21 Years

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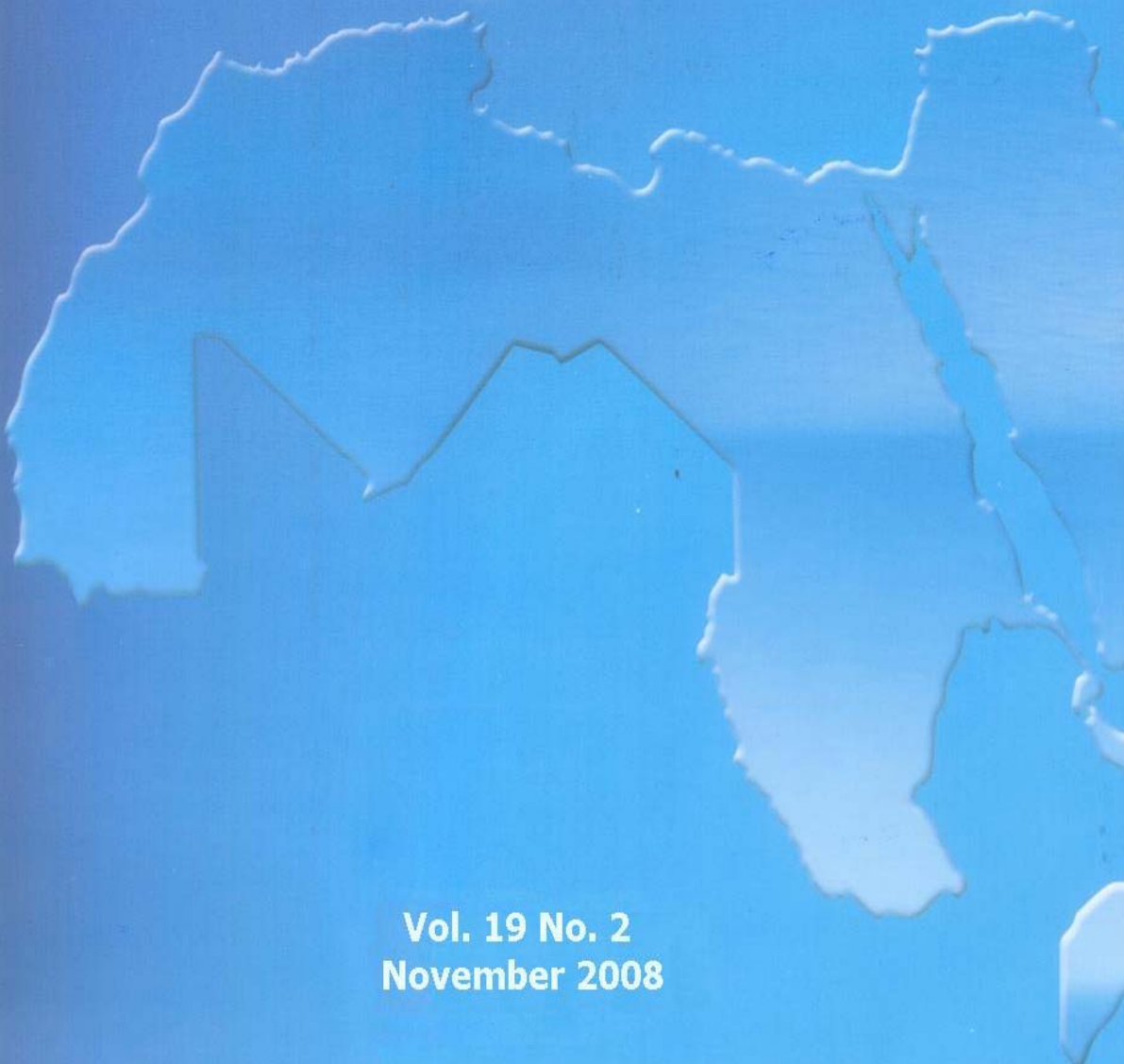

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Editorial

The Impact of Arab Culture on Psychiatric Ethics

Ahmed Okasha

تأثير الثقافة العربية على أخلاقيات مهنة الطب النفسي

احمد عكاشة

Abstract

The belief of the universality of implementing similar ethical codes in all cultures and societies is a mirage. Informed consent, involuntary admission and confidentiality are not so empowering in some traditional and Eastern societies, representing two thirds of the World population. Autonomy versus family centered decision is one of the main connectors of differences between Western and Eastern Societies. The influence of managed care and the third party in mental health services have changed not only Doctor-patient relationship, but also the disclosure of information. Informed consent in therapeutic alliances and research became a basic human right and has been emphasized in the WPA declaration of Madrid and its specific guidelines.. In what ways does acculturation change the beliefs of patients of various ethnicities? Whether we like it or not, the encounters between psychiatry and law keep bringing us back to our conflicting conceptions of the value of health on the one hand and the value of liberty, integrity and autonomy on the other. In traditional cultures, social integration is emphasized more than autonomy; that is, the family, not the individual, is the unit of society. Dependence is more natural and infirmity is less alien in these cultures. When affiliation is more important than achievement, how one appears to others becomes vital an shame. How can we practice without showing disrespect or disregard for local values? On the other hand, how can we ensure that respect for the local culture does not become a pretext for bypassing ethical guidelines, to the detriment of the patients' rights?

*Modified from my chapter in "Ethics, Culture and Psychiatry" Ed. Ahmed Okasha, J. Arboleda Florez, Norman Sartorious. American Psychiatric Press, 2000 – Whashington, DC, London , England

"Like most lads among my boyhood associates, I learned the Ten Commandments. I was taught to reverence them because I was assured that they came down from the skies into the hands of Moses, and that obedience to them was, therefore, secretly incumbent upon me. I remember that whenever I fibbed, I found consolation in the fact that there was no commandment, "Thou shalt not lie," and that the Decalogue forbade lying only as a "false witness" giving testimony before the courts where it might damage one's neighbor. In later years, when I was much older, I began to be troubled by the fact that a code of morals which did not forbid lying seemed imperfect; but it was a long time before I raised the interesting question: How has my own realization of this imperfection arisen? Where did I myself get the moral yardstick by which I discovered this shortcoming in the Decalogue? When that experience began, it was a dark day for my inherited respect for the theological dogma of "revelation." I had more disquieting experiences before me when, as a young orientalist, I found that the Egyptians had possessed a standard of morals far superior to that of the Decalogue over a thousand years before the Decalogue was written.[(1)]

This introduction with a quote of Breasted is not meant to trace the origin of ethical guidelines and values to the old Egyptians to the extent that it means to indicate the ancient origins for the need of such codes. Since the very early human interactions, that relationship had to be regulated by terms of ethical reference that highlight the red lines, which should not be crossed. It is also understandable that, while such codes are necessary to coordinate and control everyday interactions (mostly referred to by "law"), the need becomes more urgent, when the parties involved show some hierarchy of power between them. Codes regulating their interactions aim to protect the less powerful from the control of the more powerful and the latter from claims of power abuse by the former.

Since early in history, the doctor patient relationship has been one of the major power relationship,

so much so that doctors were believed to be in charge of some supernatural powers that introduces some resemblance to divinity. Towards the end of the 20th century doctors have come a long way from a status of half Gods to one of service providers whose prime task and objective is to respond to the needs of their patients and to do that to their patients', best interest and appropriateness. Furthermore, the last 40 years have witnessed an advance in medical technology and knowledge that carries with it major hopes for the management of previously incurable ailments. However, it also carries with it several frightening possibilities of abuse.

We argue that psychiatry is one of the medical branches that has been subject to heated debates over the possibilities of abuse. This is not a polemical assumption but is largely based on the nature of psychiatry and the actual abuse that this profession has witnessed throughout its history.

Being a branch that investigates the brain and for that the most obscure and unexplored functions of the brain, psychiatry has a mysticism about it that is not only perceived as such by lay people but that may, at times, give the psychiatrist a sense of omnipotence that may overshadow the modesty we should feel considering the limited amount of knowledge we possess. Mental illness was and remains an obscure, frightening category of illness, since it frequently encroaches upon one of the major gifts granted to human beings, the gift of judgment. This distorted judgment on part of a patient may be a fertile soil for abuse on part of several power structures, be they political, industrial, administrative or even familial.

It is no wonder, therefore, that psychiatric association's all over the world have been obsessed with securing their practice with a series of ethical codes that aim to protect patients from possible abuse by the profession and protect psychiatrists from their own sense of omnipotence.

The Madrid Declaration

The Hawaii Declaration issued by the WPA in 1977[2] has initiated a long process of investigation and concern within the domain of professional ethics and paved the ground for the Madrid Declaration which was endorsed by the General Assembly of the World Psychiatric Association in Madrid in 1996[3]. In its final shape, the Madrid Declaration includes seven general guidelines which focus on the aim of psychiatry as to treat the mentally ill patients, to prevent mental illness, promote mental health and provide care and rehabilitation for mental patients. The Declaration ensures the duties of the psychiatrists, prohibiting any abuse and that no treatment should be provided against the patient's will unless it is necessary for the welfare and safety of the patient and others. Emphasis is made on advising the patient or caregiver about all details of management, confidentiality and the ethics of research. An appendix to the declaration includes guidelines on specific ethical issues in Psychiatry, namely euthanasia, torture, death penalty, sex selection and organ transplantation, in addition to a summary of the 1991 UN resolutions on the rights of mental patients. A second appendix is currently under preparation addressing issues such as ethics of psychotherapy, relationship with the industry and the media, ethics of genetic research and genetic counseling and an ethical position towards ethnic discrimination and genocide. Issues of patient's consent and autonomy are the common denominators of that declaration, absolute commitment to the welfare of the patient and condemnation of abuse by political institutions or other parties cut across the declaration and its appendices.

Universality of Human Rights Declarations

Unfortunately the development of ethical declarations is not the end of the story. Human rights conventions all over the world assume a social and political set up where the individual being is the center of social attention. The Madrid Declaration, no exception to other declarations, assumes a social set up where the individual is the focus, where the individual is in charge. What if this is not

the case everywhere in the world? It is true that the more the international input in the drafting of a declaration the more it would be able to consider all difficulties but in the end the world would need a document that highlights the major principles. We argue that the implementation of codes of ethics are frequently challenged by the cultural and social set ups in which they are implemented. These challenges are not limited to the interaction of individual versus family versus community or tribe alone but also by the social position of the medical doctor and the hierarchical structure of the medical profession viz. a viz. the rest of the community, in addition to the role played by religion and other beliefs in coloring the lives and behavior of people.

No one would deny that malpractice is one of the main targets that ethical codes aim to outline, address and prevent. In our region, like other regions of the world, malpractice does exist; however, the reaction of people to that malpractice is not standard. It is, for example, very rare for people in our region to sue their doctors. This is not only based on a belief that whatever the doctor decides is the right thing but is complemented by a strong conviction that the final outcome is determined by God's will alone, no matter how the doctors try. This absolute judiciary relationship with God almost saves the mortals any responsibility for the outcome of their medical intervention. This is even more the case the more ambiguous the nature of the illness, with psychiatric disorders occupying quite a prominent position among unexplained ailments.

Cultural specificity

Arab culture values the humanitarian interaction with the doctor, to a similar, if not greater extent, than his or her technical or scientific know how. The humanitarian nature of this interaction depends on the "way" the doctor deals with the patient and his or her family and the extent by which the doctor expresses respect and acceptance for the local cultural and spiritual norms.

These norms may face us sometimes with questions such as: Do patients who are not told the diagnosis usually know it anyway? Is this information later

communicated by verbal or non-verbal means? Is the interaction between patients and family different when the patient is the head of the household? What is the perceived harm when the medical community violates cultural conventions and insists on telling the truth to the patient? What disruptions occur in the coping mechanisms of the individual and the family? In what ways does acculturation change the beliefs of patients of various ethnicities?

Eastern cultures emphasize social integration more than autonomy i.e. the family and not the individual is the unit of society. Dependence is more natural and infirmity less alien in these cultures. When affiliation is more important than achievement, how one appears to others becomes vital and shame becomes a driving force more than guilt. In the same manner, physical illness and somatic manifestations of psychological distress become more understood, acceptable and evoke a caring response rather than a vague complaint of psychological symptoms, which can be either disregarded or considered a stigma of being "soft" or worse even "insane".

Some cultures and we argue that the Arab culture is one of them, value the collectivity of the community rather than the individuality of its member citizens. Decisions are not taken on an individual level but on a familial, tribal or communal level to the best of the perceived collective interest. How can we adhere to our ethical guidelines and at the same time not discard the local values and norms of our target population. How can we practice without showing dis-respect or disregard for local values. On the other hand, how can we make sure that our respect for the local culture would not be a pretext for us to bypass the ethical guidelines to the detriment of the patient's rights?.

Whether we like it or not, the encounter of psychiatry and law keeps bringing us back to the duality that exists between our conflicting conceptions of the value of health on the one hand and our conception of liberty, integrity and autonomy on the other. Cultural, ethnic and sometimes socio-demographic data like education, age and gender, suggest different attitudes regarding patient's autonomy and informed consent. What is the

perceived harm when the medical community violates cultural conventions and insists on telling the truth to the patient? What disruptions occur in the coping mechanism in the individual and family? In what ways does acculturation change the beliefs of patients of various ethnicities?

To answer those questions it may be necessary to draw on the highlights of human interaction in this culture, and, thereby, be able to understand the challenges and difficulties that face the implementation of guidelines such as the Madrid Declaration.

To understand this pattern one has to be familiar with the main characteristics that differentiate the position of the individual within his/her community in a traditional society as compared to a western society. Although societies should not to be taken as stereotypes, yet general common attitudes could be assumed [(4)].

The following is a very crude contrast to highlight the main differences. However, it should be noted that those differences are the mainstream norm and not an absolute description of a stereotyped behavior.

Psychosocial Markers in Traditional versus Western Societies

Traditional society	Western society
family and group oriented	individual oriented
extended family (not so geographical as before, but conceptual)	nuclear family
status determined by age and position in the family, care of elderly	status achieved by own efforts
relationship between kin obligatory	determined by individual choice
arranged marriages with an element of choice dependent on interfamilial relationship	choice of marital partner, determined by interpersonal relationship
extensive knowledge for distant relatives	restricted only close relatives
decision making dependent on the family	autonomy of individual
locus of control external	locus of control internal
respect and holiness of the decision of	doubt in doctor patient relationship

the physician	
rarely malpractice suing	common
deference is god's will	self determined
doctor patient relationship is still healthy	mistrust
individual can be replaced. The family should continue and the pride is in the family tie	irreplaceable, self pride
pride in family care for the mental patient	community
dependence on God in health and disease, attribution of illness and recovery to God's will	self determined

The above table shows that cultural diversity may influence the implementation of ethics in different societies. The family structure in traditional societies, namely the extended family, decision making is group and family oriented and the western attitude towards individual autonomy does not exist. The external laws of control, the dependence on God in health and disease and attribution of illness and recovery to God's will maintain a healthy doctor-patient relationship; which makes trust, confidence and compliance a characteristic attitude in traditional societies.

Arab culture has general features. It has traditional beliefs in devils, djinnies, evil eye etc. (delusional cultural beliefs). The family structure is characterized by affiliated behavior at the expense of differentiating behavior. Also rearing is oriented towards accommodation, conformity, cooperation, affection and interdependence as opposed to individuation, intellectualization, independence and compartmentalization. The extended family helps in managing intergenerational conflicts. Young individuals vacillate between two worlds of values: one world is felt to be dying, the other is not yet born.

It may be worth mentioning that the homeless mental patients seen frequently in USA and Europe

especially after the mental health reform and closing mental hospitals, this phenomenon is unseen in the Arab World and if so, it is because of poverty and not because of mental illness. The families in some traditional societies take pride in looking after their elderly, young or adult mental patients. It is shameful to the family, if it is discovered that one of its mental patients is homeless.

Traditional versus modern healing

There are a number of important lessons to be learnt from the examination of beliefs and practices relating to psychiatric illnesses that exist in various cultures throughout the world. In many non-western cultures, native practitioners, to whom modern psychiatry is completely unknown, are treating emotionally disturbed persons. The examination of the emotional attitude and interpersonal elements in these various forms of psychological treatments offers the psychiatrist a broad perspective from which to understand the basic components of our own present day systems of psychiatry and the ethics that guide it.

Traditional forms of mental health care contain important elements, sometimes effective and frequently the only method available in some cultures, a fact which requires better understanding and studies so that it can used in understanding the complexity of relatedness to mental patients throughout cultures. Traditional treatments are characterized for being culturally compatible (familiar with the cultural value system of the clients), holistic (integrating physical, psychological, social and spiritual aspects of healing) and is usually carried out by a charismatic healer i.e. somebody who promises to be in charge and can actually do so, almost to the point of bearing the responsibility of his decisions. The therapeutic process also frequently incorporates family, tribe or group and involves the social manipulation of the client's immediate environment.

Traditional and religious healers in primary psychiatric care deal with minor neurotic, psychosomatic and transient psychotic states using religious and group therapies (El Zar), suggestion, devices, amulets and incantations. National health priorities and

health care services are not for mental health. Furthermore 75-80% of Egyptian psychiatric patients, for example, present with somatic symptoms. 60 – 70% of them present to traditional healers and GPs [5].

In Arab culture, the issue of telling the diagnosis, prognosis and lines of treatment is not viewed as empowering. Traditional societies value the family centered model. A higher value may be placed on the harmonious functioning and the family rather than the autonomy of the individual members.

Role of religion

Religion plays an important role in symptom formation, attributions (God's will) and management. Psychological symptoms are being attributed to weakness of personality, lack of faith, lack of conformity, laziness etc. hardly attributes that entitle an individual to a right of choice. Statements like "if God is willing", "I seek refuge in God from the accursed Satan", "God is the healer" etc. are widespread in our region indicating a belief that the final decision is made where no human being has control and, therefore, human choice is quite a marginal variable in determining the final outcome.

Islam is the religion of the majority in the Arab region. The fundamental principle of Islam is of an essentially theocratic society in which the state is only of value as the servant of revealed religion. The states' submission to those principles is explicitly stated in the constitution of Morocco, Tunisia, Syria, the Islamic Republic of Mauritania, Sudan, Egypt and Yemen [6].

