Death Anxiety in Palestinians during Al-Aqsa Intifada

Nahida Al- Arja - Bethlehem, Palestine

Taisir Abdallah - Jerusalem, Palestine

Nahalarja@hotmail.com , research@admin.alquds.edu

Abstract: *The aim of this study is to explore level of death anxiety among a sample (N=601) of Palestinians living in the city of Beit Jala, Village of Al-Khader, and Aida Refugee Camp in Bethlehem area. The researchers used AbdEl-Khalek scale 1996 to test the hypotheses. The cronbach Alpha was .92. To answer the hypothesis, the researchers calculated the frequencies, the standard deviations, the percentages, the mean and median, as well as the one-way analysis of variance, the t-test and Tukey test to verify the sources of variances.*

■ Introduction

Death is a universal experience but each person must face it alone usually having an effect on others. Death is a normal part of human experience (Steel, 1997) influenced by cultural differences and material circumstances. The transitions, which individuals pass from childhood to adulthood and eventually to death, are social as well as biological in nature (Giddens, 1993). Dickenson and Johnson (1993) claim that since death is a "taboo" subject it causes extra suffering for those who are dying or grieving.

The fear of death is universal and experienced by all human beings (Hyrkas et al, 1997). Death is feared for different reasons. The loss of self, the unknown beyond death, pain and suffering, lost opportunity for atonement and salvation, and the welfare of surviving family members are just some of the sources of fear of death (Neimeyer, 1994). Religion appears to offer some understanding about death and affers some relief. It is important to understand the various beliefs of multi- cultural society. Robertson et al (1997) write that humanism focuses on a form of symbolic immortality such as people live on the memory of their loved ones.

The hate or fear of death, or any other, negative emotion, can be traced back to the oldest known record history, that of Egypt. According to Zandee (1960), ancient Egyptians considered death as an enemy (AbdEl-Khalek,2003). Egyptian belief about resurrection, immortality and afterlife, ancient Egyptian were highly interested in building tombs regardless of their financial resources. One should not forget that pyramids, one of the Seven Wonders of the World, are mere tombs. Many countries have passed since that remote time. However, following the aftermath of World War II, Thanatology emerged as a legitimate area for scientific inquiry and as a respectable interdisciplinary field of study (AbdEl-Khalek, 2003).

There was a high point of interest in death anxiety in late 1970s. Another surge of growth in the mid-1980s. Also occurred (Neimeyer and Van Brunt, 1995). In the last decade in the century, the interest in death anxiety persisted and Burgeoned (AbdEL-Khalek, 2003).

For several centuries, Palestine was the homeland of Muslim, Christian and Jewish people. In 1917 the population of Palestine was 700,000 of which 574,000 were Muslims, 74,000 were Christian, and 56,000 were Jews (Brief History,2005).

In 1948, the state of Israel was founded in a sea of Palestinian blood. The four million Jews who live in Israel now have replaced more than five million Palestinian refugees who moved out of their homeland.

In 1967, a counter attack which lasted 6 days, known as " The Six Day war" launched by various Arab countries to reclaim what they've lost, failed and with grave consequences, the rest of Palestine fell under Israeli occupation which caused more loss of life and more refugees (Brief History).

The immediate cause of the second uprising (AL-Aqsa Intifada) in 2000, was because of the visit of Ariel Sharon's advance-accompanied by over 1,000 armed Israeli police officers- on the Haram al- sharif,or Al-Aqsa Mosque on 28 September 2000 .

Since resistance to Israeli military occupation began in September 2000, over 3900 Palestinian have been killed by Israel and over 40,000 have been injured. Hundreds of homes have been demolished and shelling as a means of collective punishment and thousands are being held in Israeli prisons and detention centers many without charges, and soon for the first time in history, we hear now about hunting down individual human beings by airplanes.

One of the main consequences of the Intifada is that Israel sweeps from time to time into region A under the national Palestinian authorities, including the district of Bethlehem, were the sample of the current study was selected.

The aim of the present investigation was to explore the level of death Anxiety and the correlation that, gender, religion, social status, level of education, place of dwelling and bombed houses has on death Anxiety.

■ Method

• The Sample

A convenient sample of 601 men (n=219; 36.4%) and women (n=383; 63.6%) was selected. All of them were Palestinian residents of the city of Beit Jala, (n=396; 65.89%), the village of Al-Khader (n=138;22.96%), and Aida refugee camp (n=67;11.15%) in the Bethlehem area. They represented 2.45% of the original total population (n=24,518).

