CHIEF EDITOR DR. SYED MUBIN AKHTAR

KARACHI PSYCHIATRIC HOSPITAL

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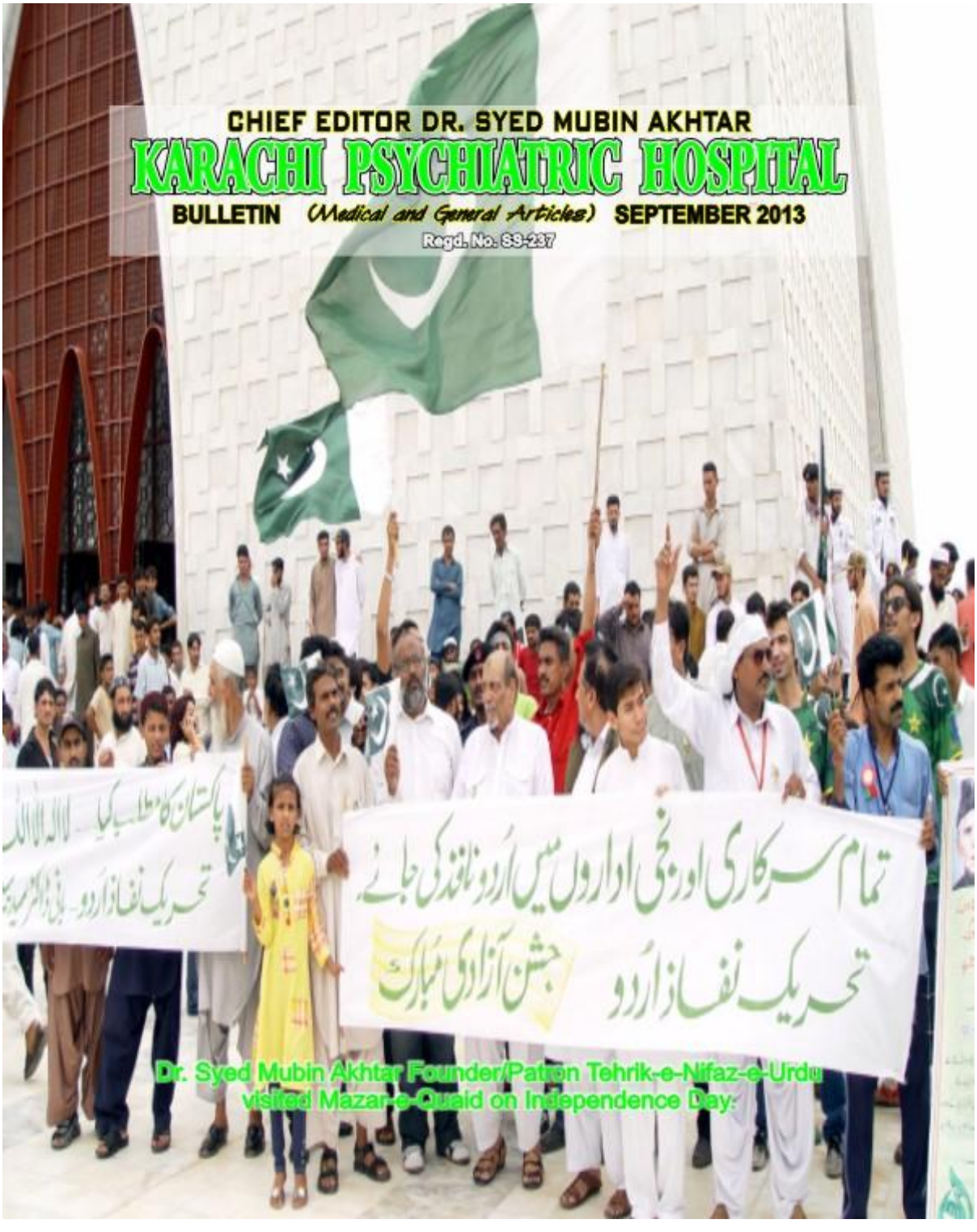

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Dr. Syed Mubin Akhtar MD., KPH along with staff on the occasion of Independence Day Celebrations

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KARACHI PSYCHIATRIC HOSPITAL

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MONTHLY BULLETIN

(Medical and General Articles)

شریعت

حضرت انسؓ فرماتے ہیں کہ رسول اللہ ﷺ جب مدینہ تشریف لائے تو آپ ﷺ کے پاس کوئی خدمت گار نہ تھا۔ حضرت ابو طلحہؓ نے میرا ہاتھ پکڑا اور رسول اللہ ﷺ کے پاس لے گئے کہنے لگے: یا رسول اللہ ﷺ! انسؓ ایک سمجھدار لڑکا ہے، وہ آپ ﷺ کی خدمت میں رہے گا۔ حضرت انسؓ کہتے ہیں، سفر میں اور حضر دونوں میں آپ ﷺ کی خدمت کرتا رہا۔ آپ ﷺ نے (دس برس کی مدت میں) کبھی مجھ سے یہ نہیں کہا کہ تم نے ایسا کیوں کیا جب میں کوئی کام کر لیتا اور جس کام میں نے نہیں کیا اس کے لیے یہ نہیں فرمایا تم نے ایسا کیوں نہیں کیا۔

(حدیث۔ بخاری)

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MENTAL HEALTH AND THE GLOBAL AGENDA

Anne E. Becker, M.D., Ph.D., and Arthur Kleinman, M.D.

When the World Health Organization (WHO) European Ministerial Conference on Mental Health endorsed the statement "No health without mental health" in 2005, it spoke to the intrinsic - and indispensable - role of mental health care in health care writ large. Yet mental health has long been treated in ways that reflect the opposite of that sentiment. This historical divide - in practice and in policy - between physical health and mental health has in turn perpetuated large gaps in resources across economic, social, and scientific domains. The upshot is a global tragedy: a legacy of the neglect and marginalization of mental health. The scale of the global impact of mental illness is substantial, with mental illness constituting an estimated 7.4% of the world's measurable burden of disease. The lack of access to mental health services of good quality is profound in populations with limited resources, for whom numerous social hazards exacerbate vulnerability to poor health. The human toll of mental disorders is further compounded by collateral adverse effects on health and social well-being, including exposure to stigma and human rights abuses, forestallment of educational and social opportunities, and entry into a pernicious cycle of social disenfranchisement and poverty. Advances in efforts to alleviate the human and social costs of mental disorders have been both too slow and too few.

Recognizing the Mental Health Burden

The cumbrous and outsized global dimensions of mental illness remained largely unrecognized until the 1990s, when the population health metric disability-adjusted life years (DALYs), which encompassed both years of life lost from premature death and years lived with disability (YLDs), was introduced. The publication of these population health data in Global Burden of Disease, which was regarded as a public health tour de force at the time, also catalyzed a transformative narrative for global mental health. The DALY rubric, along with standardized diagnostic criteria for mental disorders, allowed comparability across disorders and nations and yielded estimates of the composite burden of mental disorders that were much higher than those recognized previously. In 1995, World Mental Health outlined an agenda to redress the global crisis in mental health.

These and other publications debunked lingering questions about the universality of mental disorders and illuminated the enormous suffering associated with these disorders in low- and middle-income countries, where health care resources devoted to neuropsychiatric illnesses were disproportionately low relative to the corresponding disease burden. The scientific discourse, which had been largely theoretical and descriptive in nature, became one that encompassed an applied agenda with translational relevance.

In 2013, further documentation renders an increasingly clear and troubling picture of the enormous global burden imposed by mental disorders. The economic burdens associated with mental disorders exceed those associated with each of four other major categories of noncommunicable disease: diabetes, cardiovascular diseases, chronic respiratory diseases, and cancer. Major depressive disorder is the second leading cause of YLDs globally and ranks among the four largest contributors to YLDs in each of the socially diverse regions spanning the six continents assessed in the Global Burden of Disease Study 2010. Anxiety disorders, drug-use disorders, alcohol-use disorders, schizophrenia, bipolar disorder, and dysthymia also rank among the 20 conditions contributing the largest global share of YLDs. The aggregate burden of YLDs resulting from mental and behavioral disorders (22.7%) continues to be higher than that resulting from any other disease category, with an estimated contribution to the proportion of burden in 2010 that was similar to that in 1990.

Global Burden of Years Lived with Disability, 1990 and 2010. Yet the game-changing potential of these empirical data to increase global investments in mental health care in proportion to the size of the problem has not been realized. Instead, vast gaps in resources persist and seriously compromise access to care.

Closing Gaps in Treatment

More than 75% of persons with serious mental illness in less-developed countries do not receive treatment for it. For the minority who do have access to mental health treatment in low- and middle-income countries, there are few data available to aid in the evaluation of the quality or effectiveness of the treatment. Major deficits in the provision of care include the size of the health care workforce and the training it receives; rigorous empirical evaluation of innovative, scalable models of care delivery; and the political will to support policy, research, training, and infrastructure as explicit priorities at the national, regional, and multinational levels. None of these deficits can be properly remedied without corresponding advances in the others, creating a Gordian knot familiar to global health advocates and

practitioners.

Building Clinical Capacity

The shortage of clinicians with specialized training in assessing and managing the treatment of patients with mental disorders is a major barrier to providing adequate services in low- and middle-income countries. Building the necessary mental health workforce will require political commitments to elevate mental health to the highest tier of the global health agenda and to develop corresponding national policies that will support the kind of multisectoral planning needed to align educational objectives and resource allocation with local priorities. Partnerships among governments, nongovernmental organizations, multilateral agencies, and academia can also help to increase the capacity of the mental health workforce - for instance, by developing institutional relationships, sometimes referred to as twinning, mirroring, or accompaniment, that would successfully integrate global expertise with local knowledge.

Nonetheless, mere incremental augmentation of the workforce alone is unlikely to close the human resource gap - which is estimated to exceed 1 million mental health workers in low- and middle-income countries13 - given the present capacities to recruit and train mental health professionals.

Graduation Rates among Professional Mental Health Specialists in Low-, Middle-, and High-Income Countries.)and the prevailing models of mental health care delivery. In addition to training more mental health specialists, it is essential to make better use of their expertise by instituting enhancements and innovations that will increase the quality, relevance, and reach of clinical training. Resolving the gaps in human resources, for example, will probably entail the use of nonspecialists to deliver mental health interventions. This change will call for fresh approaches to training that anticipate the evolution of more prominent supervisory and consultative roles that can leverage the scarce supply of expertise in mental health specialties. The contribution of these specialists must go beyond that of direct service delivery alone. Specialists would be prepared to train and supervise peer nonspecialist professionals to deliver mental health treatment in primary care settings, and nonprofessional health workers would be trained in the tasks of basic case identification, monitoring, and treatment delivery. Novel pedagogic models are called for, as are rigorous evaluations of their effectiveness. The implementation of policy that supports the training, deployment, and decentralization of professionals who are qualified for assessing and delivering care for patients with mental illness - and are enabled to do so - will help to achieve meaningful, sustained progress.

Developing New Models of Treatment

The evidence base supporting the efficacy of various treatments for mental health is founded primarily on trials that were conducted in high-income countries. Because only a tiny fraction of published clinical trials have been conducted in low-income countries, the effectiveness of treatments across culturally diverse, low-income settings is largely unknown. In addition, the shortfall of health professionals with training to deliver mental health care in regions with limited resources diminishes the feasibility and relevance of these therapeutic approaches, many of which would require radical adaptation if applied within the constraints of local health care resources. Critics have pointed out that current models that rely on mental health professionals to deliver care to patients are not only unsuitable for low- and middle-income countries but are also impractical in high-income countries, where adequate numbers of mental health professionals are lacking. In this respect, a shift to a collaborative model of care delivery has been proposed. This model reconfigures the role of the mental health specialist to emphasize training, supervision, and tertiary care while transferring the bulk of direct service delivery to community health workers or primary care professionals who would receive specific training and supervision in mental health.

