in tables that were simple, self explanatory with brief comments.
- ***The discussion*** of the results included their analysis with comparison with other studies.
- ***Limitations*** of the study as mentioned were confined to the results of the Pilosky illness behavior questionnaire, as it could not differentiate between the three groups included in the study. That was attributed to possibility of wrong diagnosis as it was difficult sometimes to diagnose conversion disorder, mistakes in

the translation of the questionnaire although it was revised several times, faulty application as some times it was applied by the researcher and sometimes was fulfilled by the patients, or problems related to the patients themselves.

Several ***recommendations*** for clinical practice and research were listed by the end of the study.

6. • ***Transactional analysis. Group psychotherapy for neurotics.*** ***(Ali et al, 1991)***

• **The study was written in Arabic.**

• Both English and Arabic ***titles*** are specifying the type of psychotherapy used but not specifying the sample.

• ***The introduction*** included definition transactional analysis and rationalization of the study.

• ***The aim*** was clearly stated.

• ***Study design:*** The study is an experimental study in which the new therapeutic technique was applied on a group of patients for 30 hours with assessment of the symptoms just before and after the intervention. As that study did not contain a control group the baseline data were used to act as the control and the comparison between successive assessments helped in the evaluation of the effect of the therapeutic technique. The therapeutic technique used was not randomly or blindly applied what increases the possibility of bias.

• The bases of ***sample selection*** and calculation of ***sample size*** were not clear. The dropouts' number exceeded 20% of the subjects included in the study; as

the group started with 15 patients decreased to 9 patients when the sessions became closed and only 7 patents completed the sessions. The reasons of dropouts were clarified. They were; 1) some of the patients included in the group before accurate assessment and were found to have other disorders associated with neurosis so they were excluded, 2) some of the patients stopped attending the group but the reasons were not mentioned. That large number of dropouts increases the bias and affects the results.

- ***The assessment tools*** used were described and explained in details and referenced.
- ***The results*** were presented mainly using text to describe the successive therapeutic sessions in details. Tables and diagrams were rarely used to clarify data when needed.
- The results were ***discussed*** in details and explained as possible in correlation with previous studies.
- Clinical ***recommendation*** was suggested by the end of the study. ***Limitations*** of the work were not mentioned.

7. • ***Obsessive compulsive disorder in different cultures "An Egyptian perspective"*** ***(Okasha et al., 1991)***

• ***The title*** of the study was simple and the use of a subtitle made it more descriptive, but it would have been more specific if clarified the cultures to be compared. It was noticed that the title did not accurately describe the study.

• The study included a detailed ***introduction*** about OCD and the clear definition of culture.

• Apparently ***the aim of the study*** was to assess the cultural impact on symptom formation in OCD as well as assessing the outcome in relation to the different lines of treatment; however, the aim the work was not clearly mentioned.

• The patients included in the study were followed up for a period ranging up to 5 years.

That is a prospective study, but ***the study design*** was not mentioned.

• ***The sample*** was drawn from OCD patients attending department of psychiatry of Ain Shams, Cairo and from

those seen in private practice between the years 1968-1975. Yet the sampling method or the bases on which the sample size was collected were not clear. Besides; it was mentioned that there were drop outs as the results of the study were based on the information about 84 those were followed up. The patients who were not fully studied were discarded. Information about the total number of patients included in the study and the drop-outs was not clear. All the subjects selected were Egyptian and no other nationalities were included.

- ***The tools*** used for diagnosis or those used for follow up and assessment of outcome were not mentioned.
- ***The results*** were clearly and briefly stated. Few but simple and informative tables were used. The results were ***discussed*** in details and compared to other international studies and through that comparison the trans-cultural prospective mentioned in the title was fulfilled.
- ***Limitation*** of the work and further ***recommendations*** were not mentioned.

8. • ***The diagnostic validity of panic disorder, anxiety, depression or separate entity.*** ***(Salim et al, 1992)***

• ***The title*** was stated in a complex way that needed modulation or restatement. The same research was published in the British journal of psychiatry in 1994 under the title: ***Panic disorder. An overlapping or independent entity?*** This was a more informative title.

• ***The introduction*** was clear justifying panic disorder to be the field of research and clarifying the clinical importance of such a study.

• ***The aim of work*** was clearly stated.

• ***The study design:*** it is a case control study included 3 groups of patients representing panic, anxiety and depressive disorders and one control group. It is a suitable and simple design to hold such a comparison to reach the goal of the study.

• The sample was collected according to certain inclusion and exclusion criteria yet the ***sampling method*** and the calculation of ***sample size*** were not clear. Also, the sample was selected from Egyptian

patients attended psychiatric hospital in Kuwait or a private hospital in Cairo or referrals from state clinics. The selection of these referral sources was not justified and the sample that way is a non probability sample. That limits the results to the studied subjects.

- ***The assessment tools*** were described in details and referenced and the laboratory tests and investigations were justified with clarification of the way of sample collection.
- ***Statistical methods*** used for data analysis and correlation were clarified and explained.
- ***The results*** were simply presented and illustrated in details. The tables were simple and self- explanatory.
- ***The discussion*** included analysis of the results with possible explanation of them and demonstration of how these results agree or contrast with previously published work.
- ***Recommendations*** were mentioned by the end of the study.
- ***Limitations*** of the work were not mentioned.

9. • ***Psychiatric study of non-organic chronic pain-headache as an example.*** ***(Ali et al, 1994)***

• ***The title*** is descriptive for the phenomenon to be studied but with generalization of the results as the sample was not clear.

• ***The introduction*** was justifying studying chronic pain and the choice headache in particular.

• ***The aim*** of the study was clearly and specifically stated.

• ***A pilot study*** was done to fulfill certain objectives which were:

- To choose a representative type of non-organic chronic pain population for the sake of homogeneity of the study group.
- To test the inter-rater reliability of some psychometric tools.

The results of the pilot study were presented in details. Headache was chosen as a representative example of non-organic pain and facilitated the choice of the method of application of the assessment tools.

- ***Study design*** is case- control. Patients with non organic chronic headache were compared to patients with organic headache and psychiatric patients with no organic symptoms. It is a suitable design for such a study. Study design was not mentioned.
- ***The time, place and sampling population*** were clarified and the subjects were randomly selected according to certain inclusion and exclusion criteria but it is still a non probability sample as the type of random sample used and the sampling frame were not clear. Also, the choice of Ain Shams university hospitals OPC was not justified. So, the chances of generalizations of the results to the whole population of non-organic chronic pain patients are limited.
- Calculation of ***sample size*** was not clear.
- The number of excluded cases and the cause of exclusion were clarified together with the number of drop-outs.
- ***The tools*** used for assessment were explained, discussed for reliability and validity and referenced.
- ***The statistical methods*** used for data analysis were

described in details.

- ***The results*** were presented and illustrated using tables and graphs that were informative and simple. Some data were unnecessarily repeated in the text, tables and graphs.
- ***The discussion*** of results included detailed analysis with possible explanations and comparisons with the previous studies.
- Several clinical ***recommendations*** and suggestions for research were mentioned.
- ***Limitations*** of the study were not mentioned.

10. *Clinical association between depressive and anxiety disorders.* *(El-Fangary et al, 1994)*

- ***The title*** was simply stated but it is generalized as it did not specify the target population.
- ***The introduction*** stressed on the importance of depressive and anxiety disorders and the difficulty in clinical differentiation between them rationalizing the study.
- ***The aim*** of the study is precise specifying the point to be studied.
- The research started with four ***hypotheses*** that were simple and specific.
- ***The study design*** is cross sectional; however, it was not mentioned.
- ***The sample*** was selected from OPC of Kasr El-Aini hospital according to certain inclusion and exclusion criteria. The psychiatrists referring the patients did not know the aim or the hypothesis of the study to decrease the bias. The method of selection of the sample and way of calculation of the sample size were not clear limiting the results to the sample of the study.

- ***The tools*** used for diagnosis of patients in order to be classified into groups to be studied and the assessment tools used later were described in details ensuring their validity and reliability and were referenced.
- ***The statistical methods*** used for data analysis were named and referenced.
- ***The results*** were simply presented and illustrated with tables. The tables were self explanatory with brief text comments.
- ***The discussion:*** The results were discussed and analyzed in details and compared to literature. The discussion also contained verification of the hypotheses of the study.
- Clinical ***recommendations*** and suggestions were mentioned by the end of the study
- ***Limitations*** of the work were not mentioned.

11. • ***A comparative study of anxiety disorders in the primary school children.*** ***(Abd Rabo et al,1995)***

• ***The title*** clarified the design of the study, but it did not specify the study population and aspects of comparison.

• ***The introduction*** was detailed discussing different aspects of anxiety disorders; clarifying their magnitude in the community.

• ***The aim*** was specifying the points to be studied but it did not explain the ultimate goal behind the comparisons would be done through the study.

• ***Study design:*** It was mentioned that the study was designed as a comparative study between urban and rural primary school children and between males and females. It included two groups of children; one group from urban areas and the other from rural areas.

• The bases of selection of the subjects of the study were not clear; as the choice of the ***place of the study*** was not rationalized and the ***method of sample collection*** and calculation of the ***sample size*** were not clear. All these factors increase the bias and limit the results of the study to the sample.

- ***The assessment tool*** used in the study was explained in brief and referenced. Yet, ***the statistical methods*** used for data analysis were not mentioned.
- ***The results*** were presented mainly in tables that were self explanatory with brief text comment on the data included in the tables. Sometimes the text comments included unnecessary repetition of tabulated data. The main results of the study were summarized in few graphs that were simple but they were not commented on or even referred to in the text.
- ***The discussion*** contained a review of literature that was not in the right place as the primary purpose of the discussion is to show the relationships among the observations obtained from the results and provide a possible explanation for these observations. That review was followed by brief analysis of the results with comparison with previous studies.
- The study is lacking suggested ***recommendations*** and the ***limitation*** that the study faced.

12. • ***Comorbidity of Anxiety and Depressive Disorders in Psychiatric Outpatients.*** ***(Hamdi et al, 1995)***

• ***The title*** did not contain description of the study design or the sample included with unjustified generalization.

• ***The introduction*** discussed the overlap between depression and anxiety rationalizing for the study.

• ***The aim*** of the study was clearly stated.

• ***Study hypothesis*** is simple, specific, one tailed alternative making it easy and suitable to be tested.

• ***Study design:*** cross sectional which is a simple and suitable design to study association. The study design was not mentioned.

• ***The place, time and sampling population*** were clearly mentioned. The choice of Kasr El-Aini hospital as a place and Sundays as the day for collecting the sample was not justified.

• ***The sample*** including the first 3 patients with anxiety and/or depression presented to the OPC and gave consent. That makes it non probability sample; what

increases the bias and decreases the chance of inference of the results.

- The calculation of ***sample size*** was not clarified.
- ***The assessment tools*** used in the study were descried and referenced.
- ***The results*** were presented clearly and illustrated with tables that were self explanatory.
- ***The discussion*** included analysis of data and compared them with previous studies.
- ***Limitations*** of the work and future ***recommendations*** were not mentioned.

13. • ***Effect of crippling on the presentation of post-traumatic stress disorder.*** ***(Abdel Hamid et al, 1996)***

• ***The title is*** simple, presenting the research question but not specifying the study population.

• ***The introduction*** was brief stressing on the debate around the diagnosis of PTSD.

• ***The hypothesis*** was simple, specific, one tailed

• ***The aim*** is clearly stated with explanation of how it will be reached.

• ***The study was designed*** as a cross-sectional comparative study. The study design was not mentioned.

• ***Sampling method and sample size:*** The sampling population included the patients with PTSD presented to certain military hospital at a certain period of time; those patients were classified into crippled and non crippled groups. Then out of those subjects the groups of the study were selected without mentioning the bases for that selection. That is a non probability haphazard sampling; hindering the generalization of results.

• ***Tools of assessment and diagnosis statistical methods*** were mentioned and described in details.

- ***The results*** were presented in tables and graphs that were informative and self explanatory. Some of the graphs were just repetition of the tables.
- ***Limitations of the study*** as mentioned included; the small sample size (20 patients in each group), absence of control group, paucity of the studies done on the same subject and paucity of the literature written of the impact of crippling, physical disability and the development of PTSD. There was no attempt to assess cognitive deterioration separately to view it specific effect on recovery from injury in general and in subjects with PTSD.
- ***Recommendations*** were mentioned by the end of the study.

14. • ***Assessment of cognitive functions in OCD patients***. ***(El-Nahas et al., 1996)***

• ***The title*** was simply stated yet it was not adequately descriptive; as it was mentioned that the study will assess cognitive functions in OCD patients without specifying the population.

• ***The introduction*** was informative, with clarification of the importance of the study.

• ***The aim*** of the study was precise.

• ***Study design*** is a case-control but it was not mentioned.

• ***Sample design and sample size:*** there was no clear design or method of sampling or calculating the sample size, and the collection of sample depended on referral; as the sample included the OCD patients referred from the OPC of Ain Shams University Institute of Psychiatry (ASUIP), faculty of medicine welfare clinic and referrals from professors of psychiatry working in the university that makes it non representative for the whole population of OCD patients; what increases the probability of bias in spite of the clear inclusion and

exclusion criteria. Moreover, the relatively small number of the sample (30 patients) makes it hard to generalize the results on the whole OCD patients' population.

- ***The tools:*** the neuro-psychiatric evaluation tools used in this study are valid and were properly described and referenced. Also, the statistical tools were described in details.
- ***The results:*** the results were properly stated and illustrated with tables that were introduced in a brief clear way.
- The results then were ***discussed*** in details, analyzed and compared to other studies.
- By the end of the study the s suggested logarithm for the patho-physiology and cognitive dysfunction of OCD was concluded.
- ***Recommendations*** were mentioned to get use of the results of the study and for further research.
- ***The limitations*** of work were not mentioned.