The approach of Islam to mental illness can be traced to two main sources:

1. The basic connotations of the most common word in the Koran used to refer to the mad person i.e. insane or psychotic, which is "majnoun". This is mentioned five times in the Koran to ascribe how prophets were perceived.

2. The different uses of this word by the masses to describe the perceived eccentricity of all prophets when they first attempted to guide their people to enlightenment. It is sometimes couples with being a magician or a poet or a teacher. The Islamic jurisprudence has emphasized that criminal responsibility should

be implemented only on sane adults with free choice (7).

In Islam no responsibility was attributed to a child, a psychotic adult or a sleeping or stuporous person. The welfare and care of the mental patients in Islam are clearly the responsibility of the family.

Muslim law, down to its finest details, is an integral part of the Islamic religion and to the revelation that it represents. Consequently, no authority in the world is qualified to change it. Not to obey Muslim law is a sin leading to punishment as a heretic and, thereby, excludes the person from the community of Islam.

In Mediterranean countries, many people, especially those living in Islamic societies, have an external locus of control and all events are attributed to God's will. Islam is centered on the idea of man's obligation or duties rather than rights that he may have. Within those terms of reference issues like consent, autonomy and decision-making become complex matters.

Apart from the concept of the insane as being possessed, we have another positive concept where the insane is taken as the one who dares to be innovative, original, creative or attempts to find alternatives to a static and stagnant mode of living. It is also to be found in various attitudes towards certain mystics such as Sufism, where the expansion of self and consciousness has been taken as a rationale to label some of the Sufis as psychotic. The autobiographies of some Sufis reveal the occurrence of psychotic symptoms and many mental sufferings in their paths to self-salvation (8).

The third concept of mental illness is the consequence of the disharmony or constriction of consciousness, which non-believers are susceptible to. It is related to denaturing of our basic structure *(Al Fitrah)* and disruption of our harmonious existence by egoism, detachment or alienation, partly presented by the loss of integrative insight.

The prevailing concept of mental illness at a particular stage in the Islamic World depends on the dominance of development or deterioration of genuine Islamic issues. For instance, during deterioration, the negative concepts of the insane as being possessed by evil spirits

dominates, whereas during periods of enlightenment and creative epochs, the disharmony concept dominates and so forth.

Islam also identified the unity of body and psyche. The psyche *(Elnafs)* was mentioned 185 times in the Koran as a broad reference to human existence, meaning at different times body, behavior, affect, and/or conduct i.e. a total psychosomatic unity.

The teaching of the great clinician Rhazes had a profound influence on Arab as well as European medicine. The two most important books of Rhazes are "El Mansuri" and "Al-Hawi". The first consisting of ten chapters, includes the definition and nature of temperaments, the dominant numerous and comprehensive guides to physiognomy. Al-Hawi is the greatest medical Encyclopedia produced by a Moslem physician. It was translated into Latin in 1279 and published in 1486. It is the first clinical book presenting the complaints, signs, differential diagnosis and the effective treatment illness. One hundred years later, "El-Canoon" of medicine by Avicenna was a monumental, educational, and scientific book with better classification.

The first Islamic hospital appears to have been established by the early ninth century in Baghdad and to have been modeled on the East Christian institutions, which seem to have been mainly monastic infirmaries.

Among the hospitals that appeared throughout the Islamic world, perhaps the most famous one was that created in Cairo by the Egyptian Sultan *al-Mansour Kalaoon* in 683/1284 [(7)].

It was there, in Spain and namely in Granada, that the first mental hospital was established in Europe through the Arab Influence and from there it propagated to south France and rest of Europe.

The 14th century Kalaoon Hospital in Cairo had sections for surgery, ophthalmology, medical and mental illnesses. Contributions by the wealthy of Cairo allowed a high standard of medical care and provided for patients during convalescence until they were gainfully occupied. Two features were striking: the care of mental patients in a general hospital, and the involvement of the community in the welfare of the patients, and foreshadowed modern trends by six centuries [(9)].

Consent

What is the purpose of highlighting consent as a core element in psychiatric ethics? The primary purpose is to promote individual autonomy and to make rational decision making. It is not the mere signing of a piece of paper to protect the treating physician or institution from future malpractice complaints. Broadly it should involve explaining to the patient the risks and benefits of the proposed treatment and alternative treatment methods which exist and what the risks and benefits of those treatments are. The patient should be informed what refusal of treatment would entail in terms of risks and benefits and one should make sure that the patient is not under some sort of undue influence and that the environment is not coercive. The basic elements of informed consent are competence (which involves the capacity for decision making, taking into consideration that affective incompetence is not usually recognized by the law), information (fiduciary relationship which is rooted in respect for the dignity and autonomy of the patient) and non-coercion (note the subtle Difference between coercion and persuasion).

Common law acknowledges two instances where consent is not needed. The first is cases of necessity, where the doctor is of the opinion that treatment is in the patient's best interest and the patient is not competent to give valid consent to that treatment and the second is emergency, in order to prevent immediate serious harm to a patient or to others as to prevent a crime.

Competence

Furthermore, patients are considered legally competent unless adjudicated incompetent or temporarily incapacitated by a medical emergency. The court held that persons are competent to make treatment decisions if they are of "sufficient mind to reasonably understand the conditions, the nature and the effect of the proposed treatment, attendant risks in pursuing the treatment and in not pursuing the treatment."

Common law states, that competent adults have a right to refuse medical treatment even if this refusal results in death or permanent injury. Furthermore

competence can apply to different things: We cannot generalize i.e. competence to give consent to treatment, competence to admit yourself to a hospital and competence to agree to "do not resuscitate" order.

Decision-making

But what if the decision making process is not an individual one? Arab cultures deal with issues of illness as a family matter. Whether or not a patient is hospitalized, subject to ECT, kept or discharged from hospital is not dependent on what the patient wants on his or her own but on the estimation/need/wish of the family, both nuclear and extended. Patients may, at times, wish not to be burdened with the extra load of having to take a decision that may determine the pattern of the rest of their lives. The concept of shared responsibility is central in the Arab culture and the majority would not like to be responsible for the outcome of an individual decision.

The decision making style might be best described in our cultures as family centered. The moral, social and psychological support for which extended families in the third world are so famous for is a largely conditioned process. It is conditioned by collectivity of decision making, by consensus. An individual decision not in agreement with the collective leaves the decision maker single

in bearing the responsibility of the outcome and may deprive him or her of the familial support. This is not necessarily perceived as a negative value or pattern of relationships, but is the norm on personal interaction within families, especially if the family will be sharing in the consequences of the decision. Negative consequences of the decision are then not the patient's fault alone and he or she does not have to bear the guilt of making a wrong decision.

A demonstrative example for the issue of consent and decision making may be that of hospital admission. Voluntary admission makes up approximately 73% of psychiatric facilities in the USA. In Egypt it is 90%. In reality, the distinction between voluntary and involuntary admission is not as clear as stated in law. Patients are often induced or pressured into accepting voluntary admission. If voluntary admission were to be

maintained as truly voluntary, involuntary admission would likely increase. The family role is strong in enforcing voluntary admissions which makes no need for involuntary admissions in any region. In our region, the respect and obedience to the family decisions exceeds autonomy of the individual in importance, especially if the burden of an outpatient will lie entirely on the family with no available community social support systems.

On the other hand, it is the responsibility of the family to hear the bad news about the patient is diagnosis and prognosis and to make the difficult decision. Studying Italy, Greece, Spain and Egypt regarding the issue of telling the diagnosis of cancer shows that autonomy is not viewed as empowering. Rather it is seen as isolating and burdensome to patients who are too suffering and too ignorant about their condition to be able to make meaningful choices. It harms the patient by causing them to lose hope.

Affiliation versus autonomy

The previous attitude towards decision making indicates a social value system where autonomy is not in the center of concerns. The idea of patient autonomy is not universal. In USA 90% of physicians did not inform their patients of the diagnosis of cancer in 1961 (Blackhall et al., 1995). This was reversed in 1979 where 97% of physicians made it their policy to inform patients with cancer of their diagnosis. Most of the literature that discusses this change reviews it as simple progress from an uninformed paternalism to a more enlightened and respectful attitude towards the patient.

The same can be applied to mental illness with a major difference being the lack of stigma associated with cancer. Cultural, ethnic and probably socio-demographic factors suggest different attitudes regarding patient autonomy and informed consent. Sharing the European American model is subject to the process of acculturation.

For those who hold the family centered model, a higher value may be placed on the harmonious functioning of the family than the autonomy of its individual members. Although the patient autonomy model is founded on the idea of respect for persons,

people live, get sick, and die while embedded in the context of family and culture and inevitably exist not simply as individuals but in a web of relationships [10].

Insisting on the patient's autonomy model of medical decision making, when that model runs counter to the deepest values of the patient, may be ironically another form of the paternalistic idea that "doctors know best". A person in our region may actually change a doctor because of the way he or she conveys the information to the patient or if they insist to make the patient their only reference point in decision making.

Confidentiality

The relativity of consent and autonomy feed back into a third major element of psychiatric ethics which is that of confidentiality and disclosure of information which is another universal principle of the Madrid and other professional Declarations. Although there exists no consistently accepted set of information to be disclosed for any given medical or psychiatric situation, as a rule of thumb, five areas of information are generally provided: diagnosis, nature and purpose of the proposed treatment, consequences, risks and benefits of the proposed treatment, viable alternatives to the proposed treatment and prognosis, which is the projected outcome with and without treatment

As such, confidentiality is already a very porous matter, that it is virtually non-existent. The nurses, intern residents, social workers, psychologists, ward clerks; Medicaid reviewers and accreditation bodies are already entitled to have access to this information and to read the patient's chart. The question is therefore, related to people from outside the medical profession and its accessories which in our case, again, would be the family for example.

Telling the patient the truth about his or her condition, especially in cases where the prognosis is bad or a major decision should be taken, is not considered a virtue in our culture. In fact Arab families, although praising the technological advance of medicine "abroad", would always make the comment about the

harshness of western doctors who tell their patients the truth in the face without consideration of the emotional trauma that this would entail. In our culture, the norm is to tell the family first and then it is almost entirely left to the family to decide whether or not to convey the information to the patient.

Arab families frequently speak of their cousin who "feels" that he or she may have cancer and "who does not really want to know for sure". There is a strong conviction among our patients that not knowing the bad truth provides the patient with a hope that things may get better. Issues like preparation for death or preparing a will or other economic arrangements are hardly a matter of concern, probably because those matters are dictated by the Islamic jurisprudence with little space for interference from the patient. Preparation for death is mainly a spiritual matter with few practical implications. In the field of psychiatry, patients and their families would always like to hear that the condition will improve. Even if it does not improve , or even if it does improve only for short periods of time, they would rather see a psychiatrist who would insist " that things will get better" than one who would give the outcome in statistical, scientifically based figures, even if the two were at the end prescribing the same medication. Arabs tend to believe that recovery is the outcome of God's will, while no recovery may indicate the doctor's failure.

Conclusion

We would like to stress that we are not forwarding those patterns of interaction to bypass the implementation of ethical codes to our culture. It is still our primary mandate to secure an ethical foundation for our practice and not to leave our patients at the mercy of the good intent of the practitioner. This paper only deduces that the implementation of the ethical codes needs tact and understanding of the local constraints in order not to further jeopardize the ill-defined image of the psychiatrist and the specialty of psychiatry. We could, for example, suggest that physicians ask patients, if they wish, to be informed about their illness and be involved in making decisions about their care or if they prefer that their family handles such matters. We would

thereby be approaching the issue of consent in a broader frame-work than on the concrete day to day information. In any case, the patient's wishes should be respected allowing patients to choose a family centered decision-making style which does not mean abandoning our commitment to individual autonomy or its legal expression in the doctrine of informed consent. Rather it means broadening our view of autonomy so that respect to persons includes respect for cultural values which they bring with them to the decision making process.

الملخص

إن الاعتقاد السائد في تطبيق ميثاق القيم و الأخلاق في كل الثقافات بطريقة واحدة هو سراب بعيد عن الواقع، إن الموافقة المستنيرة و الدخول الإلزامي في المستشفيات النفسية و الخصوصية و السرية في العلاقات بالمرضى ليست ضرورة ملحة في المجتمعات التقليدية و الشرقية و التي تمثل ما يقرب من ثلثي سكان العالم، إن أهم الاختلافات بين المجتمعات الشرقية و الغربية أن القرار يعتمد على الأسرة في الأولى و على التمركز الذاتي في الثانية، لقد تغيرت طبيعة العلاقة بين الطبيب و المريض في المجتمعات الغربية خاصة بعد وجود إدارة الرعاية و التأمين الصحي و الطرف الثالث الذي يكون مسئولا عن اقتصاديات الرعاية الصحية، و كذلك الإفصاح عن المعلومات عن المريض.

لقد أصبحت الموافقة المستنيرة و التحالف العلاجي و البحوث العلمية ركناً أساسيا في حقوق الإنسان و قد تم التأكيد على ذلك في ميثاق مدريد و هو ميثاق القيم للجمعية العالمية للطب النفسي.

كيف يؤثر التشكل الحضاري في اعتقادات المرضى من الأجناس المختلفة؟ إن المواجهة المستمرة بين القانون و الطب النفسي تجعلنا في صراع دائم بين قيمة الصحة و قيمة الحرية، التكامل و الاستقلال الذاتي.

يزيد الاهتمام في المجتمعات التقليدية في التواصل الإجتماعى عن الاستقلال الذاتي، و أن العائلة و ليس الفرد هي محور المجتمع ، إن الاعتمادية و التواصل مقبولة أكثر في المجتمعات الشرقية، إن التواصل الأسرى يأخذ مكانة أكبر من الإنجاز، و كيف يظهر الإنسان أمام الأخريين هو الأساس مما يجلب العار لمن لا يلتزم بهذه العادات.

فكيف نمارس الطب النفسي دون احترام للقيم المحلية و الأعراف و التقاليد ؟ و في نفس الوقت كيف نتأكد أن الثقافة المحلية لا تتجاوز الهاديات الأخلاقية و القيم التي تحفظ حقوق الإنسان؟

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Prof. Ahmed Okasha

Professor and Director of WHO Collaborating Center for
Training and Research in Mental Health
Institute of Psychiatry, Ain Shams University
Chairman of Ethics Committee WPA (1993 – 1999)
President Egyptian Psychiatric Association
President Arab Federation of Psychiatrists
Past President and Council Member WPA
Cairo, Egypt.

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Epidemiologic Assessment of Substance Use in the Arab World

Mariana M. Salamoun[a], Aimee N. Karam[a,c,d], Tarek A. Okasha[b], Leen Atassi[a], Zeina N. Mneimneh[ae], Elie G. Karam[a,c,d]

تقييم وبائيات المخدرات في العالم العربي

ماريانا سلامون،إيمي كرم، طارق عكاشة، لين أتاسي، زينه منيمنه و إيلي كرم

ABSTRACT

Epidemiological studies on substance use are rare in the Arab world. The purpose of this paper is to present a systematic review of all published epidemiologic research in the Arab world up to 2007 using several search engines such as PubMed, PsycInfo, and IDRAAC web database. Research in the Arab world was conducted on specific subpopulations ranging from students to autopsies, at times on large numbers and only one published article on a national basis. Despite the rigid laws against substance use in this region, alcohol is the most used substance, especially among high school and university students ranging from 4.3% to 70.1%. Males use substances more than females except for tranquilizers and barbiturates, the trends changing in a recent report from the L.E.B.A.N.O.N study. As reported by Western counterparts, substances carry a burden on several levels including social impairment, problems of violence, and HIV. Risk factors for substance use include mainly family problems and peer pressure. However, there remains a clear need for national data on substance use in the Arab world in an attempt to identify the magnitude of the problem, and track it for proper monitoring and intervention.

Word count: 191

Keywords: Alcohol, Arab, Epidemiology, Substance.

Introduction

Reports by the National Survey on Drug Use and Health [(1)] show that half of the US population aged twelve and above were current alcohol users (58.1% were males), 22.7% had had binge drinking (defined as 5 or more drinks on one occasion) at least once in the previous month, and 6.6 % reported being heavy

drinkers (defined as 5 or more drinks on the same occasion on at least 5 different days in the past month). Illicit drug use was observed in (8.1%) of the total population above twelve years of age, the majority (54.5%) of whom used marijuana only, in the past month. Use of cocaine (1%), crack (0.3%), hallucinogens (0.4%) and heroin (0.1%) were relatively lower in the past year.

When compared to other regions, Europe has the highest alcohol consumption in the world. In 38 countries, the average alcohol consumption per person in 1998 was 7.3 liters; ranging from 0.9 liters (Azerbaijan) to 1303 liters per person (Luxembourg) [(2)]. The European National population surveys [(3)] have shown that cannabis is the most commonly used substance in the European adult population (aged 15–64 years) ranging between 2% and 31%. Ever use of amphetamines ranged from 0.1% to 5.9% (an exception is UK: 11.2%), ecstasy use ranged from 0.3% to 7.1%, and cocaine from 0.4% to 6%.

Substance abuse is coming to the forefront in the Arab World, as more individuals and populations are exposed to diverse cultures, introduced to a variety of contemporary substance and becoming more affluent. Consequently, while some are contributing to the world drug report (www.unodc.org). Scientific research pertaining to substance use in the Arab world has intensified, where health professionals seek to shed light on prevalence rates, etiology, risk factors, and treatment outcomes.

This paper examines prevalence rates of substance use, gender differences, co-morbidity and risk factors across epidemiologic studies in the Arab world. This enables us to understand how data in this part of the world compares to international data, and the pervasiveness of substance use, abuse and dependence in the Arab countries.

Methods

This review was conducted by the Institute for Development Research Advocacy and Applied Care (IDRAAC) for epidemiologic published articles up to end of 2007, in English, French, or Arabic language, with no restriction to study design.

Keywords: Alcohol, Amphetamine, Anabolic steroids, Analgesics, Antihistamines, Anti-parkinson,Anxiolytic, Barbiturate, Benzodiazepine, Betel nut,

Cannabis, Carbamate, Catnip, Cocaine, Codeine, Cortisol, Ecstasy, Hallucinogen, Hashish, Heroin, Hypnotic, Illicit, Kava, Licit, Marijuana, Mor-phine, Nitrite, Nitrous oxide, Opiates, Opioid, Painkillers, Phencyc-lidine, Sedatives, Stimulants, Substance abuse, Substance use, Tranquilizers.