The mean age of the sample was 40.7 (SD. 13.3). Their

ages ranged from 22 to 76 years. Of this sample, 517 (86%) were married, 45 (7.5%) divorced, 26 (4.3% widows, 9 (1.5%) separated, whereas 4 cases were undefined. Regarding sex 218 (36.4) were males, whereas 381 (63.6) were females. As for religion, 328 (54.6%) were Christians whereas 273 (45.4%) were Muslims.

Regarding education, 24 (4.5%) were illiterate, 70(11.7%) ending the primary school, 129 (21.5%) preparatory school, 202 (33.6%) secondary school, 105 (17.5%) diploma, 69 (11.5%) university and post graduate, whereas 2 cases were not defined. Half of the participants have homes, whereas the houses of the other half have been demolished by the Israeli army.

- **The Scale**

The Death Anxiety Scale (DAS) (AbdEl-Khalek, 1996) contains 15 items. Each item is answered and rated on a 5-point Likert-type format, anchored by 1: No and 5: Very much. The total scores can range from 15 to 75, with higher scores denoting higher death anxiety.

Cronbach's alpha reliabilities of the DAS among Palestinian Parents were .87, .79, .83, .67, for males, females, and the combined group of males and Females, respectively, denoting both high internal consistency and stability.

Four Factors were disclosed- fear from the dead, fear of after death, fear of deadly diseases, preoccupation by death and its thoughts-denoting a clear and viable factorial structure, interpretable factors, and factorial validity (Abdel-khalek, 1998).

■ Results

The finding of the study reveals that the significant correlations were found only on age, gender (with female sex) (Figure 3), and religion in females and the total group only (with Christian religion) (Figure 4) and a negative correlation between death anxiety and age in the total scores which reached (-.2133) at statistical significant difference (0.05).

On the other hand, social status (figure 5), education (figure 5), place of residency (figure 7) and house sheltering (figure 8) did not significantly correlate with DAS.

■ Discussion

Male and female Palestinian samples had lower mean DAS scores than their Arabic counterparts living in a safer environment, such as Kuwait, Syria, and Egypt.

Palestinian participants had been historically accustomed to live in a "climate of war" since 1967, i.e., the occupation of Israel of this part of Palestine in which they live. So there are 38 years of occupation, unrest, violence and counter violence, view the sight of dead corpses and so forth, without a feasible or visible solution. These severe conditions may operate in much the same manner as the psychotherapeutic principle of flooding (Davison& Neale, 1996).

The present result on the low DAS mean score among Palestinians is congruent with a previous study on death carried out among Lebanese adolescents and college students in January 1986 during the civil War (1975-1991). AbdEl-Khalek (1991) found that the Lebanese samples had either the same or a lower mean score on Templer's death anxiety scale (1970) than their Arab counterparts: Egyptians, Kuwaitis, and US samples. He interpreted this result as a sequence of continuous exposure to an insecure environment. It is worth mentioning that the mean age of the present Palestinian sample (M=40.7, SD 13.3 year) was higher than most of the samples used in the DAS, i.e. college students in their twenties. In a similar field, it was found that the elderly might report lower levels of death anxiety than more youthful subjects might. Likewise, well-designed large-scale surveys indicate that death subjects decreases from mid-life to old age (Neimeyer et al., 2004).

Giving the large size of the present sample (N=601), and the wide range of ages (from 22 to 76), computing the DAS-age correlation may be viable. A significant negative correlation between the DAS and age in the total scores reached (-.2133) at statistical significant difference (0.05).

The significant sex-related difference on the DAS in the present Palestinian sample was congruent with previous investigations on Lebanese participants.

Based on the present findings, it seems that there are no relationships between the DAS and specific demographic variables such as social status, bombed house, education, social status and place of residence.

■ Conclusion

- Findings show that females have higher average than males.
- The findings of the study revealed that the significant correlation was found on religion for the favor of Christians.
- There are no relationships between the DAS and specific demographic variables such as bombed house, social status, education, and place of residency.
- The findings show a low average in death anxiety among the study sample that was 50.9%.