15. • ***The Prevalence of Obsessive Compulsive symptoms in a sample of Egyptian Psychiatric Patients***. ***(Elkholy et al., 1997)***

• ***The title*** is simply stated, limiting the results to the sample studied but with no specification of the sampling population population.

• ***The introduction*** was clear and stated the importance of study of OCS in psychiatric patients.

• ***The aim*** of the study showed exactly why the study was done and the areas to be covered by it.

• ***Study design:*** it is a case control study as it compared between psychiatric patients and normal controls. The study design was not mentioned.

• ***Place of the study and study population:*** The study was held in General psychiatric OPC of ASUIP. As it is not the only psychiatric hospital in Egypt, that makes the results of the study to be applied with caution on the whole psychiatric population in Egypt.

• ***Sample design:*** Stratified random sampling was used. Random sampling decreases the bias and makes the results more reliable. The sample also was collected

according to clear inclusion and exclusion criteria for both the patients and the control groups.

- ***Sample size:*** 372 patients and 308 normal subjects were included in this study. However, it was not mentioned how the sample size was calculated for both groups.
- ***Tools*** used for psychiatric assessment were explained and referenced with description of how they would be used. The statistical methods were named with a brief hint on there use.
- ***The results:*** were stated and illustrated with tables which were informative yet some of them were complicated.
- There was a detailed ***discussion*** of the results and comparison with the related studies.
- ***Recommendations*** were mentioned in details and were classified into clinical and research recommendations. The research recommendations stressed on certain inquiries which made it specific and useful for other researchers.

Limitations of the study as mentioned in the study were:

I- the clinical population was not representative of all psychiatric disorders. II- there was no specification of the prevalence of OCS on some subtypes of different psychiatric disorders especially within neurotic disorders because of small number of cases in each subtype.

16. • ***Anxiety, depression, somatization and psychiatric morbidity in rural Minia.*** ***(Soliman et al, 1997)***

• ***The title*** is descriptive of the study but generalized the results to the whole population of rural Minia.

• ***The introduction*** was brief explaining the choice of rural population to be studied.

• ***The aim*** was clearly stated.

• ***Study design*** is cross-sectional survey, yet that was not mentioned.

• ***Sampling method:*** it was mentioned that the village included in the study was randomly selected from villages of Minia governorate. That was followed by systematic random sampling of the subjects from the village. That multiphase random sampling decreases the sampling bias.

• ***The sample size*** calculation was not justified.

• ***The tools*** used for assessment were named and referenced with no explanation.

• ***The statistical methods*** used for data analysis were

clarified in details.

- ***The results*** of the study were simple presented and illustrated with tables and graphs. They were informative and self explanatory.
- There was a detailed ***discussion*** of the results that included analysis, explanation and comparison of the results to other related studies.
- ***Limitations*** of the work and ***recommendations*** for future research were not mentioned.

17. • ***Prevalence of obsessive compulsive symptoms& disorders in a sample of Egyptian school children.*** ***(Abdel-Aziz et al., 1998)***

• ***The title*** is descriptive but it did not clarify that the study included Egyptian children living abroad. Also, it did not specify the age of the studied children.

• ***The introduction*** was clarified the magnitude of the problem and the need for the study.

• ***The aim*** was generalizing even more than the title as it stated that the prevalence of OCS and disorder was to be studied in school children aged between 9-12 years but did not specify the Egyptian children living in Qatar.

• Egyptian schools in Qatar were chosen to be ***the location of the study.*** The ***sampling population*** chosen does not represent the target population stated in the title and the aim.

• ***A two stage study design*** was used and described with details about the stages of the study without mentioning the types of study designs used in each stage. But it was clear that cross-sectional design was used.

- ***The sample*** included the whole population of Egyptian school children aging 9-12 years in Qatar. That big size of the sample (1093 children) gives the result the power to be inferred on other populations sharing the same circumstances.
- ***Assessment tools*** applied in the study were referenced and explained in details. The statistical methods were also defined and explained in details
- ***The results*** of the study were clearly mentioned, illustrated with tables that were informative, then ***discussed*** and compared to previous studies
- ***The Recommendations*** were clearly stated by the end of the study including both practical and research aspects yet they were generalized and vague especially the research recommendations.
- ***Limitations*** of the study were not mentioned.

18. • ***The relation between aggressive behavior, depressive and obsessive symptoms in a sample of Al-Azhar university students.*** ***(Abu Hegazy et al., 1999)***

• ***The study was written in Arabic with a brief English summary.***

• The translation of ***the title*** was not accurately descriptive as it was not clear that the aggressive behavior would be studied in relation to both depressive and obsessive symptoms in the sample as it was stated in the Arabic title.

• ***The aim*** of the work was clear in Arabic while it was just a repetition of the unclear title when mentioned in the English summary.

• ***A pilot study*** was conducted and it was beneficial as it gave idea about the time and place where the sample of the study would be more feasible.

• ***Site, time and procedures*** of the study were described properly. The study was conducted in the students' dormitory for Al-Azhar university male students. The female students and those from areas near to the

university such as residents of Cairo were not represented in the sample.

- ***The study design*** was a cross-sectional multistage (pilot study followed by the study proper). That is a simple and suitable study design used to study associations.
- Systematic random ***sampling*** was the method used in this study; and not stratified random sampling as translated in the English summary. It is a simple design; exposing the study to relatively low sampling errors with better representation of the population.
- The way the ***size of the sample*** was calculated and the size of target and sampling population were not clear.
- ***Tools:*** The psychometric tools used in the study were described in details and referenced while the statistical tools were not mentioned.
- ***The results*** were illustrated in many tables that were simple and informative. The comments written on each table was detailed to a degree it seemed as repetition of the information mentioned in the tables.
- ***The discussion*** of results was detailed and the results

were compared to the results of other related studies.

- ***Limitations*** of the work were mentioned in the methodology after describing the pilot study as they were; difficulty in reaching the students outside their classrooms and also the difficulty in conducting the psychometric tools inside the classrooms due to the crowd and the ongoing lectures. Also, the difficulty in reaching the same students to perform clinical interviews with them after their assessment by the psychometric tools. And it was clarified that the selection of the place of the study was to avoid theses difficulties, and that avoidance of the difficulties in selection of their sample limited the possibility of generalization of the results of the study. On the other hand, the difficulties and limitations that met the study proper were not mentioned.
- ***Recommendations:*** they were mentioned in brief and they were mainly research recommendations rather than clinical recommendations.

19. • ***Recent life events, family, job and social stressors in relation to anxiety and obsessive compulsive disorders: a comparative study.*** ***(Akram et al, 1999)***

• ***The title*** is descriptive of the content of the study with specification of the points to be studied yet, with generalization.

• ***The introduction*** was brief, emphasizing the magnitude of both GAD and OCD.

• ***The aim*** was clearly stated with explanation of how it would be reached**.**

• ***The hypothesis*** is simple, specific one tailed alternative type making it easier to be tested.

• ***The study design:*** case- control (comparative) study**.**

• ***The sampling method*** was not mentioned. The ***sample size*** was estimated to detect a difference of 10% or more of the scores used in assessment with 95% level of confidence, yet the total number of the sampling population and the method used for calculation of the sample size were not clear.

• ***The tools used for assessment*** were described in

details and referenced explaining the method of translation.

- ***Statistical tools*** used for data analysis were named explaining their use.
- ***The results*** were presented and illustrated using tables that were informative and self explanatory. The text comments highlighted some tabulated data.
- ***The discussion*** included detailed analysis and explanation of results and comparison of the results with other studies.
- ***Recommendations*** and ***limitations*** of the work were not mentioned.

20. • ***Dissociative disorders in Egyptian armed forces (cross-sectional study).*** ***(Awed-Alla et al, 1999)***

• ***The title*** is simple and clarifying the target population and the study design, but it was not clear the sample was collected from the military hospitals, which makes the generalization to Egyptian armed forces not justified.

• ***The introduction*** briefly clarified the magnitude of the problem and the need for such a study.

• ***The aim*** of the study was not mentioned.

• ***The study design*** as clarified in the title is cross sectional study; which is a suitable design to study the prevalence of certain problem in the population at a given time.

• ***The time, place and the sampling population*** were clarified and the choice of Manshiat El-Bakry military hospital was rationalized by being the main center that serves psychiatric patients in the armed forces.

• ***The sampling method*** and ***sample size*** calculation were not justified.

• ***The psychometric tools*** used were explained in details and referenced.

- ***The statistical methods*** used for data analysis were not mentioned.
- ***The results*** were presented in tables that were informative with brief text comments. Some tables contained negative data that was enough to be mentioned in the text.
- ***The discussion*** included analysis of the results and comparison between them and other related studies.
- Several recommendations were suggested with clarification of pitfalls of the current study such as:
  - Working in a psychiatric hospital led to sampling bias, as the sample included in the study covered exclusively the referred personnel for psychiatric assessment and evaluation. So, it underestimated the real prevalence of sub-syndromal and subclinical cases who did not present in the psychiatric practice.
  - The study should have compared between prevalence of hysterical neuroses in war time (retrospectively), and in peace time.
  - The study should have included a control group.

21. • ***Body dysmorphic symptoms among psychiatric illnesses.*** ***(El-Sheshai,1999)***

• ***The title*** is brief but vague, more clarification was needed.

• ***The introduction*** included definition of BDD and explanation of the overlap of diagnosis between it and other disorders. The introduction did not include any review of the literature in that subject.

• ***The aim*** of the study was clearly stated.

• ***The study design*** was not clear and the presentation of the methodology of the study was too brief to explain it. It is cross sectional study.

• ***The sampling population, sampling method, sample size and time of the study*** were not clear.

• ***The assessment tools*** used in the study were listed with no explanation of their use or way of application.

• ***Statistical methods*** used for data analysis were not mentioned.

• ***Results*** were presented and illustrated using tables. The tables were informative and self explanatory but most of the data included in the tables were mentioned

in details in the text.

- The results were ***discussed*** and explained with comparison to other studies.
- ***Recommendations*** and ***limitation*** of the work were not mentioned.

22. • ***Prevalence of anxiety symptoms in a sample of Egyptian children.*** ***(Okasha et al, 1999a)***

• ***The title*** described the study with limitation of the results to the studied sample. But it did not specify the age group of the children included and did not clarify that the study included only school children.

• ***The introduction*** was brief, stressing on clarifying the importance of studying anxiety in children.

• ***The aim*** was clearly stated with emphasis on the need of that study as the Egyptian literature lacked such information.

• ***A pilot study*** was conducted to test the response compliance and the logistic and administrative difficulties which might face the survey. That pilot study helped in calculation of the sample size for the study proper.

• ***The study design:*** it is a two stage study; the first stage was cross-sectional study to find out the prevalence of anxiety symptoms among school children, and the second stage was case-control to study demographic and familial factors associated with anxiety.

- ***The place, time and sampling population were clarified.*** The study was conducted in public and private schools in Heliopolis educational area. The choice of that area was not rationalized. Heliopolis area is not representative of all parts of the country. On the other hand, the school children are not representative for the Egyptian children as there are children who never joined school and dropouts. The sample was better collected through multistage random sampling method to decrease the bias. So, the results can not be generalized to the whole Egyptian children population.
- ***Sampling method:*** The sample was collected using multistage stratified random sampling. It is a suitable method to ensure representation of the students of the chosen area. That type of sample requires less time, effort and money than the corresponding simple random sample but the sampling error is higher so larger sample size is required.
- The basis of calculation and the statistical method used for estimation of the ***sample size*** were clearly explained.
- ***The tools*** used for assessment were mentioned in

details and referenced with explanation of the method of application.

- ***The results*** were clearly presented and illustrated with tables. The tables were informative, self explanatory.
- ***The discussion:*** The results were discussed and explained in details with comparison with literature.
- Clinical and training ***recommendations*** were mentioned by the end of the study.
- ***Limitations*** of the study and suggested recommendations were not mentioned.

23. • ***Anxiety disorder in a sample of Egyptian adolescents; a psycho-demographic study.*** ***(Okasha et al, 1999b)***

• ***The title*** was clearly stated and described the contents of the study with limitation of the results to the studied sample. The use of the term Egyptian sample was not accurate as the study was conducted in several public schools in a district in the north of Cairo.

• ***The introduction*** is clarifying the magnitude of the problem and justifying the choice of the topic to be studied.

• ***The aim*** was stated in the form of specific questions to be answered with emphasis on an ultimate objective to be reached after answering the questions.

• ***The study design:*** as the study aimed at studying the association of some psycho-demographic variables and anxiety disorder; case-control design was chosen and the choice was rationalized. It is a simple and suitable study design for such an aim. The study was conducted through two stages; the first was a screening phase for anxiety and in the second only the subjects with anxiety

were further assessed.

- ***The sampling population and the place of the study*** were specified. The study was done in several public schools in a district in the north of Cairo. The choice of that district was not rationalized. And as clarified in the study these schools have different nature than private schools. So the sample can not be representative for Egyptian adolescents other than public schools students.
- ***Sampling method:*** The schools and the student samples were chosen using multistage stratified random sampling. It is a suitable method to ensure known probability of representation of all students of the chosen discrete. That type of sample requires less time, effort and money than the corresponding simple random sample but the sampling error is higher so larger sample size is required.
- ***Sample size:*** the total number of the sampling population was mentioned and the sample size was calculated putting into consideration the probability of dropouts. But the bases of calculation of the sample size were not clear.

- ***The assessment tools*** used in the study were described in details and referenced.
- ***The statistical methods*** used for data analysis were listed.
- ***The results*** were clearly presented and illustrated with tables. The tables were informative and self explanatory.
- In ***the discussion*** the results were analyzed in details, explained and compared to previous Egyptian and international studies.
- ***Recommendations*** for clinical practice and training were suggested.
- ***Limitations*** of the study were not mentioned.

24. • ***A single photon emission computed tomography study in obsessive compulsive disorder.*** ***(Reda et al, 1999)***

• ***The title*** was clearly stated, specifying the investigation to be done and the target disorder to be studied with generalization.

