Barriers to the Diagnosis and Treatment of Depression in Jordan. A Nationwide Qualitative Study

Laeth S. Nasir, MBBS, and Raeda Al-Qutob, MBBS, MPH, DrPH

Background: **Depression is one of the most common causes of morbidity in developing countries. It is believed that there are many barriers to diagnosis and treatment in the primary care setting, but little research exists.**

Methods: **Five focus groups were conducted with the goal of exploring themes related to barriers to the diagnosis and treatment of depression, with a purposeful nationwide sample of 50 primary health care providers working in the public health clinics of the Jordanian Ministry of Health (MOH). Participant comments were transcribed and analyzed by the authors, who agreed on common themes.**

Results: **Lack of education about depression, lack of availability of appropriate therapies, competing clinical demands, social issues, and the lack of patient acceptance of the diagnosis were felt to be among the most important barriers to the identification, diagnosis, and treatment of patients with depression in this population.**

Conclusions: **Continuing medical education for providers about depression, provision of counseling services and antidepressant medications at the primary care level, and efforts to destigmatize depression may result in increased rates of recognition and treatment of depression in this population. Systematizing traditional social support behaviors may be effective in reducing the numbers of patients referred for medical care. (J Am Board Fam Pract 2005;18:125–31.)**

Major depression will be the second leading cause of disability worldwide by the year 2020.[1] Rates of depression are increasing rapidly, particularly in developing countries. It is ironic that these countries are least well prepared to deal with the epidemic. A survey of 185 countries conducted by the World Health Organization (WHO) found that 41% do not have a mental health policy, and 28% have no specific budget for mental health. Of the countries that do report mental health expenditures, 36% spend less than 1% of their total health budget on mental health.[2] In comparison, the United States and the United Kingdom spend between 5 and 10% of their annual public health budgets on mental health care; countries such as Canada and Denmark routinely spend more than 10% on such care.[3]

In addition to scarce resources, there are many systemic barriers to the diagnosis and treatment of mental disorders. These are reported to include stigmatization of sufferers, poor coordination between the mental health and primary health segments of the health care delivery system, and a lack of education of primary health workers in providing mental health services.[4] The WHO is currently developing strategies to address shortfalls in these systems, including information collection, research and policy development as well as advocacy and the promotion of mental health services in developing countries.[2]

Jordan is a developing Middle Eastern country of 5.3 million people that is undergoing rapid modernization. The population is highly urbanized; more than 80% of the population resides in urban areas. 92% of the population is Sunni Muslim, and the remainder are Christians. The health care system is relatively advanced. There are 3 major health service providers: a large private fee-for-service

Submitted, revised, 24 November 2004.

From the Department of Family Medicine, University of Nebraska, Omaha (LSN), and Department of Family and Community Medicine, University of Jordan Faculty of Medicine, Amman, Jordan (RQ). Address correspondence to Laeth S. Nasir, MBBS, University of Nebraska Department of Family Medicine, 983075 Nebraska Medical Center, Omaha, NE 68198-3075 (e-mail: lnasir@unmc.edu).

J Am Board Fam Pract: first published as 10.3122/jabfm.18.2.125 on 29 March 2005. Downloaded from http://www.jabfm.org/ on 19 April 2024 by guest. Protected by copyright.

sector, a military health service sector, and a public health service, the Ministry of Health (MOH), which provides free or low-cost services to between 30 and 40% of the population. MOH clinics are located throughout the country; 85% of the population can reach these clinics in 30 minutes or less. Depression may be highly prevalent in Jordan; one study suggested a prevalence of depression of greater that 30% in 493 randomly selected female patients presenting to primary health care clinics.[5]

Social structure in Arab countries tends to emphasize the collective good over the individual. Adherence to social mores and values is central to the culture; accommodation to the expectations of others and social closeness are highly valued. This leads to a close and interdependent relationship between the individual, the family, and the larger group. It also results in social traditions that allow people to interact harmoniously. Chief among these is what has been termed '*mosayara*,' or concealing true thoughts and feelings to save others from embarrassment or allow them to save face.[6] Arab families tend to reflect the larger society, in that they are group-oriented and hierarchical. Roles tend to be highly gender-specific. Individual people tend to be closely connected to an in-group, rather than being seen as entirely autonomous. Individual behavior tends to be seen as a family responsibility. This collective social framework also means that the concepts of privacy and autonomy may differ from those found in industrialized Western countries. It is quite routine, for example, for friends and relatives to involve themselves in clinical encounters. This may interfere with physician-patient communication if sensitive issues are to be discussed. In addition, important medical decisions are likely to be made by authority figures within the family or by the physician.