■ References

- AbdEl-Khalek,A. (2003). Death Anxiety in spain and five Arab Countries. Psychological Reports,93, 527-528.
- AbdEl-Khalek,A. (1998).Death, Anxiety, and Deprassion in Lebanese Under graduates. Omega. 37(4), 289-302.
- AbdEl-Khalek,A. (1986). Death Anxiety in Egyptian Samples. Personally Individual Difference, 7(4), 479-483.
- Dickeson,D.and Johson,M. (1993). Death, Dying and Bereavement. London: SAGE Publications.
- Palestine-Net: Brief History of Palestine From internet: Http: www.palestine-net.com/history/bhist.html
- Palestine center-Institutions and the Palestinian Economy during Oslo- from internet: http://www.palestinecenter.org/palestinelalaqsa.html
- Steele,R. (1997) open form. British Journal of Theatre Nursing. 7(5),27.
- Neimeyer, R.A., & Van Brunt,D.(1995). Death Anxiety. In H. Wass&R.A.Neimeyer (Eds.), Dying: Facing the facts (3 rd ed., pp. 49-88). Philadelphia: Taylor& Francis.
- Neimeyer,R.A.(1994).Death Anxiety Handbook. Research, Instrumentation, and Application. Bristol, PA:Taylor and Francis.
- Vinter, M. (1994). An insight into the after life? Informing patients about near death experiences.Professional Nurse, 10 (3), 171-173.

Prevalence of psychiatric emergencies
attending Emergency department in Sharkia

Abdel Shafy MK, Rafik RA, Wael Abo-hendy, Saber A. Mohamed, Mohammed A. Elmahdy

Egypt

doctor@maganin.com

Background: - Psychiatric emergencies make up a large number of conditions treated by emergency room physicians. It is mostly first seen by non-psychiatrists in emergency departments.

Aim of Work: *- To ascertain the prevalence and evaluate the Socio-demographic data, alertness, and rates of hospitalizations and severity of psychiatric emergency cases.*

Subjects and Methods: *- out of 11,699 attendant patients at medical emergency department, 200 patients with psychiatric emergency were recruited for this cohort study. Patients were submitted to medical assessment and psychiatric evaluation by semi-structured clinical interview, mini-mental state examination, brief psychiatric rating and Crisis Triage Rating Scales.*

Results: *- 200 (1.71%) patients (97 males, 103 females, and aged 29±12.5) with psychiatric emergency attended ZUH emergency department. The most prevalent psychiatric diagnoses were somatoform (24.5%), mood (18.5%), schizophrenia (11%) and anxiety (9.5%) disorders. Also, we found lower hospitalization rate (35.5%), most patients were alert (65.5%), and female (51.5%) patients were more common than males (48.5%) to present in psychiatric emergency. Hospitalized patients were found to be more dangerous, has less social support with little cooperativeness than Nonhospitalized ones.*

Conclusion: *- Psychiatric emergency constitutes a significant proportion of all medical emergencies, and it is more often in low socio-economic classes. Psychiatric education, proper social support, family education and early detection of psychiatric disorders will minimize the hazards of psychiatric illness.*

الملخص العربى: دراسة نسبة حالات الطوارىء النفسية فى قسم الطوارىء بمستشفى جامعة الزقازيق

يمثل عدد المترددين لاسباب نفسية على اقسام الطوارىء نسبة لا يستهان بها . وقد حاولنا فى هذه الدراسة قياس نسبة حالات الطوارىء النفسية، ومعرفة مدى وعيهم وحاجتهم للادخال للقسم الداخلى للعلاج. اجرى هذا البحث على 11699 متردد على قسم الطوارىء، ووجد ان مائتين (1.71%) منهم قدموا لاسباب نفسية طارئة، وقد اجرينا لهم فحص طبى ومعملى شامل بالاضافة للتقييم النفسى الذى تضمن : دراسة اجتماعية ديموجرافية، فحص نفسى كامل باستخدام البروتوكول الخاص بقسم الطب النفسى بجامعة الزقازيق، كما اجرينا القياسات النفسية التالية عليهم

1- اختبار الحالة العقلية المصغر

2- المقياس النفسى المختصر المندرج

3- المقياس المندرج للازمات الطارئة

وقد وجدت الدراسة ان 1.71% من المترددين كانوا لاسباب نفسية طارئة، اغلبهم من السيدات وقاطنى المدن وينتمى معظمهم لطبقات اجتماعية منخفضة، وقد تم ادخال 35.5% منهم للقسم الداخلى للعلاج. وقد وجدنا ان الاضطراب الخولى ثم الاضطرابات الوجدانية ثم الفصام الذهانى ثم القلق النفسى هى الاكثر شيوعا لدى هؤلاء المرضى. هذا وقد خلصنا الى انه يجب تحسين الظروف المعيشية مع زيادة النوعية بالامراض النفسية عند الاسرة والمجتمع بالاضافة الى تدريب العاملين فى الحقل الطبى من اطباء وفريض على التعامل مع طوارىء الامراض النفسية لتقليل وصمة المرض النفسى لدى مجتمعاتنا .