• ***The introduction*** was brief rationalizing the need for such a study.

• ***The hypothesis*** was complex and vague. It was stated in the form of rationale of the study rather than a clearly stated hypothesis.

• ***The aim*** of the study was specific and precise.

• ***The study was designed*** as case-control study which is a practical and simple design for such a study including usage of expansive techniques, as it allows less number of subjects than randomized studies. The study design was not mentioned.

• The subjects were included according to certain inclusion and exclusion criteria but ***method of sampling*** and way of calculation of ***sample size*** were not mentioned.

- ***The controls*** were recruited to the study as data from previous SPECT study among employees and mates working in ASUIP. The study from which the controls were selected was not mentioned to judge its reliability and evaluate the methodology used in it.
- ***The tools*** used for psychiatric assessment and imaging technique were described in details and referenced.
- ***Statistical methods*** used for data analysis were listed clarifying there uses.
- ***The results*** were presented and illustrated with tables that were self explanatory with brief text comments that clarified the tabulated data.
- ***The discussion*** included analysis and explanation of the results with comparison to the previous studies.
- It was mentioned in the discussion that the study faced difficulty in finding cases that fit for the criteria of selection and accept to do the procedure. As for the control individuals, they were taken as data from previous study.
- Several ***recommendations*** and suggestions were mentioned by the end of the study.

25. • ***Psychiatric morbidity among children of patients with OCD.*** ***(Saad& Nazeef, 1999)***

• ***The title*** did not describe the study, as it did not show that the study compared between children of OCD patients and of diabetic patients.

• ***The introduction*** stressed on the burden on the children of OCD patients and its importance in causing a psychiatric disorder in them. But the selection of children of diabetic patients to be compared with the study group was not also justified.

• ***The aim*** was clearly stated.

• ***The study design*** was not mentioned. The current study was designed as case-control study but as the study aimed at detecting psychiatric morbidity in OCD patients' children; it was more suitable to use cross-sectional design.

• ***The method of sampling*** and basis of calculation of ***sample size*** were not mentioned. The study included a case and control groups. The control group included 35 diabetic patients yet the number of there children was not mentioned.

- ***The tools used for psychological assessment*** in the study were not referenced or explained.
- ***Statistical tools*** used to analyze the results were not mentioned in the methodology of the study**.**
- ***The results*** were clearly stated and illustrated with tables and graphs that were simple and informative yet some of them were not needed as they were explained in details in the text. The results were also ***discussed*** and compared with other studies.
- ***Limitations of the study and recommendations*** were not mentioned.

26. • ***Utilization of non-psychiatric medical services by a sample of Egyptian patients with panic disorder.*** ***(Abu El-Ela, 2000)***

• ***The title*** is specific with limitation of the results to the sample but the characteristics of the sample chosen were not clear.

• ***The introduction*** is brief, clarifying the magnitude of the problem and the need for the study.

• ***The aim*** of work was clearly stated.

• It is a retrospective study. That is a simple and suitable design for such a study but that ***study design*** depends on past data that need good documentation system to avoid the information bias and faulty information.

• ***The sampling method*** and the way the ***sample size*** was calculated together with the time and place of the study were not mentioned. That hinders the generalization of the results of the study to the population.

• ***The assessment methods and*** tools were named with no details or explanations***. The statistical methods*** used for data analysis were not mentioned

- ***The results*** were simply presented and were illustrated with tables that were simple and informative.
- ***The discussion*** included analysis and explanation of the results as possible with comparison with some other studies. All the studies included in the discussion agreed with the results of the current research.
- ***Limitations*** of the work as mentioned were the small sample size, being retrospective, and the dependence on the information from the patients and their families and the previous charts and notes and available investigations reports.
- ***Recommendations*** were mentioned by the end of the study.

27. • ***A follow up study of a sample of Egyptian OCD patients: illness characteristics and outcome.*** ***(El-Nahas G., 2000)***

• ***The title*** described the type of the study but it did not clarify the study included a comparison between different treatment modalities in OCD. Although limited the results to the studied sample, describing it as Egyptian sample is not accurate.

• ***The introduction*** to the point clarifying the burden of the problem to be studied and its importance.

• ***The aim*** was clear and precise.

• ***Study design:*** it was clarified that the study was designed to be a prospective longitudinal follow-up one. The study included 3 groups of patients; patients assigned for an anti-obsessional (Clomipramine, Fluoxetine, or Fluvoxamine) and behavioral therapy, patients given only an anti-obsessional drug, and patients given an adjustment therapy (Electroconvulsive therapy (ECT), anti-psychotics, buspiron, Clonazepam, or another Serotonin reuptake inhibitor) together with anti-obsessional. They were followed up for 27 months.

It is a suitable design to study the outcome and response to treatment.

- The ***sampling population*** was the OCD patients attending OPC of ASUIP. But the ***sampling method*** and how the ***sample size*** was calculated were not mention. The patients were divided into three unequal groups according to the type of therapy they received.
- ***The psychometric tools*** and methods used for assessment and diagnosis and follow up measures were explained in details with clarification of the way they will be used and referenced.
- ***The statistical tools*** were named with clarification of their use in brief.
- ***The results*** were illustrated with tables and graphs that were few in number but simple and informative, then they were ***discussed*** in comparison with results of other studies. They could not be generalized and as a larger sample and longer period of follow up were suggested for further more informative assessments.
- ***The limitations*** of the study were summarized in the small sample size and the short period of follow up.

- ***Recommendations*** were mentioned by the end of the study.

28. • ***Medical referrals with unexplained physical complaints: psychosocial and dynamic characteristics.*** ***(Haggag et al, 2000)***

• ***The title*** specified both the target population and the points to be studied with generalization.

• ***The introduction*** explained the importance of topic of the study.

• ***The aim*** of the work was clearly stated and it was repetition of the title of the study.

• ***The study design*** is case-control. It is a suitable design for such a study as it helps in understanding associations and etiology of certain behavior or disease. Yet the study design was not mentioned by the.

• ***The sampling method*** and calculation of ***the sample size*** were not clear making it hard to depend on the results to be generalized.

• ***The assessment tools*** used were listed with no explanation of them or their use or how they would be applied. They also were not referenced.

• ***The statistical methods*** used for data analysis were

named.

- ***The results*** were simply presented and illustrated with tables. The tables were informative and self explanatory.
- ***The discussion*** of results included possible explanations of the data collected and comparisons with previous studies.
- ***Limitations of the work*** and ***recommendations*** were not mentioned.

29. • ***Point prevalence rates of obsessive compulsive symptoms and obsessive compulsive disorder in a sample of secondary school students in a rural area in Egypt.*** ***(Hammoda et al, 2000)***

• ***The title*** of the study was stated in an accurate descriptive way, with no generalization.

• ***The introduction*** included a clear definition of the OCD and reviewed the literature to clarify the importance of studying such an illness in the adolescents.

• ***The aim of work*** were clear precise and to the point.

• It was clarified that it was a two stage epidemiological study to detect the point prevalence rates of OCS, OCD; and associated risk factors among the target population. The first stage was a survey covered 1000 randomly selected students and Arabic form of SCL-90 was applied. In the second stage a semi-structured clinical psychiatric interview was carried out for the students considered positive in the first stage. Cross sectional study is the most suitable design for such a work, yet ***the***

study design was not mentioned.

- The ***target population*** was clear and the choice of the area and the schools where the study was conducted was justified, declaring that it was on the basis of feasibility and not randomly so the results of the study were not generalized.
- ***The sample*** consisted of 1000 students those were randomly chosen. The type of the random sample was not specified.
- ***The psychometric tools*** used were all standardized for Egyptian culture and tested for validity and referenced. Yet, as mentioned the research was lacking an international standardized scale as Y-BOCS in order to confirm the clinical diagnoses and to measure the severity of OCD.
- ***The statistical tools*** and software used in the calculation were named.
- ***The results*** were displayed and illustrated with tables that were few and informative.
- The results were ***discussed*** and analyzed in details with correlation with other Egyptian and international

studies.

- The ***pitfalls*** in the study were explained with self criticism that gave weight to the study. The pitfalls were:
  - Although the students inside each school were randomly selected, yet the 4 secondary schools were selected on the basis of feasibility of research and not randomly, so the results could be applied only to the selected schools themselves.
  - The research was lacking a standardized scale such as Y-BOCS, in order to confirm the clinical diagnosis and to monitor the severity of OCD.
  - Household surveys still needed in order to estimate the disorder in adolescents dropouts from schools and adolescents did not go to schools from the start.

These pitfalls were included as future directions for research and other implications and there were no other ***recommendations*** suggested in the study.

30. • ***Quality of life in Egyptian social phobia patients.*** ***(Ibrahim et al, 2000)***

• ***The title*** clarified the point to be studied and the target population of patients but not specific as generalize the results to the whole population of Egyptian social phobia patients.

• ***The introduction*** was brief, with rationalization of choice of social phobia to be studied as regards quality of life.

• ***The aim*** is clearly stated specifying the points to be studied.

• The study is case control which is a suitable design for that study yet the ***study design*** was not mentioned.

• ***The sampling population, method used for sample collection and calculation of sample size*** were not clear; hindering generalization of the results.

• ***The assessment tools*** were explained clarifying their applications and referenced.

• ***The statistical tools*** used for data analysis were mentioned in details.

• ***The results*** were simply presented and illustrated with

tables and graphs that were self explanatory. Yet, the data included in the tables were frequently repeated in the text comments and in the graphs.

- ***The discussion*** included analysis and possible explanation of the results with comparison to other studies.
- ***Recommendation*** for research was mentioned by the end of the study
- ***Limitations*** of the work were not named.

31. • ***Somatization disorder among medical outpatients in Zagazig university hospital.*** ***(Roshdy et al, 2000)***

• ***The title*** is clear and specific with limitation of the study to the outpatients in Zagazig university hospital.

• ***The introduction*** is too short stressed on the definition of somatization disorder and the difficulty of its diagnosis.

• ***The aim*** of the study is precise specifying the topic to be studied and the target population.

• The study is of cross- sectional design that helps in studying the prevalence of a certain variable in the target population at a given time. ***The study design*** was not mentioned.

• ***The place*** and ***time of the study*** and ***the target population*** were specified. The sample was selected according to certain criteria, but it was a non probability sample as it included all the patients presented to the OPC of general medicine over 3 months. ***The sample design*** and ***sample size*** calculation were not clear; what limits the results to the study sample**.**

- ***The assessment methods*** and investigations to be done were specified with description of the psychometric tools and the way they will be used.
- ***The statistical methods*** used in data analysis were named and referenced.
- ***The results*** were presented in several tables which were simple and informative with brief relevant comments that highlighted some information in the tables.
- ***The discussion*** included analysis of the results with the possible explanations with comparison with some previous international studies.
- ***Recommendation*** for clinical practice and better diagnosis were mentioned by the end of the study. ***There*** were no suggestions for research. Also, the study ***limitations*** were not mentioned.

32. • ***Are there hormonal changes in the cerebrospinal fluid of obsessive compulsive disorder patients?*** ***(Saadani et al, 2000)***

• ***The title*** clarified the research question, the target population and specified that the CSF to be tested but with no specification of the sampling population.

• ***The introduction*** is brief and to the point clarifying the importance of measuring the hormonal changes in the CSF of OCD patients.

• ***The aim*** of the study was clearly stated**.**

• ***Study design*** is case-control. It is a simple and practical design to study associations. Yet the study design was not mentioned.

• ***The sample*** was selected from inpatients and out patients with chronic and resistant OCD at Alexandria university hospital. They were compared to psychiatrically free non-emergency surgical patients. The selection of the place of study and the choice of chronic and resistant OCD cases were not justified. Also the choice of non-emergency surgical patients as controls was not rationalized as they might be under the

stress of their surgical illness and that can affect the levels of hormones. Accordingly the generalization of the results of this study is limited.

- ***The sampling method*** and calculation of ***sample size*** were not clear.
- The method of collection of CSF samples and the hormonal survey were explained in details.
- Methods used for statistical data analysis were mentioned in brief.
- Only two tables were used to present ***the results*** of the study. Both tables were self explanatory and informative. The results were also summarized in a brief text presentation stressing on the main results of the study.
- The results were discussed and explained in comparison with several previous studies.
- Studying larger number of patients was recommended to give insight for the results of the study. Otherwise, no further recommendations were suggested. Also, limitations of the study were not clarified.

33. • ***Personality profile in anxiety and depressive***

disorders: a comparative study. ***(Abd El-Mawella et al, 2001)***

- ***The title*** is descriptive for the study design, the disorders to be compared and the point of comparison but with generalization.
- ***The introduction*** was to the point; rationalizing the study.
- ***The aim*** was clearly stated.
- ***Study design*** is a comparative study between group of patients with depressive disorders and patients with anxiety disorders.
- ***The subjects*** were selected according to certain inclusion and exclusion criteria from OPC of Kasr El-Aini hospital. The choice of the place was not justified and the ***method of sampling*** and basis of calculation of ***sample size*** were not clear.
- ***Assessment tools and statistical methods*** used for data analysis were explained and referenced.
- ***The results*** were simply presented and illustrated with tables. The tables were self explanatory but some of them contained data that was repeated in the text

comments.

- In the ***discussion*** the results were analyzed in details and explained with correlation to previous studies.
- ***Recommendations*** for future studies and clinical practice were suggested.
- ***Limitations*** of the work were not mentioned.