The success of this model of collaborative care is premised in part on the feasibility and effectiveness of shifting aspects of case identification and delivery of care from mental health professionals to community health workers who receive specialized training, periodic refresher training, and ongoing supervision by professionals. Similar models of "task shifting" in the delivery of health care (e.g., using community health workers in other clinical domains in low-income settings) have been successful, including in populations that are considered to be especially difficult to treat. Several landmark studies provide conceptual support for this model for the treatment of mental illness in resource-constrained settings, including trials evaluating the effectiveness of interpersonal psychotherapy and cognitive behavioral therapy. These approaches hold undeniable promise for broadening access to effective treatments, but their potential to be scaled up and delivered in a sustained way remains untested and uncertain.

Several milestones mark substantive advances in the integration of mental health care into primary care in resource-constrained settings. Among these are the publication of the World Health Report in 2001, which was devoted to mental health; the introduction in 2002 of the Mental Health Global Action Programme (mhGAP), a WHO-led multilateral

initiative that encompassed a plan to equip primary care clinicians with training and skills in the care of patients with mental illness; and a series of reviews published in 2009 that provided recommendations on incorporating primary and specialist health professionals as well as trained community health workers into a model of collaborative care that included case identification and management. In 2010, the mhGAP Intervention Guide aimed to develop clinical capacities in mental health assessment and treatment among nonspecialists. In 2012, the WHO released a training package designed to complement the guide and also encouraged field testing.

These important achievements notwithstanding, there are scant data to allow evaluation of the large-scale feasibility and effectiveness of task shifting or its applicability across diverse settings; the suite of recommendations in mhGAP likewise awaits rigorous empirical evaluation of implementation in low- and middle-income countries that can inform future iterations. Available data are also insufficient to evaluate and refine models for training lay health workers to deliver effective mental health care. Serious efforts to incorporate local knowledge, moreover, can ensure that guidance regarding case identification and treatment continues to be refined and adjusted to the structure of a country's health system and the specific needs of its population. The perspectives of cultural psychiatrists, psychiatric epidemiologists, and medical anthropologists on the biosocial complexity of mental disorders and their presentation and course in specific cultural and social contexts will be invaluable in helping to create appropriate approaches to surveillance, diagnostic assessment, and therapeutic innovation. Although some mental health programs are noteworthy for their measure of early success (including those in Kenya and Egypt), other programs have failed as a result of daunting problems: attrition or reassignment of personnel with mental health training, disinclination to care for the mentally ill, and interruptions in supplies of essential psychotropic medicines.

Creating a Focused and Relevant Research Agenda

Deficits in the global delivery of mental health services reflect, in part, substantial gaps in scientific knowledge about virtually all aspects of the delivery of such care in resource-poor settings. Scientific publications relevant to global mental health lag behind those in other relatively well-researched and well-funded clinical domains, such as the human immunodeficiency virus-acquired immune deficiency syndrome (HIV-AIDS), malaria, and tuberculosis.

Number of Scientific Publications

Addressing Global or International Health, According to Broad Disease Category, 1991-2012., and the Supplementary Appendix, available with the full text of this article at NEJM.org). At the same time, studies of mental health in populations living in regions outside high-income countries are underrepresented in the psychiatric literature, a problem that both perpetuates global health inequities and entails missed opportunities for important scientific research. A platform for scientific sharing and a research agenda honed to remediate deficits in the delivery of care are urgently required. Finally, the augmentation of research capacity on mental health in low- and middle-income countries is vital to generating an evidence base that will guide strategic planning and implementation.

Research is needed to refine diagnostic tools and algorithms for deployment in community and primary care settings, to identify mediators and modifiers of risk and resilience, and to measure the effectiveness of conventional and novel treatment-delivery strategies in a variety of health systems. Implementation and health outcomes research are particularly exigent. Analyses of the collateral, economic, and social effects of mental disorders may inform policymakers who are interested in understanding the relative cost-effectiveness of various mental health interventions as well as the costs of withholding them. Child and adolescent mental health is a neglected area that is of great concern given the strong evidence that mental disorders are predictors of adverse economic, social, and health outcomes in adulthood, resulting in costs that are difficult to measure but easy to appreciate. Because adolescents with mental illness typically have difficulty accessing mental health care, interventions that effectively address the formidable barriers confronting them - and other vulnerable sectors of the population - are essential. Another highly ranked research goal is the integration, to the greatest extent possible, of culturally informed screening for mental illness into primary care services.

Overcoming Barriers to Equitable Care

Even in regions in which mental health services are widely available, a sizable proportion of the population with mental illness does not receive care that is specific to the illness. Cultural practices affect the ways in which people cope with social adversity, manifest emotional distress and mental disorders, and seek care. Economic and social vulnerabilities may make medicines, appointments with health care professionals, and transportation to a clinic unaffordable and time lost from work too costly. For example, even though most low-income

countries include psychotropic agents on their list of essential medicines, in 85% of those countries these medications are not available at all primary health care facilities. Moreover, the high median cost of psychotropic medicines in these countries is often prohibitive (e.g., the cost of treatment with antipsychotic agents would equal 9% of the daily minimum wage, and antidepressants 7%) and together with the expenses of other necessary care may impose economically catastrophic costs on patients. Social adversity is both a risk factor and an outcome of poor mental health, and it compounds the disenfranchisement that exacerbates social structural barriers to health care.

The most basic cultural and moral barrier to the amelioration of global mental health problems continues to be the enormously negative, destructive, and almost universal stigma that is attached to mental illnesses, to patients with a mental illness and their families, and to mental health caregivers. At its worst, this stigma nullifies personhood and constitutes an abuse of human rights. But other forms of discrimination are more subtle and more structural. Psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers are not the only professionals who are targets of discrimination; it is our experience that health policy experts are also adversely affected by stigma, with the result that many shy away from making mental health care a priority. This situation may at last be undergoing positive change. The Ministry of Health in China has begun to advocate for patients with mental illness and to advance their interests, and similar agencies in other countries have begun to do so as well. There is other evidence that the deeply institutionalized stigma surrounding the field of mental health is being challenged and overcome. This may be the most difficult barrier to quantify and yet the most important to address.

An example of how far we still have to go is the exclusion of the topic of mental health from a recent series of papers, policies, and actions advocating priority for four major noncommunicable diseases on the global health agenda. The very sound rationale for urgent and focused global attention to noncommunicable diseases includes the fact that they contribute to a high burden of disease and to poverty, that they impede economic development and the attainment of other Millennium Development Goals, and that there are evidence-based and cost-effective interventions available to address them; these same arguments make an equally convincing case for the inclusion of mental health as a priority on the global agenda.

The collective global investment in the HIV-AIDS pandemic led to the recognition that building clinical capacity, pursuing technological advances, providing training for health

professionals and paraprofessionals, and engaging in other means of enhancing the health infrastructure in the service of a particular health intervention have the potential to strengthen health systems and accrue benefits across many clinical domains. The distinct clinical and cultural challenges characterizing mental health care delivery notwithstanding, this sort of investment would also seem to be the preferred direction for mental health.

Conclusions

According to virtually any metric, grave concern is warranted with regard to the high global burden of mental disorders, the associated intransigent, unmet needs, and the unacceptable toll of human suffering. Compelling arguments have been made that investment in mental health services is a matter of cost-effectiveness, social justice, and even a smart development strategy. Despite the dispiriting near-term forecast regarding improved quality and accessibility of mental health services in poor countries, important advances have been made in the requisite scientific knowledge base and political will to develop and implement policies that can upend these inequities and reset expectations for both the quality of global mental health care and the access to it. Closer alignment with the overarching agenda for global health is evident in the strengthened political commitment to mental health care and in the multilateral partnerships marshaling the resources to improve mental health in countries with limited resources. Several major initiatives have directed funding and attention toward addressing global mental health needs. These include the Mental Health and Poverty Project and the Programme for Improving Mental Health Care, both supported by the Department for International Development in the United Kingdom; the Grand Challenges Canada program; and Grand Challenges in Global Mental Health, led by the National Institute of Mental Health and the Global Alliance for Chronic Disease, in partnership with others. In 2012, the report from the Sixty-fifth World Health Assembly urged member states and the WHO director-general to take bold corrective actions. Mental health has arrived on the global health agenda; establishing it as a priority at the highest level is essential to match aspiration to need.

Dr. Becker reports receiving payments for editorial work from John Wiley and Sons, for editorial work, travel, and meeting participation from the Academy for Eating Disorders, and for travel and meeting participation from MA Healthcare, the Succeed Foundation, the American Psychiatric Association, and the National Eating Disorders Association. No other potential conflict of interest relevant to this article was reported.

kleinman@wjh.harvard.edu

MENTAL HEALTH: STRENGTHENING OUR RESPONSE

KEY FACTS

- More than 450 million people suffer from mental disorders. Many more have mental problems.
- Mental health is an integral part of health; indeed, there is no health without mental health.
- Mental health is more than the absence of mental disorders.
- Mental health is determined by socio-economic, biological and environmental factors.
- Cost-effective intersectoral strategies and interventions exist to promote mental health.

Mental health is an integral and essential component of health. The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important consequence of this definition is that mental health is described as more than the absence of mental disorders or disabilities.

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.

Determinants of mental health

Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. For example, persistent socio-economic pressures are recognized risks to mental health for individuals and communities. The clearest evidence is associated with indicators of poverty, including low levels of education.

Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations.

There are also specific psychological and personality factors that make people vulnerable to mental disorders. Lastly, there are some biological causes of mental disorders including genetic factors and imbalances in chemicals in the brain.

Strategies and interventions

Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of

more people experiencing better mental health.

A climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.

National mental health policies should not be solely concerned with mental disorders, but should also recognize and address the broader issues which promote mental health. This includes mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labour, justice, transport, environment, housing, and welfare, as well as the health sector.

Promoting mental health depends largely on intersectoral strategies. Specific ways to promote mental health include:

- early childhood interventions (e.g. home visits for pregnant women, pre-school psycho-social activities, combined nutritional and psycho-social help for disadvantaged populations);
- support to children (e.g. skills building programmes, child and youth development programmes);
- socio-economic empowerment of women (e.g. improving access to education and microcredit schemes);
- social support for elderly populations (e.g. befriending initiatives, community and day centres for the aged);
- programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psycho-social interventions after disasters);
- mental health promotional activities in schools (e.g. programmes supporting ecological changes in schools and child-friendly schools);
- mental health interventions at work (e.g. stress prevention programmes);
- housing policies (e.g. housing improvement);
- violence prevention programmes (e.g. community policing initiatives); and
- community development programmes (e.g. 'Communities That Care' initiatives, integrated rural development).

WHO response

WHO supports governments in the goal of strengthening and promoting mental health. WHO has evaluated evidence for promoting mental health and is working with governments to disseminate this information and to integrate the effective strategies into policies and plans.

More specifically, WHO's mental health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance use disorders for countries especially with low- and middle-income. When adopted and implemented, tens of millions can be treated for depression, schizophrenia, and epilepsy, prevented from suicide and begin to lead normal lives - even where resources are scarce.

HEALTH CARE WORKERS UNPROTECTED: INSUFFICIENT INSPECTIONS AND STANDARDS LEAVE SAFETY RISKS UNADDRESSED

Wrightson K, Lincoln T"Public Citizen"

Healthcare workers -- particularly nurses, nurses' aides, orderlies, and attendants -- suffer more musculoskeletal injuries than those working in any other field, a Public Citizen report found.

Those injuries cost the U.S. about $7 billion each year, according to the which was written by Keith Wrightson and Taylor Lincoln, both of the organization's Congress Watch division.