Search Engines: The search engines used were: PsycINFO, PubMed, and IDRAAC website search engine: (www.idraac.org).

Arab countries and regions: The countries included were: Algeria, Bahrain, Egypt, Gaza, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates, UAE, and Yemen. In addition, the following regions were included: Arab, Gulf, and Middle East.

Screening search results and categorization: The search resulted in a large number of articles which were screened, and of which 197 articles were reviewed for being possibly relevant. The full text for the probably relevant articles were retrieved either online through subscriptions or ordered from local or international libraries, or requested as hard copies from the authors (through many trials of contact by email or regular mail). We were able to retrieve 143 references out of which only 47 were included this review. The non-relevant references were non-epidemiologic studies (e.g. clinical trials, case-control studies), non-Arab samples, or dissertation abstracts. The results of this search will be presented first by country in alphabetical order, and then followed by a comparison across countries (Table 1).

Results

Egypt

Recent publications were scarce in Egypt. The published research targeted a variety of populations, such as community samples, student populations and clinical samples. In studies covering secondary school students, university students, and industrial workers in Egypt lifetime prevalence rates revealed that alcohol was mainly the predominant substance of choice among all categories, with secondary school students reporting the highest amount of consumption (22.5%), followed by male university students (22.1%), industrial workers

(20.1%), and lower rates by female university students (7.2%) [4].

Similar to the male university student population, female university students demonstrated a peak age of onset of 19 years for trying tranquilizers (5.1%), followed by stimulants (4.8%), and hypnotics (4.2%), and they were least likely to use hashish (0.8%). Approximately 22% of the female students first tried alcohol just before 12 years. Male students first used narcotics (hashish: 15.4%) and alcohol at 12 years; tranquilizers (5.8%), stimulants (14.0%), and hypnotics (4.2%), were mostly first tried between 15 and 16 years of age (4-7). Factors predicting substance use included getting ready for exams, "stress", personal bodily problems and pains, and peer pressure [6].

A representative sample of 4% of male secondary school pupils enrolled during the academic year of 1985/86 [7] were divided into: urban and rural groups. The highest rate of substance ever used by the students was narcotics (5.9%), and 16.3% admitted to continued use of narcotics (narcotics included in this Egyptian study cannabis, opium, and heroin), followed by ever use of minor tranquilizers (2.7%), hypnotics (2.3%), and stimulants (1.8%). Prescription psychotropic drugs were used at least once by 5.5% of the male sample, and 21.4% of these reported continued use, of which only 16.2% used them more on a regular basis (4-10 times a month). Higher rates of alcohol use were recorded by the rural student population (28% vs. 21.14% in the urban sample) and continued use of narcotics was more prevalent among the urban student population, 17.6% of urban ever users vs. 10.2% of rural ever users. Additionally, the urban student population was found to start alcohol and prescription psychotropic drugs at a younger age (Urban: 45% - 62% vs. Rural: 27% - 41% before age 15 years).

In clinical samples, substance use was often found to be primary or secondary to a co morbid psychiatric disorder. In a sample of 100 schizophrenic patients attending he outpatient facility in 2001; twenty six met the DSM-IV criteria for substance abuse (N = 7 whose substance abuse was primary) [8]. Most substances abused by the patients were antiparkinsonian drugs (38.5%),

followed by of cannabinoids, narcotics/opioids, and benzodiazepines (11.51% each), and lastly alcohol, which was only detected in two patients (7.7%).

An early report on serological tests from a large and diverse population (n= 29261) grouping drug addicts, female prostitutes, international travelers, blood donors, and foreigners who resided in Egypt for more than thirty days indicated an exceedingly low prevalence (0.2%) of HIV in Egyptian drug addicts [9].

Jordan

In a sample of 5064 students randomly chosen (54.9% females) from six universities and four intermediate colleges [10] the prevalence of alcohol ever use was 16.6% (11.8% of the population used at least once in the previous month, 8.1% had used for less than 6 days in the previous month, and 1% had consumed alcohol for more than 20 days in the previous month). The highest prevalence of other substances ever used were sedatives (12.9%), followed by volatile substances (6.8%), hashish/marijuana (4.6%), the anti-parkinsonian benzhexol (3.3%), amphetamines/stimulants (3%), and the least substance ever used were opiates/heroin (1.5%). Approximately similar patterns were noted for use of substances at least once in the previous month (with heroin/opiates least used); however, reports indicated that use of sedatives was equally if not more prevalent (12.5%) among the students in the previous month than alcohol use (11.8%). Rates of any substance used at least once in the past month were relatively higher among males than females. Risk factors significantly relating to substance use included peer encouragement and substance use/abuse, abuse of alcohol and psychoactive substances in the neighborhood, and/or poor family communication.

An earlier study by Abu Al-Ragheb and Hadidi [11] assessed the burden of substance use through a toxicological examination of all autopsies (N=6109) between 1978 and 1996. Postmortem cases of individuals who died between the ages of one and seventy, at the Jordan University Hospital revealed that deaths pertaining to drugs and alcohol totaled 0.98% (n = 60) of the cases, higher in males (66.6%) followed by children (21.6% under the age of five,

resulting from accidental ingestion). Alcohol was equally prevalent as drugs in causing fatal poisoning.

Kuwait

In Kuwait, two studies were identified on different samples [12, 13]. In a sample of 1058 systematic admissions to the emergency room of a general hospital and a specialist traumatology hospital only 10% of the patients tested positive (blood) for alcohol use, and a significant high alcohol-associated casualty rate (22%) characterized the clinical diagnosis of delirium/coma [12]. In another study drug misusers, in male army conscripts in Kuwait (N=2183), were self-administered the Arabic version of the 28-item Drug Abuse Screening Test (DAST, 14), and a urine analysis was performed [13]. A total of 4.4 % of unprescribed psychoactive drugs was reported with cannabis constituting the lowest (0.1%), followed by morphine (0.2%), and amphetamine (0.7%). Amphetamines were significantly linked to family or social problems, physical dependence, and hospitalization.

Lebanon

Until recently most data in Lebanon had been collected on university students (15-19). The earliest reported studies on substance use were done on a university population (N = 429) registered between 1972 and 1973 [19]. Self-filled questionnaires surveyed 14% of the students about ever use of drugs. Marijuana was the most common drug used: 17% of the participants reporting to have used marijuana at least once (18% males, 14% females) with this use peaking in university years, amphetamines (8%), LSD (2%), and tranquilizers (17%).

A closer look at patterns of substance use, specifically benzodiazepines, was assessed through questionnaires given to a randomized sample of the Lebanese population (N = 1000) aged 18 years and above (20). A total of 9.6 % of the sample population reported the use of benzodiazepines in the previous month, with females twice more likely to do so (12.1% vs. 6.8% for males).

In a study by Karam et al [16] on university students using self filled questionnaires, females were more likely to use “licit” substances such as tranquilizers (13.3%) and barbiturates (10.6%) vs. (7.6%) and (6.3%) in males

respectively, whereas males tried "illicit" substances such as cannabis (3.7 %) more than females (0.7%). Use of licit substances (tranquilizers, barbiturates, morphine, and codeine) appeared to increase with age. Problems pertaining to alcohol use in the student population mirrored in nature those reported in the western countries: traffic accidents, physical fights, etc. In addition, risk factors to alcohol use/abuse or dependence the presence of an excessive drinker in the immediate family, and friends' and parents' attitudes towards drinking. Practice of faith and parental control served as protective factors against alcohol use, abuse and dependence.

A survey on alcohol use among students (N=954) taking introductory English courses at the American University of Beirut during the fall semester of 1998, who completed the Control and Prevention's Youth Risk Behavior Survey that 66.5% of the students (70.9% males and 61.4% females) used alcohol at least once per day on one or more days during the past month, while 11.5% had at least 5 alcoholic drinks in a row on one or more days during the past month (17.3% males, 4.6% females) [21]. Also university students reported lower rates of ever trying illicit substances (12%) where males were almost twice more likely to do so (14.7%) than females (8.8%).

Karam et al [22] selected a total of 222 records of all inpatients consecutively admitted to Saint George Hospital University Medical Center who fulfilled the clinical entity of dual diagnosis (ever substance and ever other mental disorder). Schizophrenia was co morbid with cannabis abuse (44.8%), bipolar disorders with cocaine abuse (42.1%), anxiety disorders with tranquilizers (36.8%), depression with medicinal painkillers (including opiate preparations) and barbiturates (19.3%), and heroin abuse was highest in the pure substance abuser group (mostly antisocial personality disorder); whereas the prevalence of alcohol abuse was comparably high across all diagnostic categories.

A study on samples from two major private universities in Lebanon (an American and a French system university), used self filled questionnaires covering 25% of the entire population in both universities [18]. Phase I

(1991) was based on the DIS-III [23], and lifetime prevalence of alcohol use was 49.2%. 14.9% of the drinkers ever drunk as much as one bottle of liquor in one day, 5.1% ever had 7 drinks or more every day for 2 weeks, and 10.7% had 7 or more drinks per day, every week for a period of 2 months or more. However, phase II (1999), carried a decade later (and thus based on the DIS-IV), showed a sharp increase in lifetime alcohol use (70.08%) from phase I. The average number of drinks was 1.11 ±2.01 drinks/ day for the total sample. Alcohol abuse and alcohol dependence increased from phase I (2.8% and 2.9% respectively) to phase II(9.1%, 5.3% respectively). No differences were found between age groups in terms of alcohol ever use abuse, dependence and excessive use. Nevertheless, intoxication was most prevalent among the older age group (over 22 years of age), 16.97 ± 2.54 years was the mean age of intoxication in phase one (1991), and 17.04 ± 2.41 years in phase two (1999).

In a comprehensive assessment of substance use in Lebanon, and published in the Rapid Situation Assessment report (17) rates of ever use were reported for high school students (2001) and university students (1999): cocaine (1.7% high school vs. 1.2% university students), ecstasy was used by 2.8% of the high school student population (this assessment was limited to the high school sample); university students reported more ever use of hashish/marijuana (8.8%), tranquilizers (13.1%), amphetamines/ stimulants (4.3%), and medicinal opiates/barbiturates (5.2%) vs. 6.8%, 3.3%, 1.2%, & 1.2% in the high school sample. Heroin use was equivalent in both populations (0.8% each). 33.33% of the clinical (hospital and rehab) and "street" samples had been arrested by the legal authorities previously, and equally a third of those arrested had had previous treatment for use. Through focus group discussions and key informant interviews, street users felt that peer pressure was a primary factor associated with substance use; while shoplifting, prostitution, and gambling constituted only distant secondary factors.

Recently, IDRAAC undertook the L.E.B.A.N.O.N study (Lebanese Evaluation of the Burden of Ailments and Needs Of the

Nation), which is the first national study in Lebanon and the Arab region in coordination with Harvard University (USA) and the World Health Organization (Geneva) [24]. 2857 Lebanese adults (≥18 years) representing the adult population in Lebanon were administered the Composite International Diagnostic Interview Arabic version. The 12-month prevalence of alcohol abuse in Lebanon was 1.2% and 0.2% abused drugs (DSM IV). Socio-demographic correlates of substance use disorders were younger age (18-34 yrs) and never been married. More results are under analysis [25]. The lifetime prevalence of alcohol abuse was 1.5% and drug abuse 0.5%, with males reporting significantly higher rates than females [26]. Cross-national findings from the WHO World Mental Health Surveys have shown that lifetime tobacco use was most common in the US (74%), followed by Lebanon (67%), Mexico (60%), and some European countries. The median age of onset for cannabis was between 18–19 years, and for Lebanon 21 years [27].

Morocco

High school students (N=678) enrolled in their first semester in 1984 in the regions of Taza and Tetouan were the target of an epidemiological study on drug use [28]. A considerably larger amount of students at Tetouan ever used cannabis (15.56% vs. 2.7% in Taza) and alcohol (1.55%), separately or in combination with other substances (cannabis and alcohol combined constituting the highest prevalence: 7.56%), with the duration of use ranging from two to four years.

Kjiri et al., [29] conducted a cross-sectional study to assess drug use among 1208 university students (744 women, 466 men) using an anonymous self-adm-inistered questionnaire. Results showed that 12.5% of students reported alcohol use, 11.7% cannabis, 3.6% psychotropic drugs, 1.0% cocaine and 0.8% heroine. Women (42.9%) used psychotropic drugs more than men (11.9%), $p<0.001$.

Oman

Jaffer et al., [30] investigated risky health behaviors among Omani adolescents in a nationally representative sample of secondary school students (N=3114, 48% boys) who were given a self administered questionnaire.

Results showed that 46% of students were current smokers, 4.3% current alcohol consumers, and 4.6% had been persuaded to take drugs by peers.

Palestine

Most retrieved studies in Palestine target both Arab and Jewish populations, in an attempt to highlight patterns and differences in substance abuse (especially alcohol abuse) between the two different groups. Between 1992 and 1995, a study examining the problems associated with substance abuse, assessed 292 battered women above eighteen years of age (69.9% were Jewish) in Kfar Saba. Results revealed that in contrast with Jewish batterers, Arab batterers had a significantly higher substance abuse score [31].

A National Household Survey on Drug Abuse was carried, based on interviews of a national multistage probability sample from the North, Haifa, Central and Tel Aviv [32], with women comprising the majority of the sample (60%). "Current" drinking rates were highest among female secular Jews (43.4%), and more than double of that of secular Arab women (19.6%). Arab men (39.6%) and women (34.9%) engaged in more 'heavy drinking' (defined as five or more drinks within a few hours) in the month prior to the study than did Jewish men (21.8%) and women (8.1%). Higher levels of education (≥ 13 years) were associated with higher rates of drinking among Arab women (but not men) and both genders among Jews. Religiosity, income, and occupation also seem to be linked to the patterns of drinking, Arab men and women with below average income, and some degree of religiosity were less likely to submit to binge drinking. Significantly less drinking occurred in married Arab women (3.7%), yet, professional Arab women and men were more apt to report higher levels of drinking as opposed to Arabs from other occupations [32].

However, in a later study by Neumark et al. [33], in a methodology similar to the previous study (2001 see above) , frequent binge drinking (defined as having five or more drinks within a 'couple of hours' in the previous month) was predominant in the Jewish sample, with an overall binge-drinking rate of 9.2%. In 2003, Abu Qamar and colleagues (34) assessed the

the prevalence of substance abuse among 1007 students in 1st and 4th year of study at Art and Science colleges in Gaza Strip. Four universities (mean age 20.4 years) participated in the cross-sectional study (Al Azhar 29.6%, Islamic 30.58%, Open Alquds 11.62%, and Al Aqsa University 28.2%). The results showed that 17% of student had ever used substance over the past year, 11.7% abused tobacco (71.6% cigarettes, 23% hubble-bubble, 4.4% smoke cigars, and 0.9% pipe), 1.2% abused alcohol, 1.09% abused sedatives, < 1% abused any of other substances (opiates, cannabis, inhalants, hallucinogenic, stimulants). Tobacco abuse was more common among single students (11.74%) and males (21.4%) but did not differ across the places of residency (cities 10.4%, camps 11.9%, 14.2% village, 17.8% housing project). Other factors found to be related to higher substance abuse included: larger family size (11 + members) especially in using hallucinogenic substances. For males factors included psychological stress, curiosity, and sexual desire, while for females: treating physical problems, getting rid of emotions of weakness, facing academic challenge, and treating mental disorders.

Saudi Arabia

Three of the retrieved studies covered clinical samples of patients admitted to various hospitals across Saudi Arabia (35-38). Given that the studies were limited to clinical populations, this review will be mainly concerned with the burden associated with substance abuse, co morbidity with other psychiatric disorders, and an assessment of treatments of substance abuse.

Patients (N = 485) attending outpatient clinics in Jeddah in 1989 with an initial diagnosis of a psychiatric disorder (37) stated while being interviewed that they initiated substance use to alleviate psychiatric disturbances (3%), or turned to alcohol to cope with insomnia, social phobia and/or an anxiety state (52.6%). Out of 170 patients, 35% were referred by the police, some of whom had criminal records (4.9%).

In a study by Abdel-Mawgoud et al. [35], various treatment modalities were assessed in terms of average length of stay, average daily census, use of psychotropic controlled medications and

dropout rates. A review of treatments adopted at different time periods were divided into three consecutive phases: Phase I (1986-1991): in which drug therapy was adopted, and was judged by the investigators to be least effective, with a "high" average daily census (128.3), and average length of stay in the center (37.5 days), as patients apparently amplified their complaints to receive free drugs for a longer period of time. Phase II (1991-1993) constituted an attempt to implement a " bio-psycho-social" model and prescription restriction, by seeking international expertise to improve and enhance the treatment program, and was marked by a drop in the average length of stay and average daily census. Nevertheless, the cultural and language barriers apparently rendered the program "ineffective". Phase III (1993-1994) was characterized by a modification of the phase II treatment program, as problems were assessed and changes were investigated: (such as the reinforcement of hospital hierarchy, reviewing the hospital structure, training needs reassessed, quality assurance officer appointed, etc) to parallel and be sensitive to the Saudi culture. Staffs' and patient's attitudes were clearly altered by the changes; increases in performance and cooperation levels were noted, as well as an increase in average length of stay (35.8 days vs. 25.8 in Phase II) and a decline in dropout rates (2.8% vs. 24% in phase II).

The prevalence of HIV among intravenous drug users was investigated by Njoh and Zimmo [(36)] through testing a sample of Saudi males (n = 2628) at Al-Amal Hospital who met the DSM-IV criteria for drug dependence. The third generation qualitative Enzyme Immunoassay was used to detect antibodies to HIV type 1 and/or type 2, and the Western blot test was used as a confirmatory test. Only four intravenous users (0.15%) tested positive for HIV by the Western blot test.

Overdose, another significant aspect of substance abuse was assessed through toxicological examinations and autopsies of deaths resulting from overdose between 1990 and 1997 [(39)], and the conclusion of the investigator was that Saudis experienced higher overdose fatalities (77%) than other Arabs (3.5%).