34. • ***Pregnancy Related Obsessive Compulsive Disorder (A study in an Egyptian sample).*** ***(Asaad& Esmaill,2001)***

- ***The title*** is stated using the least informative words, and limited the results to the studied sample but it did not clarify the study design or the sampling population.
- ***The introduction*** is brief, to the point and stressed on explaining the rationale of the study.
- ***The aim*** was stated clearly and to the point
- ***The study design***: it is a comparative study as the study compared between pregnant and non-pregnant females. Yet the study design was not mentioned.
- ***The place of study*** and ***sampling population*** were clear. But the basis of calculation of ***sample size*** and ***method of sampling*** were not clarified. That would make it hard to infer the results of the study to the whole population.
- ***The assessment tools*** were explained and referenced and the statistical methods were named clarifying their use.
- ***The results*** were properly described and illustrated

with only two tables. The tables were simple and self explanatory.

- The results were ***discussed*** in details and compared to previous literature.
- ***Recommendations*** for further research and research topic were suggested by the end of the study.
- ***The*** limitations of work were not mentioned.

35. • ***Somatic symptoms in depressive and anxiety disorders.*** ***(Draz et al, 2001)***

• ***The title*** is simple, clearly stated but not specific.

• ***The introduction*** stressed on the importance of somatic symptoms in the differentiation between anxiety and depression; explaining the rationale behind that study.

• ***The aims*** of the work were clearly stated specifying the population of the study.

• ***The study design*** was not mentioned. The study based on comparison between two groups of patients; one for group for depressive disorders and the second for anxiety disorders.

• ***The sample:*** The selection of the subjects and the calculation of the sample size were not justified**.** All the subjects were selected from OPC of Kasr Al-Aini hospital in a random order. There was not obvious frame for the sample what makes it a non probability sample, and the choice of the sample only from OPC of Kasr Al-Aini limits the representation of the whole population of anxiety and depression patients in Egypt.

- ***The psychometric tools*** used in the study were explained in details and referenced.
- ***The statistical methods*** used for data analysis were named with clarification of their use.
- ***The results*** were presented and illustrated using tables and graphs. Most of the table contained non significant data that was enough to be presented in the text. Also, the graphs were repetition of the tables.
- The results were ***discussed*** in details and explained in comparison to previous literature.
- ***Recommendations*** were suggested.
- ***Limitations*** of the work were not mentioned.

36. • ***Socio-demographic, clinical and psychometric profile of a sample of Egyptian patients with social phobia.*** ***(El Raey et al,2001)***

• ***The title*** clarified the target population, and point to be studied with limitation of the results to the sample included but using the term of Egyptian sample was not accurate.

• ***The introduction*** was brief, included definition of social phobia and its etiology and associated disorders.

• ***The aim*** is clearly stated specifying the points to be studied.

• ***Study hypothesis*** is complex, vague as the variables to be tested were not specified.

• The study is case-control as the social phobia patients were compared to normal individuals. That is a suitable design for that study yet the ***study design*** was not mentioned.

• ***The sampling population, method used for sample collection and calculation of sample size*** were not clear; hindering generalization of the results.

• ***The assessment tools*** were named and referenced with

no explanation of them or how the were applied.

- ***The statistical tools*** used for data analysis were not mentioned.
- ***The results*** were simply presented and illustrated with tables that were self explanatory.
- ***The discussion*** included analysis and possible explanation of the results with comparison to previous studies.
- Several ***recommendations*** were mentioned by the end of the study
- ***Limitations*** of the work were not named.

37. • ***Gender related psychobiological differences in obsessive compulsive disorder patients.*** ***(Sadek et al., 2001)***

• ***The title*** briefly described the study with generalization that was not justified in the study.

• ***The introduction*** was precise showing some differences between male and female OCD patients and the importance of such studies.

• ***The aim*** was stated clearly, detailed.

• ***The study design*** was a comparative survey which is a suitable design for the aim of the study.

• ***The Place and time of the study*** were declared but without rationalization of the choice of Kasr El-Aini hospital to be the place of the study.

• ***The sample*** was collected through systematic random sampling, which is a simple way decreasing the bias. But as the study was designed to be a comparative study so stratification was needed to ensure suitable representation of both genders in the sample.

• ***The psychometric tools*** used were all listed with there references, followed be detailed explanation. All are

valid tools.

- ***The results*** were illustrated using tables and graphs. They were informative but some of the tables contained unimportant data that complicated the tables. For example in table 10 (that was entitled comparison between male and female patients regarding symptoms on Hamilton- Depression scale) the symptoms for both groups were demonstrated in number and percentages in the case of presence and absence of each symptom. It would be more simple and informative to demonstrate the positive results for both groups to compare the symptoms. Moreover, the comment written after several table was just repetition of the content of the table. As regards the graphs they were simple but they repeated the information in the tables.
- In ***the discussion*** the results were analyzed in details and compared them to past literature.
- ***The recommendations*** were listed by the end of the study in details and most of them were related to research.
- ***The limitations*** and pitfalls of the work were

mentioned and that gave weight to the study, and they were:

- The study could not cover the whole spectrum of the field of gender difference in OCD.
- Absence of enough published data to warrant drawing of firm conclusion as regards the existence of sexual dimorphism of OCD.
- Some of the information gathered in the study, being retrospective could lead to a sort of confusion or misleading; besides some information could not be obtained due to ignorance or absence of the informants.
- Assessment of peripheral serotonin and the relationship between the peripheral and central serotonin was not explicitly defined.

38. • ***Cognitive Styles in Obsessive Compulsive Disorder (A Study in an Egyptian Sample).*** ***(Asaad et al., 2002)***

• ***The title*** limited the results to the studied sample but it did not clarify the study design or the sampling population.

• ***The introduction*** is brief, to the point and stressed on explaining the rationale of the study.

• ***The aim*** of work was clearly and precisely mentioned.

• This study is a case-control study which is a suitable design for this study, but the ***study design*** was not mentioned.

• Both sample and normal control groups were selected according to certain criteria, yet the ***sample size*** and ***sampling design*** were not clear. Also the ***sampling population*** was not identified. That hinders generalization of the results of the study.

• ***The assessment tools*** were explained and referenced and the statistical methods were named clarifying their use.

- ***The results*** were presented in tables with few comments. The tables were simple and informative with clarification of unavailable data, yet some titles were not clearly describing the table.
- ***The discussion*** of results overviewed the general principles deduced from the results with explanation and comparison of the results with previous research.
- ***The limitations of work*** and ***recommendations*** were not mentioned.

39. • ***Obsessive compulsive symptoms in schizophrenia patients: a neuro-psychological study.*** ***(Eid et al., 2002)***

• ***The title*** is simple, clearly stated but not specific.

• ***The introduction*** was to the point stressing on the relation between schizophrenia and OC symptoms.

• ***The aim of work*** was to the point, using simple, direct and few words.

• ***The study design*** was not mentioned. As the work is concerned with studying an association, case-control or cohort designs would have been suitable choices.

• ***The sampling population*** was clarified as the study was conducted on patients referred from Kasr El-Aini and other private mental health hospitals in greater Cairo.

• ***The sample*** was selected according to several inclusion and exclusion criteria from referrals of patients. That makes it a non probability sample (as there is no known probability of selection for each patient of the whole target population), with difficulty in

estimating the sampling errors. Therefore, validity of inference to the whole population can not be ascertained. Also, it was not mentioned on what bases its size was calculated.

- ***The tools*** used were all referenced and explained in details with clarification of the statistical tools.
- ***The results*** were analyzed and illustrated with tables that were simple. Then the results were discussed and compared to previous Egyptian and international previous results.
- ***Recommendations*** were mainly related to research. And the ***limitations*** of work were not mentioned.

40. • ***Dissociative Disorders and Childhood abuse: An Out-Patient study in Egypt.*** ***(Haggag, 2002)***

• ***The title*** clarified the research question in simple, specific words. The title showed that the study will be done on out patients in Egypt. That was unaccepted generalization as the study was done only in Ismailia.

• ***The introduction*** clarified the history of the diagnosis of dissociative disorders then the size of the problem in Egypt and the relation between dissociative disorders and childhood abuse. The first part of the introduction contained detailed unneeded information for such a study.

• The study had two ***aims;*** the first was to systematically study a group of an outpatient population presented with dissociative experiences; without clarifying what was meant by systematic study. And the second was to test the hypothesis of the study. The importance of testing such a hypothesis was not clear.

• ***The study hypothesis*** is a simple, specific, one tailed hypothesis that was stated as one of the aims of the

study.

- ***The study design:*** case-control study and it is a suitable design to study associations. The study design was not mentioned.
- ***The study sample included*** consecutive patients presented to out-patient psychiatric clinic of Suez Canal University Hospital with chief complaint of a dissociative experience, in the period from February to October 2001. While the control group included apparently normal subjects. ***The time, place of the study*** and ***target population*** were quite clear but that is a non probability ***sampling method*** that makes generalization not possible as representation of the sample to the general population can not be assumed.
- The base of calculation of ***sample size*** was not clear.
- ***The psychometric tools*** and ***methods of statistical analysis*** were mentioned, explained and referenced.
- ***The results*** were properly presented and illustrated with tables that were simple, informative and self explanatory with brief comments. The results then were analyzed and compared with previous studies.

- Clinical suggestions were mentioned by the end of the study. There were no ***recommendations*** suggested. ***Limitations*** of the work were not mentioned either.

41. • ***Obsessive Manifestations and Symptoms in Children Attending Psychiatric Clinics: An Egyptian Study.*** ***(Rakhawy et al, 2002)***

• ***The title*** is simple, yet not accurately descriptive of the study.

• ***The introduction*** is brief stressing on the prevalence of Obsessive manifestations in the population and the difference between adults and children having these symptoms. But, there was obvious rationale for the study.

• ***The aim*** of work was clearly stated. That aim is more generalized than what was mentioned in the title, as the study aimed at evaluation of obsessive and compulsive manifestations and symptoms in children visiting and in those non-visiting psychiatric clinics.

• ***Study design*** was comparative between children attending psychiatric clinics and school children with no psychiatric disorders. That study design is suitable for the aim of the study. The study design was not mentioned.

• ***Sampling method*** and calculation of ***the sample*** size

were not clarified what limits the results to the study sample.

- ***Tools*** used for assessment were explained in brief.
- ***Statistical tests*** used for data analysis were mentioned with explanation of their use.
- ***Results*** were simply presented and illustrated with tables. the tables were self-explanatory and informative.
- ***The discussion*** of results was detailed with possible explanation and comparison with literature.
- ***No recommendations or limitations*** of work were mentioned.

42. • ***The prevalence of obsessive compulsive phenomena in a sample of substance abuse patients: an Egyptian study.*** ***(El-Kholy, 2003)***

• ***The title*** is simply describing the study but without specification of the characteristics of the studied sample.

• ***The introduction*** was brief explaining the nature of addictive behavior as regards its relation to compulsions and rationalizing the need for such a study.

• ***The aim*** was clearly stated with simple and specific research question.

• It is a comparative study between substance abuse patients and normal subjects; it is simple, cheap and easy applicable design to study associations. ***The study design*** was not clearly mentioned.

• ***The time, place and sampling population*** were specified. The choice of the OPC of ASUIP was not justified.

• ***The sample*** was selected according to certain inclusion and exclusion criteria by non probability sampling. The ***sample size*** determination was not clarified.

- ***The assessment methods and statistical tools*** used in the study were named and referenced.
- ***The results*** were presented in details and illustrated with tables. The tables were simple, informative and self-explanatory but some of them contained negative data that was enough to be mentioned in the text.
- ***The discussion*** of results was detailed with explanation of the data obtained in correlation with other related studies.
- ***Recommendations and limitations*** of the work were not mentioned.

43. • ***Repetitive Trans-cranial magnetic stimulation in obsessive compulsive disorder.*** ***(El-Nahas G.,2003)***

• ***The title*** is simple with the least possible wards, but it is not specific.

• ***The introduction*** was simple and summarized focusing on defining the topic to be studied and its importance.

• ***The aim*** of the study was clearly and precisely mentioned.

• ***The study design*** was not clarified. For the researches on effect of a treatment modality randomized controlled clinical trial is most reliable design, whereas it is not the design of the current study.

• ***The steps*** of the study and measures of assessment and follow up were properly explained.

• ***The sampling population*** included referrals OCD patients from OPC of ASUIP and private clinics.

• ***The sample*** was selected according to certain inclusion and exclusion criteria mentioned in the study. Yet there was no clear sampling method or proper randomization. Also, it was not obvious how the sample

size was calculated; beside it was relatively small (15 patients) what makes the inference of the results not possible.

- ***The tools*** used in the study were valid, described in details and referenced. The statistical tools used were not mentioned.
- ***The results*** were analyzed, and illustrated with few, simple and informative graphs. Then they were discussed and compared to previous studies.
- The only ***recommendation*** mentioned was to study the rTMS more before it is fully integrated in psychiatric diagnosis and management**.**
- ***Limitations*** of the work were not mentioned.

44. • ***Social Phobia in Collage Students in Egypt: frequency, correlates and determinants.*** ***(Haggag & El Sheikh, 2003)***

• ***The title*** described the topics to be studied but it generalized the results of the study to the whole population of collage students in Egypt.

• ***The introduction*** stressed on the magnitude of social phobia and why it is studied.

• ***The aim*** of the study was clearly stated.

• ***Study design:*** The study is a cross sectional study held on the students of second grade in faculty of education in Port Said. The study design was not mentioned.

• ***The sample:*** The choice of the sample was not justified, as it was not clear why exactly these groups were chosen. That method of sampling limits the results to the study sample and makes the generalization to the whole target population as mentioned in the title not valid. Moreover, it was mentioned that there were dropouts but it was not clear why they were dropped.

• ***The assessment tools and statistical methods*** used for data collection and analysis were described in details

and referenced.

- ***The results*** were presented in details and illustrated with tables that were self explanatory, yet some of them contained negative data that were enough to be mentioned in the text. Also, several data were presented both in the text and in tables leading to unneeded repetition.
- The results were discussed in details and analyzed with comparison to previous studies.
- The study ***limitations*** as mentioned were; the data presented in the study come from self-ratings of subjects not a diagnostic interview. At the same time, the sample studied was not a representative community sample. For those reasons the findings were not considered a true reflection of the frequency of social phobia in the community.
- ***Recommendations*** were mentioned by the end of the study.