The increased number of on-the-job injuries may be the result of comparatively sparse rates of safety inspections at healthcare facilities, according to 2010 data from the Occupational Safety and Health Administration (OSHA).

The report compared OSHA-reported data between physical labor-intensive industries to draw comparisons for rates of inspection, injury, and employment. For example, the construction sector included 9.1 million workers in its ranks in 2010; they suffered a total of 74,950 injuries. Construction sites were subject to 52,179 OSHA inspections in that year.

In comparison, the healthcare and social assistance sector employed 18.9 million workers in 2010, who reported 176,380 injuries that year. OSHA conducted 2,504 inspections of healthcare and social assistance facilities in that same year.

"A partial explanation for the greater number of inspections in construction and manufacturing likely has to do with the severity of the injuries those employees tend to suffer," the report noted, adding that in 2010, 774 construction workers died, while 141 workers in the healthcare and social assistance field died that year.

They cautioned that although the proportion of deaths may explain the lower volume of inspections, "healthcare

inspections would need to be increased by about a factor of four to bring them into parity with construction sector inspections."

Additional explanations for the lower number of inspections include limited resources -- OSHA had a budget of $535.2 million budget for fiscal 2013 to monitor 7 million work sites and implement other programs -- and limited regulations aimed improving healthcare worker safety.

For the latter, the report noted that a 2000 ergonomics standard that "required employers to implement ergonomics programs in response to employee complaints about work-related musculoskeletal disorders" never took effect, and was repealed in early 2001 through a joint House and Senate effort.

However, the authors noted that prior implementation of OSHA standards has been successful in protecting healthcare workers and has also resulted in unexpected innovation and financial benefits for workers. One example is the Bloodborne Pathogens Standard, which requires exposure control, storage, and disposal of sharp devices and needles.

In addition, the Needlestick Safety and Prevention Act requires employers to "implement new developments in safety technology" and to "solicit employees' input in the selection of sharp devices."

They also noted that state laws and mandates from employers on safe practices and safe patient handling have helped protect employees at healthcare sites.

To address current deficits in employee safety, the report listed several recommendations for OSHA and also suggested prospective future regulations.

For safe patient handling, they recommended, the use of lifting and transfer aids or similar devices should be a requirement while caring for residents and patients, and this device assistance should be required during all shifts and units.

To address workplace violence, employers should take a zero-tolerance policy for workplace violence, verbal threats, and nonverbal threats, the report suggested. Additionally, facilities should require employees to report instances of workplace violence and offer suggestions on methods to minimize risk, as well as protection for those who report workplace violence.

The authors also suggested an amendment to current bloodborne pathogen regulations which included requirements for a comprehensive log of sharp device injuries that would be reviewed by management, use of the best-available technologies for sharp devices, and consultation with employees before the purchase of new sharp devices.

Finally, the report warned that the OSHA requires additional funding to "dramatically increase its number of inspections" and enforce new legislation, adding that the burdens placed on the healthcare industry will only increase as the number of baby boomers requiring nursing and living assistance grows over time.

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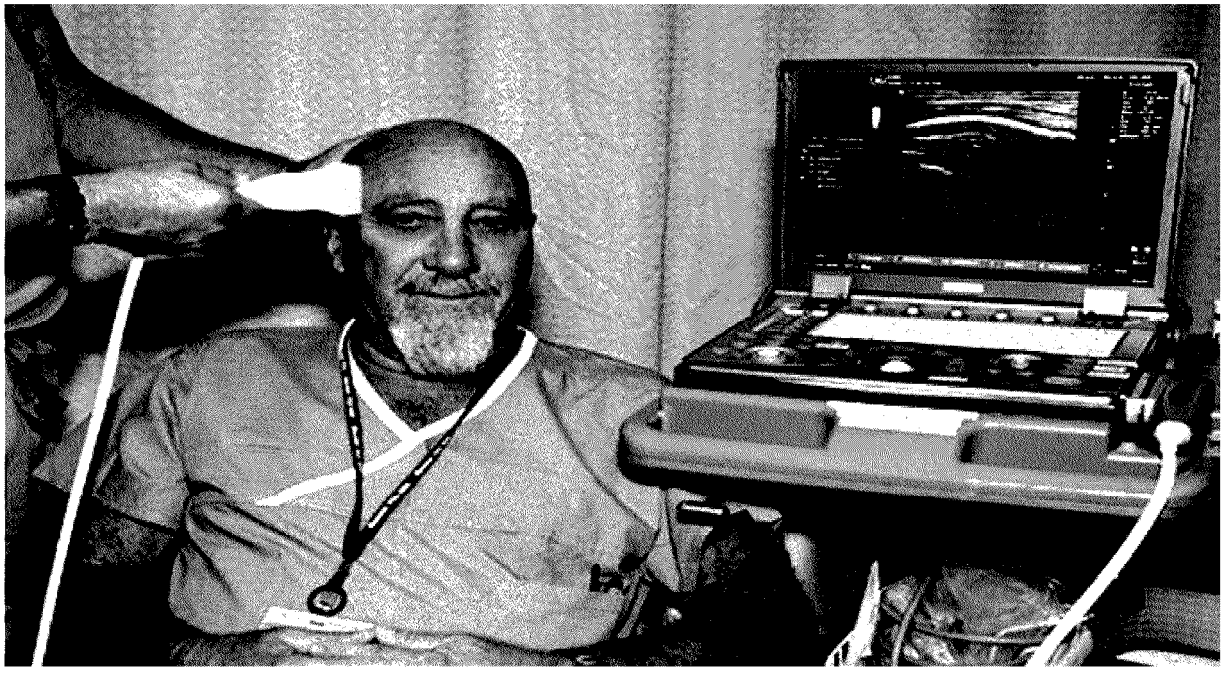
http://www.medpagetoday.com/HospitalBasedMedicine/RiskManagement/40572?xid=nl_mpt_guptaguide_2013-07-19&utm_source

GOOD VIBRATIONS: MEDIATING MOOD THROUGH BRAIN ULTRASOUND



Ultrasound vibrations applied to the brain may affect mood, UA researchers have discovered. The finding potentially could lead to new treatments for psychological and psychiatric disorders.

University of Arizona researchers have found in a recent study that ultrasound waves applied to specific areas of the brain appear able to alter patients' moods. The discovery has led the scientists to conduct further investigations with the hope that this technique could one day be used to treat conditions such as depression and anxiety.

Dr. Stuart Hameroff, professor emeritus of the UA's departments of anesthesiology and psychology and director of the UA's Center for Consciousness Studies, is lead author on the first clinical study of brain ultrasound, which was published in the journal Brain Stimulation.

Hameroff became interested in applying ultrasound to the human brain when he read about a study by colleague Jamie Tyler at the Virginia Polytechnic Institute, who found physiological and behavioral effects in animals of ultrasound applied to the scalp, with the waves passing through the skull.

Hameroff knew that ultrasound vibrates in megahertz frequencies at about 10 million vibrations per second, and that microtubules, protein structures inside brain neurons linked to mood and

consciousness, also resonate in megahertz frequencies. Hameroff proposed testing ultrasound treatment for mood on human brains.

"I said to my anesthesiology colleagues, 'we should try this on chronic pain patient volunteers.'" His colleagues respectfully suggested he try it on himself, first. Hameroff acquiesced.

After 15 seconds with an ultrasound transducer, a standard ultrasound imaging device, placed against his head, Hameroff felt no effect.

"I put it down and said, 'well, that's not going to work,'" he said. "And then about a minute later I started to feel like I'd had a martini."

His mood was elevated for the next hour or two, Hameroff said. Aware that his experience could be a placebo effect, an imagined effect derived from his expectation to feel a change, Hameroff set out to properly test the treatment with a clinical trial.

With research committee and hospital approval, and patient informed consent, Hameroff and his colleagues appliedtranscranial ultrasound to 31 chronic pain patients at The University of Arizona Medical Center-South Campus, in a double blind study in which neither doctor nor subject knew if the ultrasound machine had been switched on or off.

Patients reported improvements in mood for up to 40 minutes following treatment with brain ultrasound, compared with no difference in mood when the machine was switched off. The researchers confirmed the patients' subjective reports of increases in positive mood with a Visual Analog Mood Scale, or VAMS, a standardized objective mood scale often used in psychological studies.

"Encouraging!"Hameroff remarked. "We're referring to transcranial ultrasound as 'TUS,'" he added. "Which is also the airport code for Tucson."

"This was a pilot study which showed safety, and some efficacy, for clinical use of TUS," Hameroff said. "Beause important structures called microtubules in all brain neurons vibrate in the ultrasound range, and help mediate mood and consciousness, TUS may benefit a variety of neurological and psychiatric disorders."

The discovery may open the door to a possible range of new applications of ultrasound in medicine.

"We frequently use ultrasound in the operating room for imaging," said Hameroff. "It's safe as long as you avoid excessive exposure and heating."

The mechanical waves, harmless at low intensities, penetrate the body's tissues and bones, and an echo effect is used to generate images of anatomical structures such as fetuses in the womb, organs and blood vessels.

Additionally, the high-frequency vibrations of ultrasound, which far exceed the range of human hearing and are undetectable when passing through the body, may be more desirable than existing brain stimulation techniques such as transcranial magnetic stimulation, or TMS. Used to treat clinically depressed patients, TMS can have side effects including what some describe as an unpleasant sensation of magnetic waves moving through the head.

After finding promising preliminary results in chronic pain patients, Hameroff and his colleagues set out to discover whether transcranial ultrasound stimulation could improve mood in a larger group of healthy volunteer test subjects.

Jay Sanguinetti, a doctoral candidate in the department of psychology and his adviser John Allen, a UA distinguished professor of psychology, were intrigued by Hameroff's idea of testing ultrasound.

They conducted a followup study of ultrasound on UA psychology student volunteers, recording vital signs such as heart rate and breath rate, and narrowed down the optimum treatment to 2 megahertz for 30 seconds as the most likely to produce a positive mood change in patients.

"With 2 megahertz those who were stimulated with ultrasound reported feeling 'lighter,' or 'happier;' a little more attentive, a little more focused and a general increase in well-being," Sanguinetti said.

Allen and Sanguinetti then began a double blind clinical trial to verify the statistical significance of their findings and to rule out any possibility of a placebo effect in their patients. Results of the trials are being analyzed, Sanguinetti said.

"What we think is happening is that the ultrasound is making the neurons a little bit more likely to fire in the parts of the brain involved with mood," thus stimulating the brain's electrical activity and possibly leading to a change in how participants feel, Sanguinetti said.

The UA researchers are collaborating with the Silicon Valley-based company Neurotrek, which is developing a device that potentially could target specific regions of the brain with ultrasound bursts. The UA researchers will work with a prototype of the Neurotrek device to test its efficacy and potential applications.

Said Sanguinetti: "The idea is that this device will be a wearable unit that noninvasively and safely interfaces with your brain using ultrasound to regulate neural activity."