■ Introduction

Psychiatric emergency has been extensively studied along years with different Trans-cultural presentations. Psychiatric patients make up 3-11% of the total general hospital emergency visits *(Gerson & Bassuk, 1983).* However, *Oyewmi et al., (1992)* found that visits for psychiatric emergency services during their study in Canadian City represented 2.32% of the total number of visits to emergency facilities. *Gerard, (1998)* classified psychiatric emergency into: Major psychiatric emergencies: Represent a threat to life e.g.: suicidal, overdose, homicidal, agitated and sever adverse drug reaction, and Minor psychiatric emergencies:

severely distressing but not a threat to life e.g. grief, panic attacks, and rape. During the past 25 years there has been a shift away from institutionalizing mentally ill patients towards reliance on community services. Psychiatric emergencies facilities are often the only source of treatment and support for many of the chronically disabled people living in the community *(Perlmutter et al., 1986). Witkin et al.*, (1989) reported that, during the past 15 years there have been a rapid increase in the growth and utilization of psychiatric emergencies facilities in the United States. The psychiatric emergency service is now the main entry point into the network of mental health service for people in need of help.

The accessibility of emergency room, the belief emergency treatment is none stigmatizing and a lack of community to long term treatment, make psychiatric emergency facilities desirable in communities to manage the emotional and behavioral problems of its members (*Oyewumi et al.,* 1992).

- **Aim of work**

The objective of this study was to assess the prevalence and evaluate the socio-demographic aspects of psychiatric emergency cases attending emergency department at Zagazig University Hospital (ZUH) in addition to studying some clinical contributions regarding severity of illness, cognitive state, and rate of hospitalization among those patients.

- **Subjects and methods**

200 consecutive referral patients (97 males, 103 females, aged from 9-78 with mean age 29±12.5) who attended the emergency department at ZUH with Psychiatric emergency, were recruited for participation in this cohort study. Patients were assessed by proper medical examination and routine laboratory tests. Psychiatric evaluation done to the patients by two psychiatrists using:-

1- Semi-Structured Clinical Interview (SSCI) derived from Psychiatric department protocol of ZUH. It covers, mainly, socio-demographic data, personal history, past history, family history, and diagnosis according to DSM-IV diagnostic criteria.

2- Mini-Mental State Examination (MMSE) designed by Folestien and colleagues from Baltimore (Folestien et al 1975) as the most widely used and studied screening measure of cognitive impairment. It has the advantages of brevity, ease of administration, and high inter-rater reliability. It can be easily incorporated into routine clinical practice. It is not useful for the detection of focal cognitive deficits and insensitive to frontal lobe disorders. A score of less than 24 was initially suggested for distinguishing between impaired and normal subjects with a reasonably high degree of specificity and sensitivity. It has been clearly established that the MMSE is very vulnerable to the effects of age, education, and socio-economic status. It takes on average 5-10 minutes to be completed.

3- Brief Psychiatric Rating Scale (BPRS) (Over &Gorham 1962) has been widely recognized and used both for the routine follow up and research assessment of psychiatric patients.

4- Crisis Triage Rating Scale (Bengeldrof et al 1984) to expedite the rapid screening of emergency psychiatric patients who require hospital admission from those who are suitable for out patient crisis intervention treatment. It has three dimensions: - Dangerousness, Support system, and Motivation and Ability to cooperate.

Data management and statistical methods:

The data has been coded and entered on an IBM compatible personal computer using the statistical package SPSS ver. 9.0.

The data was summarized using the mean and standard deviation for continuous type, while percent was used for the qualitative type. The differences between groups were tested using the student's t-test and ANOVA for continuous data. The chi-square test was used for qualitative data. The correlation between two continuous groups was assessed using the Pearson's correlation test. The level of significance for all above mentioned tests was at $P<0.05$ (Saunders & Trapp, 1994).