Depression is highly stigmatized in the Arab world.[7] Mental illness in general tends to be looked on as a flaw in the sufferers' character or upbringing and, via the collective ethos of the community, as a family or group failing rather than an individual failing. Previous studies of Arab society have suggested that when a psychological problem arises, patients and families typically turn first to family and community resources for help.[8] These resources may take the form of informal social contact within the family or larger kinship group. It may also involve traditional healers.[9] If these communal resources prove insufficient, families may then turn to the professional community for assistance.[10] Patients' and families' perception of stigmatization seems to increase at this point, with the recognition that a potentially 'shameful' medical diagnosis might be made. The presence of a stigmatizing illness, particularly one that may have a heritable component, often results in extensive efforts to deny or conceal it to preserve the family reputation.[11]

Methods

This study is part of a larger study of providers perceptions of quality of health care in the Jordanian MOH. In January and February 2004, 5 focus group discussions were conducted in 5 different cities and towns in Jordan, representing the northern, central, and southern regions of the country. A purposeful sample of primary health care providers were chosen to form a sample representing approximately equal numbers of physician and nonphysician providers of health care actively practicing in the MOH at the primary clinic level in each of the 12 Governorates of the Kingdom. The workers chosen for the study traveled from their site of usual work to the focus group site. This reduced the logistic problem of the study team having to travel to multiple, remote sites. Two focus groups were held in the northern region, 2 in the central, and one in the southern region of the country to reflect the relative population and clinic densities in different parts of the country. All the participants chosen agreed to participate. The Jordanian MOH does not have a formal Institutional Review Board; therefore, the study design was reviewed and approved by the National Safe Motherhood Steering Committee consisting of physicians, academicians, community representatives; and national policymakers who took into account the bioethical dimensions of the study.

A focus group guide was prepared and discussed by the authors, reviewed for accuracy, and translated into Arabic. Back translation was believed to be unnecessary in that both authors are bilingual in English and Arabic. The focus group questions were broad, open-ended questions. Several of these questions had been developed and used in a previous study[12] on barriers to the diagnosis and treatment of depression (Table 1). These questions were followed up as necessary by more specific "probe" questions. Each of the 5 focus groups con-

J Am Board Fam Pract: first published as 10.3122/jabfm.18.2.125 on 29 March 2005. Downloaded from http://www.jabfm.org/ on 19 April 2024 by guest. Protected by copyright.

Table 1. Selected Focus Group Questions

What makes you think that a patient has depression?
How does depression differ from other conditions that you see in your practice?
When you see a patient with depression, how do you decide what to do?
What do you see as barriers to treatment of depression in your practice?

sisted of 10 participants, and each lasted between 1.5 and 2 hours. Before the focus group, the participants answered a brief questionnaire regarding demographic data such as age, sex, specialty or degree, and length of service with the MOH.

One of the authors, an experienced focus group facilitator (LSN) moderated the focus groups, accompanied by a cofacilitator, a dietician with extensive public health field experience. The focus group facilitator started the discussion, and the cofacilitator noted important points in the discussion and important nonverbal communication. Because the study group was heterogeneous, special attention was paid to building rapport within the group before starting the focus group discussions and encouraging members who seemed reluctant to speak out.

Data Management and Analysis

All focus group sessions were conducted in Arabic, audiotaped, translated into English, and transcribed. We considered a comment by a participant to be any coherent utterance in response to a question. The transcribed data and field notes were independently reviewed by the authors, an academic physician and researcher with extensive experience in qualitative and quantitative research methods (RQ), and an academic family physician with an interest in primary care psychiatry and experience in both qualitative and quantitative research (LSN). Common recurring themes were identified. Ten themes common to all focus groups were identified initially. Each theme was assigned a unique descriptive name. Three themes initially named "patient responses," "family responses," and "referral" were believed to be closely related to the larger themes "patient acceptance of the diagnosis" and "treatment" and so were collapsed into them to form the 7 major themes outlined below. Finally, the authors selected the most representative comments to illustrate the themes presented in this article.