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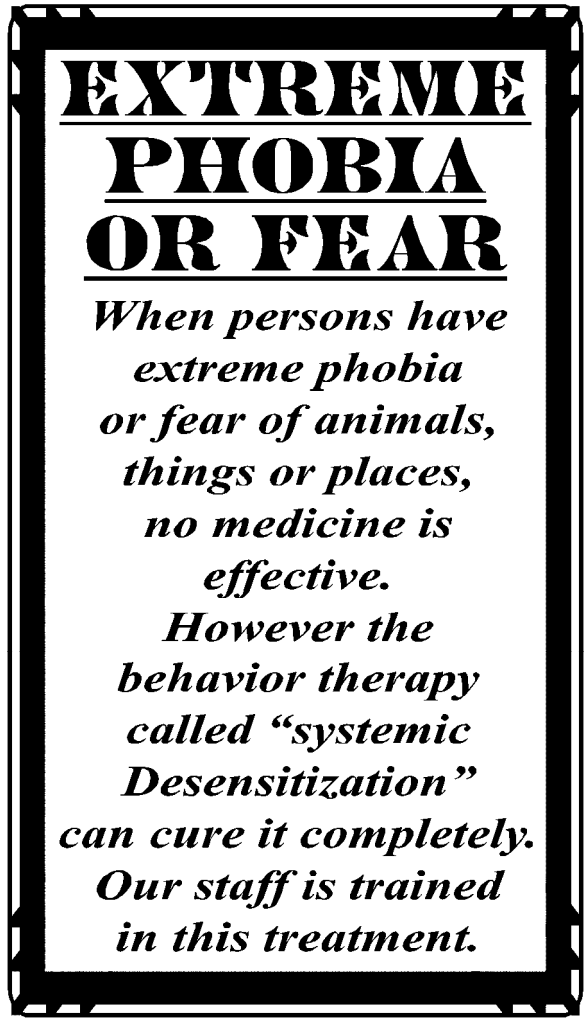

HARSH PHYSICAL PUNISHMENT IN CHILDHOOD AND ADULT PHYSICAL HEALTH

Afifi TO, et al"Pediatrics"

Children who were punished physically had higher risks for cardiovascular disease, arthritis, and obesity in adulthood, researchers found.

Compared with adults who were not punished physically as children, those who received harsh physical punishment in childhood were 24% more likely to be obese (95% CI 1.05-1.47) and 35% more likely to have arthritis (95% CI 1.10-1.69).

Children disciplined with physical punishment were also significantly more likely to have cardiovascular disease as adults (adjusted OR 1.38, 95% CI 1.08-1.76), though this association only approached significance after additional adjustment (aOR 1.28, 95% CI 1.00-1.64).

Prior research has established relationships between physical punishment -- such as pushing, grabbing, shoving, slapping, and hitting -- and mental disorders, aggression, delinquency, and physical injury. Additionally, other research has shown a link between long-term effects on health-related quality of life with physical abuse, sexual abuse, emotional abuse, intimate partner violence, and neglect. However, past studies have not explored long-term physical health consequences on adults who grew up receiving physical punishment.

The authors studied the effects of physical punishment on eight long-term health effects in a sample of 34,226 U.S. adults and compared with a representative sample of U.S. adults.

Data were collected through the National Epidemiologic Survey on Alcohol and Related Conditions for 2004 to 2005, which assessed physical punishment and childhood maltreatment.

Participants were considered to have received physical punishment as a child if they responded with 'sometimes or greater' to a question on how often they were pushed, grabbed, shoved, slapped, or hit by an adult in their home. The authors cautioned that some of those physical interactions may also be considered maltreatment or may have been coupled with other forms of abuse or maltreatment.

The study also assessed eight physical conditions and whether participants were afflicted by them in the past year, including arteriosclerosis or hypertension, hepatic disease, diabetes, cardiovascular disease, gastrointestinal disease, arthritis, and obesity. Obesity was categorized by the participant's reported height and weight, while the other conditions were diagnosed by a healthcare professional.

Covariates included gender, age, income, years of education, marital status, ethnicity, family history of household dysfunction, and Axis I and II mental disorders, which included major depression, dysthymia, mania, hypomania, social phobia, generalized anxiety disorder, panic disorder with or without agoraphobia, specific phobia, agoraphobia, posttraumatic stress disorder, alcohol abuse, drug abuse, and nicotine dependence, and antisocial, avoidant, dependent, borderline, histrionic, paranoid, schizoid, schizotypal, narcissistic, and obsessive-compulsive personality disorders.

The researchers adjusted odds ratios twice, including one model that adjusted for sociodemographic data and another that added household dysfunction and Axis I and II disorders.

The prevalence of physical punishment was lower than that of child maltreatment (3.6% versus 38.1%).

In addition to associations between physical punishment and cardiovascular disease, arthritis, and obesity, there was a significant correlation with physical punishment and any physical condition (aOR 1.24, 95% CI 1.05-1.47).

Odds of a given condition were lower after adjustment for household dysfunction and mental disorders.

The authors also noted that when odds of participants being subject to any of the eight physical condition categories were compared, there was no significant difference in odds between those who had been maltreated or those who had experienced physical punishment as children.

They offered a number of potential mechanisms of action for these relations, such as dysregulation of the hypothalamus-pituitary adrenal axis, altered brain structure, and the relation between emotional and physical health seen in patients subject to maltreatment.

In an accompanying editorial, Rachel Berger, MD, of the Children's Hospital of Pittsburgh of the University of Pittsburgh Medical Center, and Adam Zolotor, MD, of the the University of North Carolina School of Medicine, found the authors' conclusions about physical punishment to be lacking, particularly in their use of "harsh physical punishment" as the target in the association.

They cautioned that the study should have included nonharsh physical punishment in its measures, adding that "physical punishment which does not reach the level of being considered harsh is likely the most common type of discipline," though they did not define what constitutes nonharsh physical punishment.

The study was limited by a cross-sectional design, absent measures of lifetime outcomes for the eight physical conditions, and lack of confirmation of self-reported data. The authors also found the study was limited by retrospective data collection, retrospective recall of parental psychopathology, and missing data on parental physical health conditions.

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'FIRST BIONIC EYE' RETINAL CHIP FOR BLIND

University Hospitals (UH) Eye Institute will be one of the first medical centers in the United States to offer the Argus® II Retinal Prosthesis System ("Argus II").

The Argus II is the first and only "bionic eye" to be approved in countries throughout the world, including the U.S. It is used to treat patients with late stage retinitis pigmentosa (RP). Argus II was developed by Second Sight Medical Products, Inc., located near Los Angeles.

In preparation for the launch of Argus II later this year, implanting centers, including UH, will soon begin to accept consultations for patients with RP. UH is one of a select number of medical centers in 12 major markets in the nation, and the only one in Cleveland and the state of Ohio, chosen by Second Sight to offer the Argus II, which received FDA approval earlier this year. Argus II works by converting video images captured by a miniature camera, housed in the patient's glasses, into a series of small electrical pulses that are transmitted wirelessly to an array of electrodes on the surface of the retina. These pulses are intended to stimulate the retina's remaining cells resulting in the corresponding perception of patterns of light in the brain. Patients then learn to interpret these visual patterns thereby regaining some visual function.

"This is a remarkable breakthrough," said Suber S. Huang, MD, MBA, Director, UH Eye Institute's Center for Retina and Macular Disease, who also served as the Independent Medical Safety Monitor for clinical trials of the system and gave the summary closing to the FDA Ophthalmic devices panel.

"The system offers a profound benefit for people who are blind from RP and who currently have no therapy available to them. Argus II allows patients to reclaim their independence and improve their lives." RP is a rare inherited, degenerative eye disease that often results in profound vision loss to the level of bare light perception or no light perception. It affects nearly 100,000 Americans. Noted Cleveland businessman and professional sports owner Gordon Gund is blind from this disease.

"We are thrilled that several of the nation's top hospitals will be the first to offer Argus II to patients in the U.S.," said Brian Mech, Vice President of Business Development, Second Sight. "After an intensive and difficult selection process, these sites were chosen for their cutting-edge approach to medicine and unparalleled commitment to patient care. We are confident that RP patients seeking treatment at these centers will benefit greatly from the best-in-class services these sites provide."

Argus II had more than 20 years of work in the field, three clinical trials, more than $100 million in public investment by the National Eye Institute, the Department of Energy, and the National Science Foundation, and an additional $100 million in private investment.

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ACCORDANCE TO DIETARY APPROACHES TO STOP HYPERTENSION (DASH) IS ASSOCIATED WITH SLOWER COGNITIVE DECLINE

Morris, M et al"AAIC"

Evidence continues to grow that a diet rich in vegetables, legumes, and nuts -- and low in fat -- may help to protect against cognitive decline in older persons.

Adherence to the Dietary Approaches to Stop Hypertension (DASH) diet was linearly associated with slower cognitive decline in a prospective cohort study of persons 65 years and older (P=0.006).

"To put this into context, people in the top tertile of adherence to the diet were the equivalent of 4.5 years younger in age than people in the lowest tertile," she said.

Randomized controlled trials have shown that the DASH diet offers a host of cardiovascular benefits, from lowering blood pressure to preventing diabetes and reducing cholesterol, inflammation, and oxidative stress.

After a study presented at AAIC in 2009 suggested the diet may also be protective against cognitive decline, investigators called for further prospective research to validate the findings -- which is just what Morris and colleagues did.

The researchers studied 1,559 participants of the Rush Memory and Aging Project who agreed to complete a 139-item validated food frequency questionnaire.

A DASH diet score was created based on consumption of the food groups and nutrient components that comprise the diet -- fruits, vegetables, whole grains, nuts and legumes, dairy, meat, and fish, sodium, sweets, saturated fats, and total fat -- with higher scores reflecting better DASH accordance. Participants were then divided into tertiles based on their DASH scores.

"It's a nice way of looking at the diet as it incorporates the entire dietary pattern, not the individual nutrients, which do not act alone in the body," Morris said. "Also the public health message is a little easier to relate: People might not underhand what tocopherol is, but they do understand servings of whole foods."

In addition to annual neurological examinations, participants agreed to a battery of 19 cognitive tests covering episodic memory, semantic memory, working memory, visuospatial abilities, and perceptual speed. The final cohort comprised 823 participants who completed the food questionnaire and had undergone two or more cognitive assessments over a median follow-up time of 4 years.

Results showed that in mixed models adjusted for age, sex, race, and education, the higher the DASH score, the slower the rate of cognitive decline. Specifically, each 1-point increase in DASH score was associated a 0.01-point decrease in the rate of cognitive decline (P=0.006).

"When looked at individually, this linear relationship held true for all of the cognitive domains analyzed," Morris said.

Further analysis revealed that the DASH components that contributed most to slower cognitive decline were increased consumption of vegetables, nuts, seeds, and legumes and lower intake of total and saturated fat.

Ronald Peterson, MD, of the Mayo Clinic, told that more and more evidence suggests that cardioprotective diets may also help to preserve cognition.

Other heart-healthy diets, such as the Mediterranean diet, have also been linked to better cognition, he noted.

http://www.medpagetoday.com/TheGuptaGuide/Neurology/40566?xid=nl_mpt_guptaguide

FRENCH STAMP INSPIRED BY TOPLESS FEMINIST CAUSES STIR

A new stamp emblazoned with the face of Marianne, France's revolutionary symbol, has caused a stir after its creator said it was inspired by a Ukrainian feminist known for topless protests.

The stamp, unveiled by President Francois Hollande on national day, shows the face of a youthful, dewy-eyed Marianne from the shoulders up, her long hair flowing down and her hand raised.

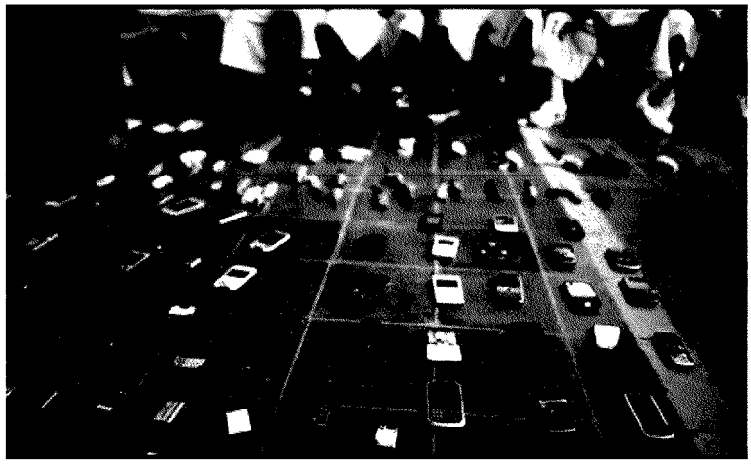
"For all those who ask who the model was for Marianne, it's a mix of several women, but particularly Inna Shevchenko," Olivier Ciappa, one of the stamp's designers, said on his Twitter account.