45. • ***Characteristics of Obsessive Compulsive Disorder Detected through Rural Population Screening in Comparison with A Sample of Outpatients: an Egyptian Study.*** ***(Haggag et al, 2003)***

• ***The title*** is descriptive of the study but the sample included in the study was not specified. So the use of the phrase "an Egyptian study" is unjustified generalization.

• ***The introduction*** is to the point rationalizing the conduction of the study.

• ***The aim*** was clearly stated with specification of the point to be covered by the study.

• ***The study design*** as mentioned is cross-sectional population-based study. That is a suitable design to reach the aim of the study.

• ***The place*** of the study was specified but as it was held in Ismailia the results should only be limited to that governorate as the sample included does not represent people in other areas with different characteristics. Also the choice of the village where the study was conducted was not justified.

• ***The sample was selected by*** cluster sampling as the

village consisted of 58 hamlets; of them 6 were chosen by simple random sampling. That method of sampling saves time and makes it easier to collect data.

- ***The sample size*** calculation was justified in details.
- ***The tools*** used for assessment were described in details and referenced.
- ***Statistical methods*** were mentioned clarifying their use.
- ***The results*** were presented in details with illustration with table. The tables were informative and self-explanatory.
- The results were ***discussed*** in details and compared to previous studies.
- The ***study limitation*** was clarified as the obtained frequencies of clinical and subclinical OCD is limited in this study to a rural population so it can not be generalized to represent frequency of OCD in the Egyptian community at large.
- No ***recommendations*** were mentioned.

46. • ***Epidemiology of anxiety disorders in rural Minya; Life time prevalence, comorbidity and quality of life.*** ***(Mahfouz et al, 2003)***

• ***The title*** is clear specifying the target population and the topics to be studied.

• ***The introduction*** is simple, brief, emphasizing the importance of anxiety disorder and rationalizing the study.

• ***The aims*** of the study were clear and specific.

• It is a cross-sectional study. That ***study design*** is simple and suitable to study the prevalence of a certain problem. The study design was not mentioned.

• ***The target population and sampling method*** were clear. The sample was a stratified random sample with proportionate sample size to the different areas of the village included. That is the most suitable sample design to ensure representation of certain subcategories of the population in the sample. But the choice of the village itself was not justified. Also, the way the sample size was calculated was not clear.

• ***A pilot study was done*** to detect any difficulties and to

deal with them before starting the main research and to get familiar with working in community setting. And it revealed several data that helped in classification of the symptoms whether reaching the diagnosis of particular disorder or sub-syndromal form of the disorder.

- ***The assessment tools*** were described in details and referenced, while the statistical methods used for data analysis were not mentioned.
- ***The results*** were clearly presented and illustrated with tables. The tables were simple, self-explanatory with brief text comments that sometimes included repeated data.
- ***The discussion*** contained analysis and possible explanation of the results with comparison to several international studies.
- ***Recommendations*** for clinical practice or research and ***limitations*** of the work were not mentioned.

47. • ***Risk of Suicide in Panic Disorder.*** ***(Mansour et al, 2003)***

• ***The title*** is simple but not specific.

• ***The introduction*** is brief focusing on the importance of the topic of the study.

• ***The aim*** of the study was not mentioned but at the beginning of the abstract it was stated that the study attempted to find the risk of suicidal ideation and suicide attempts associated with panic disorder.

• ***The study design*** is a cross-sectional study which is a suitable design to study the distribution of a certain problem in a population at a given time. It would be better to use a case-control or cohort study to find and confirm the association between suicide and panic disorder. The study design was not mentioned.

• ***The sampling method*** and ***sample size*** calculation were not clarified what makes the results not inferable on general population.

• ***Psychometric tools*** used for assessment and diagnosis were listed showing the way of application yet they were not referenced.

- ***Statistical methods*** used for data analysis were not mentioned.
- ***Results*** were presented and illustrated simply using tables with brief comments that sometimes repeated data mentioned in the tables.
- ***Discussion***: The results were discussed**,** analyzed in details and compared to other studies.
- The greatest ***limitation of the study*** as mentioned was its reliance on Beck scale for suicidal ideation which is an instrument that is self-administered by paper pencil or on computer. A clinical interview approach might be needed to determine what exactly patients mean when they report that they "thought" about committing suicide. It may be that the suicidal ideation reported by these patients is very transient and that most individuals rule out this option very quickly or easily. Another limitation was that few of the patients also had current major depression, and it was not clear what effect this comorbidity would have. Finally, some of the subjects might have had a past history of major depression that was not reported because they did not seek treatment for

it.

Recommendations for research or clinical practice were not mentioned.

48. • ***Clinical study on a sample of Egyptian panic patients attending on psychiatry, chest and cardiac out patient on El-Hoseen university hospital.*** ***(El-Mahdy et al, 2004)***

- ***The study was written in Arabic.***
- The Arabic ***title*** was specific and identifying the study population with no generalization. Unfortunately, the English translation contained several mistakes.
- ***The introduction*** was brief, to the point.
- ***The aims*** of the study were stated in a precise, simple way.
- ***The study design*** is cross-sectional. It is a suitable design to study the prevalence of a certain disease. The study design was not mentioned.
- The sample was collected by non-probability sampling method according to certain inclusion and exclusion criteria. The ***place, time of the study and the sampling population*** were clearly specified but the ***sampling method*** and the calculation of the ***sample size*** were not mentioned. That makes it hard to generalize the results

of the study.

- ***The assessment tools and procedures*** were explained and described in details and referenced.
- ***Statistical methods*** used in data analysis were not mentioned.
- ***The results*** were presented and illustrated with tables and graphs. The tables were simple and self explanatory with brief comments. The graphs were repetition of the tables and were not entitled.
- ***The discussion*** of the results was detailed with comparison to other studies.
- ***Recommendations*** for better diagnosis and research were mentioned by the end of the study.
- ***Limitations*** of the work were not mentioned.

49. • ***Assessment of the quality of life in a sample of Egyptian obsessive compulsive disorder patients.*** ***(Nasreldin et al., 2004)***

• ***The title*** described the study and the target population with limitation of the results to the studied sample but it was better to clarify that the whole sample was selected from Kasr El-Aini. .

• ***The introduction*** and ***the aim*** were to the point.

• Cross sectional design was used, but ***the study design*** was not mentioned

• The ***sampling population*** and ***the place*** where the study was conducted were clarified with no rationalization.

• ***The sample design:*** systematic random sampling method was used and set several inclusion and exclusion criteria were set for the sample. The bases on which ***the sample size*** was calculated were not clear.

• ***Assessment and statistical tool*** were properly explained and referenced.

• ***The results*** of the study were properly mentioned and

illustrated with tables that were sometimes complicated including too much data, as in table 8 that compared between Y-BOCS symptom check list and each item of PCASEE. The two axes of the table were not named.

- ***In the discussion*** the results were explained and compared with other Egyptian and international studies.
- Further ***recommendations*** and ***limitations*** of the work were not mentioned.

50. • ***Care giver burden among schizophrenic and obsessive compulsive disorder families: A comparative study.*** ***(Abou-Zeid et al, 2005)***

• ***The title*** stated in a descriptive way clarifying the aim, type of the study but with generalization of the results that was not justified in the study.

• ***The introduction*** was brief, to the point and clarified the need for such a research.

• ***The aim*** was clearly stated with justification of the choice of schizophrenic as a control group although it was better to mention that explanation in the introduction or to be delayed to the material and methods.

• ***The study was designed*** to be a comparative cross-sectional study. That was a suitable design to fulfill the aim.

• ***Time, place and sampling population*** of the study were clarified.

• ***The sample:*** A clear definition of the care giver was stated according to which the sample was included in

the study. The groups included key relatives of 30 OCD patients and 41 schizophrenics. The method of sampling and the bases of calculation of sample size of both OCD patients and schizophrenics groups were not clear.

- ***The psychometric tool*** used for assessment was appropriately explained and referenced. Also, the statistical tools were named clarifying there importance.
- ***The results*** were illustrated in few informative tables yet abbreviations were used in the tables without mentioning what they stand for.
- *In* ***the discussion*** the results were analyzed and compared to other studies with caution in generalization.
- ***Recommendations*** for further research and ***study limitations*** were mentioned at the end of the study giving more weight and reliability to the results. The study limitations were:
  - The study had relied on hospital population than the community sample.
  - The study was limited by small sample size.
  - A relationship between nature and severity of OCD symptoms and degree of burden of care was

not mentioned.

51. • ***Prevalence of anxiety among medical students in different grades: An Egyptian study.*** ***(Bakr& El-Sayed, 2005)***

• ***The title*** is simple but it generalized the results to the medical students in Egypt although the study included only Ain-Shams University.

• ***The introduction*** was brief, stressing on the magnitude of anxiety in medical students.

• ***The objectives*** of the study were clearly stated.

• ***The study design*** was not mentioned. Cross-sectional design is a suitable one to study the prevalence of a problem in a certain population at a given time.

• ***The time and place of the study and sampling population*** were clear but the choice of Ain Shams University was not rationalized. It was mentioned that the students included in the study were randomly chosen from different grades. The selection of the sections of practical round included was not rationalized and the total number of students in each grade was not clear. That makes it non representative sample for the whole population of the Egyptian medical students. The most

suitable method of sampling for such a study would by multistage random sampling.

- The estimation of the ***sample size*** also was not clarified.
- ***Assessment tools and statistical methods*** used were briefly mentioned without referencing.
- ***The results*** were simply presented and were illustrated with tables. The tables were informative with brief text introduction that highlighted some data.
- ***The discussion*** included explanation and analysis of data in correlation to other related studies.
- ***Clinical recommendations depending on literature were suggested by the end of the study.***
- ***Recommendations*** and study ***limitations*** were not mentioned.

52. • ***Prevalence of body dysmorphic disorder in an Egyptian sample.*** ***(Guemei et al, 2005)***

• ***The title*** clarified the purpose of the study and limited the results to the studied sample but the use of the term Egyptian was not accurately describing the sample.

• ***The introduction*** is brief, to the point, explaining the magnitude of the problem and clarifying the need for such a study in Egypt, as it was the first study to detect the prevalence of BDD in Egypt.

• ***The aims of the study*** were stated precisely with specification of the point to be studied.

• ***The study design*** was chosen to be cross sectional; which is a suitable design to study the prevalence of a certain problem.

• ***The sampling method:*** The sample was collected using cluster random sampling as mentioned in the study. In that method of sampling the target population are originally present in clusters (groups) that are quite similar regarding socio-demographic characteristics and factors related to the problem and each cluster contain various categories of age, gender, occupation, social

class, education, etc. Then the sample frame of the clusters should be prepared and a simple random sample of the clusters would be selected. The assumption of representation of such a sample is based on:

- The similarity of or the homogeneity among all clusters
- The heterogeneity within each cluster.

In the current study the frame of clusters and the way the clusters were chosen were not clear. The clusters chosen were ASUIP, faculty of nursing Ain- Shams university, faculty of art (psychology department), Cairo University and two nursing school at El-Abbasia mental hospitals. All are heterogeneous clusters and non of them contain various categories representing the whole population (Egypt). That makes it unrepresentative sample.

- ***The sample size*** calculation was not justified.
- The number of dropouts and the explanation of that loss of subject were clarified in details.
- ***A pilot study*** was conducted to detect and difficulties in the applications of the tools and to assess the time needed for answering the questionnaires and lastly to

determine the way of application of the assessment tools. The results of the pilot helped in overcoming some difficulties in the application of the study.

- ***The assessment tools*** were described in details with explanation of the way of their application and referencing.
- ***The statistical methods*** used for data analysis were mentioned with explanation of their use.
- ***The results*** were presented in tables that were informative and simple.
- ***The discussion*** contained brief introduction depending on literature that introduction would better contain an overview of the general principles that were deduced from the results. Later a summary of methodology was included then the results were analyzed in details with possible explanation and comparison with previous studies.
- Educational, clinical, research and social ***recommendations*** were mentioned in details by the end of the study.
- ***Limitations*** of the work were not mentioned.

53. • ***Psychiatric profile of chronic pain (Egyptian sample).*** ***(Moussa et al, 2005)***

• ***The title*** is simple but not specific.

• ***The introduction*** is brief, explaining the magnitude of the problem and justifying the choice of that topic to be studied.

• ***The aim*** was clearly stated.

• ***The study designed*** as a comparative study between patients with psychogenic low back pain and those with organic cause for the pain.

• The sample was selected according to certain inclusion and exclusion criteria. ***The time and place*** of the study were clarified but the ***sampling method*** and way of calculation of ***sample size*** were not clear.

• ***The assessment tools*** used in the study were described in details and referenced.

• ***The statistical*** methods used for data analysis were mentioned.

• ***The results*** were presented and illustrated using tables that were simple, self explanatory with brief comments

that clarified the tabulated data in brief.

- ***The discussion*** included detailed analysis and explanation of the results with comparison with previous studies.
- ***Clinical recommendations*** were mentioned by the end of the study.
- ***Study limitations and recommendations*** were not mentioned.

54. • ***Social phobia in secondary school and university students: an Egyptian study.****(Ragheb et al,2005)*

• ***The title*** is descriptive of the study but with generalization.

• ***The introduction*** is stressing on the burden of social phobia and justifying the choice of the study topic.

• ***The study hypothesis*** is simple, specific, one-tailed alternative type. That makes it easily tested hypothesis.

• ***The aims*** of the work were precise, clearly stated specifying certain questions to be answered through the study.

• The study is a cross sectional study. The ***study design*** was not mentioned.

• ***The sampling method:*** The study included two groups; one included secondary school students, and the second included university students. The sample was selected using multi-stage random sampling technique. That sampling method requires less time, effort and money than the corresponding simple random sample. Yet it increases the sampling error and bias and a larger

sample size is required.