Table 2. Focus Group Participant Characteristics

	Number	Average Age	Average Years (Range) of Service in MOH*
Physicians (M/F)	24 (15/9)	43.8 years	12.4 (1 to 28)
Nurse Asst. (M/F)	9 (0/9)	36.9 years	14.8 (10 to 21)
Midwives (M/F)	17 (0/17)	35 years	13.7 (6 to 29)

* MOH, Ministry of Health; M/F, male/female.

Results

A total of 50 health care providers participated in the focus groups: 35 of the participants were female, 24 were physicians, 17 were midwives, and 9 were nursing assistants. The mean age of participants was 38.5 years (range, 28 to 59 years) (Table 2). All except 2 of the physicians were general practitioners without advanced degrees; one was an obstetrician, and the other held a diploma in tropical medicine.

Recognition of Depression

Focus group participants were nearly unanimous in their agreement that depression was commonly seen in the health centers. In the focus groups, physicians reported that diagnosis of depression was generally made empirically. There was little awareness among the physicians of diagnosis based on specific criteria. There was some discussion as to what constituted 'real' depression. One physician felt that "as long as [the patients] had hope," the condition was not true depression. Some focus group members felt that depression is a diagnosis of exclusion: "Sometimes the patient comes to you complaining of physical illness, you do all the tests and they're normal." Participants reported detecting depression by observation of a patient's conduct: "Sometimes his behavior, he has a different manner about him. . . . " and "We pay attention to his mood, to his movements (and) his symptoms." One physician felt that depression tended to occur seasonally: "Most cases [of depression] come in the spring and fall. For the past 2 months or so, we haven't seen any. It begins in the spring and fall." A number of physicians reported feeling uncomfortable making the diagnosis and would promptly refer patients suspected of having depression: "Even if you are certain of the diagnosis, he needs follow-up and treatment."

J Am Board Fam Pract: first published as 10.3122/jabfm.18.2.125 on 29 March 2005. Downloaded from http://www.jabfm.org/ on 19 April 2024 by guest. Protected by copyright.

Factors Predisposing to Depression

Most of the health care providers interviewed felt strongly that depression was most commonly seen in patients exposed to adverse circumstances such as poverty and other marital and family dysfunctions. Polygamy, although permitted in Islam, is uncommon in Jordan but was frequently mentioned by the focus group participants as being a common source of family dysfunction leading to depression.

- "Depression is coming from the situation we are living in. We always say, 'God have mercy on these people'. Imagine you get married and your in-laws start causing problems."
- "It depends on his wife. Is his wife respectable or not. Does he have 2 wives at home or 3. You have to look at all these aspects for a patient with depression. . . . "
- "They don't have money to have a baby, or the husband wants to marry another wife. We give her some counseling, and she is a little better."

Although predisposing factors for depression in married persons tended to cluster around marital or financial issues, in younger age groups, causes of depression were believed to vary between the sexes. In women, themes revolved around lack of autonomy, whereas for young men, the lack of meaningful employment was felt to be a dominant factor:

- "Two weeks ago, a girl came to me. . . she wanted to speak to me alone. . . she couldn't get out of the house. . . her parents were afraid if she went out, she would see shoes or a headcover or something she wanted [that they couldn't afford]."
- "90% of the cases I see in men [are due to lack of] work. . . he goes to his mother, or his sister or his brother [and] he begs ½ dinar (about $0.70) every day. He has been to University, [he asks you]. . . should I work pushing a cart?"

Patient Acceptance of the Diagnosis

One clear theme to emerge from the focus groups was the discomfort and anxiety that the diagnosis of depression brought to the clinical interaction. One physician compared the response to that of a patient being diagnosed with hypertension or diabetes: "People accept it; for example, to speak to people with diabetes or hypertension about this condition, he takes it lightly—'avoid certain foods'—for example, and 'things will be fine my son, things will progress fine' and he will give and take with you. But when it's [a psychological problem] he starts pushing the subject—'where is the clinic, reassure me—what are they going to give me' and so on."

Often, patients or families wait until they are in crisis before coming to the physician: "[He] feels so much shame that he waits until he is very uncomfortable, until he can't stand it—[or] he can't stand his son or daughter—the situation he is in." Others send relatives to the physician for a referral. "Sometimes the patient himself does not come. He sends his father or sister saying, 'I want a referral.' People are ashamed."

Barriers to Seeking Care

In the focus groups, some health care providers felt that community inquisitiveness inhibited people from seeking care for depression. One midwife said: "No one goes to the Health Center without everyone knowing him. 'Why have you come?' A whole sea of people sitting here asking 'Why has he come? What's wrong with him?'"