The 23-year-old Shevchenko, a Ukrainian who has been granted political asylum in France, is the leader of the French branch of Femen, a self-declared "radical feminist" group known for its topless protests against sexual exploitation of women, sexism and religious institutions.

Wearing a bonnet and always bare-breasted, she has also been a fixture of French stamps for decades, and artists are regularly asked to design new versions of the revolutionary symbol.

SCIENTISTS POWER MOBILE PHONE USING URINE

Agence France Presse



British scientists said they have harnessed the power of urine and are able to charge a mobile phone with enough electricity to send texts and surf the Internet.

Researchers from the University of Bristol and Bristol Robotics Laboratory in south west England said they had created a fuel cell that uses bacteria to break down urine to generate electricity, in a study published in the Royal Society of Chemistry journal Physical Chemistry Chemical Physics.

"No one has harnessed power from urine to do this so it's an exciting discovery," said engineer loannisleropoulos.

"The beauty of this fuel source is that we are not relying on the erratic nature of the wind or the sun; we are actually reusing waste to create energy.

"One product that we can be sure of an unending supply is our own urine," he added.

The team grew bacteria on carbon fibre anodes and placed them inside ceramic cylinders.

The bacteria broke down chemicals in urine passed through the cylinders, building up a small amount of electrical charge which was stored on a capacitor.

Ieropoulos hoped that the cell, which is currently the size of a car battery, could be developed for many applications.

"Our aim is to have something that can be carried around easily," he explained.

"So far the microbial fuel power stack (MFC) that we have developed generates enough power to enable SMS messaging, web browsing and to make a brief phone call.

"The concept has been tested and it works - it's now for us to develop and refine the process so that we can develop MFCs to fully charge a battery."

They hope the technology will eventually be used to power domestic devices.

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http://www.newsdaily.com/article/26f960e5427baca1629beba88c775ab8/scientists-power-mobile-phone-using-urine

LOW SELF-CONTROL PROMOTES THE WILLINGNESS TO SACRIFICE IN CLOSE RELATIONSHIPS

F. Righetti, C. Finkenauer, E. J. Finkel..Psychological Science

When faced with the choice of sacrificing time and energy for a loved one or taking the self-centered route, people's first impulse is to think of others. "For decades psychologists have assumed that the first impulse is selfish and that it takes self-control to behave in a pro-social manner," says lead researcher Francesca Righetti of VU University Amsterdam in the Netherlands. "We did not believe that this was true in every context, and especially not in close relationships."Righetti and colleagues sought to examine whether impulsivity, in close relationships, might actually benefit others.They found that participants whose self-control was taxed (and were thus more impulsive) were more willing to sacrifice time and energy for their romantic partner or best friend than participants whose self-control wasn't taxed.In one study, to find out whether they would sacrifice in actual practice, the researchers told couples they would have to talk to 12 strangers and ask them embarrassing questions. The participants didn't know that they wouldn't actually have to follow through with the task.

Participants with high self-control opted to split the burden right down the middle -- assigning six strangers to themselves and six strangers to their partner. But participants with low self-control opted to take on more of the burden, sacrificing their own comfort to spare their partners.

A final experiment revealed that married individuals low in trait self-control sacrificed more for their partners, yet were also less forgiving of their transgressions -- presumably because self-control is required to override the focus on the wrongdoing and think instead about the relationship as a whole.

While sacrificing for a partner may help to build the relationship on a day-to-day basis, Righetti and colleagues note that it could backfire over the long-term, compromising individuals' ability to maintain a balance between personal and relationship-related concerns.This balance is a perennial issue for anyone in a close relationship:"Whether it's about which activities to engage in during free time, whose friends to go out with, or which city to live in, relationship partners often face a divergence of interests -- what is most preferred by one partner is not preferred by the other," notes Righetti.

The field of research is relatively new, so the jury is still out on what effects sacrifice has on relationship well-being, but Righetti is hopeful that research over the next few years will shed more light on the link.

Co-authors on this research include CatrinFinkenauer, also of VU University Amsterdam in the Netherlands, and Eli Finkel of Northwestern University.

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www.sciencedaily.com/releases/2013

PHYSICAL ACTIVITY FREQUENCY AND RISK OF INCIDENT STROKE IN A NATIONAL US STUDY OF BLACKS AND WHITES

McDonnell MN, et al"Stroke"

People who consider themselves physically inactive have an increased risk of stroke, adding to previous evidence of the association, results of a large cohort study showed.

Self-reported low activity was associated with a 20% increase in stroke risk, as compared with people who reported higher levels of physical activity.

Adjustment for traditional stroke risk factors reduced the impact of physical activity to 14% excess risk, which was no longer statistically significant.

Any effect of physical activity is likely to be mediated through reducing traditional risk factors.

Physical inactivity trails only hypertension as a contributor to stroke risk, having an estimated population-attributable risk of 28.5%.

Whether precise amounts or type of activity influences stroke risk has been unclear, the authors noted in their introduction.

Meta-analyses have suggested that regular physical activity reduces stroke risk by 25% to 30% as compared with little or no activity. Recent evidence has pointed toward differences in the impact of physical activity on stroke risk by sex.

In an effort to clarify the association between physical activity and stroke, McDonnell and colleagues analyzed data from the Reasons for Geographic and Racial Differences in Stroke (REGARDS) study, a national, multiracial prospective cohort study.

The analysis comprised 30,239 REGARDS participants ?45, including oversampling in the Stroke Belt region of the southeastern U.S.

Baseline data collection included self-reported physical activity, defined as the weekly frequency of activity sufficiently intense to cause sweating. Physical activity could include leisure, commuting, and occupational activities.

On the basis of the activity frequency, investigators separated the participants into three groups: 1=no activity, 2=one to three times per week, and 3=four or more times weekly.

During a mean follow-up of 5.7 years, investigators documented 918 incidents of stroke and transient ischemic attack.

After adjustment for age, sex, race, and interaction between age and race, a significant association between physical activity and stroke emerges.

Comparison of the lowest and highest

frequencies of physical activity produced a hazard ratio of 1.20 (95% CI 1.01-1.42). Self-reported frequency of one to three times weekly was associated with a hazard ratio of 1.14, which did not achieve statistical significance (95% CI 0.96-1.35).

After adjustment for other stroke risk factors (diabetes, hypertension, body mass index, alcohol consumption, and smoking), the hazard declined by 30% to 1.14 and was no longer significant (95% CI 0.95-1.37, P=0.17).

Investigators also compared the highest frequency of physical activity with a weekly frequency of zero to three. The analysis produced an adjusted hazard ratio of 1.18 for stroke for the lower frequency (95% CI 1.01-1.36). Adjustment for region, urban/rural residence, and socioeconomic status attenuated the association and made it no longer significant (HR 1.17, 95% CI 0.99-1.36).

Analysis by stroke type (ischemic versus hemorrhagic) did not appreciably alter the results.

Separate analyses of men and women showed a significant association between frequency of physical activity and stroke risk among men (HR 1.26 to HR 1.30) but not women.

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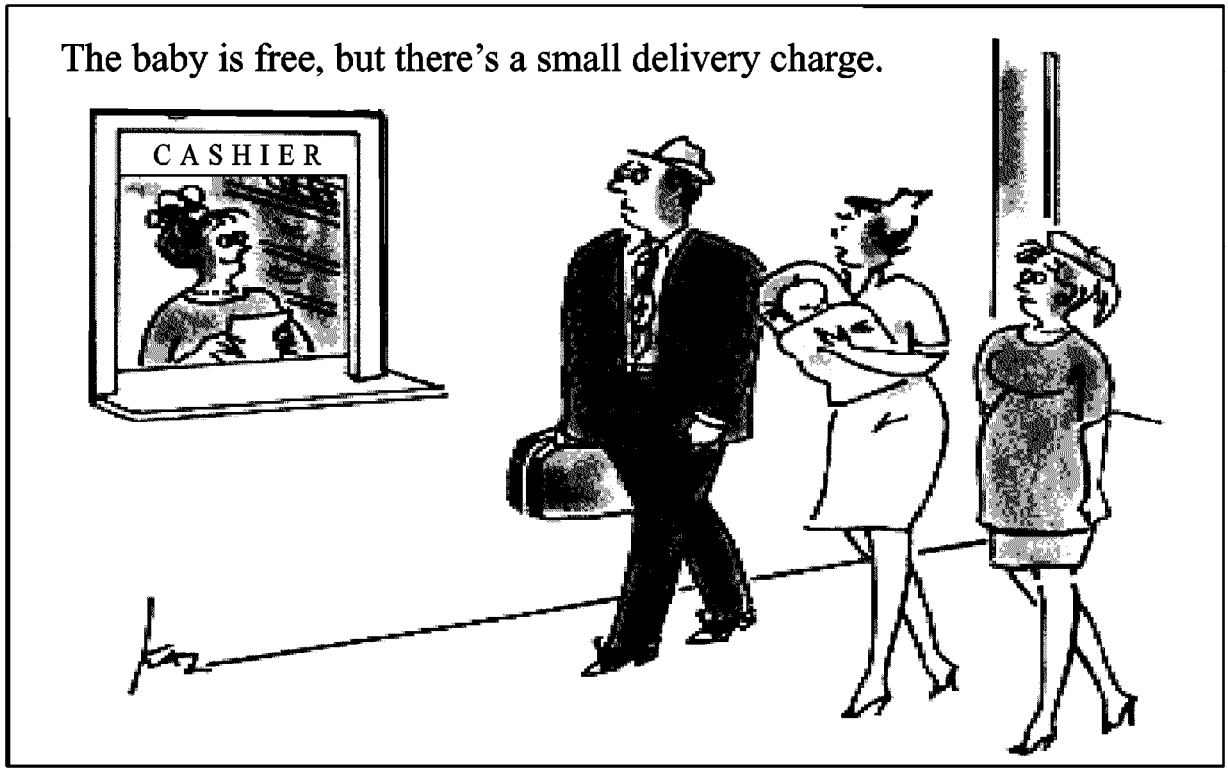
http://www.medpagetoday.com/Cardiology/Strokes/40577?xid=nl_mpt_DHE_2013-07-20&utm_content=&utm_medium



TEMPORARY MARRIAGE BECOMES POPULAR AMONG YOUNG UK MUSLIMS

(From an article by Murtaza Ali Shah in the News)

Young British Muslims are increasingly turning towards Mut'ah or temporary marriage for better understanding with each other and to assess if the couples are compatible and can last long but also to balance their religious beliefs with their modern Western lifestyle.

A research by the BBC has shown that Mut'ah, an ancient Islamic practice that unites man and woman as husband and wife for a limited time, is being adopted by young people from all Muslim backgrounds including those of Pakistani heritage.

Researcher and journalist Shabnam Mahmood, who investigated the Mut'ah practice in Britain, told The News that there are no official statistics available for the number of people who carry out the 'NikahMut'ah' because the contracts are performed between a man and woman and it is a private affair. "Many people are willing to talk openly about the subject. Many are reluctant to admit that they have had or are in a 'NikahMut'ah'.

She added: "Many use it during the engagement process until the day of their marriage is fixed. I found that it was mainly carried out among the Shia population but there are many Sunnis I spoke to who had also done a 'NikahMut'ah'. In Britain there are many Shias from the Pakistani community who have done 'NikahMutah'. The Sunnis tend to do it less but still I met some Pakistani Sunnis who said they would do it if they needed to."