- The whole sample was selected from Cairo, the selection of Cairo to be the site of the study And the selection of Ain-Shams University were not justified. That limits the chances of generalization of results to secondary schools students outside Cairo, and university students other than Ain-Shams students.
- The ***sample size*** calculation was not clear. The number of the dropouts was mentioned but with no explanation of the cause.
- ***The assessment tools*** used were explained in details and referenced with specification of the tools that needed translation and description of the steps and methodology used for the translation.
- ***A pilot study*** was done to obtain feedback from the subjects and determine cut-off score for one of the tools (social phobia inventory). The results of the pilot study were presented briefly and they were used to make the final modification in the translations of the tools.
- ***The statistical methods*** used to analyze the collected data were listed with explanation of their use.

- ***The results*** were simply presented and illustrated with tables that were informative and detailed.
- The results were ***discussed*** and analyzed with possible explanations of them and were compared with previous Egyptian and international studies.
- ***Limitations*** of the work were mentioned giving more weight to the study and they were;
  - The presence of significant difference in gender distribution between school and university groups which limited the use of some data.
  - Co-morbid psychiatric and substance use disorders were not checked which might have an impact on the degree of disability and on the quality of life reported.
  - The study was conducted in an urban setting which would limit its generalization to rural ones.
  - The high rate of school dropouts and considerable number of adolescents not joining secondary school makes the results not as representative as they would be if the study was house-hold.
  - The tools used in the study were designed for different culture; which might have limited the

assessment of other possible social situations or physical symptoms more prevalent in the Egyptian culture.

- The help seeking behavior by social phobia subjects was not commented upon in the results section. That was because non of them sought any kind of help.

- ***Recommendations*** for research and several clinical recommendations were mentioned by the end of the study.

55. • ***Prevalence of Obsessive Compulsive Disorder among female secondary school students in Cairo.*** **(Soltan et al., 2005)**

• ***The title*** was clearly and simply stated.

• ***The introduction and the aim*** of the study were clear giving an explanation of why the study was carried out.

• ***Study hypothesis*** was complex multi alternative hypothesis, which makes it difficult to be tested.

• ***Study design:*** Cross sectional design was used, yet that was not mentioned.

• ***A pilot study*** was done and helped in the assessment of the way LOI-CV was used later.

• ***Place of the study:*** three areas representing the urban, semi-urban and rural areas in Cairo were chosen. But it was not mentioned on what bases they were classified or how these areas were chosen.

• ***Sample design:*** the design or the method of sampling was not clear. That would make it hard to simply infer the results of the study to the whole population.

• ***Sample size:*** it was mentioned that the sample size

should not be less than 500 students yet the equation used and the way it was calculated were not clear.

- ***The tools:*** the neuro-psychiatric evaluation tools used in this study are valid and were properly described and referenced. The details of the statistical methods used in the study were described.
- ***The results:*** the results were properly stated and illustrated with tables which were informative. The results were discussed in details, rationalized and compared to other previous local and international studies. This gives more weight to the results.
- Several ***recommendations*** for further research and early diagnosis of OCD were listed by the end of the study.
- The study met several ***difficulties and limitations*** which were as follows as mentioned.
    - Some students were not reliable in answering the inventory so they were excluded.
    - Small size of the sample.
    - OCD severity was not assessed.

    When the research was started in the rural areas,

only one general secondary school was found and there were no private schools. So, two shifts of that school were taken.

56. • ***Impact of personality profile on patients with obsessive compulsive disorder in an Egyptian sample.*** ***(Kamel et al, 2006)***

• ***The title*** is not specific as the characteristics of the studied population and the study design were not clear.

• ***The introduction*** stressed on the effect of personality at all levels of the clinical practice of psychiatry and the rational of choosing OCD patients as the group of study; showing the importance of the study.

• ***The aim of*** the study was stated in details of what exactly would be researched through the study.

• ***The hypothesis*** was complex, one tailed, specific as regards the subjects, variables and the expected results.

• ***The study design***: it was clearly mentioned that it was a comparative study. Cross sectional design is a simple design suitable for studying associations.

• ***The period of the study, the place and the sampling population*** were clarified in details, but without justification of the choice of the places of the studies. It was mentioned that the selection of the places of the study aimed at including several social classes but the

parameters by which the social class in the chosen hospital was assessed were not clear.

- ***A pilot study*** was conducted prior to the study proper in order to fulfill specific objectives that were; determination of the sample size, assess reliability of the diagnosis and ascertainment procedures, and lastly; to test the feasibility regarding time of administration and linguistic simplicity of the tools. The objectives were satisfied by the end of the pilot study what helped in the execution of the study proper.
- ***The sample*** was selected according to specific inclusion and exclusion criteria by convenient sampling, which is a type of non-probability sampling. Generalization of the results form this study is not possible as representativeness of a sample of that type can not be assumed. ***The sample size*** was calculated according to a pilot study that helped in determination of the sample size. The patients whom were excluded or dropped out were mentioned in details with convenient explanation of the causes. That guarantees the honesty of the results and increases its reliability.

- ***The psychometric tools*** used were tested for reliability, simplicity, referenced and the reason for their use was justified, with clarification of the methods used for statistical analysis.
- ***The results*** were mentioned in details with proper illustration with few, simple and informative tables, and were discussed comparing them with previous studies. The results of the study were not generalized.
- ***Recommendations*** and ***Limitations of the study*** were mentioned by its end. The limitations as mentioned were:
  - The results could not be easily generalized to individuals with OCD in the community, as the OCD subjects in the study were mostly recruited from the psychiatric OPC
  - The fact that OCD in known to be heterogeneous disorder with several subtypes. Putting into consideration the relatively small sample of the study, this may limit the generalization of the findings. So, the results could be only regarded as suggestive.

- No follow-up data have been presented
- Personality features might not be accurately elicited; in part because their assessment might have been influenced by their current axis I symptoms. Moreover, Informants were not available for many cases to be questioned in order to get more accurate personality profile.

57. • ***Cognitive styles in Obsessive compulsive disorder.*** ***(Aly et al, 2007)***

• ***The title*** was clearly stated but not specific.

• ***The introduction*** was brief, to the point with clarification of the magnitude of the problem in the Egyptian society; justifying the need for such a study.

• ***The aim*** of the study was clearly and precisely mentioned.

• ***Study design*** as mentioned by the researches was an out patient comparative survey of OCD patients. That design is a suitable, simple design that helps in studying associations.

• ***The places*** chosen for the study were mentioned with no rationalization of the choice. The study was conducted in OPC of ASUIP, Kasr El-Aini and students' Hospital of Cairo University. They are not representative for the whole population of OCD patients.

• ***The method of sampling*** was mentioned to be random sample; with no clarification of the type of random sample used, that makes it a haphazard sample with

decreased chances of generalization of the results. The bases of calculation of the ***sample size*** also were not clear.

- ***The psychometric tools*** used for assessment were explained but with out proper referencing; for example the Arabic version of dysfunctional attitude scale was used and it was mentioned that it was prepared by Abaza, 1998 yet that name was not present the references. That makes the validity and reliability of such a scale can not be judged, so its results can not be reliable. It was clarified that there was difficulty in applying the cognitive style test as it requires average educational level not less than secondary school education and the test was designed to suit western rather than Egyptian culture. That difficulty was an obstacle in continuing the test.
- ***Statistical methods*** used for data analysis were mentioned in brief.
- ***The results*** were presented in simple, informative tables with brief text comments. Several tables contained non-significant of negative data that was

enough to be mentioned in the text.

- The results were then analyzed and discussed in details with correlation to previous studies.
- ***Recommendations*** for clinical practice and research were mentioned by the end of the study.
- Apart from clarifying the difficulty met in applying the cognitive style test and was mentioned in the methodology and discussion; no other ***limitations*** of the study were mentioned. And it was realized that the results of the study were generalized.

58. • ***A comparative study of dynamic dimensions in Egyptian patients with anxiety and depressive disorders.*** ***(Bayomy et al, 2007)***

• ***The title*** describes the contents of the study simply specifying the type of study and the targeted patients but generalizing it to the whole Egyptian population of patients.

• ***The introduction*** is too brief explaining the use of psychodynamic approach in the study, but the field of study itself was not justified.

• ***The aim*** of the study was clearly stated with short note about the debate about the relationship between anxiety and depression.

• ***The hypothesis*** is simple, specific and one tailed alternative what makes it easy to be tested.

• ***The study design:*** it is a case- control (comparative) study including three groups of subjects; one for depressed patients, the second for anxiety patients and the third included controls. That study design is a suitable one to fulfill the goal of the study.

- The sample was selected according to certain inclusion and exclusion criteria, but the ***method of sampling*** and the way the ***sample size*** was calculated were not clear. The whole sample was selected from Kasr El-Aini hospital. That makes it non representative sample for the whole population of depression and anxiety patients in Egypt.
- ***The psychometric tools*** used and procedures followed in the study were described in details and referenced.
- ***The statistical tools*** used for data analysis were listed and referenced.
- ***The results*** were simply presented and illustrated with tables. The tables were informative and self explanatory.
- In the beginning of ***the discussion*** the aims of the study were listed. There were three more aims to be fulfilled over the aim stated in the introduction of the study. These secondary aims used the collateral data collected in the study. That increases the value of the research. That was followed by discussion of the psychometric tools used in the study then the results were analyzed in details and explained as possible with

comparison with the previous literature.

- ***Limitations of the work mentioned were:***
  - The relatively small number of the sample.
  - In subgroup comparison, all anxiety disorders like social phobia and GAD could not be included as the number of patients was not fit for the statistics.
- Several ***recommendations*** were suggested by the end of the study.

59. *Psychiatric adjustment in children and adolescents with chronic fatigue syndrome.* *(Zyada et al, 2007)*

- ***The title*** did not clearly describe the study content.
- ***The introduction*** was clear, to the point rationalizing the study.
- ***The aims*** of work were clearly stated specifying the points to be studied.
- ***The study design:*** It was mentioned that the study was designed to be comparative between children and adolescents suffering from chronic fatigue syndrome and organic patients and healthy children. Moreover, the study had an interventional part using cognitive behavioral therapy. That case- control study is a suitable design to fulfill the aims of the study.
- The sample was selected according to certain inclusion and exclusion criteria. ***The sampling method*** and basis of calculation ***of sample size*** were not mentioned.
- ***The assessment tools*** were described in details with explanation of the way of their application and referencing.

- The group cognitive behavioral psychotherapy applied on a group of the patients was described in details clarifying the difficulties and limitations in it. Also, a follow up study was conducted after one month, three months and after one year of psychotherapy to assess its results.
- The ***statistical analytic tools*** were briefly mentioned.
- ***The results*** were presented and illustrated with tables that were informative. Some of the tables contained data that were repeated in the text.
- The results were ***discussed*** in details, introducing the possible explanations and were compared to previous studies.
- The ***limitations*** of the whole study were not mentioned.
- The study inspired several clinical and research ***recommendations*** that were mentioned by the end of the study.

THE DISCUSSION

The term neurosis encompasses a broad range of disorders of various signs and symptoms ***(Sadock and Sadock, 2004)***. It worth to be mentioned that neurotic disorders are thought to be caused by an unconscious conflict that generates anxiety; symptoms develop when an individual's defenses can not cope adequately with this anxiety. ***(Toy and Klamen, 2007)***

The term neurotic disorders is still retained in the ICD-10 in the rubric "neurotic, stress related and somatoform disorders", while DSM-IV has effectively carved up the neuroses into: anxiety disorders, somatoform disorders, dissociative disorders and adjustment disorders ***(Semple et al., 2005***).

This work was done to make use of the Egyptian studies on neurotic disorders in order to identify the gaps in Egyptian researches to overcome these defects in the future. The ICD-10 classification was followed in organizing the reviewed studies.

In Egyptian studies reviewed the life-time prevalence of anxiety (neurotic) disorders was found to be 15.3% in general

adult population. It was found that the most prevalent neurotic disorder is specific phobia, followed by panic disorder without agoraphobia, GAD, social phobia, panic disorder with agoraphobia, OCD, posttraumatic stress disorder PTSD, and finally agoraphobia without history of panic. ***(Mahfouz et al, 2003)***

In this study several databases were explored in the period from March to June 2007 to collect Egyptian studies on neurotic disorders. 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, 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.

Of a total of 70 studies collected OCD was the most frequently studied disorder (24 studies), and studies on neurotic disorders (23 studies) those included studies on GAD, mixed anxiety and depressive disorders and comparisons between several neurotic disorders and other psychiatric disorders. Studies on GAD and mixed anxiety disorders could not be listed and counted separately as most of the studies included comparisons between GAD and other neurotic disorders and the information about GAD and mixed anxiety disorders included in the review were taken from these studies, then studies on Somatoform disorders (7 studies), phobic anxiety disorders and dissociative disorders (5 studies each), panic disorder (4 studies) and PTSD and neurasthenia were the least disorders to be studied (one study each).

After collection of the available Egyptian studies on neurotic disorders they were classified according to the ICD-

10 to the several disorders and a literature review was done. In that review the disorders were organized in their order in the ICD-10. The available data about each disorder 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 neurotic disorders in the Egyptian community. Some Egyptian researchers conducted there research in other Arab countries and included samples of different nationalities, these studies were not included in the review or the critical appraisal. These were ten studies (table 13). They were all done in different areas in Saudi Arabia except the study by ***Elsayed et al, 2006*** on Psychiatric morbidity and somatic symptoms in patients with functional dyspepsia; and was done in Abu Dhabi. The only study done in another Arab country and included in the review was the study of ***Mostafa et al, 2001*** on clinical and cultural characteristics of obsessive compulsive disorder in Eastern Saudi Arabia was only included in a trans-cultural comparison between OCD patients in different cultures.