In a study examining the co morbidity of substance use and other psychiatric disorders (40), 9% of the in-patients (N = 799) at a voluntary detoxification unit were found to have a relatively low prevalence of mental disorders such as personality disorders (4%, especially antisocial personality disorder 3.5%), drug induced psychosis (2%), mood disorders (0.37%), anxiety disorders (0.37%) and other disorders like substance induced dementia (0.38%) and schizophrenia (1%). Antisocial personality disorder was commonly associated with alcohol use (9%), heroin (4%) and volatiles (2.5%). Traffic accidents (12%) resulting from alcohol and/or heroin use were observed in patients attending an outpatient facility in 1995. 21% of heroin users had injection related problems (Abscess, Cellulites, Septicemia, Deep vein thrombosis, Digital gangrene, Limb atrophy, Abscess away from injection site) and 69% had hepatitis C virus.

The burden of substance abuse was evaluated through reports from inpatients admitted at two hospitals in Saudi Arabia (n = 423) and interviews using the Brief Psychiatric Scale (DSM-IIIR and ICD -10). Results showed that the major problems encountered by the subjects were violence (99.3%), imprisonment (50.9%), health problems (32.4%), and financial problems (30.5%), loss of job (13.5%), drug overdose (9.5%), and divorce (6.9%) (38). A majority of the patients (74.2%) stated that their prayers were irregular, 6.4% were not praying at all, with a smaller percentage (19.4%) praying regularly.

In a smaller clinical sample of one hundred and twenty Saudi males in a hospital in Dammam, poly-substance abusers displayed significantly more cognitive deficiencies, and were as a result less likely to be employed, and maintain employment (although results lacked statistical significance, $p<0.37$); however, length of abuse did not appear to be a contributing factor. Poly abusers were predominantly reported use heroin, hashish, and alcohol [41].

Sudan

There was a lack of published data on substance abuse among females in Sudan, with only one study assessing substance use among them. In an early study,

Rahim [42] interviewed a sample of both males (n = 108) and females (n = 96) randomly selected from a population consensus (including an indigenous sample studied previously), and found that the prevalence of substance abuse is relatively low (0.4%), with a smaller amount of participants reporting substance abuse, as opposed to complaints pertaining to other psychiatric illnesses and symptoms (such as Depressive illness, generalized anxiety disorder, somatoform disorder, conversional reactions, and psychotic pain syndrome). Although the author states, "*alcoholism among females is very rare*", no data from the community sample could support or refute this claim, since gender differences were not statistically significant. Nevertheless, the clinical sample's homogeneity in terms of gender may be indicative of possible gender differences in substance abuse in the Sudanese population. Noteworthy, is the burden associated with substance abuse in the clinical sample. Marital conflicts (63%), legal problems resulting from offenses (40%), traffic accidents and head injuries (29%), financial offences (13%) and social scandals (11%) were among the dilemmas emanating from substance abuse. The study also reflects on relapse, with 61% of the patients having previously been admitted to a hospital.

Tunisia

The available published research is limited to a random sample of Tunisian school students (n = 353) between twelve and twenty-four years of age, registered during the academic year of 1998-1999, and whose knowledge, attitudes and practices were assessed through self-administered questionnaires [43]. Alcohol consumption was noted by 26% of the students, the majority of whom were males (43.9% vs. 7.6% females), and 12.7% of the students reported drug use, mainly cannabis (68.8%), while comparatively fewer students reported medicinal substance use (31%). Again, males maintained higher rates of substance use than females (22.6% vs. 7.6%). Conflicts with parents, violence, and theft were among the burdens and risk factors associated with drug use.

Another study assessing a small sample of patients with HIV (n = 60), hospitalized and/or in

consultation in June 1995 [44] found that 48% have been contaminated by intravenous drug use (predominantly males n=28, only one female with HIV attributed her disease to intravenous drug use).

United Arab Emirates (UAE)

In 1996, in the city of Al-Ain in UAE, an extensive psychiatric survey was undertaken on a systematic sample (N = 1394) of adults over 18 years of age, focusing on households of Emirates nationals [45]. 5.2% of all the households had one or more members with substance use problems. A modified version of the Composite International Diagnostic Interview (CIDI) instrument was used, and the ICD-10 diagnoses were formulated. The overall lifetime prevalence of substance "misuse" was low (0.4%), yet, once more, males' were found to have higher rates (0.7%) of substance "misuse" than females (0.1%).

A clinical assessment and structured interview of male substance abusers (N = 79) at a corrective institution for drug abusers in Dubai (UAE), did not find any significant association between unemployment and drug abuse or with its duration [41].

Yemen

Prevalence rates and gender differences were assessed in two studies on Yemenites. The first study by Litman et al. [46], randomly selected a small sample of participants from each household in two Yemenite villages in Israel . Participants were between the ages of fifteen and sixty five, and were administered structured questionnaires. Thirty-nine percent of participants used Khat, with higher rates in males (50%) compared to females (27%). In addition, use of Khat was more prevalent among Yemeni born participants (34%) above forty years of age, while lower rates were recorded by Israeli born participants who were less than twenty years old (27%).

In Yemen, *Catha edulis*,(locally known as Khat), is traditionally chewed, and is a cultural practice. Its stimulant properties have motivated many studies to explore its potential side effects. Accordingly, most research on substance abuse in Yemen, focused on Khat-chewing. In 1984, mothers in delivery units in all hospitals in Yemen (N =1181consecutive deliveries) were administered a questionnaire

by the midwife delivering them about their baby's birth-weight, and their chewing habits. A significant birth-weight difference of 120g between Khat users and non-users was documented, with 35% of khat users delivering lower birth-weight babies. The authors state that this difference may be attributable to malnutrition, because of Khat's anorectic effect [47].

The third study was a cross-sectional survey using the Symptom Checklist-90 (SCL-90), completed by 792 participants in rural and urban areas in Yemen [48], and supported previous data on gender differences in Khat use: males higher ever use (81.6%) vs. females (43.3%). Patterns of Khat use were predominantly heavy use (at least every day) for males, and were more "occasional" use (at least once a week) for females. Expectedly, male users started at an earlier age and use it longer (16-67 years) than females (18-55 years).

Discussion

Although studies in various countries differed in their selection of the substances to be assessed in the population, it would nevertheless be interesting to draw comparisons from the reviewed epidemiologic literature from the Arab region between prevalence rates of various sub-stances, and examine consistent risk factors (such as age of onset and age as a risk factor), burden associated with substance use, and co morbidity of substance use with other psychiatric disorders. However, no valid comparisons could be achieved, not the least being the enormous differences in sample design and the methods used to retrieve information (instruments, etc.). However some general conclusions can be drawn on the following topics:

Prevalence of substance use. Alcohol is consistently shown to be one of the most common substance used across most Arab countries with harmful related consequences [4, 16, 17, 28, 49-51]. There is a diversity of substances being highly used among com-munity samples in the Arab world such as Egypt, Jordan and Lebanon [4, 6, 10, and 17]. Cannabis and tranquilizers (and in some specific subgroups medicinal products) top the lists and narcotics are much lower. Low rates of sub-stance use were published in research about Sudan and the UAE [45].

Gender differences. Data collected from the Arab world seems to reinforce the international data on gender differences [27], with males having higher prevalence rates of substance use than females in almost every country (Egypt, Jordan, Lebanon, Palestine, United Arab Emirates, and Yemen). Yet, tranquilizers and barbiturates seem to be particularly popular among females, an aspect that is consistent in the published research across the Arab region.

Co-morbidity: Frequently and especially in clinical samples, substance use was found to be co morbid with other psychiatric disorders, and presented as either primary or secondary to the diagnosis. Results vary, while a study in Egypt highlights the correlation between anti-parkinsonian medication use and schizophrenia [8]; in Lebanon, schizophrenia was most often associated to cannabis abuse [22]. Cocaine use (Lebanon) when studied was mostly associated with Bipolar disorders.

Burden. Burden pertaining to substance use is vast and appears in diverse forms and parallels reports from the western world, ranging from social impairment, and head injury up to HIV or death [9, 11, 36, 39, 44, 52-54]. Although problems vary immensely across the Arab region, a common ground could be formulated across the countries. Common problems linked to substance use included social and familial problems, legal offences, arrests, and imprisonment, traffic accidents, health problems, violence and physical fights, financial problems, drug overdose, and divorce [13, 18, 37-40, 42]. Studies on HIV have been on the rise in the Arab world in the recent years, as the detrimental effects of intravenous drug use have gained greater public concern and mental health care workers have become curious about the prevalence rates and magnitude of this disease in the population. Relatively low incidences of HIV in drug addicts were reported in published studies from Egypt (0.2%) (9) and in Saudi Arabia (0.15%) (36); the only published research in Tunisia revealed that 47% of the males contracted HIV from intravenous drug use. These low incidences of HIV could be partly explained by the fact that most available published studies are early on in the history of the

epidemic. In addition, a study in Saudi Arabia [40] reported 0.4% deaths resulting from substance use, and 69% of heroin users were diagnosed with hepatitis C virus.

Risk factors. Studies in Morocco and Egypt addressed whether cigarette smokers were more likely to abuse other substances than non-smokers. Both studies [55, 56] supported the assumption that smoking was a potential risk factor for subsequent substance use (25% of smokers use substances) and significantly increases the prospect of ever drinking alcohol (39.70%), trying narcotics (32%), and /or psychotropic drugs (22.13%) [55]. Family and friend's attitudes towards substance use, the presence of a user in the immediate family, strictness towards time spent on homework, peer pressure, and/or poor family communication were found to be risk factors [16, 17, 10]. In most Arab countries there are very stiff laws on drug abusers, and alcohol use is forbidden by the Islamic religion, except in Lebanon where there is a diversity of religions including Christianity. Practice of faith and implementation of parental control served as protective factors against alcohol use, abuse and dependence [16, 17]. As reported by international studies [27], drug use was more common among younger age groups. The ages of onset and ages as risk factors for substance use are consistent across the Arab studies, with the bulk ranging between twelve years and nineteen years. On the other hand, international studies suggested a longer period of risk extending to adulthood among recent cohorts [27]. Alcohol use maintained the lowest age of onset (12 years), and males reported earlier initiation of substance use than females; however, there is new evidence suggesting a higher risk among females in initiating substance use in more recent cohorts [27].

Conclusion. The disparity between US, European and Arab data on substance abuse cannot be conclusive, and neither can be used as basis for comparison, but points in general to lower rates of substance abuse and dependence in the Arab region when compared to the USA. Due to the diversity of sample selections in the Arab countries, no match could be made between the methodologies used in the

National Survey on Drug Use and Health (NSDUH) studies from the USA and those of the Arab world. With regards to the European data, figures in the published research in the Arab world tend to fall in the lower to mid range categories (from 1% to 20%) of the European data. National studies encompassing the wide array of substances is needed in the Arab countries, to identify the magnitude of the problem, provide more representative information, characterizing the population at large; this would probably enhance the availability of prevention campaigns, services and adequacy of therapeutic interventions, all directed towards alleviating the burdens associated with substance use.. In Lebanon, IDRAAC, has taken a step towards building a national mental health database through conducting the LEBANON study [24-27]. This national study is providing data using sampling methodology and analysis similar to a large number of countries worldwide which is providing for international comparisons not only of base rates but also for risk factors, co-morbidities, burden, treatments from and across a variety of settings and could help in the efforts to understand, treat and possibly prevent better this complex and highly serious group of disorders.

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الخلاصة

إن الدراسات الميدانية في شأن استعمال الكحول والمخدّرات نادرة في العالم العربي، والغرض من هذه الورقة هو تقديم عرض منهجي لكل الدراسات الميدانية التي تم نشرها في العالم العربي حتى نهاية العام 2007، وتم لهذا الغرض استخدام عدد من آليات البحث، كـ PubMed و PsycINFO وقاعدة بيانات IDRAAC على شبكة ا لإنترنت. وقد أجريت البحوث في العالم العربي حتى الآن على فئات إجتماعية فرعية محددة، راوحت ما بين عينات من الطلاب، وعينات من الجثث التي تم تشريحها، وفي بعض الأحيان شملت أعداداً كبيرة، لكن بحثاً واحداً فحسب أجري على مستوى وطني حتى الآن.

على الرغم من القوانين الصارمة لمكافحة استعمال الكحول والمخدّرات في المنطقة العربية، تبقى الكحول أكثر مادة يتم استعمالها وخصوصاً في صفوف تلامذة المدارس الثانوية وطلاب الجامعات، اذ تراوح النسبة بين 4.3 ٪ و 70.1 ٪. ويستعمل الذكور المواد أكثر من الإناث باستثناء المسكنات والمنوّمات، وقد تغيّرت النزعة وفق تقرير حديث لدراسة
*L.E.B.A.N.O.N ووفق دراسات غربية، فان استعمال المواد كالكحول والمخدّرات يسبب عدداً من الظواهر السلبية، كالاختلالات ا لإجتماعية، ومشاكل العنف، وفيروس نقص المناعة المكتسب (ايدز). ومن أبرز عوامل الخطر التي تدفع إلى استعمال الكحول والمخدّرات، المشاكل الأسرية وضغوط الأقران. ومع ذلك، ثمة حاجة واضحة لبيانات وطنية عن استعمال الكحول والمخدّرات في العالم العربي، سعياً إلى تحديد حجم المشكلة ومسارها، والتمكن تالياً من مراقبتها والتدخل على نحو أفضل.

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Country	Reference	Date of Study	Sample (n)
Egypt	Asaad et al., 2003	2001	Schizophrenic patients attending the outpatient department of Ain Shams University Psychiatric Institute (n=100)
	Soueif et al., 1986	1983-1984	Egyptian male students attending Cairo and Ein-Shams Universities (n=2711)
	Soueif et al., 1987	1983-1984	Female Egyptian university students (n=2366)
	Soueif et al., 1990	1985-1986	Secondary school pupils (n=14656)
	Watts et al., 1993	1986-1990	Drug addicts, female prostitutes, international travelers, blood donors, and foreigners who resided in Egypt for more than thirty days (n=29261)
Jordan	Abu Al-Ragheb et al., 1999	1978-1996	Postmortem cases of autopsies at the Jordan University Hospital (n=6109)
	Suleiman et al., 2003	2001	Students from 6 universities and 4 intermediate colleges (n=5064)
Kingdom Saudi Arabia (KSA)	Abdel-Mawgoud et al., 1995	1986-1994	Patients admitted to Al Amal Hospital, Dammam
	Amir, 2001	-	Saudi male poly-substance abusers in a hospital in Dammam (n=120)
	El-Fawal, 1999	1990-1997	Cases of death resulting from substance overdose (n=249)
	Nayyer, 2000	1995-1996	In-patients at a voluntary detoxification unit (n=799)
	Njoh et al., 1997	1995-1996	Saudi males at Al-Amal Hospital with drug dependence (n=2628)
	Osman, 1992	1988-1989	Patients attending outpatient clinics in Jeddah (n=485)
	Qureshi et a.l, 2000	1996-1998	Inpatient males admitted at two hospitals in Saudi Arabia (n=423)
Kuwait	Bilal et al., 1988	1986-1987	Systematic admissions to the emergency room of a general hospital and a specialist traumatology hospital (n=1058)
	Bilal et al., 1992	1986-1987	Drug misusers in male army conscripts in Kuwait (n=2183)
Lebanon	Karam et al., 2000	1991	University students (1851)
	Karam et al., 2002	1972-1992	Inpatients consecutively admitted to Saint George Hospital University Medical Center who had ever substance and ever other mental disorder (n=222)
	Karam et al., 2003	1999, 2001	High school and university students (n=1500), clinical population (n=72) and "street" sample (n=103)
	Karam et al., 2004	1991, 1999	Students from 2 major private universities (n=1980 Phase I, n=2328 Phase II)
	Karam et al., 2006; 2008	2002-2003	Uninstitutionalized Lebanese adults (n=2857)
	Naja et al., 2000	-	Randomized sample of Lebanese adults (n=1000), current benzodiazepine users (n-496)
	Nassar et al., 1973	1972-1973	University students (n=427)
	Shediac-Rizkallah et al., 2001	1998	Students taking introductory English courses at the American University of Beirut (n=954)
	Tamim et al., 2003	1998-1999	University students (1964)
Morocco	El-Amrani et al., 1986	1984	High school students enrolled in their first semester in the regions of Taza and Tetouan (n=678)
	Kjiri et al., 2005	-	University students (n=1208)

Oman	Jaffer et al., 2006	2001	Omani adolescents in a nationally representative sample of secondary school students (n=3114)
Palestine	Abu Qamar et al., 2007	2003	University students (n=1047)
	Neumark et al., 2001; 2003	1995	A national multistage probability sample (n=5954)
	Rabin et al., 1999	1992-1995	Battered women in Kfar Saba (n=292)
Sudan	Rahim, 1989	1964-1965	A sample randomly selected from a population consensus from a suburban part of Khartoum (n=204)
Tunisia	Amrani et al., 2002	1998-1999	Tunisian school students (n=353)
	Tiouiri et al., 1999	1995	Patients with HIV hospitalized and/or in consultation iat La Rabta Hospital (n=60)
United Arab Emirates (UAE)	Abou-Saleh et al., 2001	1996-1997	Adults systematically sampled from Al Ain community (n=1394)
	Amir, 2001	-	Male substance abusers at a corrective institution for drug abusers in Dubai (n=79)
Yemen	Abdul Ghani et al., 1987	1984	Mothers in delivery units in all hospitals in Yemen (n=1181)
	Litman et al., 1986	1982-1983	Participants from each household in two Yemenite villages (n=136)
	Numan, 2004	2000-2001	Yemeni adults representing mostly urban population of students, state employees and housewives (n=792)

Table 1. Characteristics of epidemiologic studies on substance use in the Arab world summarized in this review*
* Other studies included in the Discussion: Derbas et al., 2001 (Bahrain); Maghazaji et al., 1982 (Iraq); Njoh et al., 1995 (KSA); Bartal et al., 1988, (Morocco); Nadim et al., 1984 (Sudan); Othman et al., 2002 (Syria)

[a] Institute for Development Research Advocacy and Applied Care (IDRAAC), Lebanon.
[b] Institute of Psychiatry, Ain Shams University, Cairo, Egypt
[c] Department of Psychiatry and Clinical Psychology, Faculty of Medicine, Balamand University, Lebanon
[d] Department of Psychiatry and Clinical Psychology, St George Hospital University Medical Center, Lebanon.
[e] Program in Survey Methodology, Institute for Social Research, University of Michigan, USA.