■ Results

There were, along 3 months period, 11699 attendants to the emergency department, 200 (1.71%) of them (97 males and 103 females, with mean age 29±12.5, age range 9-78 with peak age 17-34) presented with psychiatric emergencies with the following diagnoses in chronological order:- Somatoform disorder 49 (24.5%), Mood disorders 37 (18.5%), including major depression 21 (10.5%) and bipolar disorder 16 (8%), Schizophrenia 22 (11%), Anxiety disorders 19 (9.5%) (mainly panic attacks & PTSD), Substance abuse 16 (8%), Mental disorder due to general medical condition 14 (7%), Adjustment disorders 12 (6%), Suicidal 13 (6.5%), Drug induced movement disorder 6 (3%), Delirium 4 (2%), Acute Grief Reaction 3 (1%), Personality disorder 2 (1.5%), Dissociative disorder 2 (1%), Psychosexual 1 (including Gender identify disorder) (0.5%).

Figure (1)

Prevalence of psychiatric emergencies according to DSMIV classification

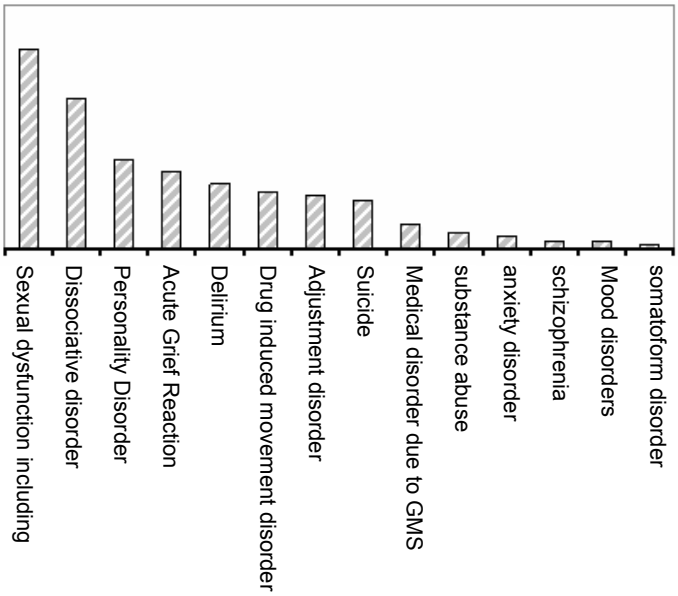


Table (1)
Age Distribution

Age	Number	Percentage
< 10	6	3%
10 – 20	39	19%
20 – 30	71	35.5%
30 – 40	46	23%
40 – 50	18	9%
50 – 60	10	5%
> 60	10	5%

Table (2)
Sex, Marital status, Residency, Education, and Occupation of psychiatric emergency patients

Item		Number	Percentage
Sex	Male	97	48.5%
	Female	103	51.5%
Marital status	Married	80	40%
	Single	94	47%
	Divorced	15	7.5%
	Widowed	11	5.5%
Residency	Rural	83	41.5%
	Urban	117	58.5%
Education	< 6 years	71	35.5%
	6-12 years	90	45%
	> 12 years	39	19.5%
Occupation	Not working, housewife	63	31.5%
	Students	48	24%
	Semiskilled	49	24.5%
	Skilled	40	20%

Figure (2):
Precipitating factors in psychiatric emergencies shows that Familial & social problems form the two most common precipitating factors of psychiatric emergencies:- they represents 23% & 21% respectively.

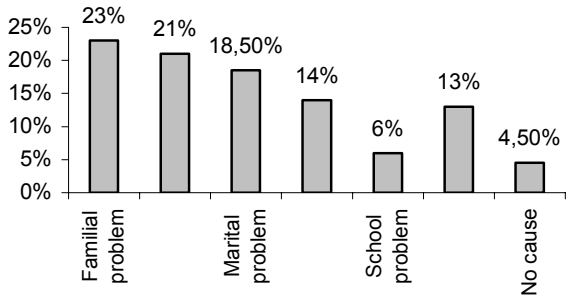


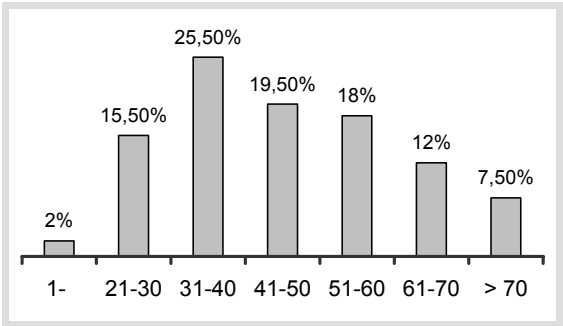
Table (3)
Results of MMSE in hospitalized & non hospitalized patients shows that alert 65.5%, drowsy 26.5%, stupor 6.5%, to coma 1.5%.