Another described a common scenario in which patients actively seek out people who do not know them so they can maintain their anonymity: "Sometimes a woman—poor thing—will come and see us. Maybe she has a problem and is bothered or something. She prefers to speak to us girls who are not from the same village. She doesn't want girls from the same village to know, so she will ask to sit (and talk) with you. So we sit with her."

Focus group participants reported that the stigma of depression was particularly strong for women and that even the intimation of mental illness would affect their prospects for marriage: "Particularly with women. They want to be married. If they have depression, they will never be married [if someone finds out]." One midwife summarized the problem: "In our society, they take everything to be shameful. . . they don't accept that this [condition] is from God, and it is preordained. Everything is shameful, there is nothing that is not their fault, they are embarrassed, so they are lost."

Health Care Responses to the Diagnosis of Depression:

Responses to the diagnosis of depression fell over a wide range. The dominant theme among physicians was that depression was not a diagnosis that

J Am Board Fam Pract: first published as 10.3122/jabfm.18.2.125 on 29 March 2005. Downloaded from http://www.jabfm.org/ on 19 April 2024 by guest. Protected by copyright.

they had the experience or time to treat: "We don't even try to deal with it. There's no time in any case. . . you sit with him for 2 hours, and he will tell you about from when he was first born, until today." Another felt that depression was not a 'real' illness: "Some patients come in thinking they're sick. You have to examine him, check him, and convince him he's not sick."

One physician seemed unsure about the ability of physicians to treat mental illness successfully and in getting patients to accept treatment: "As doctors, we have only been successful. . . in the people with diabetes or hypertension—our word has become high [trusted and respected]. Now they say 'give me a prescription for [my medicine]. . . to prevent strokes and heart attack. . . ' and for these things, he will accept it. Doctors, God bless them, have been successful in ameliorating physical illness."

Another theme to emerge was the role some physicians played in concealing the diagnosis, thereby allowing the patient to save face in the context of having a 'shameful' condition. One physician compared the diagnosis of depression to being diagnosed with scabies, which in many Arab cultures is considered the prototype of a disgusting and shameful disease: "For example, once or twice a year you see a case of scabies. He asks you 'What is this illness?' you tell him 'allergy.' Do you tell him he has scabies? It would be the end of the world!"

Another physician felt that unless he used deception to normalize the condition to the patient, he was unlikely to get the patient to 'buy in' to the diagnosis or treatment: "The doctor has to. . . [tell him stories], tell him, 'friend, once the same thing happened to me, and thank God, friend, I went to someone—he gave me some few pills. . . and I took the pills. . . I saw myself improve day by day.' You have to tell him stories, to interact with him. Other than this way, it is very difficult. Very few doctors will get into this subject. . . . "

Only a few physicians expressed the opinion that depression was a condition needing ongoing care. One physician taking this position said: "It needs treatment, it needs follow up. I will give it the same importance as I will for a patient with diabetes. We'll talk to him. If I can help him, I'll help him. If not, we'll refer. That's my opinion."

Treatment of Depression

Responses regarding the treatment of depression also varied widely. It was felt that many patients sought treatment with private physicians or outside of the local area because of privacy issues: "Most of them go to a private doctor. They prefer the treatment to be outside. . . [of the local area]." Treatment of depression with medications was also felt to be problematic. In common with many other developing countries, the Jordanian MOH does not routinely provide antidepressant medication to primary health clinics; therefore, patients must be referred to a higher level of care for pharmacological treatment of depression. Patients fearing stigmatization often refuse to go to a psychiatric center: "I have a patient who has a problem. I keep referring her to psychiatry, but she won't go." Focus group participants reported that they used benzodiazepines and anticonvulsants most frequently in treating depression.

"Tegretol (carbamazepine) and Valium (diazepam) and like that are available at all the Centers. Some more medicines are available in the comprehensive centers, but not all the medicines." One physician voiced her concerns about treating patients with these medications: ". . . I worry about addiction. . . [I use] Lexotanil (bromazepam) and Valium. . . I will give him a prescription once, for example, if it's a severe problem. . . Lexotanil and Valium are the medicines we have available." Health care providers were aware of the danger of suicide in depressed patients and were unanimous in their response to this problem. "I will evaluate the situation and have him back. I won't refer him immediately. But if the patient comes in and says 'I'm going to commit suicide'—immediately I will refer."