Table 13: studies on neurotic disorders conducted in Arab countries other than Egypt

	YEAR	Author/s	ARTICLE TITLE
1.	1987	Arafa M, Amin Y, Mousa F.	Cognitive components of anxiety: A comparison of panic disorder and generalized anxiety disorder
2.	1989	Mohamed RT. Supervisors: Shaalan M, Hammouda M.	استخدام الفن فى علاج القلق النفسى
3.	1992	Ahmad M.	A comparative clinical and psychometric study of phobic, depressive and anxiety disorders
4.	1992	Arafa M.	Self-Esteem in a Psychotherapeutic Setting: A Comparison of Anxiety and Depressive Disorders
5.	1994	Reyad MA. Supervisors: El-Akabawi A, Shaalan M.	Suitability of psychodrama in the treatment of neurotic patients
6.	2001	Bassiony M, Abdel Aal I, Al Amin H, Saad A, Al Nagar K, Rashed N.	Generalized Social Phobia: Prevalence and Clinical Correlates.
7.	2001	Mokhtar A, Raslan M, Abu Al-Ela I, Abd El-Hakim R.	Re-diagnosis of inpatients termed "Hysterical in Saudi milita ry hospital and their use of medical services: Retrospective clinical study.

8.	2001	Mostafa A. Supervisors: Lotaief F, Rahim S, El-Fiky M, Asaad T, El-Sayed M.	Clinical and cultural characteristics of Obsessive Compulsive Disorder in Eastern Saudi Arabia
9.	2003	Abdelsamei A.	Serum lipid levels in patients with generalized anxiety disorder, major depressive disorder and patients with comorbid anxiety depression
10.	2006	Elsayed O, El-Adl T, Asal A, Shahada M.	Psychiatric morbidity and somatic symptoms in patients with functional dyspepsia: A comparative study with duodenal ulcer patients.

There are two studies those were conducted on Egyptian residents in Arab countries; the first is *"The diagnostic validity of panic disorder; anxiety, depression, or a separate entity" that* was done by ***Salim et al, 1992*** on Egyptian patients attending psychiatric hospital in Kuwait, the second was done by ***Abdel-Aziz et al, 1998*** who studied prevalence of obsessive compulsive symptoms and disorder in a sample of Egyptian school children in Qatar. So, they were included in the review.

Epidemiology:

As regards the Egyptian studies on epidemiology of neurotic disorders; it was noticed that most of them were either hospital-based as the samples were collected from out-patients

and inpatients of psychiatric hospitals, and private clinics or from hospitals and clinics of other medical specialties or the samples were collected from collages and schools. The community based and house held studies were few and included the studies by ***Soliman et al, 1997*** on Anxiety, depression, somatization and psychiatric morbidity in rural Minia, ***Mahfouz et al, 2003*** on epidemiology of anxiety disorders also in rural Minia and ***Haggag et al, 2003*** on OCD in Ismailia. That selection of studied groups is mostly due to the feasibility of these population and easier sample collection. But this lead to deficiency in the epidemiological data about neurotic disorders in Egypt as these populations can not represent all categories included in the community.

Etiology:

Although several researchers studied the etiology of different neurotic disorders in Egypt, the factors covered were the psychosocial factors including social stressors, family dynamics and family history of psychiatric illness. There were very few available studies on the biological aspects of neurotic disorders. Imaging and laboratory investigations related to the diagnosis of neurotic disorders in Egyptian patients were limited to SPECT study in OCD patients by ***Reda et al, 1999***,

assessment of different hormones levels in CSF of OCD patients by ***Saadani et al, 2000***, and measuring the serum serotonin level in OCD patients by ***Sadek et al, 2001.*** That is most probably due to the complicated techniques needed for such studies, and the limited resources for research in Egypt.

Clinical picture:

The clinical presentations of some neurotic disorders were described in the reviewed studies especially in panic disorder and OCD, but in other disorders the studies were not enough to give a full picture of the disorder and the cultural impact on its presentation. The psychometric tools were the investigations used in the studies.

Management:

The Egyptian literature lack studies on different modalities of therapy in Egyptian neurotic patients. The studies conducted in that field include the study of ***Ali et al, 1991*** on transactional group psychotherapy in neurotic patients. And two studies by ***El-Nahas*** one in ***2000*** compared between OCD patients on anti-obsessional drugs (Clomipramine, Fluoxetine, or Fluvoxamine) and behavioral therapy, patients only on anti-obsessional and patients given an adjuvant therapy (ECT, anti-psychotics, Buspiron, Clonazepam, or another Serotonin reuptake inhibitor) together

with the anti-obsessional drug. The other study done by ***El-Nahas, 2003*** was on rTMS in obsessive compulsive disorder.

Outcome and quality of life:

The quality of life in patients with neuroses was assessed in different disorders while the prognosis and outcome of the different neurotic disorders were discussed in few studies as part of the follow up done for the included patients such as; ***Okasha et al, 1991*** studied the 5 years prognosis of patients with OCD received several modalities of treatment, ***Kamel et al, 2006*** who studied the prognosis of OCD with and without PD. Otherwise, there were no follow up studies that aimed at studying the long term outcome of these disorders. The limited time ascribed for data collection and difficulty in keeping contact with patients for long periods may be the contributing factors in such deficiency.

Impact of neurotic disorders on the care givers and community was only studied in Panic disorder by ***Abu EL-Ela, 2000*** and ***El-Mahdy et al, 2004*** who studied the burden of panic disorder on general hospital services and in OCD by ***Abou Zeid et al., 2005*** who compared between schizophrenic patients and OCD patients as regards the caregiver burden.

Gaps in the reviewed Egyptian research on different neurotic disorders:

The few numbers of studies in some neurotic disorders limited the available information about them in the Egyptian community so the review was defective in covering all aspects of these disorders.

- ***Phobic anxiety disorders:***

Social phobia was almost the only type of phobic disorders studies in the Egyptian community. There were only two survey studies on social phobia one was conducted by ***Haggag& El Sheikh, 2003*** on a sample of university students and the second was done by ***Ragheb et al, 2005*** on a sample of secondary school and university students. There were no surveys for phobias on other categories of the population. The clinical presentation and symptoms of social phobia and quality of life of the phobic patients were studies by ***Ibrahim et al, 2000*** and ***El Raey et al, 2001*** but they were not enough to give a full picture of the clinical picture of the disorder. As regards the biological aspects, modalities of therapy and outcome of the disease there were no available data in the reviewed research.

- ***Panic disorder:***

Only four studies were found on panic disorder and they introduced hospital-based data about different aspects of the disorder, as all the studies were conducted on samples of patients attending clinics of different medical specialties. The Egyptian literature lacks community based studies on panic disorder. Clinical picture and psychiatric comorbidities with panic disorder were studied as well as the burden of the disorder on general medical services. The dilemma of diagnosis of panic disorder was studied by ***Salim et al, 1992*** who compared panic patients with patients with GAD and depression from several social, psychological and some biological aspects. There were no available researches about etiology of panic disorder or modalities of therapy. Also, there were no long term follow up studies on the outcome of the disorder in Egypt.

- ***Generalized and mixed anxiety disorder:***

Studies done on GAD and mixed anxiety disorders alone were few. These disorders were frequently studies as part of comparison with other neurotic disorders or depression or to study their comorbidity with other psychiatric disorders especially depression. The available epidemiological data

about GAD and mixed anxiety disorders were either hospital based or collected from studies on samples of university students. That leaves a huge gap in the epidemiological profile of these disorders in Egypt. There were no available data about biological aspects, etiology, management or outcome of these disorders in Egyptian population.

- ***Obsessive compulsive disorder:***

It was the most frequently studied neurotic disorder in the reviewed research. Several aspects of the disorder were covered including epidemiological, etiological aspects, clinical picture, comorbidity with other disorders, some therapeutic modalities and outcome of the disorder, as well as the impact on care givers and comparisons between OCD patients in different cultures were done. Also, OCD was studied in special groups of patients including children and pregnant females. It was the only neurotic disorder where radiological investigations were done as in the study by ***Reda et al, 1999*** on SPECT in a sample of OCD patients. Moreover, CSF hormonal levels were assessed in a sample of OCD patients by ***Saadani et al, 2000*** and serum serotonin level was measured by ***Sadek et al, 2001***. In spite of that relatively large number of studies, the only community based study was conducted in rural area in Ismailia by ***Haggag et al, 2003.*** The other studies

were either hospital based or included samples of university and school students. The therapeutic modalities studied included pharmacotherapy and rTMS and both were studied by ***El-Nahas in 2000& 2003*** respectively, other therapies such as psychotherapy were not studied.

- ***Posttraumatic stress disorder:***

Only one study was conducted by ***Abdel hamid et al, 1996*** on PTSD. It studied the effect of physical disability (crippling) on the presentation of PTSD in patients with PTSD who attended wars. That study was not enough to give an idea about PTSD in the Egyptian population.

- ***Dissociative disorders:***

There were no available community surveys on dissociative disorders. It was noticed that two out of five studies reviewed on dissociative disorders were conducted on samples of military personnel while the rest were hospital based. Several aspects of the disorders were studied but there were no available data about the etiology and management.

- ***Somatoform disorders:***

Prevalence of the different somatoform disorders was studied in a relatively big sample of patients attending OPC of

general medicine in Zagazig university hospital by ***Roshdy et al, 2000***, yet there were no community surveys for that group of disorders. The available socio-demographic data about somatoform disorders are deficient in the reviewed studies. There were no enough studies on etiology, clinical picture, management or outcome of these disorders. Two out of seven studies were conducted on BDD one by ***El-Sheshai et al, 1999*** on body dysmorphic symptom among psychiatric illnesses and the other was done by ***Guemei et al, 2005*** on Prevalence of BDD in a sample of university students. Also, there were two studies on persistent somatoform pain disorder; one by ***Ali et al, 1994*** on non-organic headache and the other was by Mousa et al, ***2005*** on non-organic chronic back pain, both studies were conducted on samples of patients attending different OPC. These studies still not enough to give a whole picture of these disorders.

- ***Neurasthenia:***

Only one study was found about neurasthenia by ***Zyada et al, 2007*** who studies CFS in a sample of children and adolescents between 4-16 years old. That study is not enough to cover all aspects of neurasthenia in the Egyptian population.

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.
- Some of the introductions stressed on definitions and assessment of the problem from western points of view and using the international literature to rationalize the study without clarifying the impact of that problem on the Egyptian culture. That may be due to the lack of solid knowledge about the Egyptian community and the difficulties in obtaining the Egyptian studies. Together with the shortage in complementary epidemiological national studies that gives data about the whole Egyptian community.

- 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.
- 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.

- 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.

- 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.

- 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.

- 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.
- 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

I. Due to the wide scope of the topic of the study as it included all neurotic disorders 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 three large Egyptian universities located in Cairo and two main Egyptian journals of psychiatry that makes the review missing the studies published else where.

II. In the libraries searched there were no available computer data bases what made it difficult to collect all studies on neurotic disorders 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
- The library of faculty of medicine for males: All studies done in the field of psychiatry were classified according to their subject and were collected in an index printed by the department of psychiatry. Another index was available in the library including all the studies done in the field of neuro-psychiatry arranged in chronological order. That index was more up to date and included all the studies

done. The studies were available with easy access to them with exception of few studies that were included in the index and not available.

- The library of faculty of medicine for females: The titles of the studies were collected and arranged in chronological order in the library index. Most of the studies were available especially the recent studies but it was hard to have any copies of any parts of the studies. The difficulty in having any parts of the studies made it difficult to include them in the critical appraisal so the studies of Al-Azhar university faculty of medicine for female were excluded form the review.

All the studies obtained from Al-Azhar University were written in Arabic with English summary.

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. 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.

RECOMMENDATIONS

Research recommendations:

1. Organization and planning for future researches, in order to have complementary research that covers several aspects of the studied topics.

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

3. A more comprehensive systematic review involving all Egyptian universities is needed to collect all the available data about the different psychiatric disorders including neurotic disorders in Egypt.

4. A national Egyptian survey involving all Egyptian governorates is needed to assess the prevalence of different neurotic disorders.

5. More recent studies are needed to explore the specific epidemiological and clinical characteristics of this group of disorders.

6. Several and more complementary researches are needed to cover the biological aspects of neurotic disorders as well as the several management approaches and outcome of these disorders.

Educational recommendations:

1. Clear guidelines for conducting a scientific research and writing a scientific paper in Egyptian research centers are needed to optimize research in Egypt.

2. Education in Egypt should include improvement of skills of critical appraisal of scientific papers.

Recommendations to improve the search for Egyptian literature:

1. Measures to improve the search in the libraries of the Egyptian universities are needed including suitable computer databases that simplify the search for available Egyptian studies.

2. Soft copies of the Egyptian studies are needed to replace the paper copies as they are easily store and more accessible.

3. A network between the Egyptian Universities containing a database for all available Egyptian studies will facilitate easy access to these studies from any place in the country.

THE SUMMARY AND CONCLUSION

The term neurosis encompasses a broad range of disorders of various signs and symptoms. ***(Sadock and Sadock, 2004)***

Neurotic disorders are thought to be caused by an unconscious conflict that generates anxiety; symptoms develop when an individual's defenses can not cope adequately with this anxiety. ***(Toy and Klamen, 2007)***

In Egyptian studies the life-time prevalence of anxiety (neurotic) disorders was found to be 15.3%. It was found that the most prevalent neurotic disorder is specific phobia, followed by panic disorder without agoraphobia, GAD, social phobia, panic disorder with agoraphobia, OCD, posttraumatic stress disorder PTSD, and finally agoraphobia without history of panic. ***(Mahfouz et al, 2003)***

This work was done to make use of the Egyptian studies on neurotic disorders to identify the missing points in Egyptian researches to overcome the defects in the future. So that work aimed at:

- Systematically reviewing & appraising the available Egyptian studies on Neurotic disorders.
- Generation of recommendations for further studies.
- Providing a summary of clinical M.S.c thesis& M.D, thesis on Neurotic disorders done in Ain-Shams University, Psychiatry Department *(these will be included as an Appendix)*.