The BBC featured a Pakistani origin girl Sara, a 30 year old pharmacist from Birmingham, who explained that she entered into a 'NikahMut'ah' because she didn't want to break the bounds of Sharia and wanted to know her prospective husband in a relaxed atmosphere. She was temporarily married for six months before committing to a full marriage with her partner.

"We stipulated the duration, my father's conditions, and I requested what you would call a dowry where the guy gives a gift to the girl. It's simple, straightforward and doesn't take long at all," Sara said.

Mut'ah is a controversial topic and while some sections of the Muslims societies consider it Islamic and halal, some think its haram and forbidden. While some Muslims clerics have called the practice "prostitution", others have argued that Mut'ah exactly prevents "prostitution".

Omar Farooq Khan, president of the AhlulBayt Islamic Society at Bradford University, said the practice is on the increase among Shia students on university campuses. He agreed that it

was a taboo subject but provides a buffer to the "girlfriend or boyfriend" culture.

Khola Hassan, a spokesperson for the UK Islamic Sharia Council, said the practice is strictly not allowed.

SayyadFadhilMilani, spiritual leader at the Al-Khoei Centre in Brent, north-west London, said: "Islam does not permit relationships like those between a boyfriend and a girlfriend. So a nikahmut'ah gives them an opportunity to get to know each other before committing themselves to a full marriage."

Omar Ali Grant, a convert to Islam from London, told the programme he has had around 13 temporary marriages but argued that he was just trying to find the right person to spend his life with.

The News is aware that many well-known converts to both Shia and Sunni Islam have entered into NikahMut'ah but in many instances have kept it a secret. A former showbiz celebrity who became Muslim several years ago, told The News on condition of anonymity that she has had three 'NikahMut'ahs' because she didn't want to rush into a full marriage to find that the man was not of her liking.A practising Muslim from European background, she is currently in a NiakhMut'ah and lives in London.

MALALA YOUSAFZAI VERSES OTHER MALALAS

(From an article by Ayaz Amir in the News)

At the UN the message was a bit clouded. For one, Malala was being shepherded by that unconvincing US Global Envoy for Education, former British prime minister Gordon Brown. With Tony Blair, he was one of the principals who took his country into a false and unjust war against Iraq, laying that country to waste, displacing two million people, resulting in the deaths of hundreds of thousands (the definitive tally still to be determined), and, among other consequences, turning a largely secular country into a breeding ground of sectarian violence. There was no Al-Qaeda in Iraq before. Thanks to the Iraq war, there now is.

To see this figure not taken seriously by even his countrymen anymore, championing Malala'scause, even if Malala and her father can do with all the help they can get, it grates. If Tony Blair, Dick Cheney, and Gordon Brown were the only ones at the gates of heaven selling entry tickets, they would still invite questioning glances.

Malala when she was shot at didn't have to say anything. She was her own message, the experience she had gone through enough to rock the whole of Pakistan, and the world besides. But at the UN what she said, eloquent though it was, touched only one aspect of the truth.

"Thousands of people have been killed by the terrorists and millions have been injured", she said. But who are the terrorists? If we accept the American definition of terrorism, that Al-Qaeda and the Taliban are terrorists, is it all that irrelevant to ask as to who's killed more people since the September 11 attacks, the 'terrorists' or the apostles of right, the Americans? Who's responsible for the horrors of Iraq? And what was the connection between the 9/11 attacks and Iraq?

Malala is not to be blamed. Even if we take her words as her own, it is not for her to write a PhD dissertation on terrorism and its various permutations. That is the business of others. Even so, the choreography of her UN appearance sends across a clear political message: that there is a body of men who are terrorists, who are responsible for the violence plaguing the world, and that we - Gordon Brown and his armies - are the purveyors of light, prophets of virtue, including education for girls and equal opportunities for women…in short, the torchbearers of civilisation.

Malala is not the issue here. This message is the issue, for it is as distorted and indeed as perverted as the grounds made out for the twin occupations of Afghanistan and Iraq.

There is so much literature, western literature, that has come out about Bin Laden and Al-Qaeda. There are so many books, some of them fascinating and revealing, about the Bush White House and the shenanigans of Dick Cheney and Don Rumsfeld. The Al-Qaeda guys may sound bigoted and misguided, with a one-dimensional view of the world. They don't come across as criminals. But the key figures of the Bush administration with their lies and manipulations, manipulating not just the world but their own institutions, they really come across as a bunch of outright criminals. Even the CIA was telling them, ever so timorously, about judiciousness and restraint. But these cowboys rode roughshod even over those weak caveats.

The same thing was happening in the UK, Blair and Brown but principally Blair, manufacturing a tissue of lies and half-truths to support the case for going to war, and after the event twisting and shuffling to evade historic responsibility for what they had done. Brown was a forgotten figure after losing office, no one paying much attention to him. Far from helping Malala, it is Malala who has helped him by making him look useful and relevant. And this is just the beginning. There is a book to be written and a Hollywood documentary to be made. So my guess is that escaping Brown won't be that easy.

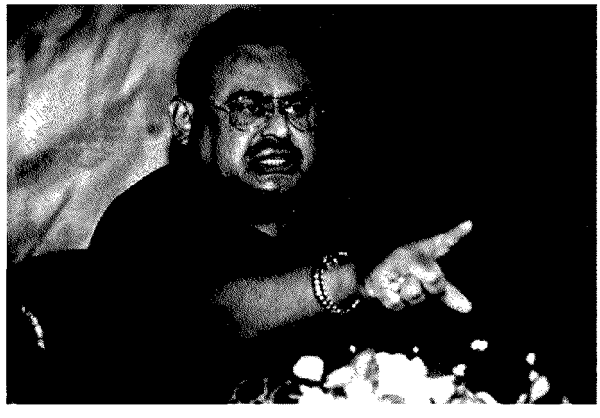
"I raise up my voice", said Malala, "not so that I can shout but so that those without a voice can be heard." The US army used depleted uranium shells to wreak havoc on the Iraqi town of Fallujah. America's role in the 'war on terror' could fill a new set of Nuremburg diaries. But the chances are remote of any child victim of the Fallujah bombing, or a child victim of drone strikes in Pakistan's tribal areas, being given a hearing at the UN. To the victors not only the spoils, but also the interpretation of history.

ALTAF IN THE EYE OF THE STORM

The party that has ruled Karachi with an iron fist from London has three serious criminal investigations in Britain to deal with

(From an article by Murtaza Ali Shah in the News)

These are troubling times for the MuttahidaQaumi Movement (MQM). The party of middle-class origins, which rules Pakistan's commercial hub with full control, has been in trouble at various stages since its foundation almost three-and-a-half decades ago but what the party is going through at the moment is unprecedented in its nature and has serious implications for the party, its leadership and its future course of action.



The MQM has attempted to look normal and calm amidst the storm currently swirling around it, but the advent of social media and the proliferation of regulated and irregular news outlets has caused the party serious headache. While the MQM's past troubles with the 'establishment' has its origin in Pakistan, the current troubles have their origin in the United Kingdom, which must be troubling for the MQM leader and founder, AltafHussain, who made London his base more than two decades ago and operated from the UK unscathed and untroubled all these years despite severe reservations expressed by sections of the Pakistan government.

The MQM has always said that Hussain left Pakistan because politically motivated charges were registered against him - all those charges were scrapped when the infamous National Reconciliation Order (NRO) was implemented, making AltafHussain stand in the league of Benazir Bhutto and Asif Ali Zardari as amongst the biggest beneficiaries of the NRO.

Perhaps, things changed forever on 16 September 2010 when Dr Imran Farooq, one of the founders and convener of the MQM, was butchered outside his home on Green Lane in Edgware, about five minute walk from the MQM's London headquarters. The Counter-terror Command Unit of the

Metropolitan Police is investigating the killing and suspects that DrFarooq, who had been sidelined from the party at the time of his killing due to differences with the leadership, was killed because he had ambitions to start his own political party and was in talks with members of the MQM in Britain and Karachi for the formation of his own party.

So far, at least 8 people linked with the MQM have been interviewed under caution.

On July 24 this year, the police arrested IftikharHussain, 52, a cousin of AltafHussain, and interviewed him in relation to DrFarooq's killing and bailed him till a date in September. The Met Police says it is determined to catch the killers of DrFarooq.

On December 6 last year, the Metropolitan Police executed a search warrant under Section 1 of the Police and Criminal Evidence Act (PACE) at the MQM Secretariat in London in relations to DrFarooq's killing but the police were shocked to find a large quantity of hard cash stashed in the corner of a room. The police seized the money and thus began a new investigation under the Proceeds of Crime Act (POCA) - which is money laundering investigation.

On the 18th of June this year, the police launched dramatic raids in Edgware area on two properties - one of which is registered under AltafHussain's name - and found large amounts of cash. The BBC has claimed that the seized amount from Hussain's House is £200,000 and the MQM's office about £150,000 and the amount seized from the third house - if not more properties - is not known but the MQM leader has said that the money seized was "political donation".

In any case, what is undisputed is the fact that the MQM leaders have a lot of questions to answer. The discovery of properties, as reported in media, worth millions of pounds for a party leadership that extols its middle-class credentials time and time again has exposed the party to ridicule and it will be hard for the property to employ the same rhetoric of revolution and austerity as its opponents will come back with digs at the party leadership's own immense wealth - which is now known in public.

Then there is a third investigation which directly involves AltafHussain and the speeches he has made to Pakistan from London. This investigation started after Hussain allegedly threatened Pakistan Tehreek-e-Insaaf (PTI) supporters during his 'Teen Talwar' speech and Pakistani TV anchors soon after the 11th May elections. After Imran Khan encouraged his middle-class and educated supporters to protest against the alleged threats of Hussain, an unprecedented number of Pakistanis wrote and called the Metropolitan Police demanding an investigation into the remarks of AltafHussain for 'inciting violence" in Pakistan through his speeches.

AFAQ CALLS FOR REOPENING CASES AGAINST ALTAF

(From an article by ShamimBano in the News)

The Pakistani government must pursue the British authorities to extradite AltafHussain and reopen hundreds of murder cases against him, said MohajirQaumi Movement-Pakistan (MQM-P) chairman Afaq Ahmed.

"The MQM chief has been involved in a number of high-profile cases of murder of his party workers, including Azeem Tariq," he alleged while addressing a press conference at his residence in DHA.

"If cases against President Ali Zardari can be opened, then AltafHussain should also be tried in about 14,000 murder cases in which he was directly involved," Ahmed added.

MuttahidaQaumi Movement leader Dr Imran Farooq's grisly murder was another addition to the morbid list.

"But it will be unfair on the face of Hussain to be involved in only one murder case," said Ahmed. "He must be investigated for thousands of murder cases in Karachi."

Answering a question whether he would become a party against the MQM chief, Ahmed replied that he was already a party in several cases filed in the Sindh High Court.

Recalling the murder of MQM chairman Azeem Tariq in 1993, he said that everyone knew who the murderer was. "If the MQM chief was really sincere with Tariq, the condition of his grave would have been in a better condition as compared to the others in the same necropolis."

"Altaf would soon reach its logical end and nobody can save him. He must bear the fruit of what he sowed."

Commenting on Hussain's wealth, the MQM-P chief claimed that if it was indeed only party fund donated by its activists and supporters, then the details must be submitted to the election commission.

"The MQM collects money through illegal means, including China-cutting plots," he alleged. "All the looted money should be brought back to the country. This scandal is much bigger than the finance companies scam."

Ahmed feared that if the situation persisted, Karachi would be pushed into a state of virtual lockdown with a prevailing air of dread.

"The investigation of British authorities in the Imran Farooq murder case has opened a new bloody chapter in Pakistani politics which will result in violence beyond this country's border," he said, requesting the Mohajir youth to revisit their strategy and come out of the turbulence.