Correspondence:
Prof. Elie G. Karam
P.O.Box: 166227
Achrafieh, Lebanon 1100 2110
Email: egkaram@idraac.org
Running title: Substance Use in the Arab World

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Evaluation of Quality of Life in Kidney Transplantation Patients in Bahrain

Charlotte A. Kamel[1], Fathi Abdelgadir Salih[2]
Reginald P. Sequeira[3], Emily Kamel[4].

تقييم نوعية الحياه لدى مرضى زراعة الكلية في البحرين

شارلوت كامل، فتحي صالح، ريجينالد سقيره واميلي كامل

Abstract

Objective : To evaluate the quality of life (QOL) in patients who had undergone kidney transplantation in Bahrain.

Methodology: Forty two subjects living in Bahrain who had received primary kidney transplant for end stage renal disease and 40 healthy controls were studied. Data was collected by personal interview and from medical records using a questionnaire. The questionnaire included sociodemographic data and psychometry implementing the General Health Questionnaire and the Psychological General Wellbeing Schedule. Both groups were age- and gender-matched.

Results: No significant differences were detected between the groups in the prevalence of psychiatric morbidity, although the control group experienced greater morbidity than the transplant group. No significant differences were detected between the transplant and the controls in the mean scores of the General Well-being Schedule or its subscales.

Conclusion: The QOL of the renal transplant and the matched healthy controls are almost similar. The effectiveness, acceptability and economic impact of renal transplantation should take into consideration the QOL dimensions of the kidney transplant recipients.

Keywords: Quality of life; renal transplantation; End stage renal disease; Bahrain.

Introduction

With the advent of potent immunosuppressive therapy, a dramatic improvement in kidney transplantation has been achieved

in the last decade. Long-term survival rates have been variously reported to be 60% (10 years), 44% (20 years), and 36% to 78% (10 years) in adults, and 68% (20 years) in pediatric transplant [1,2]. These successes made kidney transplantation a replacement choice of treatment for End-Stage Renal Disease (ESRD). There is now more focus on long term survival and the (QOL) of that survival.

Quality of life is defined as a "continuously functioning reciprocal interaction between the patient and his environment"[3]. It is a multi-dimensional concept, consisting of general, physical, mental, and social aspects [4]. Prototype studies of QOL in kidney transplantation confirmed that transplantation is the best modality of treatment for ESRD[5,6].

It is generally believed that kidney transplantation not only produces a clinical outcome superior to that of maintenance dialysis but is cost effective as well[7]. In addition, there is evidence that the QOL is better for recipients of successful transplant than for patients on dialysis [5]. In their work about the QOL of patients with ESRD, Evans and colleagues showed that the QOL of transplant recipients compared well with that of the general population [5].

From a narrow perspective the QOL in renal transplant recipients improves primarily in work and activity. From a broad and multidimensional perspective, the quality of life in kidney transplant recipients is improved with respect to affective dimensions such as life satisfaction, personal development and fulfillment, and self-esteem, along with the ability to fulfill usual role responsibility[8].

For patients with ESRD, both transplantation and dialysis can prolong survival. However, quality of life is significantly better after successful transplant [5, 9-12].

The aim of this study was to determine the quality of life of a group of patients who had undergone kidney transplantation in Bahrain and to compare them with a group of normal controls. Also the above findings were compared to corresponding results from other parts of the world.

Subjects

The sample of the study consisted of 82 subjects living in Bahrain,

out of whom 42 had received primary kidney trans-plant in Bahrain, and another 40 were taken as a control group which consisted of subjects with no apparent health problems, matched for age and gender to the transplant group.

Subjects' age ranged between 21 and 60 years (mean=38.07, SD=9.85). The transplant sample included 30 (71.4 %) male subjects and 12 (28.6%) female subjects, and 28 (66.7%) subjects were married. Twenty-two subjects (52.4%) had secondary education, and the majority (n=40; 95.2%) were of Bahraini nationality.

Methods

A cross-sectional study design was used. Data were collected from patients, from medical records, and from health care professionals who were familiar with the patient's functional status and were members of the multidisciplinary transplant team in Bahrain. Information on socio-demographic variables, emp-loyment status and subjective indicators of the quality of life were obtained during a personal interview. To ensure that the data acquired were of high quality, the persons involved in the collection of data were trained in the administration of uniform study procedures. Data were collected using a questionnaire consisting of 2 main sections: a sociodemographic section, and a psychometry section.

Subjects were administered the questionnaire within six months from the date of the trans-plantation surgery. The psychometry section included the Psychological General Wellbeing Schedule[13], and the General Health questionnaire[14].

The Psychological General Well-Being Schedule [13] is one of the most relevant quality of life scale and was used in the most influential publication of health-related QOL[5]. It consists of 22 items plus an extra item to correlate the scale with the experience of time dimension. The scale has been validated by comparing the total score with scales like the Beck Depression Inventory, the Zung Depression scale and the Hopkins SCL-90. The correlation coefficients have been around 0.70[13]. The homogeneity of the scale in terms of coefficient alpha has been evaluated in many studies and the values have been around 0.90. The scale is subdivided into the

following subscales: Anxiety subscale; Depression subscale; Positive well-being items; Self control; General health; and Vitality items. In addition to that the schedule have alpha items which measure performance or symptoms, and beta items which measure subjective satisfaction or coloring of thoughts.

Coefficient alpha was calculated for the six dimensions from the data collected from the sample. The values of coefficient alpha was in the range of 0.54 - 0.85. For most of the measures the value of coefficient was above 0.75 which indicates that these measures are adequately reliable. Values of the coefficient for positive wellbeing, and self control were relatively low (0.54, 0.55).

Statistical Analysis

To ascertain the equivalence of the patients and control groups with regard to the background variables, including age, gender, marital status, education, and employment the two groups were compared using t-test for mean age, and exact contingency table methods for age groups and the rest of the variables. Comparison of the two groups with regards to prevalence of psychiatric morbid conditions was done by exact contingency table methods. Comparison of the two groups on the six dimensions of wellbeing was carried out via independent-samples t-test between mean scores of either group.

Results

Analysis of the demographic variables showed that no statistically significant differences of the percentage distribution of age groups, of mean age in years, or of the percentage distribution of gender groups were detected between the transplant group and the control group. Both groups can then be considered age- and gender-matched (Table 1). No subsequent bias related to age or gender was to be expected in the answers of both groups to the General Health Questionnaire or to the General Well-being Schedule.

The majority of subjects in transplant and control were married (66.7% and 55% respectively), had secondary education (52.4% and 60% respectively), were employed (57.1% and 65% respectively) and of Bahraini nationality (95% and 70% respectively). Transplant and control groups thus tend to be socially-equivalent except for

some inevitable minor variations (Table 2). No statistically significant differences were detected between the transplant group and the control group in the prevalence of psychiatric morbidity using the General Health Questionnaire, although the control group experienced higher morbidity figures than the transplant group (30% and 19% respectively (Table 3).

Table 4 shows the mean and standard deviation of the two groups on the various dimensions of the General Well-being Schedule. The means of the two groups tend to be close and no statistically significant differences were detected between the transplant group and the control group in the mean scores of the General Wellbeing Schedule and its subscales. Thus, the quality of life as estimated by this schedule was approximately similar in either group.

Discussion

The basic psychometric properties, i.e., reliability and validity, of the questionnaire used for assessing QOL in ESRD are essential. Since these questionnaires are culturally sensitive instruments, it is necessary to translate the English questionnaire into the local language and back – translation into English [15-19]. In our study a cross cultural adaptation of the questionnaire into Arabic was performed. To the best of our knowledge there have been no previous studies investigating the QOL in the Middle East using the Arabic version of the questionnaire.

The general finding from our study is that kidney transplantation did not worsen the quality of life of patients who did undergo kidney transplantation. In fact, in some subscales, patients who received kidney transplant had better scores than the control group composed of healthy subjects.

Patient outcomes including the quality of life in kidney transplantation can be affected by several factors: (1) the case mix (some patients are older and sicker than others), (2) the treatment approach (some approaches enhance patient outcomes), and (3) the characteristics of the transplantation centers (patients at some centers are better rehabilitated than those at other centers) as reported by Evans et al. 1985. Our study showed that the transplant recipients consistently reported

nearly equivalent objective and subjective quality of life compared to normal subjects. QOL comparisons with the general population show that the life circumstances of patients with end-stage renal disease, as interpreted subjectively, may not be as poor as some have believed[20,21]. But the evidence remains clear that, with the exception of transplant recipients, patients with ESRD, and those patients on alternative methods of renal replacement therapy (hemo-dialysis or peritoneal dialysis) have a poor objective quality of life (work status and functional ability [5,19].

Several studies have demon-strated that in patients with ESRD who have undergone kidney transplantation or on dialysis, the disease alone does not determine QOL, but many non-disease related factors (sex, age, education, socio-demo-graphics) play important additive role in the perception of QOL[19,22,23]. In our study the majorities of patients was married, had secondary level education and were employed.

With the improvements in short and long term graft and patient survival after kidney trans-plantation over the last two decades, health-related QOL is becoming an important additional outcome parameter. Global and disease specific instruments are available to evaluate objective and subjective QOL. It is generally accepted that QOL improves dramatically after successful kidney transplantation compared to patients maintained on dialysis treatment.

It is less clear which immuno-suppressive regimens confer the best QOL. Although limited in number, studies seem to favor non-cyclosporine based protocols. These differences may be related to the adverse effects related to each immunosuppressant; for example, cyclosporine produces effects on domains of appearance, tacrolimus / sirolimus-induced fatigue, and calcineurin inhibitor induced tremor. Whether a specific immuno-suppressive therapy is superior to others in terms of health related QOL remains to be determined [24].

QOL is an indicator of ther-apeutic efficacy in the outcome of patient care and it usually reflects a patient's subjective perception of current health status [25]. As defined by the World Health Organization, QOL is an indivi-dual's perception of their position

in life in the context of culture and value systems in which they live with relation to their goals, expectations, standards, and concerns. Health care providers need to interpret QOL results cautiously for patient care, in order to prevent aggravation of disease and policy making [26].

The relationship between psychological factors and health related QOL is incompletely understood. Studies have suggested a relationship between depression as assessed by the Beck Depression Inventory (BDI) and mortality in ESRD patients. The trait anxiety and depressive symptoms were strongly associated with the health related QOL in ESRD patients on hemodialysis [27, 28]. However, we did not find any significant differences in the levels of anxiety and depression between transplant and control groups.

Social support has beneficial effects on the domains of QOL. Family support helps coping, managing severity of illness, and stressful situations[29]. In a study from Turkey, married patients showed significantly better QOL than single patients, indicating that most patients experience good support from their children and spouses[19,30]. The majority of our renal transplant patients lived with their families, because most patients experience good support by family in the traditional Arab culture. To what extent the findings on QOL we have observed in transplant patients are determined by non-disease factors need to be explored further.

Health policy issues regarding the management of patients with ESRD in developing countries, especially the cost-benefit analysis of kidney transplantation [31] need to consider the QOL dimensions as well.

Conclusion

Kidney failure has a high cost in terms of health related quality of life. We found that the QOL was comparable in kidney transplant patients compared with matched healthy control subjects. Further research is necessary to determine patients' QOL over time in a longitudinal study setting. The effectiveness, acceptability and economic impact of renal transplantation should take into consideration the QOL dimensions.

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الملخص
تهدف الدراسة إلى تقييم نوعية الحياة لدى مرضى زراعة الكلى في البحرين.
الدراسة شملت 42 مريضا زرعت لهم كلية مع عينه ضابطه تشمل أربعون شخصا من الأصّحاء.
وقد جمعت المعلومات من المقابلة الشخصية ومن ملف المريض باستعمال استبيان خاص.
وقد شمل الاستبيان المعلومات الشخصية والعائلية والقياس النفسي باستعمال استبيان الصحة العامة ومقياس العافية العامة .
وكانت العينتان متماثلتان من حيث العمر والجنس وقد دلت الدراسة على أن العينة الضابطة كانت أكثر بقليل من عينة المرضى من حيث انتشار الاضطرابات النفسية ولكن الفرق لم يكن ذو دلالة إحصائية ، كما أن المجموعتين لم تظهرا فروقاً هامة في إستبيان الصحة العامة ومقياس العافية العامة .
وخلصت الدراسة إلى أن نوعية الحياة لدى المرضى الذين تلقوا زراعة الكلى والمجموعة الضابطة كانت متشابهة ، وأن نوعية الحياة لهؤلاء المرضى يجب أن تؤخذ بالاعتبار عند مناقشة فعّالية وتقبل وكلفة زراعة الكلى .

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Table 1: Age and gender distribution of the study groups.

Variable	Transplant Group (n= 42) N	%	Control Group (n= 40) N	%
Age groups (Yrs)				
20 - 39	18	42.9	24	60.0
40 - 49	14	33.3	11	27.5
≥ 50	10	23.8	5	12.5
Total	42	100.0	40	100.0
Pearson Chi-square	2.83, df = 2			
P-value	P > 0.05			
Significance	Not significant			
Mean age (SD))	39.10 (4.75)		38.30 (7.57)	
t- test	0.36, df = 80			
P-value	P > 0.05			
Significance	Not significant			
Gender				
Male	30	71.4	26	65.0
Female	12	28.6	14	35.0
Total	42	100.0	40	100.0
Pearson Chi-square	0.39, df = 1			
P-value	P > 0.05			
Significance	Not significant			

Table 2 : Sociodemographic profile of the study groups.

Variable	Transplant Group (n= 42) N	%	Control Group (n= 40) N	%
Marital status				
Single / Separated	14	33.3	18	45.0
Married	28	66.7	22	55.0
Total	42	100.0	40	100.0
Pearson Chi-square	1.17, df = 1			
P-value	P > 0.05			
Significance	Not significant			
Educational Level				
No education	4	9.5	1	2.5
Primary / Intermediate	16	38.1	13	32.5
Secondary	22	52.4	24	60.0
University	0	0.0	2	5.0
Occupation				
Unemployed	2	4.8	0	0.0
Employed	24	57.1	26	65.0
Housewife	12	28.6	4	10.0
Retired	2	4.8	0	0.0
Student	2	4.8	10	25.0
Nationality				
Bahraini	40	95.2	28	70.0
GCC	2	4.8	10	25.0
Arabic	0	0.0	2	5.0

Table 3 : Prevalence of morbid conditions in the study groups.

Morbid Condition	Transplant Group (n= 42) N	%	Control Group (n= 40) N	%
General Health Questionnaire				
No morbidity	34	81.0	28	70.0
Morbidity	8	19.0	12	30.0
Total	42	100.0	40	100.0
Pearson Chi-square	1.33, df = 1			
P-value	P > 0.05			
Significance	Not significant			

Table 4 : Dstribution of mean scores of General Well-being Schedule in the study groups.

Subscale	Transplant Group (n= 42) Mean (SD)	Control Group (n= 40) Mean (SD)	t-test	P-value
General Well-being	76.6 (17.09)	77.9 (17.85)	- 0.33	> 0.05
Anxiety	16.1 (4.21)	16.3 (5.97)	- 0.09	> 0.05
Depression	11.2 (3.28)	11.2 (5.06)	0.04	> 0.05
Positive Well-being	11.6 (2.82)	11.9 (3.60)	- 0.46	> 0.05
Self Control	11.5 (2.20)	11.1 (2.99)	0.81	> 0.05
General Health	9.9 (3.86)	10.0 (3.96)	- 0.11	> 0.05
Vitality	12.3 (5.04)	12.5 (5.51)	- 0.14	> 0.05
Alpha items	32.2 (9.01)	31.6 (9.95)	0.28	> 0.05
Beta items	39.7 (7.62)	36.6 (9.01)	1.72	> 0.05

Corresponding Author :
Dr. Charlotte Kamel,MBBCh, DPM, FRCPsych.
Consultant Psychiatrist
Ministry of Health
P.O. Box 28494, Manama, Bahrain.
Tel.: 00973 39604334
Tel/Fax 00973 17250770
Email: drckamel@yahoo.com

[1]Department of Psychiatry, [3]Department of Pharmacology & Therapeutics, College of Medicine & Medical Sciences;
[2]Faculty of Education, College of Postgraduate Studies, Arabian Gulf University, Bahrain;
[4]Department of Epidemiology, Mansoura University, Egypt.

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Menstrual Associated Sleep Disturbance: A Study in an Egyptian Sample

Tarek Asaad, Mohamed Fikry, Hassan Awwad, Azza AbdelNasser

إضطراب النوم المرتبط بالطمث (دراسة في عينة مصرية)

طارق أسعد, محمد فكرى, حسن عواد, عزة عبد الناصر

Abstract

Objectives: To investigate the problem of sleep in relation to menstruation, addressing only women in the childbearing period.

Methods: The study included 100 women with sleep complaints excluding those above the age of 40, any history of physical or mental disorder and any marked irregular menstrual cycles. A standardized sleep questionnaire was asked and polysomnography done pre- and postmenstrual in addition to assessment for the presence of premenstrual dysphoric disorders.

Results*:* 100 women have been asked to reply to a questionnaire concerning sleep problems in the premenstrual period. 48 reported significant sleep complaints, including insomnia, hypersomnia and excessive daytime somnolence. 9 were found to fulfill DSM-IV criteria of premenstrual dysphoric disorder (PMDD). 19 females including those with PMDD accepted to be evaluated by polysomnography (PSG) once in the premenstrual phase and another postmenstrual. Comparing results of sleep profile pre- and postmenstrual revealed increased sleep latency, decreased efficiency and increased arousals premenstrual. Comparing patients with PMDD to other females with premenstrual sleep complaint revealed only less SWS in PMDD. ***Conclusions:*** Evaluation of sleep profile in women with premenstrual sleep complaints, revealed mainly sleep continuity disturbance manifested by the significant increase in sleep latency. Overall findings are in support of considering premenstrual sleep problems as a separate diagnostic entity, at least for some females, which is still in need of further studies.

Key Words : Menstruation, Menstrual associated disorders, Sleep , Sleep disturbance.

Introduction

Sleep complaints tend to be frequently described in relation to menstruation, whether linked to premenstrual period or associating menopause [6, 3, 1].

In a previous work [2], the problem of sleep with meno pause had been investigated in an Egyptian sample, confirming the negative influence of menopause on sleep, reported by other several investigators[5,10,11,1]. In such a study, a correlation between impaired sleep quality and severity of menopausal symptoms, as well as high depressive symptomatology had been found in the absence of diagnosable depressive disorder, indicating either a causal relation or a common origin for both sleep disturbance and menopausal symptoms, mostly related to hormone imbalance.