Item	Nonhospitalized		Hospitalized		Total	
Result of MMSE	N = 129	%	N=71	%	200	%
Alert	90	69.7	41	57.7	131	65.5
Drowsy	25	19.3	28	39.4	53	26.5
Stupor	9	7.5	2	4.9	11	6.5
Coma	3	2.5	0	0	3	1.5

Table (4):
CTRS in hospitalized & non hospitalized patients

CTRS	Total		Hospitalized		Non hospitalized		T	P
	N	%	N	%	N	%		
3	4	2	4	5.6	0	0	16.58	≤0.001 high sign.
4	9	4.5	8	11.3	1	0.7		
5	11	5.5	8	11.3	3	2.3		
6	21	10.5	16	22.2	5	3.9		
7	29	14.5	16	22.2	13	10		
8	18	9	8	11.3	10	7.7		
9	16	8	4	5.6	14	10.8		
10	11	5.5	2	2.8	9	7		
11	32	16	2	2.8	30	23.3		
12	16	8	2	2.8	14	10.8		
13	18	9	1	1.4	17	13.2		
14	14	7	0	0	14	10.8		
15	1	0.5	0	0	1	0.7		
Mean	8.5		7.18		11.8			
S.D.	2.4		2.59		2.9			

Figure (3)
Results of BPRS shows that most patients (90.5 %) scored from 21 – 70 on the BPRS.



Discussion

Our major findings in this study were the low prevalence rate of psychiatric emergency in comparison to other emergencies, the chronological order of psychiatric disorders as a causative factor in attending patients in emergency, the low rate of hospitalization to psychiatric ward, higher percentage in females than in males, singles and married patients were more prone to come in emergency, and most of patients were alert.

One of the major findings in this study was the low prevalence rate of psychiatric emergency (1.71 %) cases which is very close to Adityanjee et al., 1988 (2%) reports in an Indian study despite it is, at the same time, so far from German findings (9.2%) reported by Pajnok et al. 2002. We think that the relatively low prevalence rate in our study might be explained by the role of mental stigma, emergency doctors trials not to stigmatize their patients, the limited physician-patient contact time, medical co morbidity, patient resistance for mental illness, and the inadequate psychiatric training for emergency doctors all might contribute to the lower reporting of psychiatric emergency in our community. We found that the most common psychiatric disorders are in a chronological manner: Somatoform disorder (24.5%) followed by Mood disorder (18.5%)

then schizophrenia (11%), anxiety disorder (9.5%), and lastly substance abuse (8%) which reported as the lowest psychiatric disorder in emergency department. Contrary to our results, Oyewmi et al., 1992 Moecke et al., 2001 and Kadels et al., 2003 found that substance and alcohol abuse disorders were the most common prevalent causes (29%, 70%, and 32.8% respectively) of psychiatric emergencies. These differences between our results and others` might be attributed to the cultural, legal and religious factors in lowering the rate of substance abuse in our population.

However, in our study, 35.5% only of cases necessitated admission at psychiatric ward while 64.5% were suitable for outpatient management. These figures are in consistence with Taylor et al. 1996 (31% hospitalized vs. 69% outpatient), Prokudin 1985 (33% vs. 67%), and Schyder et al. 1999(34.1% vs. 65.9%) findings despite the different causes of admission between our studies and theirs`. Our major causes of admission were found to be schizophrenia followed by bipolar disorder manic type and then lastly major depression. However, James et al., (1991) found 61% of psychiatric cases need admission because of the violence. These differences in the causes of admission between us and others might be attributed to the overcrowding of patients in hospitals in Prokudin 1985 study and the high social support and familial ties in our culture.