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خود یہ احساس ہو جائے یا کوئی اللہ کا بندہ ان کی بروقت رہنمائی کر دے۔

صفحہ نمبر ۴۹ پر آپ فرماتے ہیں پھر اب تھوڑے تھوڑے وقفے کے بعد نئی نئی ادویات ایجاد ہو رہی ہیں، لیکن نئی دوائیں بہت مہنگی ہیں۔ جبکہ پرانی دوائیں انتہائی سستی اور موثر ہیں۔

صفحہ نمبر ۶۰ پر کہتے ہیں میں نے ایک چھوٹی سی ریسرچ میں ۴۰ مقتول عورتوں کا پتا چلایا تو اس میں سے ۳۳ فیصد اپنے خاوند کے ہاتھوں ماری گئی ۔ مجھے تقریباً یقین ہے کہ قاتل اس پیرانوئیڈ بیماری کے مریض تھے۔

صفحہ نمبر ۶۵ پر ڈاکٹر صاحب مرگی کے بارے میں لکھتے ہیں کہ مرگی کے دورے کی سب سے بڑی نشانی یہ ہوتی ہے کہ ہر دفعہ یہ ایک ہی شکل اور ایک ہی تصویر میں حملہ کرتی ہے۔ جیسا کہ کرکٹ میں دوبارہ کھیل دکھایا جاتا ہے۔ اگر دورے کی شکل ہر دفعہ بدلتی رہے تو وہ مرگی کا دورہ نہیں ہوگا، بلکہ ہسٹریا کا دورہ کہلائے گا۔ ایک ماہر ڈاکٹر کو پوری تفصیل کے ساتھ مریض کے اس رشتے دار سے معلومات لینی چاہئے جس نے یہ دورہ ایک سے زیادہ بار دیکھا ہو، جو ذہین ہو اور اچھا مشاہدہ رکھتا ہو۔ عموماً معلومات دینے کے لئے ماں اور بیوی سے بہتر ذریعہ کوئی نہیں ہو سکتا۔

حادثات اور صدمات کے دیرپا نفسیاتی اثرات (PTSD) کے بارے میں ڈاکٹر صاحب لکھتے ہیں کہ میں نے اوپر قتل وغارت کا ذکر تو کیا ہے لیکن بے حساب جنسی زیادتیاں ہو رہی ہیں جس میں پہلے تو صرف عورتیں ہی نشانہ بنتی تھی لیکن اب معصوم بچے بھی اس بہیمانہ ظلم کا شکار ہو رہے ہیں اور مرد بھی نہیں بچ پاتے۔ عراق کے ابوغریب میں جو واقعات پیش آئے ہیں ان کے نفسیاتی اثرات نے ساری دنیا کو ہلا کر رکھ دیا ہے اور یہ نام نہاد مہذب دنیا کے لئے شرم اور رسوائی کا باعث بنتے جا رہے ہیں۔

وقفے وقفے کے بعد ایسی وارداتوں کی اطلاعات ٹی وی اور دوسری میڈیا پر بڑے زور شور سے نمایا کر دیا ہے۔

خبریں پڑھنے اور سننے والے بھی مریض بن جاتے ہیں۔ پچھلے دنوں میرے پاس پچاس پچپن سال کا لمبا تڑنگا افغان باشندہ آیا جو برطانیہ سے آیا تھا۔ اس کے بقول اسے ستمبر ۲۰۰۱ء کے بعد امریکیوں نے گرفتار کر کے تین مہینے اپنی ایک جیل میں بند کر دیا۔ وہ کہتا ہے کہ سوائے سوال وجواب کے مجھ پر کوئی تشدد نہیں کیا نہ کسی دوسرے پر کیا، لیکن جب سے گھر آیا ہوں میری زندگی اجیرن ہو گئی ہے، میرے دل پر خوف ہے کہ اگر میں گھر سے باہر نکلا تو امریکن یا ان کے افغان حواری گھر کا دروازہ توڑ دینگے اور ان کی گھر کی عورتوں کو بے عزت کرینگے۔ اس کی یہ بے عزتی اپنے ہمسایوں کے سامنے ہوگی۔ یہ پی ٹی ایس ڈی (PTSD) کا مریض ہے۔ بقول اس کے کہ اس نے کسی جنگ میں حصہ نہیں لیا۔

صفحہ ۸۸ پر ذہانت کے باب میں آپ فرماتے ہیں۔ ذہنی صلاحیت ناپنے کے بہت سے طریقے ایجاد کئے گئے ہیں۔ خود مغربی ملکوں میں بہت کوششیں ہوئیں لیکن میرے اپنے خیال میں کوئی ایک طریقہ قبولیت عامہ حاصل نہیں کر سکا ہے۔ ذہانت کو ناپنے کا بہت بڑا تعلق مقامی ثقافت سے ہوتا ہے جس میں زبان بطور خاص اہم ہے، اس لئے یورپ یا دیگر مغربی ممالک کی ذہانت ناپنے کے طریقے ہمارے ملک کیلئے نا صرف ناقص ہیں بلکہ گمراہ کن اور نقصان دہ ہیں۔ ہمیں ذہانت ناپنے کے طریقے خود ایجاد کرنے ہوں گے۔ کتاب معلومات سے بھرپور اور دلچسپ ہے۔ اس شعبے سے تعلق رکھنے والوں کو ضرور اس کا مطالعہ کرنا چاہئے۔

(ڈاکٹر سید مبین اختر)

تھا'Malleus Malficarum'"یعنی چڑیل کی ہتھوڑی"۔ مضمون کے حوالے سے ان نشانیوں کو میں نہیں لکھ رہا ہوں، جن کا شوق ہے وہ برٹش انسائیکلو پیڈیا کے وچ کرافٹ یا وچ ہنٹنگ کے عنوان کے نیچے ظلم کی ساری تفصیلات پڑھ سکتے ہیں۔ اس ظلم کی زیادہ شکار بچاری بوڑھی اور غریب عورتیں ہوتی تھیں، جو کہ لاوارث ہوتی تھیں اور کچھ چھوٹا موٹا مالش کا کام یا سرخی، تیل، کاجل وغیرہ بیچ کر گزارا کرتی تھیں۔ ان پر تشدد کر کے ان سے منوالیا جاتا تھا کہ وہ چڑیل ہیں، ان کے شیطان کے ساتھ تعلقات ہیں اور ان کے گرد نواح میں جو چوریاں چکاریاں اور دوسرے شیطانی کام ہیں وہ سب ان کے کئے ہوئے ہیں۔ ان کی سزا یورپ کے ممالک میں ستون سے باندھ کر آگ میں جلانا ہوتا تھا۔ انگلینڈ والے ان پر مہربانی کر کے صرف پھانسی دے دیا کرتے تھے۔ ظلم و بربریت کا یہ دور دو تین سو سال تک جاری وساری رہا۔ امریکہ میں ۱۶۸۲ء کے مساچوسٹ(Massachusetts) میں ایک گاں میں جس کا نام سیلم(Salem) تھا۔ ظلم و بربریت کا جو بازار گرم ہوا اس کے اوپر کئی کتابیں لکھی جا چکی ہیں۔ اور سوئزرلینڈ جس کو ہم جنت نظیر اور مہذب ترین ملک سمجھتے ہیں آخری عورت کو ۱۹۵۶ء میں زندہ جلایا گیا۔

صفحہ نمبر ۱۸ پر ڈاکٹر صاحب لکھتے ہیں ایک علامت جو خصوصی طور پر مغربی ملکوں کے مریضوں میں جو زیادہ پائی جاتی ہے بمقابلہ ہم پاکستانیوں کہ وہ ہے احساس گناہ۔ انگریز بہت جلد احساس گناہ میں مبتلا ہو جاتے ہیں۔ وہ سمجھتے ہیں کہ عذاب، ابدی میں مبتلا ہو گئے ہیں اور اس کے نجات یا معافی نہیں ہوگی، اشارہ حضرت آدم اور حضرت حوا کے اس گناہ کی طرف ہے جو ان سے جنت میں سرزد ہوا (Orginal sin)۔ اس کے مقابلے میں اسلام میں چونکہ یہ یقین کیا جاتا ہے کہ اللہ نے حضرت آدم کی توبہ قبول کر لی تھی، اس لئے انسان معصوم پیدا ہوتا ہے۔ صفحہ نمبر ۳۰ پر ڈاکٹر لکھتے ہیں کہ کئی ڈاکٹر گلہ کرتے ہیں کہ ان کو سروس میں وہ سہولیات نہیں ملتی جو فلاں فلاں شعبوں کے افراد کو ملتی ہیں لیکن وہ بھول جاتے ہیں کہ ڈاکٹری کے پیشے میں ایسی ایسی خوشیاں ملتی ہیں جو دل اور روح کو خوش کر دیتی ہیں۔

صفحہ نمبر ۴۲ پر ڈاکٹر صاحب لکھتے ہیں ذہنی امراض میں سب سے بڑی مصیبت جس کا گھر والوں کو سامنا کرنا پڑتا ہے وہ مریض کا عدم تعاون ہے۔ ڈاکٹر کے پاس لے بھی جائیں تو گولیوں پر قسم قسم کے اعتراض، بعض گولیاں شروع میں غنودگی پیدا کرتی ہیں اس پر بھی مریض کا اعتراض، کبھی خود گھر والے بھی کہتے ہیں کہ یہ تو ڈاکٹر نے نشے کی دوائی دے دی ہے، قسم قسم کے مشورے، خدا خدا کر کے اگر ڈیپریشن(Depression) اچھا بھی ہو جائے اور مریض اپنی نارمل زندگی گزارنے لگے تو باوجود بار بار سمجھانے کے رشتے دار مرض کے ٹھیک ہوتے ہی اس کی دوائی بند کر دیتے ہیں، اور مرض کی علامتیں تھوڑے وقفے کے بعد دوبارہ ظاہر ہونے لگتی ہیں۔ پھر ڈاکٹر کو بُرا بھلا کہہ کر کسی اور کے پاس چلے جاتے ہیں اور وہ اپنے حصہ کا خون پی کر واپس پھر کسی دماغی امراض کے ڈاکٹر کے پاس لے جانے کی تلقین کرتے ہیں۔

صفحہ نمبر ۴۴ پر ڈاکٹر صاحب فرماتے ہیں کہ عام لوگوں کو میں یہی نصیحت کر سکتا ہوں کہ جب بھی کوئی رشتہ دار اپنے عام مزاج، گفتار، کردار یا طور طریقوں میں تبدیلی دکھائے، خاص کر اگر وہ پریشان کن ہوں تو ذہنی مرض کا شک دل میں ضرور لانا چاہئے۔ پچھلے پچاس سال میں ان امراض کا کافی حد تک علاج ممکن ہو چکا ہے۔ اور وہ لوگ خوش قسمت ہونگے جن کو

تبصرہ کتاب

ذہن کی دنیا

مصنف ڈاکٹر محمد شفیق

یہ کتاب ڈاکٹر صاحب کے مضامین جو روزنامہ ''آج'' کے کالموں میں چھپتے تھے ذہن کی دنیا کے نام سے ان کو اکٹھے کر کے ایک کتاب میں پرو دیا گیا ہے۔ دیباچہ محمد طحہ خان نے لکھا ہے اور میں چاہتا ہوں کہ ان کا آخری پیغام اس تبصرے میں بھی نقل کر دوں وہ فرماتے ہیں ''میں نے ڈاکٹر محمد شفیق کو اسم بامسمیٰ پایا ہے۔ ان کی مشفقانہ گفتگو دل پر شبنم کی پھنوار بن کر گرتی ہے۔ ان کا حسن سلوک ذہن میں پھول کھلاتا ہے اور سانسوں میں خوشبو آنے لگتی ہے۔ ان کی پہلودار شخصیت علم دوست بھی ہے، علم پرور بھی، تہذیب کی علم بردار بھی ہے اور شائستگی کا اظہار بھی۔ ان سے مل کر اطمینان قلب اور روحانی سکون ملتا ہے اور ہر شخص کہتا ہے کہ جو اپنے کو سمجھے زمانے سے چھوٹا وہی درحقیقت بڑا آدمی ہے۔ ڈاکٹر صاحب کے چھوٹے چھوٹے مضامین تقریباً ۳۰، ۲۵ کی تعداد میں ہیں۔ اور وہ خوب لکھتے ہیں۔''