Counseling was also felt to be an option in the treatment of these patients. In general, physicians felt that they didn't have the time or training to counsel patients: "He wants someone to sit and listen to him. . . and we don't have time."

Midwives seemed to feel more comfortable counseling women with mood disorders and social problems. Several described advice they would give to women experiencing depression. "Sometimes a mother comes with her son—she is disturbed, bothered by her mother-in-law—she is placing her under psychological pressure. The mother-in-law tells her 'do this, do that' for her son. . . we start to guide her. . . we tell her to tell her mother in law

J Am Board Fam Pract: first published as 10.3122/jabfm.18.2.125 on 29 March 2005. Downloaded from http://www.jabfm.org/ on 19 April 2024 by guest. Protected by copyright.

'OK, OK' and don't do anything her mother-in-law tells her."

Another nurse-midwife said: "Some [patients] come to you and when you talk to them they feel safe, and you find they come back time and again because they don't have people to talk to. In certain ways, we speak to them, they get better. . . she comes back happy and she wants to speak more. . . we don't solve the problem completely, but time after time, after a number of visits, we find she has changed. We tell them, 'you are not the only one in the world who is in this situation—perhaps I, the one who is speaking to you—have the same problem. . . ' we speak to her in a general way, a general conversation. And maybe if we give her safety [freedom to speak], there will be a solution. [We tell them,] 'when you find yourself bothered in your home by your children, or your husband, come to us, it will be a change, you will see what's around you, hear the news, you'll see everyone sitting around you is like you' [has the same problems]."

Visions of Improvement

Several physicians expressed an interest in getting further training in psychological issues: "The physician, if he would get educated in psychiatry courses and if we have our physicians do this, they'll help the patient more than referring them to a psychiatrist. People are not sophisticated. If you tell them 'I'll refer you to a psychiatrist,' they'll say: 'Hey! I'm not crazy.' No, I'll treat him for his illness, and I'll treat him from the psychological aspect, I'll have gone to courses in it, and that will be better." Other providers expressed the wish that the MOH would staff the primary health clinics with social workers or specialists to treat patients with depression. "Each primary health center should have specialists. Because many people are afraid to be referred to a psychiatrist."

Discussion

The literature on depression from developing countries suggests that low recognition of depression and suboptimal treatment are common in primary care.[13] Our study seems to support these observations and to reveal issues unique to Jordanian and other Arab societies.

Health care providers felt that depression was very common in the primary care clinics. This perception is paired with observations that utilization of mental health services by patients is very low. This finding is consistent with a study comparing utilization rates between Jewish and non-Jewish populations in Israel, suggesting significant underutilization of mental health services by Arab populations.[14]

Barriers reported in this study included family and patient resistance to the diagnosis, uncertainty inherent in making the diagnosis, concerns about treatment efficacy, competing clinical demands, and a desire to maintain social harmony in the clinical interaction. Physicians were generally unfamiliar with specific antidepressant medications but expressed interest in pursuing further education in psychiatric subjects. Developing initiatives to train primary health care workers in the recognition and treatment of affective disorders paired with the development of culturally sensitive communication skills and the provision of counseling and antidepressant medications at the primary care level would be likely to lead to improved outcomes.

Focus group participants felt that marital and family problems, poverty, and lack of social support all predisposed patients to depression, assumptions that are supported by the literature from developing countries.[15] Polygamy was mentioned frequently as a cause of family strife leading to depression. A study from Syria suggests that polygamy is a major risk factor for psychiatric morbidity among low-income women.[16] Others have suggested that among married Muslim women, the label of psychiatric illness may be used by the husband or his family as an excuse for him to take a second wife[17,18] or as grounds for divorce.

Some midwives reported offering social support to female patients expressing emotional distress. In Arab society, family and friends are a natural form of social support, and it is likely that these women are instinctively replicating this traditional pattern of mutual social assistance. This type of intervention has the advantage of being culturally acceptable, minimally stigmatizing, and probably effective.[19] The fact that midwives with little or no formal psychiatric training seemed able to effectively engage women with emotional problems and initiate culturally acceptable interventions suggests that further evaluation of these activities is warranted. Providing midwives with the training to evaluate, counsel, and educate female patients expressing emotional distress, referring those who meet certain criteria or who fail to improve with

J Am Board Fam Pract: first published as 10.3122/jabfm.18.2.125 on 29 March 2005. Downloaded from http://www.jabfm.org/ on 19 April 2024 by guest. Protected by copyright.

support might be effective in increasing detection and appropriate treatment of female patients with depression and other psychiatric morbidity.