Interestingly, In our sample, female patients (51.5%) found to be more common than males (48.5%) to seek emergency psychiatric service in consistence with Gabbard et al., 1994 and contradictory to an Egyptian study by Okasha 1966 who reported that males are more common (57.4%) than females (42.4%). This difference may be attributed to the fact that many females in our society are exposed to many stressors, more easily to express themselves in psychiatric terms, and the prominent somatoform disorders in our sample.

Moreover, we found 55.5% of emergency patients came from urban areas which is very close to the findings of (Tsuang et al., 1992) & (Baxter et al., 1988) While Pajonk et al. 2002 and Baretels et al. 2002 found no significant difference between rural and urban residency in emergent psychiatric patients. This may indicate the hazards of overcrowding of urban areas with subsequent social deprivation and weak family ties. Also, the stresses associated with life style in urban areas may play a role.

Interestingly, 65.5% of our patients were alert followed by drowsy, stupor and coma, (26.5%, 6.5%, 1.5% respectively) in accordance with Henneman et al., (1994) BPRS in our hospitalized patients was 64.8±7.99, While in non hospitalized patients it was 47.9. The cut off score of BPRS was 54 (i.e. more than or equal 54 indicates hospitalization and less than 54 indicates that oupatient treatment is sufficient. Our result found to be very close to that of Paulette et al. 1989 While inconsistent with Apsler et al. 1983 who found that the mean score of BPRS in hospitalized and non hospitalized patients were 54, 40 respectively. This controversy might be due to the higher severity of illness among our sample patients.

The mean score of CTRS in our hospitalized patients was 7.18±2.9 while in non hospitalized patients, it was 11.8±2.3. There was negative correlation between CTRS score and hospitalization. Those who were admitted were more dangerous, had less social support with little cooperativeness. It is supported with results of Bengeldrof ET al.1993 who reported the same results by his opinion that patients with 3- 8 CTRS requires hospitalization.

■ Conclusion

Psychiatric emergency constitutes a significant proportion of all medical emergencies, and it is more often in low socio-economic classes. Psychiatric education, proper social support, family education and early detection of psychiatric disorders will minimize the hazards of psychiatric illness. Proper psychiatric training is inevitable for undergraduate medical students and emergency doctors to improve their clinical skills to cope better with the increasing psychiatric emergency cases.

Acknowledgment to Dr. Amira Fouad

■ References

- Mark, H.; beers, M.D. and Robert Berkow (1999): Merck manual of Diagnosis & therapy, seventeenth edition.
- Witkin, M.; Anawar, R.A. and Dickstein, L.J. (1989): Emergency service in psychiatric facilities. National institute of Mental Health. Statistical Note Rock. N.I.M.H. 2nd ed., 136-143.
- Oyewumi, L.K.; Odejide, M.D. and Kazzrian, S.S. (1992): psychiatric emergency services in a Canadian city. Prevalence pattern of use, clinical characteristics and patient's disposition. Can. J. psychiatry. 37: 91-99.
- Diagnostic and Statistical Manual of Mental Disorder, (1994): (DSM IV): The American Psychiatric Association Washington.
- Folestien, M.F.; Folestien, S. and Mchugn, P.R. (1975): Mini Mental Status Examination: A practical methods of grading cognitive state of patients for the clinician. J. psychiatry. Res. 12: 189-198.
- Overall, L. and Gorham, R. (1962): Brief psychiatric rating scale. Psychological report. 10:799-810.
- Bengeldrof, H.; Levy, L. and Emerson, B. (1984): A crisis Triage Rating Scale. J. Nerv. Ment. Dis. 172(2): 424-430.
- Adityanjee, and Mohan D (1988): Determinants of emergency room visits. Int. J. Soc. Psychiatry. 34(1): 25-300.
- Pajonk, F.G.; Bartels, H.H. and Gruenberg, K.A.S. (2002): per clinical psychiatric emergencies: Frequent & treatment necessities in urban compared to rural regions in Germany.
- Moecke, H.; Batels, H.H. and Pajonk, F.G. (2001): psychiatric emergencies in preclinical emergency medical service: frequent, treatment, and assessment.
- Kardels, B.; Beine, K.H. and Wenning, F. (2003): Psychiatric emergency cases in hamm/westhalen.
- Taylor, L.D.; Marzyk, P.M. and Leon, A.C. (1992): The suicide syndrome. J. Clin. Psychiatry. 25: 173-188.
- Taylor, J.; Lawries, S. and Geddes, J. (1996): Factors associated with admission to hospital following emergency psychiatric assessment. Health. Bull. 54(6): 467-73.
- Prokudin, Vr. (1985): Epidemiologic analysis of a contingent of patient with psychosis who applied for emergency psychiatric services in Ethiopia: Zh Nevropatol Pskhiatr. Im. 85(8):1221-5.
- Schnyder, U.; Klaghofer, R. and Leuthold, A. (1999): Characteristics of psychiatric emergencies & the choice of intervention strategies: Acta Psychiatr. Scand.; 99(3); 179-87.
- Okasha, A. (1966): Tran cultural psychiatry. In Okasha clinical psychiatry. Cairo. The Anglo Egyptian Bookshop. 1131:1135.
- Gabbard, G.W.; Langston, J.W. and Verrilli, M.R. (1994): psychodynamic psychiatry in clinical practice: American psychiatric press. Washington. The DSM IV ed., 65-89.
- Tsuang, M.T.; Simpson, J.C. and Feliming, J.A. (1992): Epidemiology of suicide. Int. Rev. Psychiatry. 4:117-128.
- Baxter, S.; Chodorkoff, B. and Underhill, R. (1988): Psychiatric emergencies; dispositional determinants and the validity of the decision to admit. Am. J. Psychiatry. 124: 1542-1548.
- Byrne, M.; Murphy, A.W. (2003): Frequent attends to an emergency department: Ann. Energ. Med. 41(3): 309-18.
- Byrne, M.; Murphy, A.W. (2003): Frequent attends to an emergency department: Ann. Energ. Med. 41(3): 309-18.
- GerardClancy, M.D. (1998): University of Lowa Hospitals emergency psychiatry service handbook.