اگر ان کی فہرست پر ایک طائرانہ نظر ڈالی جائے تو سر درد، اوسی ڈی ، ہسٹیریا، موڈ کا پیڈولم ، شیزوفرینیا، خوف، گھبراہٹ، مرگی، نسیان، حادثات وصدمات کے دیرپا ہ نفسیاتی اثرات، اوڈیزم، ذہنی پسماندگی، بچوں کی بے جا شرارت، بچپن، بچپن سے آگے، بچپن سے جوانی تک، نشہ آوار اشیاء کا استعمال خصوصا افیون ، چرس ، تمباکو ، شراب، عورتوں کے مخصوص امراض اور باہمی تعلقات کی اہمیت ، ذہنی بیماریاں ، تعصب اور جہالت کے شکنجے میں وغیرہ وہ لکھتے ہیں، ایک اندازے کے مطابق کہا جاتا ہے کہ انگلینڈ میں آج بھی تقریبا ۵۰ فیصد ذہنی بیمار ڈاکٹر کے پاس جانے کو تیار نہیں ہوتے۔ بس یوں ہی گھٹتے رہتے ہیں ، گھر والوں کو کراہاتے رہتے ہیں، یا تنگ آ کر خودکشی کر لیتے ہیں۔ سویڈن جیسے خوشحال ملک میں ۱۰۰ مرنے والوں میں سے ۱۰ نے خود کشی کی ہوتی ہے۔ وہ اس ہی مضمون میں فرماتے ہیں بہت سارے سینئر ڈاکٹر پروفیسر اپنے شعبے کی بیماری کے تو اچھے ماہر ہوتے ہیں۔ اور بیماریو ں کا بڑے ذوق وشوق سے علاج کرتے ہیں۔ جوں ہی ان کا خیال بنتا ہے کہ یہ مریض نفسیاتی ہے تو اکثر وبیشتر ان کا رویہ بدل جاتا ہے۔ ان کے لب ولہجے میں غصہ، سلوک میں ملامت اور اس قسم کی الزام تراشی کر دیتے ہیں جیسے گھر پر رشتے دار کرتے ہیں۔ ان کا خیال بلکہ یقین ہوتا ہے کہ نفسیاتی بیماری کا اول تو کوئی وجود ہی نہیں اور پھر بھی اگر ایسا کوئی مسئلہ ہو تو اس مریض کو کوئی رشوت مطلب وقتی خوشی دے دی جائے، کوئی سزا دے دی جائے تو معاملہ حل ہو جائے گا۔ کئی کئی مہینے اور کبھی تو کئی کئی سال گزر جاتے ہیں کہ ذہنی مریض ذہنی امراض کے ڈاکٹر کے پاس ہی نہیں پہنچ سکتا کیونکہ ایسے ڈاکٹروں کے متعلق عموما لوگوں میں یہ مشہور ہوتا ہے کہ یہ تو پاگلوں کا ڈاکٹر ہے۔ علاج کی مزاحمت مریض خود کرنے لگتا ہے ،اور کہنے لگتا ہے کہ کیا میں پاگل ہوں جو آپ مجھے اس کے پاس لے کر آئے ہیں۔

دو مشہور پوپ صاحبان کے نام آتے ہیں جن میں ایک کا نام پوپ انوسنٹ ہشتم تھا۔ انہوں نے ایک کتاب لکھوائی تھی جس میں چڑیل عورتوں کو پہچانے کی ساری نشانیاں دی ہوئی تھیں ۔اس کتاب کا نام

Association and the Malir Bar Association for July 15.

Councils Act".

He said that due to lawyers' strikes, thousands of litigants faced hardships because their cases could not be heard. He submitted that the bar associations had deviated from their purpose of existence, which is to assist the court for dispensation of justice. He said lawyers' frequent strike calls were against the independence of professional lawyers who take fees from their clients for proceeding their cases.

He prayed to the court to restrain the bar associations from issuing strike calls and to provide injunction to those lawyers who want to appear before the court to proceed their cases against such calls. After preliminary hearing of the petition, the SHC division bench, headed by Justice Ahmed Ali M Sheikh, issued notices to the Sindh Bar Council, the Sindh High Court Bar Association, the Karachi Bar

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تبصرہ: اب تو متحدہ نے ہڑتال کے لفظ کے بجائے ''سوگ'' استعمال کرنا شروع کر دیا ہے اور اس سوگ میں مزید لوگ قتل کر دیئے جاتے ہیں اور کئی گاڑیاں جلا دی جاتی ہیں۔ متحدہ کے بندوق بردار غنڈے پورے شہر میں دندناتے پھرتے ہیں اور جبری سب کاروبار بند کرا دیتے ہیں۔ ان میں ادویات اور خوراک کی دُکانیں بھی شامل ہیں۔ پچھلے دنوں ہمارے ہسپتال کو کھلا دیکھ کر اس پر خُوب گولیاں چلائی گئیں، جس سے دروازوں اور کھڑکیوں کے شیشے ٹوٹ گئے اور باہر کھڑی ہسپتال کی گاڑیوں اور موٹر سائیکلوں کو بھی نشانہ بنایا گیا۔ گاڑیاں بند کرنے کی وجہ سے لوگ بیماروں کو ہسپتال نہیں لے جا سکے اور جو مریض ہسپتالوں میں داخل تھے ان کے لیے کھانا پہنچانا محال ہو گیا۔

ایک دوسرے قسم کی ہڑتال وکلا حضرات کرتے ہیں۔ ان کو کسی سے کوئی شکایت ہوتی ہے تو وہ فوراً عدالتوں کا بائیکاٹ کر دیتے ہیں۔ اسی سے تو غریب عوام ہی پریشان ہوتے ہیں جو عدالتوں کے چکر لگاتے رہتے ہیں کسی دوسرے شخص کو تو کوئی تکلیف نہیں پہنچتی۔ یہ کہاں کا انصاف ہے۔ متحدہ کے بندوق بردار غنڈے ہر جگہ زبردستی دُکانیں بند کرا دیتے ہیں اور گاڑیاں روکتے ہیں اور جلاتے ہیں۔ مگر پولیس اور رینجر کو کوئی نظر نہیں آتا، نہ ان غنڈوں کو روکتے ہیں، نا انہیں گرفتار کرتے ہیں۔ غنڈے اطمینان سے اپنے حکم کی تعمیل کرواتے ہیں اور پولیس و رینجر اطمینان سے گھومتے پھرتے رہتے ہیں جیسے کہ یہ حکومت کے نہیں متحدہ کے ملازم ہیں۔ کیا ان لوگوں سے باز پرس نہیں ہونی چاہئے۔ کیا الطاف حسین یہاں کا حاکم ہے یا قائم علی شاہ اور نواز شریف.....؟

سیاسی جماعتیں ہڑتال نہ کرنے کا اعلان کریں

احتجاج کا ایسا طریقہ کار پیش کیا جائے گا جس سے کاروباری سرگرمیاں زیاد متاثر نہ ہوں

ٹارگٹ کلنگ، سیاسی جماعتوں کے احتجاج اور ہڑتالوں نے تاجروں کی مشکلات میں اضافہ کردیا

عتیق میر

آل کراچی تاجر اتحاد کے چیئرمین عتیق میر نے بھرپور یقین کا اظہار کیا ہے کہ کراچی کی تاجر برادری متحدہ قومی موومنٹ سمیت دیگر تمام سیاسی جماعتوں کے ذمے داران کو آئندہ ہڑتال نہ کرنے اور احتجاج نمائندگاہ نے ہفتہ 8 جون کو آرام باغ فرنیچر مارکیٹ میں منعقد کئے گئے ہنگامی اجلاس میں احتجاج کے مختلف طریقہ کار اور تجاویز پر غور کیا جو کہ رواں ہفتے رابطہ کمیٹی کے ارکان سے ملاقات میں پیش کی جائینگی، اس موقع پر عتیق میر نے اجلاس کے شرکاء سے خطاب کرتے ہوئے کہا کہ سیاسی جماعتوں کو احتجاج کا ایسا طریقہ کار پیش کیا جائیگا جس سے کاروباری سرگرمیاں زیادہ متاثر نہ ہوں۔انہوں نے کہا کہ ہڑتال سے گریز کرنے والی سیاسی جماعتوں کے خلاف ہونے والے کسی بھی ظلم اور زیادتی کے خلاف تاجر برادری بھرپور آواز اٹھائے گی، شہر کے امن وامان اور تجارتی سرگرمیوں کی بہتری میں معاون ومددگار سیاسی جماعتوں سے بھرپور تعاون، بہتر روابط اور اشتراک قائم کیا جائیگا۔

اس سے قبل آل کراچی تاجر اتحاد کے بیس رکنی نمائندہ وفد نے جمعرات 6 جون کو عتیق میر کی قیادت میں MQM کی رابطہ کمیٹی کے ارکان عامر خان، ڈاکٹر صغیر احمد، واسع جلیل اور کراچی تنظیمی کمیٹی کے انچارج ڈاکٹر ندیم احسان سے ایم کیو ایم کے مرکز 90 پر ملاقات کی جس میں تاجر برادری کی جانب سے ایم کیو ایم سمیت تمام سیاسی وغیر سیاسی جماعتوں کے کارکنان اور ہمدردوں کے بہیمانہ قتل کی بھرپور مذمت کی گئی اور ایم کیو ایم کے قائد جناب الطاف حسین کی جانب سے پارٹی میں جاری تطہیری عمل کے سودمند نتائج سامنے آنے کی توقعات کا بھی اظہار کیا گیا۔

Bar associations served notices on plea against strike calls

The Sindh High Court issued notices to several bar associations on a petition filed against frequent strike calls called by these associations. Petitioner Ahmed Qureshi submitted that the bar associations were issuing calls for boycotting court proceedings on "petty issues" and termed them "unjust and against the Legal Practitioners and Bar

Question on addiction, sex, psychiatry or the possession syndromes

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THE EDITOR

KARACHI PSYCHIATRIC HOSPITAL

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Staple or stick with tape

Dr. Syed Mubin Akhtar along with colleagues of Tehrik-e-Nifaz-e-Urdu visited grave of Baba-e-Urdu Moulvi Abdul Haq on occasion of his death anniversary (16 Aug 2013)

Dr. Syed Mubin Akhtar with advocate on the occasion of filing petition on behalf of Tehrik-e-Nifaz-e-Urdu and speaking to media persons (19 Aug 2013)

Dr. Syed Mubin Akhtar and others addressing the gathering on the occasion of Iftar/Dinner Party on 27th Ramzan 1434 Hijri.

EID MILAN

Fouzia Siddiqui with other guests on the occasion of Eid Milan
at Karachi Psychiatric Hospital Female Ward

Intikhab Alam Suri, Zia Awan, Riaz Bajwa & Syed Salahuddin
distributing gifts to guests on the occasion of Eid Milan
at Karachi Psychiatric Hospital Male Ward

Dignitaries of the area cutting the cake on the occasion of Eid Milan
at Karachi Psychiatric Hospital Quaid Abad Branch