Aim of the Work

The aim of the present study was to investigate the problem of sleep in relation to menstruation, addressing only women in the childbearing and premenopausal period (as menopause had been considered in a previous study), taking both subjective and objective evaluation into consideration.

Subjects and Methods

The study included 100 women randomly selected from relatives of patients attending gynecology and psychiatry clinics of Ain Shams University Hospitals. In the period between May 2004 & April 2005, females with history suggestive of any physical or mental disorders were excluded, as well as females with markedly irregular menstrual cycles. At the same time, only those below 40 years of age were included to avoid the possible influence of premenopausal changes on sleep profile.

Subjects were asked to reply to a standardized sleep questionnaire, concerning sleep problems in the premenstrual period, compared to other phases of the menstrual cycle.

Subjects with sleep complaints who accepted to be further evaluated through sleep laboratory studies were subjected to all night polysomnography (PSG) done at two occasions. Within the first one week prior to menstruation and the second

3-5 days after the end of menstruation.

Subjects with sleep complaints were also assessed for the presence of "premenstrual dysphoric disorder" PMDD, using DSM IV criteria (1994).

Statistical analysis comparing sleep profile of females during pre- and postmenstrual phases was considered. Also, comparison between patients fulfilling DSM-IV criteria for PMDD and the other females with premenstrual sleep pattern was considered using mean standard deviation and student "t" test.

Results:

The mean age of the study sample was 29.40 ± 5.69 years.

Results of sleep questionnaire assessment:

a. 48 women reported significant sleep problems in the premenstrual period.

b. 10 women reported mainly hypersomnia or insomnia in the form of difficulty in initiation and / or maintenance of sleep.

c. 23 women reported both insomnia and excessive daytime somnolence.

d. 15 women reported mainly hypersomnia or hypersomnolence, without a significant complaint of insomnia.

Results of assessment for "premenstrual dysphoric disorder PMDD": 9 females out of the 48 women with sleep complaints were found to fulfill the DSM-IV criteria of premenstrual dysphonic disorder.

Results of polysomnographic (PSG) assessment:

a- 19 females accepted to be evaluated by all-night PSG done at two occasions: first, within one week premenstrual and second, 3-5 days after stoppage of menstruation. Comparison between sleep profiles at the two phases is shown in table (1). Significant differences included less sleep efficiency, increased latency as well as increased arousals in premenstrual phase.

b- Among the 19 females evaluated by PSG, were the 9 women fulfilling DSM IV criteria of PMDD. Sleep profile of patients with PMDD, compared to other females is given in Table (2). The only significant difference between the two groups was decreased slow wave sleep % (SWS) in patients with PMDD.

Table (1): PSG findings of women during pre-versus post-menstrual phases

Sleep variable	Premenstrual phase	Post-Menstrual phase	T-value	"p"
1- Sleep latency (SL) (min)	17.9±2.89	9.1±3.8	8.5	**P<0.001
2- Sleep Efficiency (SE)	75.3±6.2	8 9.12 ± 2.13	9.21	**P<0.001
3- Stage I %	3.51±0.71	3.48 ± 0.61	0.03	P > 0.05
4- Stag II %	51.45±2.8	51.66 ± 2.65	0.23	P > 0.05
5- Stag III %	9.14±1.81	9.2 ± 1.71	0.1	P > 0.05
6- Stag IV %	10.9±1.65	10.28 ± 1.59	1.19	P > 0.05
7- Slow wave sleep (sws) %	20.04±3.46	19.48 ± 3.30	0.51	P > 0.05
8- REM %	25.0±2.9	25.38 ± 2.5	0.51	P > 0.05
9- REM latency (min)	72.4±6.14	71.9 ± 5.88	0.25	P > 0.05
10- SWS latency (min)	30.4±4.23	30.1 ± 4.11	0.22	P > 0.05
11- Arousal index	11.41±2.75	8.50 ± 3.2.	3.21	* p < 0.05
12- Apneas / hour	0.5±3.4	0.5 ± 3.4	0.0	P > 0.05
13- Desaturations / hour	0.1±0.82	0.1 ± 0.82	0.0	P > 0.05
14- Periodic leg movement Index (PLMS Index)	3.6±2.71	3.6 ± 2.70	0.0	P > 0.05

** = Significant*
*** = highly significant*

Table (2): PSG profile of patients with PMDD versus other females with premenstrual sleep complaints, but with no PMDD.

Sleep variable	Patient with PMDD	Females without PMDD	T-value	"p"
1-sleep latency (SL) (min)	18.2±2.21	17.1±3.2	0.88	P > 0.05
2-sleep Efficiency (SE)	74.8±5.88	76.5±4.9	0.48	P > 0.05
3-stage I %	3.95±0.91	3.60±0.74	0.94	P > 0.05
4-stage II %	52.5±0.75	51.94±0.69	1.16	P > 0.05
5-stage III %	8.45±1.3	9.61±2.42	1.34	P > 0.05
6-stage IV %	9.62±1.26	10.88±2.68	1.45	P > 0.05
7-SWS %	18.67±2.56	20.49±1.1	2.62	* < 0.05
8-REM %	25.68±2.61	23.97±2.81	0.92	P > 0.05
9-REM latency (REM)(min)	71.8±5.6	72.9±7.14	0.64	P > 0.05
10- SWS latency (min)	30.1±3.82	30.8±4.5	0.42	P > 0.05
11-Arousal index	12.1±2.6	11.1±2.8	0.74	P > 0.05
12-Apneas/hour	0.4±2.71	0.55±3.24	0.92	p> 0.05
13-Desaturations/hour	0.08±0.72	1.1±2.1	0.02	P > 0.05
14-periodic leg movement index (PLMS index)	3.8±2.61	3.4±2.84	0.1	P > 0.05

* = Significant

Discussion

Finding in the present study do confirm the high prevalence of sleep disturbance among premenstrual females, similar to what had been previously suggested by other investigators([6,3,1,13]).

Despite the possible theoretical biologic similarity between premenstrual and premenopausal periods, the nature of sleep complaint is not exactly the same in both conditions. Premenstrual women tend to show more hypersomnia or hyper somnolence than menopausal women. It might be that other several factors than hormonal imbalance could interplay in explaining the sleep disturbance associated with menopause like increased risk of mood disorders [9], the presence of flushes and night sweats[10] , in addition to the psychological meaning of menopause to females.

Objective evaluation of sleep profile in women with premenstrual sleep complaints, revealed mainly sleep continuity disturbance, manifested by the significant increase in sleep latency, decrease in sleep efficiency and increased number of arousals. Such findings appear similar to what had been observed [11] in menopausal women, who reported strong association between EEG sleep measures and the ratio of circulating oestrogen to LH levels.

Apart from sleep continuity problem, our study did not show any significant change in sleep architecture between pre- and postmenstrual phases, reflecting the non- specificity of PSG as a biologic correlate in explaining sleep changes in such conditions.

Comparing patients with premenstrual dysphoric disorder (according to DSM-IV criteria) and other females with premenstrual sleep complaint without such a disorder, revealed no significant change apart from decreased slow wave sleep (SWS) in depressed patients. The absence of REM sleep changes known for depressions in patients with premenstrual dysphonic disorder might indicate a different biologic origin for this disorder. Apart from major depression, however, larger scale studies are still needed to investigate this point more thoroughly and

precisely. These data also are in support of considering sleep problems associated with pre-menstrual period as a "separated diagnostic entity" different from PMDD, or other psychological symptoms of the so- called: "premenstrual syndrome".

This concurs with what has been suggested by the International Classification of Sleep Disorders Revised ICSD-R (1997)[7], which considered " Menstrual associated sleep disorder", under the section of " proposed sleep disorders" According to this classification, 3 forms of menstrual associated sleep disorder can be recognized:

(1) Premenstrual insomnia

(2) Premenstrual hypersomnia and

(3) Menopausal insomnia.

Diagnostic criteria emphasize that the disorder is present for at least three months and that no other medical, mental or sleep disorder accounts for the symptoms, except for pre-menstrual syndrome.

In the recent 2nd edition of the ICSD (ICSD-2, 2005), "menstrual associated hypersomnia" has been included under "recurrent" or "periodic" hypersomnia.

A final conclusion which is in need of further studying is whether gonadal hormones can influence "sleep" by direct mechanisms, or not. Such direct effect can be viewed through the influence of gonadal steroids on the brain and its neurotransmitters (mainly serotonin), which had been shown by other authors [12].

Of course, large scale studies correlating gonadal hormonal changes with changes in neurotransmitter brain activity and associated sleep alteration will be of great benefit in improving our understanding of the nature of sleep disturbance associated with menstrual cycle changes.

الملخص

تم في هذه الدراسة اختبار مائة من النساء باستخدام إستبيان خاص باضطرابات النوم وذلك في المرحلة التي تسبق حدوث الطمث وأبدي ثمان وأربعون منهن شكاوي ملحوظة متعلقة بالنوم في هذه الفترة تتراوح بين الأرق وكثرة النوم والميل إلي النعاس أثناء النهار ، وأستوفي تسع منهن المعايير التشخيصية لإضطراب "عسر المزاج السابق للطمث" وفقاً للدليل التشخيصي والإحصائي للإضطرابات النفسية الجزء الرابع. ولقد وافق تسعة عشر من هؤلاء

النساء على إجراء الفحص بواسطة جهاز تخطيط النوم المتعدد (البوليسمنوجرام) وذلك مرتين الأولي قبل حدوث الطمث والثانية بعد انتهائه. وأظهرت النتائج وجود نقص في كفاءة النوم وتأخر في البداية مع زيادة معدل اليقظا ت في المرحلة السابقة للطمث ، ولم تظهر النتائج فروقاً ذات دلالة إحصائية بين مرضي عسر المزاج السابق للطمث وغيرهن فيما عدا نقص نسبة النوم ذي الموجات البطيئة في مرضي عسر المزاج. وجاءت النتائج بصفة عامة مؤيدة لإعتبار "اضطراب النوم السابق للطمث" تشخيصاً مستقلاً بذاته ، علي الأقل في بعض الإناث وهو ما يحتاج إلي دراسات أخرى في المستقبل.

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Correspondence :
Dr. Tarek Asaad
Prof. of Psychiatry, Ain Shams University, Cairo , Egypt.
dr.tarekasaad@yahoo.com

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The changing space of childhood in the West and its relationship to narcissism and children's mental health

Sami Timimi

عالم الطفولة المتغير في الغرب وعلاقته بالنرجسية والصحة النفسية للأطفال

سامي تميمي

Abstract

Rates of diagnosis of psychiatric disorders in children have increased dramatically in most Western countries in recent decades. This article explores some of the possible socio-cultural reasons for this. The impact of the growth of Narcissism (love or pre-occupation with the self) in Western culture on both children and their families is discussed. Implications for professionals working with children who are growing up in Western or non-Western societies are outlined.

Introduction

Firstly I need to ask the reader to keep in mind my own scepticism about what I have written, as I fear it is often in danger of slipping into a romanticised stereotyped view of childhood. This is an ever present danger in most discourses on childhood, as children are so often receptacles for projections of our own (particularly parental) unfulfilled wishes and thus these discourses can easily become conflated with sentiments about the general state of society. In addition, my arguments necessarily suffer with the over-generalisations needed in order to give my narrative a sense of coherence. Real life is never as simplistic and all cultures contain diversity at every level. Nonetheless, these genuine concerns about the difficulty of reaching beyond shifting social constructions should not deflect from pointing out that something is going on for children in rich, industrialised free market based societies, and that this something is more than a little disturbing. What I shall limit myself to doing is to paint a bit of the background Context into which children in such societies are born without attempting the more complex task of translating this into its effects

at the 'micro' level of individual children and their families.

The case of bilingual support worker Aishah Azmi, who was suspended as classroom assistance by a school in West Yorkshire (UK) after she insisted on wearing a veil in certain lessons, is symbolic of the way priorities seem to have become distorted in countries such as the UK. The decision of the school was supported by most senior politicians in the UK. Aishah was suspended on the grounds that the veil impeded her communication with the children and therefore interfered with their education. Leaving aside whether this decision is right or wrong, writing as a psychiatrist who works in the UK, I find it ironic that we attack the symbols of a belief system and culture from which Western societies have much they could learn with regards raising and educating children and instead paint the traditions that Aishah symbolises as detrimental to children's well being. After all it is societies like the UK's that are struggling with increasing problems of alienation, anti-social behaviour, alcohol and drug misuse, bullying, violence, eating disorders, self harm, behaviour disorders, and neglect in the young, to mention but a few. I do not wish to romanticise other cultures concepts of childhood and child rearing nor do I wish to minimise the enormity of the task of improving children's lives across the world, particularly in the context of an aggressive market led neo-liberal globalisation, destabilised communities, and regional conflicts with all the devastation to family life this brings and where some local cultural beliefs are clearly problematic (like female infanticide). However, I wish to state firmly and confidently that amongst those more stable and rooted cultures across the world, sophisticated discourses on childhood and child rearing spanning millennia, exist (including within Islam) with many anthropological and other studies confirming that such communities do not share the same magnitude of problems with anti-social behaviour, anxiety states and so on, amongst the young (see Timimi, 2005a). I am not saying that we can import sets of beliefs and practices from other cultures and simply transplant them in Britain or any other country and expect them to

work. However, some reflection on the nature of beliefs, values and practices in our own and other societies may help inform us about things that can be done in our bid to develop these in a way that can be applied to the unique context each culture has. After all cultures are never static, always transforming and, in particular in the era of globalisation, always open to influences from outside its immediate set of traditions.

I also want to acknowledge that our ideas about what an ideal childhood should look like, is culturally constructed. Thus whilst the immaturity of children is a biological fact, the ways in which this immaturity is understood and made meaningful is a fact of culture [(1).] Members of any culture hold a working definition of childhood, its nature, limitations and duration based on a network of ideas that link children with other members and with the social ecology [(2).] While they may not explicitly discuss this definition, write about it, or even consciously conceive of it as an issue, they act upon these assumptions in all of their dealings with, fears for, and expectations of, their children [(3).] This makes it difficult to pass a value or scientific judgment about whether children are better or worse off in any particular culture or society, as the idea that there are universal ideals or natural unfolding process that all children should be able to 'have', is suspect. Nonetheless, children are socialised by belonging to a particular culture at a certain stage in that culture's history, so certain differences in children's behaviour can be seen as a result of different child rearing philosophies and socialisation processes. We can, therefore, make some comparisons, whilst keeping in mind the above caveats and indeed using them to help us 'interrogate' any naïve or romanticised assumptions.

Changing childhoods in the West

There are however, some things that we can say with reasonable certainty. We know that the space of childhood has changed. Contemporary Western culture has witnessed rapid changes that effect children. Well documented changes include: children's diets (which have increased in sugar, saturated fats, salt, chemical additives and decreased in certain essential fatty acids and fresh

fruit and vegetables); family structure (which has seen the demise of the extended family, increase in separation and divorce, increase in working hours of parents, and a decrease in the amount of time parents spend with their children); family lifestyle (there has been an increase in mobility, decrease in 'rooted' communities, and an increasing pursuit of individual gratification); children's lifestyle (which has witnessed a decrease in the amount of exercise, the 'domestication' of childhood due to fears about the risks for children resulting in more indoor pursuits such as computers and TV); the commercialisation/commodification of childhood (increase in consumer goods targeted at children and the creation of new commercial opportunities in childhood, for example the 'parenting' industry and the pharmaceutical industry) and changes in the education system (modern teaching ideology is rooted in methods such as continuous assessment and socially orientated worksheets that favour the learning style of girls over boys). These changes are occurring at a time when standards in the West for what is considered to be acceptable behaviour in the young and acceptable child rearing methods are both narrowing. It is now harder than ever to be a 'normal' child or parent [(4).]

Increase in psychiatric disorders in children

In parallel with this claims are being made that 'mental' disorders among the young in Western societies (such as emotional, anxiety, eating, and behavioural disorders) have been steadily increasing in the past few decades [(5)] despite the perception that recent generations have 'never had it so good'. Figures for prescriptions of psychotropic medication to children and adolescents both illustrate the depth of this problem and the peculiar cultural style of responding to it. For example, researchers analyzing prescribing trends in nine countries between 2000 and 2002, found significant rises in the number of prescriptions for psychotropic drugs in children, were evident in all countries- the lowest being in Germany where the increase was 13%, and the highest being in the UK where an increase of 68% was recorded [(6).] Of particular concern is the increase in rates of

stimulant prescription to children. By 1996 over 6% of school-aged boys in America were taking stimulant medications [7] with children as young as two being prescribed stimulants in increasing numbers [8]. Surveys show that in some schools in the United States over 17% of boys are taking stimulant medication [9] and it is was recently estimated that about 10% of school boys in the United States take, have taken or will take a stimulant [10]. In the UK prescriptions for stimulants have increased from about 6,000 in 1994 to over 450,000 children by 2004 a staggering 7,000+% rise in one decade [11].

Is this the canary in the mine? These rapid changes in practice in the area of children's mental health have not come about as a result of any major scientific discovery [12, 13, 14 and 15]. There are two other possibilities that could explain these dramatic increases. The first is that there has been a real increase in emotional and behavioural disorders in children leading to greater public scrutiny and concern about such behaviours which, in turn, has resulted in a greater professional effort to understand and alleviate these behavioural and emotional problems. The second possibility is that there has not been a real increase in emotional and behavioural disorders in the young but there has been a change in the way we think about, classify, and deal with children's behaviour – in other words our perception of and the meaning we ascribe to children's emotions and behaviour. Both possible causes for the rapid increase in our identification of and treatment for mental health disorders in the young require an examination of contexts. Indeed the third, and in my opinion, most likely possibility that explains the increase is an interaction between the aforementioned two possibilities. In other words, it could be that changes in our cultural-/environmental contexts are causing increases in certain emotional and behavioural problems and these, in turn, are changing our perception of and the meaning we give to childhood behaviour, and this in turn, is changing the way we deal with childhood behaviour and our common cultural practices around children (such as child rearing and education), which in turn is further increasing these behaviours and so on.