- James, H. and Scully, (2001): National medical series; evaluation & Management of psychiatric emergencies.
- Apsler, R.; Ellen, Ph.D. and Bassuk, E. (1983): Differences among clinicians in the decision of admit. Arch. Gen. Psychiatry 40: 113-1173.
- Paulette, M.; Gilling, M.D. and Hillard, M.D. (1989): The psychiatric emergency services holding area: effect of utilization of inpatients resources. Am. J. psychiatry. 146:369-372.
- Perlmutter, R.A.; Slaby, A.E. and Groves, J. (1986): Emergency psychiatry and the family: the decision to admit. Arch. Gen. Psychiatry. 12: 153-162.
- *Gerson, S. and Bassuk, E. (1983):* Psychiatric emergencies: an overview. Am. J. Psychiatry. 137: 1-11.

إضحـــى مبـــارك 1426

تتقدم أسرة شبكة العلوم النفسية العربية إلى الزملاء الأطباء و أساتذة علم النفس و كافة المسلمين بأحر التهاني بمناسبة عيد الأضحى المبارك سائلين الله العلي القدير أن يلهمنا الرشاد وأن ينير بصيرتنا ويهدي عقولنا إلى ما فيه خير المسلمين والإنسانية جمعاء.

وكل عام وأنتم/نحن/هم بخير...

عن أسرة شبكة العلوم النفسية العربية

" مجانيـــن " الصحـــة النفســـية للجميـــع

www.maganin.com

المركـــز العربـــي للطـــب المســـنـــد

www.arabicebm.com

البقـــاء للـــه وحـــده

الأستاذ الدكتور أسامـــة محمـــد الراضـــي في ذمة الله

"يا أيتها النفس المطمئنة ارجعي إلى ربك راضية مرضية فادخلي في عبادي وادخلي جنتي"

ببالغ الحزن والأسى تنعى شبكة العلوم النفسية العربية إلى أساتذة علم النفس والطب النفسي وفاة المغفور له الأستاذ الدكتور:أسامة محمـد الراضـي (أستاذ الطب النفـسي – الطائف، السعودية -رئيس الجمعيـة العالمية الإسلاميـة للطب النفسـي (سابقاً) - مدير خدمـات الطب النفسـي في المملكة العربية السعودية)

بهذه المناسبة الأليمة ، نتقدم إلى أسرة الفقيد و إلى جميع الأطباء النفسانيين العرب بأحر التعازي سائلين الله العلي القدير أن يتغمده برحمته الواسعة و يسكنه فراديس جنانه و يرفع درجاته. وإنا لله وإنا إليه راجعون.

شبكة العلوم النفسية العربية