In order to fulfill that aim several databases were explored in the period from March to June 2007 to collect Egyptian studies on neurotic disorders. 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 Cairo University, Egyptian journal of psychiatry, and current psychiatry.

Of a total of 70 studies collected OCD was the most frequently studied disorder (24 studies), followed by studies on neurotic disorders (23 studies), then studies on Somatoform disorders (7 studies), phobic anxiety disorders and dissociative disorders (5 studies each), panic disorder (4 studies) and PTSD and neurasthenia were the least disorders to be studied (one study each).

After collection of the available Egyptian studies on neurotic disorders they were classified according to the ICD-10 to the several disorders and a literature review was done. In that review the disorders were organized in their order in the ICD-10. The available data about each disorder were categorized into data related to epidemiology, etiology, clinical description, management, and outcome as far as possible.

Critical appraisal of the Egyptian studies on neurotic disorders included in the systematic review was done.

The conclusion: although the great effort spent in the Egyptian research it was noticed that it lacks coordination to offer complimentary data about the profiles of different neurotic disorders. Further effort is needed to collect the available research to construct a national data base that will help in planning for the future research according to the needs of the community.

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الملخص العربى

تعتبر الأعراض العُصابية مثل القلق و الإرهاق و قلة النوم واسعة الانتشار حيث يعانى منها ما يقرب من نصف البالغين فى وقت ما، كما أن واحد من كل سبعة أشخاص يمكن تشخيصه بأحد الاضطرابات العُصابية. وقد قامت منظمة الصحة العالمية بعمل بحث على الأمراض العقلية فى 14 دولة؛ على حوالى 25000 شخص ووجد أن ربع الأشخاص يعانون من اضطرابات نفسية. وكان أكثرها الاكتئاب (10%) يليه القلق و يمثل (8%). ***(Craig and Boardman, 1997)***

و تعرف العُصابية بأنها اضطراب مزمن غير ذهانى يتميز بوجود قلق يشعر به المريض أو يظهر فى سلوكه مباشرة أو تحت تأثير الحيل الدفاعية؛ و قد يظهر على شكل أعراض مثل الوساوس أوالرهاب..... و تتميز هذه الأمراض بعدم تأثر القدرة على الاتصال بالواقع، و عدم خروج السلوك عن العادات الاجتماعية بشكل كبير رغم انها قد تعوق الشخص. و الاضطراب الناتج عنها يكون مستمر أو متكرر و لا يرتبط برد فعل مؤقت لضغوط معينة. ***(Sadock and Sadock, 2004)***

تصنف الاضطرابات العُصابية إلى : الاضطرابات الرهابية، اضطرابات قلق أخرى، اضطرابات الوسواس القهرى، اضطرابات التكيف، اضطرابات تفككية (اضطرابات تحويل)، اضطرابات ذات شكل جسدي (جسدنة)، اضطرابات أخرى . ***(ICD 10, 2007)***

و يعد المرضى العصابيين من المرضى المزمنين الذين يمثلون عبئا على الخدمات الصحية.***(Lloyd et al., 1996)***

كما أن بعض الاضطرابات العُصابية مثل القلق و الهلع قد تؤدى إلى سلوكيات خطيرة؛ بل و تزداد فيها الوفيات نتيجة الانتحار، الحوادث أو حتى نتيجة عدم تشخيص أمراض عضوية مصاحبة لها. ***(Sims and Prior, 1978)***

هؤلاء المرضى يحتاجون تدخل عضوى و نفسى و اجتماعى فعال خصوصا الذين يعانون من مرض شديد والذين لم يتحسنوا خلال سنة. ***(Jenkins. 1995)***

و لأهمية الاضطرابات العُصابية و كونها تمثل واحدة من كبريات مشاكل الصحة العامة؛ فقد قامت الكثير من الدراسات المصرية بمناقشة هذا

الموضوع. و يجب علينا إعادة قراءة هذه الأبحاث لإلقاء الضوء على ما تم تقديمه والاستفادة منه لكى نسعى إلى المزيد من البحث العلمى الذى يغطى جميع جوانب هذا الموضوع.

الهدف من العمل

1. المراجعة النظامية مع التقييم للدراسات المصرية التى تم عملها عن الاضطرابات العُصابية
2. تقديم التوصيات المطلوبة من أجل دراسات إضافية
3. تقديم ملحق يحوى ملخصات لرسائل الماجستير و الدكتوراه التى تم عملها عن الاضطرابات العُصابية فى قسم الطب النفسى جامعة عين شمس.

من أجل انجاز الأهداف تم عمل مراجعة نظامية للأبحاث المصرية المتوفرة عن الاضطرابات العُصابية فى مكتبة كلية الطب بجامعة عين شمس،مكتبة كلية الطب بجامعة الأزهر، مكتبة كلية الطب بجامعة القاهرة،الأبحاث المصرية المنشورة فى بعض مجلات الطب النفسى و ذلك فى الفترة من مارس إلى يونيو 2007.

وقد واجهت مرحلة جمع البيانات بعض الصعوبات كان أهمها اتساع دائرة الاضطرابات النفسية التى يتضمنها البحث مما صعّب جمع كل الرسائل و

الأبحاث المصرية، مع الوضع فى الاعتبار ضيق الوقت و صعوبة الوصول إليها، لذا فقد تم تحديد ثلاثة من أكبر الجامعات المصرية و الموجودة بالقاهرة لجمع الرائل منها بالإضافة إلى مجلتين مصريتين متخصصتين فى الطب النفسى. و لوحظ فى هذه المرحلة أن مكتبات كليات الطب التى تضمنها البحث كانت تفتقر إلى نظام كومبيوتر يسهل البحث عن الرسائل خصوصا مع الأعداد المتزايدة من الأبحاث التى تتم مناقشتها كل عام ،و يحتفظ بنسخ إلكترونية منها لحمايتها من التلف بمرور الوقت. كما أنه لا توجد شبكة إلكترونية متكاملة تربط جميع المكتبات التابعة لكليات الطب فى مصر لتسهيل الحصول على الأبحاث من أى مكان.

اولاً : بالنسبة لجامعة عين شمس

تميزت مكتبة كلية الطب بهذه الجامعة بسهولة البحث عن رسائل الماجستير و الدكتوراه المسجلة بها من عام 1963 و الحصول عليها حيث تم تبويبها بطريقة معينه بحيث شملت كل من الدراسات خاصة بالطب النفسى و الأعصاب مرتبة زمنيًا مما أغنى عن البحث فى أماكن أخرى.

ثانيًا : بالنسبة لجامعة الأزهر

تمت مراجعة أكثر من مكتبة تابعة لجامعة الأزهر وهى المكتبة المركزية و مكتبتى كلية الطب لكل من البنين و البنات بالقاهرة، و كانت أكثر هذه المكتبات تنظيمًا و سهولة فى الحصول على الرسائل هى مكتبة كلية الطب– بنين. و رغم و جود نظام إلكترونى للبحث فى المكتبة المزكزية للجامعة إلا أنه لا يزال تحت الإنشاء كما أن المكتبة تحتوى على عدد قليل من الرسائل التى قدمت فى الطب النفسى بالجامعة، و تحتاج لمزيد من الجهد لجمع الباقى منها خاصة و أن جامعة الأزهر من أكبر الجامعات المصرية التى لها عدة أفرع فى محافظات مختلفة. أما كلية الطب للبنات فرغم سهولة التبويب إلا أن العديد من الرسائل لم تكن موجودة كما صعب الحصول على نسخ من الرسائل الموجودة لنقدها مما أدى إلى استبعادها من البحث.

ثالثا : بالنسبة لجامعة القاهرة

رغم كونها أقدم الجامعات المصرية إلا أن الرسائل المتاح البحث عنها تبدأ من عام 1990 حيث تم جمع كل الرسائل العلمية السابقة لهذا العام ووضعها فى مخزن شامل مما شكل صعوبة بالغة فى الوصول الى تلك الدراسات الخاصة بقسم الطب النفسى بكلية الطب.

رابعا: بالنسبة لمجلات الطب النفسى المصرية:

تم البحث فى مجلتين أساسيتين هما المجلة المصرية للطب النفسى و التى تميزت بوجود اسطوانة مدمجة عليها جميع أعداد المجلة من عام 1979 و حتى 2004 مما سهل الحصول على تلك الأبحاث، أما الأعداد التالية فقد كان معظمها متاحا فى مكتبة مركز الطب النفسى بجامعة عين شمس. و المجلة الثانية كانت CURRENT PSYCHIATRY و التى تم البحث فيها من عام 1999 بعد إذن المشرفين عليها بمركز الطب النفسى جامعة عين شمس.

و قد تم تصنيف الدراسات التى تم الحصول عليها كالآتى:

1. الدراسات التى تتناول معدل الانتشار
2. الدراسات التى تتناول الأسباب
3. الدراسات التى تتناول الوصف الإكلينيكى
4. الدراسات التى تتناول محصلة و نتائج الاضطرابات العُصابية
5. الدراسات التى تتناول كيفية التعامل مع الاضطرابات العُصابية

وذلك لكل اضطراب من الاضطرابات العُصابية حسب التصنيف الدولى العاشر للأمراض. و قد كان العدد الإجمالى للدراسات التى تضمنها البحث سبعين دراسة؛ منها 24 دراسة عن الوسواس القهرى، 23 دراسة عن

الاضطرابات العَصابية عامة و اضطرابات القلق، 7 دراسات عن اضطرابات الجسدنة، 5 دراسات لكل من الاضطرابات الرهابية و اضطرابات التحول، 4 دراسات عن الهلع، و دراسة واحدة لكل من اضطراب الوهن و اضطراب ما بعد الصدمة.

وكان الملاحظ ان الدراسات الانتشارية تجرى فى معظم الأوقات بالمستشفيات أو المدارس و الجامعات و القليل منها هو الذى اعتمد على عينات أخرى من المجتمع مما أدى عن نقص المعلومات عن انتشار الأمراض العُصابية فى المجتمع المصرى. أما الدراسات التى تتناول أسباس تلك الأمراض فقد كانت قاصرة من الناحية البيولوجية و قد يرجع ذلك للتكلفة العالية لهذه الأبحاث و التعقيدات التقنية التى تواجهها.

تباينت الأبحاث التى تتناول الوصف الإكلينيكى للاضطرابات العُصابية حيث تم تناول بعض الأضطرابات فى أكثر من دراسة مثل اضطراب الوسواس القهرى و اضطراب الهلع فى حين كان الوصف اللإكلينيكى لباقى الاضطرابات قاصر عن إعطاء صورة متكاملة عن الاضطراب. و كانت الدراسات التى تناولت الطرق المختلفة لعلاج الاضطرابات العصابية قليلة العدد و لم تكن كافية لدراسة هذا الجانب المهم. وأخيرًا كانت الدراسات التى تتناول محصلة و نتائج

الاضطرابات العُصابية ايضًا غير كافية حيث كانت الدراسات التى تتابع المرضى لفترات من الزمن قليلة العدد و قد يكون السبب ضبق الوقت المحدد للأبحاث أو صعوبة الاتصال بالمرضى الذين تضمنتهم العينة.

و قد نقدت الدراسات التى تم الحصول عليها نقدًا موضوعيًا مع مناقشة نتائجها فى هذا البحث. و كانت أهم الملاحظات التى وجدت أثناء النقد تتلخص فى أن معظم الدراسات كانت معتمدة على أبحاث أجنبية لتبرير إجراء الدراسة ،و أن نتائج الأبحاث فى كثير من الدراسات تم تعميمها على نطاق واسع رغم أن طريقة اختيار العينة و حجمها لم يبررا هذا التعميم، كما أن القليل من الرسائل و الأبحاث المنشورة هو الذى تضمن فرضية بحثية واضحة. كان توضيح مناهج البحث المستخدمة فى الدراسات المصرية التى تمت مراجعتها قليلا ما يذكر و قد لوحظ أن معظم هذه الدراسات كانت دراسات وصفية ؛ إما انتشارية أو تعتمد على المقارنة بين عينة البحث و عينة ضابطة؛ فى حين كانت الدراسات التجريبية أوالتنبؤية والتى تتابع المرضى لفترات من الوقت قليلة. كما أن معظم العينات التى تم اختيارها لم تشمل قطاعات كبيرة من المجتمع المصرى.

ولذلك فقد تبين لنا أننا فى حاجة الى المزيد والمزيد من الدراسات و الأبحاث الأضافية فى هذا المجال و بخاصة أنه هناك الكثير من أوجه القصور فى الأبحاث الموجودة حاليا كما أنه من الضرورى التعاون بين العديد من المؤسسات العلمية من أجل أخراج هذه الأبحاث والدراسات فى صورة أفضل

ولأننا نهدف إلى التكامل البحثي فقد لفت انتباهنا أنه بالرغم من احتواء الأبحاث الإكلينيكية المصرية على توصيات مستقبلية فإننا نأمل وجود إستراتيجية واضحة المعالم للتخطيط لأبحاث مستقبلية هدفها التواصل البحثي وعدم الأكتفاء بالأبحاث الحالية حتى نصل فى النهاية الى صورة متكاملة عن الاضطرابات النفسية عمومًا فى مصر. كما يجب توجيه الأنظار إلي أهمية اكتساب كل باحث مهارة المراجعة النقدية للأبحاث وهذا يتحقق من خلال مشاركته في أبحاث كثيرة للتدرب على الأساس العملية للبحث العلمي.

وفي النهاية تم عمل ملحق أضافى يحتوى على ملخص لأهم النقاط التى اشتملت عليها البحوث الأكلينكية التى تم عملها فى قسم الطب النفسى بكلية الطب بجامعة عين شمس والتى تناولت الاضطرابات العُصابية مع قائمة بالدراسات المصرية عن الاضطرابات العُصابية التى تمت مراجعتها.