The impact of 'Narcissism'

In a short paper such as this I cannot possible explore in any detail the impact of changes in the space of childhood in Western modernity that I listed above. Instead I will confine the rest of this article to the impact a particular aspect of its value system which has become embedded in daily discourse due, at least in part, to reliance on rather aggressive forms of neo-liberal free market principles and the growth of individualism. This is the problem of 'narcissism'. Narcissism describes the character trait of 'self love' or in the more everyday sense 'looking after number one'. The spread of narcissism has left many children in a psychological vacuum, preoccupied with issues of psychological survival and lacking a sense of the emotional security that comes through feeling you are valued and thus have an enduring sense of belonging.

One of the dominant themes used by advocates of neo-liberal free market economy ideology is that of 'freedom'. At the economic level this is a core requirement of free market ideology. Companies must be as free from regulation as possible; to concentrate on competing with others, with maximizing of profits the most visible sign of success. There is little to gain from social responsibility (only if it increases your 'market share'). At the emotional level the appeal to freedom can be understood as an appeal to rid us of the restrictions imposed by authority (such as parents, communities and governments) (16). By implication this value system is built around the idea of looking after the wants of the individual – narcissism. Taking this a step further, once the individual is freed from the authority they are (in fantasy at least) free to pursue their own individual self-gratification desires, free from the impingements, infringements, and limitations that other people represent. The effect of this on society is to atomise the individual and insulate their private spaces to the degree where obligations to others and harmony with the wider community become obstacles rather than objectives. In this 'look after number one' value system, other individuals are there to be competed against as they too chase after their personal desires. This post second world

war shift to a more individualistic identity was recognized, as early as the mid-1950s, by commentators who first spoke about how the new 'fun based morality' [17] was privileging fun over responsibility – having fun was becoming obligatory (the cultural message that you should be ashamed if you weren't having fun). With the increase in new possibilities for excitement being presented, experiencing intense excitement was becoming more difficult, thus creating a constant pressure to push back the boundaries of acceptable and desirable experiences and lifestyles, opening the doors, amongst other things, to subcultures comfortable with drinking to excess, violence, sexual promiscuity, and drug taking.

In this value system others become objects to be used and manipulated wherever possible for personal goals and social exchanges become difficult to trust as the better you are at manipulating others the more financial (and other narcissistic) rewards you will get. Such a value system, which ultimately seeks to eradicate or at least minimize social conscience as a regulator of behaviour, cannot sustain itself without our moral conscience beginning to feel guilty [16]. Thus it is no coincidence that those who are the most vociferous advocates of free market ideology tend also to advocate the most aggressive and punitive forms of social control. Whereas some of these guilt-induced policy proposals are aimed at putting some restraint on unfettered competitiveness, greed and self seeking; amongst those more fanatical believers in the ability of market ideology to solve its own problems (and thus best to leave the market to get on with it), the most common defence used to try and deal with the anxiety produced by this guilt is through finding target scapegoats for this anxiety. In other words, instead of facing up to the suffering the encouragement of narcissism brings to the world, our leaders need to convince us that our problems are due to other evils (like fundamentalist Islam, asylum seekers, homosexuals, single parents, bad genes etc.). As a result another hallmark of Western culture's increasing psychological reliance on developmentally immature impulses that encourages it to avoid taking responsibility for its

beliefs and practices, is the so called 'blame culture', which fills the media and contemporary discourse more generally.

In any culture, children and then adults come to acquire their subjective selves through incurporation of values beliefs and practices that sustain the desired social relationships of that culture [18]. People, Althusser argues, can only know themselves through the mediation of ideological institutions. So how do the ideologies of modern Western capitalism influence the way children and their parents see themselves, their roles and subsequently the way they behave?

In this narcissistic value system others can easily become objects to be used and manipulated for personal goals, thus social exchanges become more difficult to trust as the better you are at manipulating others the more narcissistic rewards you can get. Dependence when it occurs is more likely to happen with professionals thereby reinforcing the idea and status of the expert. As Amin points out [19] Western capitalist ideology has necessarily led to the domination of market values, which penetrates all aspects of social life and subjects them to their logic. This philosophy pushes to the limit of absurdity an opposition between humankind and nature. The goal of finding an ecological harmony with nature disappears as nature comes to be viewed as a thing to be similarly manipulated for selfish ends.

With narcissistic goals of self-fulfilment, gratification and competitive manipulation of relationships so prominent, together with the discouragement of the development of deep interpersonal attachments, it is not difficult to see why so-called narcissistic disorders (such as anti-social behaviour, substance misuse, and eating disorders) are on the increase [20, 21]. A heightened concern for the self can be both 'liberating' and simultaneously oppressive. At the very least it makes the transition to taking on responsibility for others (as parents must) problematic.

A system of winners and losers

The attention given to individual cases of child abusers whom society can disown as not belonging to or being (at least in part) the product of its culture masks Western governments implementation of national and international policies that place

children at great risk and the extent to which it can support an 'abusive' culture. Monetarist policies of the 80's and 90's cut health, social, welfare and education programmes as well as enforcing similar austerity measures on developing countries, policies that had a particularly adverse effect on children and families [22, 23]. This also has a class specific character with the plight of poor children being viewed as self-inflicted and the more insidious problem of neglect of their children by middle class parents often passing unnoticed. With the increase in the number of divorces and two working parents, fathers and mothers are around their children for less of the day. A generation of 'home aloners' are growing up. The amount of time children have with their parents has dropped dramatically in recent decades in the West, and the back up systems that extended families presented are dwindling [24]. As families get smaller and spend less time with each other, children lose the learning opportunities that come in social systems more geared to social responsibility/ duty – instead of having to negotiate several relationships within regular contacts with multiple kin, children increasing live in more emotionally charged small units (the nuclear family, single parent families etc.) trying to psychologically survive within a fiercely competitive and individualistic culture.

Children are cultured into this value system by virtue of living within its institutions and being exposed daily to its discourse. Ultimately this is a system of winners and losers, a kind of survival of the fittest where compassion and concern for social harmony contradicts the basic goal of the value system. As this system is showing itself to be bad for children's happiness a similar process as above works to try and distance awareness of the anxiety arising from the guilt thus produced. Instead of asking painful questions about the role parents/teachers/governments/etc. may be playing in producing this unhappiness, children's difficulties can be viewed as being the result of biological diseases that require medical treatment (we can blame their genes).

These social dynamics also get projected directly onto children. Children come to be viewed as both victims (through adults using

and manipulating them for their own gratification) and potentially 'evil' scapegoats (as if it is these nasty children's bad behaviour that is causing so many of our social problems) [25]. This reflects a profound ambivalence that exists toward children in the West. With adults busily pursuing the goals of self-realization and self-expression (these being the polite middle class versions of self-gratification), having absorbed the free-market ethic, children when they come along, will, to some degree, 'get in the way'. A human being, who is so utterly dependent on others, will inevitably cause a rupture in the Western value system goals of narcissism that individuals who have grown up in these societies will have been influenced by to a greater or lesser degree. Children cannot be welcomed into the world in an ordinary and seamless way. They will make the dominant goals of modern life more difficult. They will, to some degree, be a burden.

More and more surveillance

Thus far I have suggested that a basic feature of modern Western free-market based culture is an increasingly narcissistic value system, which interrupts children's and families' lives in a number of adverse ways. The complex dynamics of our concepts of self increasingly shaped along narcissistic notions, interacting with the collective guilt and fear of retribution, becoming a loser in the competition, or fear of pilfering of one's accumulated resources, means that governments feel the need to police these potentially dangerous selves in an increasing variety of ways. Thus, one feature that has changed dramatically over the past century of Western society is the amount of surveillance to which parents and their children are subjected. The state has all sorts of mechanisms of surveillance and an 'army' of professionals tasked with monitoring and regulating family life as if they are aware that children are struggling in this culture and deal with their guilt by individualising and 'scapegoating'. This is not to say that we do not need surveillance as the effects of child abuse are many and far reaching. But we must also ask the question of what the impact of this is on non-abusive families and on attitudes and practices of child rearing more generally. The increase in levels of anxiety

amongst parents who may fear the consequences of their action, has reached the point where the fear is that any influence that is discernible may be likely to be viewed as undue influence, making it more likely that parents will leave essential socialising and guidance to the expertise of professionals [15].

Life has thus become difficult for parents who are caught in a double pressure when it comes to raising their children. On the one hand there are increased expectations for children to show restraint and self-control from an early age, on the other there is considerable social fear in parents generated by a culture of children's rights that often pathologizes normal, well-intentioned parents' attempts to discipline their children. Parents are left fearing a visit from Social Services and the whole area of discipline becomes loaded with anxiety. This argument holds equally true for schools. Parents often criticise schools for lack of discipline. Schools often criticise parents for lack of discipline. This double bind has resulted in more narcissistic power going to children. Parents are being given the message that their children are more like adults and should always be talked to, reasoned with, allowed to make choices, to express themselves and so on [4].

The atomization of society also means that there is a lack of common ownership of rules and values with regards to upbringing of children. Children may learn that only certain individuals have any right to make demands and have expectations with regards their behaviour and with the task of parenting coming to be viewed in Western culture, as one that needs childcare expert's advice in order to get it right, a form of 'cognitive parenting' has arisen whereby parents are encouraged to give explanation and avoid conflicts [26]. This hands-off, particularly verbal model of parenting is both more taxing and less congruent with children's more action based view of the world.

Into this anxiety loaded, narcissistically pre-determined vision of childhood and practices of child rearing, new diagnoses (such as childhood depression, Attention Deficit Hyperactivity Disorder, Aspergers syndrome) appear to provide a temporary relief to the beleaguered, intensely monitored child carers.

By viewing children's poor behaviour and distressed emotional state as being caused by an 'illness', all are apparently spared from further scrutiny. The result however, fits into another aspect of Western 'fast culture'. With the widespread application of the techniques of medicine to manage children's behaviour and emotional state, particularly through use of drugs, the approach to children's mental health has achieved what I call the 'McDonaldisation' of children's mental health. Like fast food, recent medication centred practice came from the most aggressively consumerist society (USA), feeds on people's desire for instant satisfaction and a 'quick fix', fits into a busy life-style, requires little engagement with the product, requires only the most superficial training, knowledge and understanding to produce the product, de-skills people by providing an 'easy way out' thereby reducing resilience, creates potentially life long consumers for the product, and has the potential to produce immeasurable damage in the long term to both the individual who Consume these products as well as public health more generally.

Conclusion

As a child and adolescent psychiatrist who has dual heritage (with an English mother and Iraqi father) and who has experienced growing up in both Arab and Western culture I am naturally interested in what each tradition can offer the other to enrich the experience and mental health of children. I have outlined how certain features of Western culture have rapidly changed the space of childhood in the West. I have suggested that modern Western culture is built on a particularly aggressive form of neo-liberal free market capitalism and that one of the consequences of this is an increasingly narc-issistic culture. When narcissism is privileged over social res-ponsibility one of the first groups to lose out is children. This has contributed to an increase in mental health problems amongst children in the West (such as emotional disorders, behavioural disorders, and substance misuse) as well as changing ideas about what constitutes 'normal' childhood and childrearing.

In the era of globalisation those with a more powerful economic influence have been exporting not only their goods but also their value system. Visions of child-hood and family life carved out within Western culture (including those developed by psycho-medical groups) may not be in the best interests of children around the world. Indeed, there is a good case for arguing the converse – that professionals working with children in the West may have much to gain by learning more about how non-Western cultures understand both childhood and child rearing [13]. In addition professionals working in non Western settings should think twice before uncritically accept-ing beliefs and practices about family life and childhood that were developed in the West and simply transplanting these into settings where such values and practices may be alien to the population and undermine approaches that may actually be more protective of children's mental health.

خلاصه

لقد طرأت في معظم البلدان الغربية في العقود ا لأخيره زيادة هائلة في تشخيصات الإضطرابات النفسية عند الأطفال. ونستطلع في هذه المقالة بعضاً من الأسباب الاجتماعية-الثقافية المتعلقة بهذا الموضوع. كما نناقش وقع نمو النرجسية (حب الذات أو انشغال البال بالذات) في الثقافة الغربية على كل من الأطفال وعائلاتهم. ونتطرق كذلك إلى ما ينطوي عليه هذا الأمر من مضامين بالنسبة للمهنيين الذين يعملون مع الأطفال الذين ينشأون في محيط الحضارة الغربية أو غير الغربية.

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Correspondence:
Professor Sami Timimi
Consultant Child and Adolescent Psychiatrist and
Director of Postgraduate Medical Education
Lincolnshire Partnership Foundation NHS Trust
Visiting Professor of Child and Adolescent Psychiatry
University of Lincoln, UK
E-mail: stimimi@talk21.com

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Review Article

Prevention of Post Traumatic Stress Disorder in the Aftermath of War

Numan S. Ali, Tori Snel

الوقاية من إضطراب الضغوط التالية للصدمة في فترة مابعد الحرب

نعمان سرحان علي وتوري سنيل

Abstract

This paper examines a traditional model of PTSD prevention addressed at three levels: (1) primary - preventing exposure to trauma, (2) secondary - preventing the development of PTSD immediately after trauma exposure and (3) tertiary – preventing the worsening of PTSD. The psychological profile that emerges from Iraq's experience of war and sanctions offers insight as well as challenges for the debate as to whether PTSD is preventable. Costs associated with many pharmacological and psychosocial approaches, for example, may render prevention a low priority for funding. Further, while the DSM-IV provides a psychiatric framework for single-trauma exposure in its description of PTSD some note that 'it fails to capture the full range of disruption caused by multiple and repeated exposures' . These are important considerations in the aftermath of war when trauma-related disorders are likely to be a greater public health concern than in the years that preceded it.

Keywords: PTSD, prevention, trauma, war

Introduction

PTSD is categorized as a response to a terrifying or disturbing event(s) 'outside the range of the usual human experience [1,2]. It also has been Considered a 'normal response to an abnormal situation' [3] though when core symptoms of intrusion, avoidance and hyper arousal persist, the response risks becoming maladaptive. Some believe repeated exposure to excessive stress is among the criterion linked to a PTSD

response in trauma survivors (4). Others suggest that vulnerability to PTSD increases when prior dramatization is compounded with successive traumatic events (5,6,7). These risks are also influenced by gender and individual differences, such as pre-existing psychiatric disorders, inadequate social support and genetic pre-disposition, including neuro-biological functioning which might affect how levels of danger are perceived and handled (8,9).

Although not all people exposed to the severe traumas of war develop PTSD, cross-cultural investigations consistently reflect elevated rates of PTSD among traumatized populations (10,11,12), which exceed those found in the US population. Data from the US National Comorbidity Survey indicated PTSD prevalence rates were 5% and 10% respectively among American men and women (13). The rates of PTSD were higher in post-conflict settings such as Algeria (37%), Cambodia (28%), Ethiopia (16%), and Gaza (18%) (14).

Others maintain a PTSD diagnosis is rare (15,16,17). In the case of Iraq, the population has been estimated to have elevated PTSD symptom levels by expert and non-expert alike, but a figure has yet to be realized. An important consideration for researchers and clinicians is the likelihood that multiple trauma exposure will be a common experience for many. Research on displaced Iraqi adolescents reported between four and five high magnitude stressors per individual, e.g. experiences of bombardment, physical assault, attempted kidnapping, and witnessing dead bodies (18). This is supported in other studies examining the traumatic experiences of Iraqis since 2003 (19,20); one study suggested trauma-related experiences risk becoming ‘the number one public health concern for Iraq' (21). Developing a mental health framework within which to address this concern should include the traditional PTSD prevention typology though with a measure of caution: PTSD is comorbid with other

mental disorders, including Acute Stress Disorder, General Anxiety Disorder and depression (22).

Primary Prevention

Primary prevention of PTSD works on the premise that trauma should be avoided or, at least, the risks of exposure reduced. For countries facing the threat of conflict, this is a vital first step that should include advocacy at the community, national and international level if the trauma of war is to be avoided. In the event it cannot be, trauma exposure might be reduced via prevent preparedness. Interventions that increase the predictability of aversive experiences are believed to work as a psychological inoculation against exposure, e.g. informational preparation and simulated scenarios involving dead bodies and explosions have demonstrated a protective effect on first responders and military personnel [(23)]. A study comparing trained and untrained political activists who had been tortured demonstrated that the latter exhibited higher symptom levels of PTSD (24). Civil defense practices such as safety procedures during air strikes could prevent death and serious injuries thus reducing susceptibility to PTSD responses linked to bereavement or fear for one's safety. More practically, limiting the viewing of media coverage preceding and immediately after war breaks has also been shown to help (25).

Mental health professionals might consider the prevention of war itself beyond their purview, however, it is possible to play an active role by: (1) adhering to the highest ethical standards so as to avoid contributing to conflict, such as through the kind of restraint exhibited by the American Psychiatric Association when faced with the prospect of interrogating Guantanamo Bay detainees; and (2) reaching beyond the confines of scientific collaboration to inform the world community about the psychologically damaging effects of war, which is achievable through broad contact with legislators, the media and NGOs when disseminating research outcomes.

Secondary Prevention

This is an evaluative phase in which mental health

professionals can assess the setting, limitations and availability of resources, including human resources, e.g. trained individ-uals. Secondary prevention targets identified populations who might benefit from mental health support due to previous trauma exposure, intensity of exposure and family history. They may not necessarily be clinical populations, but would normally have been assessed as populations at risk. In settings like Iraq such populations might include those who suffered experiences of bombardment, bereavement or witnessing violence. Increased domestic violence as a consequence of stresses brought on by war, e.g. displacement, job loss and disrupted education will also mean others could benefit from support at this level.

Prime objectives at the evaluative phase include assessment of the individual's access to social support and promotion of resilience, such as through increasing self-esteem and developing coping skills. Adequate social support has been linked to decreased vulnerability towards developing psychological problems following a stressful event. Conversely, the lack of social support as well as the avoidance of support post crisis has been associated with increased PTSD (26). The opportunity to talk about traumatic experiences can improve recovery since traumatic memories and associated feelings of fear or anxiety can be weakened through repetition in active conversation (27).

Combined Treatment, Pharmacotherapy and Psychological therapy

The combined use of pharmacotherapy and psychological therapy for PTSD treatment is practiced in clinical settings where the condition is viewed more as a psychobiological dysfunction. A recent Cochrane Collaboration review found evidence to support short-term treatment of PTSD using medication stating that it was significantly more effective than placebo across PTSD symptom clusters (28). Selective serotonin reuptake inhibitors (SSRIs) proved more effective than older generation antidepressants making it the first line medication choice for PTSD treatment. However, there is ongoing

debate as to whether medication or psychotherapy is the more efficacious approach for PTSD treatment. Another Cochrane Collaboration review is underway that compares both approaches (29).