This study has several limitations. The sample of practitioners was small and heterogeneous and therefore may or may not accurately reflect the views, attitudes, and opinions of primary care providers throughout the MOH system. It is also possible that the focus group setting inhibited some participants from expressing their views. There was, however, remarkable agreement among all the focus groups; the themes reported were common to all focus groups. This study is intended to generate theories and hypotheses about the barriers to diagnosis and treatment of depression in the primary care setting of MOH clinics in Jordan. It is unclear whether these themes accurately reflect barriers in other medical settings. Future studies are needed to further define these barriers.

Finally, there exists a critical need for further studies of depression in the Arab cultural context. Future studies focusing on cultural concepts of mental illness, the development of nonstigmatizing approaches to depressed patients and their families in primary care, identification of factors that are protective against mental illness, and the continued development of locally validated, clinically useful screening instruments in Arabic would be important steps in the development of a regional research agenda.

References

1. Murray CJL, Lopez AD, editors. The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020 [monograph on the Internet]. Cambridge (MA): Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press; 1996 [cited 2004 May 10]. Available from: http://www.nimh.nih.gov/publicat/burden.cfm.
2. World Health Organization. Mental health: responding to the call for action [monograph on the Internet]. Geneva, Switzerland: World Health Organization; 2002 [cited 2004 May 10]. Available from: http://www.who.int/gb/ebwha/pdf_files/WHA55/ea5518.pdf.
3. World Health Organization. Atlas of mental health resources in the world. Geneva, Switzerland: World Health Organization; 2001.
4. Patel V, Abas M, Broadhead J, Todd C, Reeler A. Depression in developing countries: lessons from Zimbabwe. BMJ 2001;322:482–8.
5. Hamid H, Abu-Hijleh N, Sharif S, Raqab M, Mas'ad D, Abbas A. A primary care study of the correlates of depressive symptoms among Jordanian women. Transcult Psychiatry. In press.
6. Dwairy M. Foundations of psychosocial dynamic personality theory of collective people. Clin Psychol Rev 2002;22:343–60.
7. Jumaian A, Alhmoud N, Al-Shunnaq S, Al-Radwan S. Comparing views of medical employees and lay people towards stigma in mental health issues. Jordan Med J 2004;38:80–3.
8. El-Islam F. Some transcultural aspects of depression in Arab patients. Islamic World Med J 1984;1:48–49.
9. Racy J. Psychiatry in the Arab East. Acta Psychiatr Scand Suppl 1970;211:1–171.
10. Al-Issa A, editor. Al-junun: mental illness in the Islamic world. Madison (CT): International Universities Press; 2000.
11. El-Sendiony M. The effect of Islamic sharia on behavioural disturbances in the Kingdom of Saudi Arabia. Saudi Arabia: Makkah Printing and Publishing; 1981.
12. Susman JL, Crabtree BF, Essink G. Depression in rural family practice: easy to recognize, difficult to diagnose. Arch Family Med 1995;4:427–31.
13. Patel V. Why we need treatment evidence for common mental disorders in developing countries. Psychol Med 2000;30:743–6.
14. Al-Krenawi A. Mental health service utilization among the Arabs in Israel. Soc Work Health Care 2002;35:577–89.
15. Caracci G, Mezzich JE. Culture and urban mental health. Psychiatr Clin North Am 2001;24:581–93.
16. Maziak W, Asfar T, Mzayek F, Fouad F, Kilzieh N. Sociodemographic correlates of psychiatric morbidity among low-income women in Aleppo, Syria. Soc Sci Med 2002;54:1419–27.
17. Al-Krenawi A. Women of polygamous marriages in primary health care centers. Contemporary Family Ther 1999;21:417–30.
18. Chaleby K. Women of polygamous marriages in inpatient psychiatric services in Kuwait. J Nerv Ment Dis 1985;173:56–58.
19. Sanua V. Psychological intervention in the Arab world: A Review of Folk Treatment. Presented at the 85th Convention of the American Psychological Association; 1977 Aug 26–30; San Francisco, California. Washington DC: American Psychological Association; 1977.

J Am Board Fam Pract: first published as 10.3122/jabfm.18.2.125 on 29 March 2005. Downloaded from http://www.jabfm.org/ on 19 April 2024 by guest. Protected by copyright.