A recommendation from the UK's National Institute of Clinical Excellence (NICE) rated trauma-focused psychological therapy over pharmacotherapy as the routine first line treatment for PTSD (30). Among the more efficacious psychological treatments for PTSD symptomatology, cognitive behavioural therapy or CBT with some evidence demonstrating that trauma-focused CBT (TFCBT) yields better outcomes than CBT. In both cases, the methods apparently influence the brain by correcting exaggerated emotional responses triggered by traumatic memories that the anterior cingulate would normally extinguish, but is prevented from doing so by the presence of PTSD. Other psychosocial interventions have not achieved this (31), which highlights the value of teaching CBT and TFCBT to students of psychiatry, psychology and others related to the mental health profession.

Another PTSD treatment approach, eye movement reprocessing and desensitization or EMDR, has shown mixed results in trials comparing it to other treatments for single-incident PTSD. There is limited empirical evidence to support its effectiveness for treating multiple trauma PTSD. Rubin noted in his literature review that if EMDR is to be used for treating clients with multiple trauma one should do so 'in light of the inadequate evidence base, be guided by future evaluations of EMDR with these populations, and recognize that many more sessions of EMDR, with less robust effects, may be required than what they might expect.'(32) Standards of training for therapists have also been mixed though Level II training from an accredited instructor is the accepted standard.

Interventions for Mass Delivery

Following war or disaster, it is not unusual to find mental health services and personnel overstretched. The looting and destruction of Baghdad's Al

Rashad and Ibn Rushd Psychiatric Hospitals in April 2003 is an example of how unexpected obstacles can prevent support from being offered when it is most needed. Inroads have been made with the development of psychological interventions that address practical concerns for mental health services in war affected communities because: (1) the techniques can be administered to groups rather than individuals; (2) delivery can be from non-mental health professionals given a brief training; (3) validated diagnostic tools are available that include simple to administer, validated self-report measures; (4) few sessions are required; and (5) running costs are low. These have gained an empirical footing as effective tools for alleviating PTSD related symptoms; examples include 'Teaching Survival Techniques' (33,) and 'Writing for Recovery' (34), which incorporate elements of CBT using techniques developed for children and adolescents. Both have shown good results in published and unpublished research (35-39). Given 43.5% of the Iraqi population is under age 15 (40), this is an important contribution particularly in the absence of well-controlled medication treatment trials for childhood PTSD (41).

Tertiary Prevention

Psychiatry becomes more actively engaged at the tertiary level in cases of established PTSD. There is overlap between secondary and tertiary prevention since most treatment approaches can be used for both. Efforts should be focused on preventing the development of chronic PTSD. By this time a variety of symptoms have become chronic and personality changes might be noted, e.g. symptoms of apathy, chronic tiredness, lack of initiative and paranoid thoughts. Atypical symptoms such as sleep disturbance, recurrent nightmares, flashbacks and chronic low mood are also persistent at this point. The clinical management of chronic PTSD is complicated by comorbid disorders such as depression, anxiety and panic disorder and although PTSD is effectively treated in the short-term via SSRIs, trials have demonstrated increased relapse rates in fluoxetine and sertraline

(43) On the other hand, SSRIs have been associated with lower rates of dependence and withdrawal than benzodiaz-epines; in particular, paroxetine has demonstrated good symp-tom reduction (42). On the whole, SSRIs are considered the first line for medical treatment of PTSD.

Conclusion

Trauma-related disorders are an unfortunate consequence of war that could lead to wider social problems, such as substance abuse and family breakdown, if not addressed. PTSD is among the more studied of these and has generated research that offers a structured treatment approach using the traditional primary, secondary, and tertiary prevention model. Within this framework, effective treatments support both the psychobio-logical and psychological approaches towards PTSD prevention. Trauma-focused psychological therapies are gaining empirical ground as the first line treatment for secondary prevention while combined treatment using SSRIs is favoured for short-term support at the tertiary level. Innovative psychological interventions have also addressed the many problems faced by overstretched mental health services in the aftermath of war, e.g. cost, human resources, and outreach, via mass delivery of survival skills-based teaching and structured writing. Further re-search would strengthen the PTSD prevention framework particularly research generated by those countries where mul-tiple trauma exposure is not uncommon since the current framework is mainly based on single-incident exposure.

الملخص

تتفحص هذه المقالة النموذج التقليدي للوقاية من اضطراب الضغوط التالية للصدمة وعلى ثلاثة مستويات : (1) الوقاية الأولية وذلك بمنع التعرض إلى الصدمات , (2) الوقاية الثانوية وتعنى بمنع حدوث هذا الاضطراب بعد التعرض إلى الصدمة مباشرة , (3) الوقاية الثلاثية أي منع تدهور الحالة بعد نشوء الاضطراب.

إن النموذج النفسي الذي يبرز من تجربة العراق في الحرب والحصار ا لإقتصادي يوفر إدراكاً و تحديات للحوار فيما إذا كان هذا ا لإضطراب قابل للوقاية . إن تكلفة

الوسائل المتعددة مثل العقاقير والأساليب النفسية والإجتماعية مثلا , قد تضع الوقاية في أسفل سلم أولويات الدعم المادي.

تعتمد ملزمة التشخيص والإحصاء (الطبعة الرابعة) إطار التعرض إلى الصدمة لمرة واحدة وذلك في تعريفها لإضطراب الضغوط التالية للصدمة , ويلاحظ البعض أنها تفشل في تغطية المدى الكامل للضرر الذي يسببه التعرض إلى الصدمات المتعددة والمتكررة وهي من الاعتبارات المهمة في فترات ما بعد الحرب عندما تكون الإضطرابات المتعلقة بصدمات الحرب من إهتمامات الصحة العامة أكثر من الفترات التي تسبق الحرب .

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Numan S. Ali FRCPsych
Consultant Psychiatrist
Baghdad Teaching Hospital
Baghdad – Iraq
E-Mail : numanali@hotmail.com
Tori Snell MSc
Department of Psychology
University of Leicester
Leicester – UK.
E-Mail tori.snell@gmail.com

Letter to the editor
Suicide in the Arab World

Dear editor

I read with great interest the review article on Suicide in the Arab World by Karam et al published in the Arab Journal of Psychiatry, vol. 19, May 2008. Karam et al highlighted important findings that need to be addressed as part of an Arabic suicide management strategy. These findings include: methods of self-harm, precipitating factors, psychiatric diagnoses and psychiatric follow up of suicide attempters [(1)]. However not all the Arab countries were represented in this review. This may be due to lack of studies, low level of interest, limited resources and even lack of service. These countries e.g. Eritrea, Mauritania and Somalia should not be forgotten. The Arab Federation of Psychiatrists (AFP) in collaboration with the Arab League needs to help towards addressing the unmet needs of these countries. I also recommend having a Special Interest Group (SIG) among the SIGs of the AFP for Suicide research and prevention.

An important element that weakens retrospective studies is the uncertainty about data recording. I therefore agree with Karam et al who expressed concern about the accuracy of data recording [(1)]. This is a recognized problem in the healthcare system of the Arab World. It is worth noting that the healthcare system in the Arab World is not homogenous. Some Arab countries with high income have adopted a robust modern model e.g. Kuwait, UAE and Saudi Arabia. Other Arab countries with high standard of human resources but low income e.g. Egypt lacks the well developed healthcare system with a primitive primary care [(2)], poor record keeping and absence of clearly defined catchment' areas [(1)]. This may make it difficult to plan for pan-Arab suicide research programme but not impossible. Certainly there is a need for Pan-Arab research programmes in the field of suicide and deliberate self-harm in particular and in Psychiatry in general. These programmes should be designed to help the development of a Pan-Arab suicide prevention strategy. The need for such programmes will increase with the globalization and progressive changes influencing the population of Arab World including economic, social and cultural.

Interestingly immigrants from nations with low suicide rates e.g. Arabic, many Mediterranean and many South American nations tend to maintain the low suicide level in their new environment while immigrants from East Europe tend to have a higher risk of suicide in their new countries [(4)]. This may reflect the impact of cultural background and religious belief of immigrants. Whether this difference persists in the second and subsequent generations or not? This question is yet to be answered.

Muslims and Roman Catholics always had lower suicide rates than Protestants. A balanced religious belief seems to be strongly negatively connected with suicidal behaviour [(3)]. In my opinion a healthy religious belief must play an important role in our pan-Arab suicide prevention strategy.

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Mamdouh EL-Adl
MBBCh, MSc, MRCPsych
Consultant Psychiatrist, Northampton, UK
Northamptonshire Healthcare NHS Trust
e-mail: mamdouh.eladl@nht.northants.nhs.uk

Book Review:

Suicide Risk Management
A Manual for Health Professionals

Edited by:
Stan Kutcher: Professor of Psychiatry and Associate Dean of International Medical Development and Research, Dalhousie University, Halifax, Canada
And
Sonia Chehil: Assistant Professor of Psychiatry and Deputy Head of International Psychiatry
Dalhousie University, Halifax, Canada

This book of 134 pages was published in 2007 by Blackwell Publishing Ltd. It includes 9 chapters & 4 appendices.

Chapter 1: Understanding Suicide Risk. In this chapter the authors raise important questions and answer these questions, using an interesting style, in an attempt to improve awareness of health professionals and rectify some of the wrong concepts about suicide risk. Chapter **2: Suicide Risk Assessment**. The Authors outlined a 4-page Suicide Risk Assessment Guide (SRAG). SRAG can be used to guide the clinical interview for the evaluation of individual suicide risk. **Chapter 3: Putting It All Together: The Tool for Assessment of Suicide Risk (TASR).** TSAR includes 3 sections: **(1)** individual profile, **(2)** symptom profile and **(3)** interview profile. TSAR is designed to be used by clinicians to document a summary of their assessment of a patient who may be suicidal. Although in chapter 1 the authors acknowledged that religious belief influence suicide risk, religious belief was not reflected in TASR. **Chapter 4: Suicide and Youth**. In this chapter the authors discuss the complexity of assessing youth suicide risk. **Chapter 5: Commonly Encountered Problems in the Evaluation of Suicide Risk.** In this chapter the authors describe clinicians' common emotional, cognitive and behavioural responses to individuals who self harm and advice the clinicians on how to avoid common traps**. Chapter 6: Suicide Prevention.** This is a brief chapter in which the authors refer to suicide prevention strategies and divide them into two main

categories: Population Strategies and Individual Strategies. **Chapter 7: Suicide Intervention.** This chapter discusses three basic principles to consider while managing the suicidal patient: **(1)** Safety and Security to protect the patient from harm. **(2)** Support: individuals who did not need admission to hospital should not be discharged unless adequate arrangements for safety and support are in place. **(3)** Targeted intervention. **Chapter 8: Post-suicidal Interventions.** The authors outlined 4 main principles: **(1)** Support to colleagues who one of their patients had committed suicide. **(2)** Learn from the death of any patient whatever the cause. **(3)** Counseling to family of the deceased and to relevant others is highly important. **(4)** Educate: it is important to take the opportunity e.g. suicide of a famous person to educate the public about suicide and the importance of identifying and treating mental illness. **Chapter 9: Clinical Vignettes for group or Individual Study.** The 8 cases in this chapter have been developed to provide the reader with an opportunity to practice their suicide risk assessment skills and can be used as a training course material or for continuing health education.

The book has 4 Appendices that provide copies of the tools to be used for clinical purposes by experienced clinicians and for education/training purposes. **Appendix 1:** Suicide Risk Assessment Guide (SRAG). **Appendix 2:** Tools for Assessment of Suicide Risk (TASR). **Appendix 3:** 6-item Kutcher Adolescent Depression Scale (KADS). **Appendix 4:** Chehil and Kutcher Clinical Assessment of Adolescent Depression (CAAD).

I found this book an interesting easy read with useful information and structured approach towards assessment and management of risk. I recommend this manual to colleagues in the Arab World especially to those interested in the area of suicide both for clinical and academic purposes. I am also very keen that Arab expertise produces a similar manual that addresses the specific needs of patients and clinicians in the Arab World. Collaboration between Arab Psychiatrists practicing in the Arab World and in the West for this purpose would be an advantage.

Mamdouh EL-Adl
MBBCh, MSc, MRCPsych
Consultant Psychiatrist, Northampton, UK
Secretary of the British Arab Psychiatric Association (BAPA)
Mamdouh.eladl@nht.northants.nhs.uk

Language disorder in schizophrenia

Boufoula boukmees

إضطراب اللغة عند مرضى الفصام

بوفوله بو خميس

الملخص

تهدف هذه الدراسة إلى التعرف على التغيرات التي تحدث في لغة المرضى المصابين بالفصام، إذ توجد عدة نماذج مقترحة مثل نموذج فريث (C.Frith) الذي إقترح أن مريض الفصام يعاني من عدم القدرة على معالجة النوايا، ومن جهته رأي بلولر (E. Bleuler) أن إضطرابات اللغة عند مرضى الفصام هي ترجمة وتعبير عن اضطرابات التفكير عندهم، أما شابمان (Chapman) فقد رأى أن الخلل يكون في التخطيط.

حاول الباحث الإجابة على الأسئلة التالية:

1 - ما هي الإضطرابات اللغوية التي يعاني منها مريض الفصام؟

2 - هل يعاني مريض الفصام من فقر الخطاب؟

3 - هل يخطط مريض الفصام لأفعاله؟

4 - كيف يعالج مريض الفصام نوياه ونوايا الآخرين؟

5 - هل يضطرب عند مريض الفصام الانتباه الإنتقائي؟

لقد صمم الباحث إستبيان لدراسة لغة مريض الفصام سماه (تعداد اللغة عن الفصامي)، ويحتوي الإستبيان على 148 بنداً إختار منها الباحث 60 بنداً لإختبار فرضياته، وبعد تحليل المعطيات ظهرت النتائج التالية.

- يعاني مريض الفصام من تلاشي في التداعيات كما تكون إجاباته خارجه عن الموضوع.
- من أهم الإضطرابات اللغوية التي ظهرت عند هؤلاء المرضى: التوقف والنمطية والوظوب. (block, Sterotypy, Perseveration) .
- يكون كلامه غريب ومبهم.
- تكون عباراته غير مفهومه وغير منطقية.
- لا يعالج نواياه ولا نوايا الآخرين.
- يميل إلى الرمزية.
- يعاني من الشرود وعدم الإنتباه.

الكلمات الأساسية: فصام – توهم – خطاب – مؤشر لغوي .

المقدمة

تحاول هذه الدراسة التطرق إلى أهم الإضطرابات اللغوية التي تظهر عند المرضى المصابين بالفصام . يتميز الفصام عن غيره من الأمراض النفسية بثراء أعراضه خاصة اللغوية منها، حتى قيل عن الفصام أنه مرض (اللغة والتعبير) وقيل عنه مرض العقل.

1 - دوافع إختيار البحث:

- شيوع مرض الفصام فهو يعد من أكثر الإضطرابات الذهانية إنتشاراً في المجتمع الجزائري، إذ يشكل مرضى الفصام النسبة الكبرى من نزلاء المستشفيات النفسية.

- ظهور المرض في مرحلة هامه من التطور، فهو يصيب الشباب مما يجعله موضع إهتمام من أطراف مجتمعية متعددة.

- تميز لغة مرضى الفصام: حيث يوجد في هذه اللغة خصائص تميزها عن لغة المرضى النفسيين الأخرين ومن أهم هذه الخصائص: الغرابة، الإبتكار والتنوع والتباين والكثرة.

- تزايد الإهتمام بموضوع الفصام: حيث ظهر إهتمام متزايد بالفصام في مختلف الجامعات و مراكز البحوث، إن إبحار بسيط على الشبكة العنكبوتيه العالمية يؤكد ذلك.

- فائدة لغة الفصامي في التشخيص: تعتبر اللغة عند مرضى الفصام معبره عن الإضطرابات الأخرى المعرفية والنفسية واللسانية مما جعلها عنصراً لا غنى عنه في التشخيص، وقلما يخلو مرجع في الطب النفسي أو علم النفس المرضي أو التصنيف المرضي من ذكر إضطرابات اللغة ضمن عناصر التشخيص.

2 - أهداف البحث:

- دراسة الإضطرابات اللغوية التي تظهر عند مريض الفصام الزوري.

- محاولة تفسير هذه الإضطرابات وربطها بالأعراض السريرية.

3 - إشكالية البحث:

الفصام إضطراب ذهاني مزمن يصيب الإنسان في مرحلة المراهقة وهو الأكثر شيوعاً في مجموعة الإضطرابات الذهانية، ويتميز الفصام بظهور التوهم وهو فكرة خاطئة للمريض يقين تام بصحتها، وتمتد أعراض الفصام للجوانب الوجدانية والسلوكية الحركية والمعرفية. فعلى الصعيد الوجداني يلاحظ عند المريض لامبالاة وجدانية وسلبية ونكوص وإضطرابات في العلاقات الإجتماعية، وعلى الصعيد المعرفي توجد إضطرابات في التداعيات حيث تكون غامضة، كما يضطرب في التفكير فيصبح فوضوي وغامض ومتقطع وكما تظهر إضطرابات في اللغة .

وعلى الصعيد السلوكي يظهر التناقض وهو ميل المريض في أن واحد إلى المظاهر السلبية الإيجابية لمختلف الأفعال النفسية. [1]

ويتميز مريض الفصام أيضاً بأفكار توهميه وهي عبارة عن إعتقاد ويقين خاطئ يستلزم منه تقديم تفسير لحركاته وتجاربه [2] . وقد يكون لهذه الأفكار التوهميه مضامين متنوعة كالإضطهاد والعظمة، والتوهم الديني والجسدي وتوهم الإشارة للذات [3] اهتم العلماء بدراسة خطاب المريض بالفصام بإعتباره الجزء المفضل لظهور الإضطرابات اللغوية بالإضافة لأن

الخطاب يعبر عن فكر. إن دراسة السلوك اللغوي في هذا المرض بينت وجود إضطرابات لغوية عديدة تعبر عن مختلف أعراض الفصام.

لقد ظهرت عدة تفسيرات للفصام منها العقلية والتحليلية والمعرفية، فقد رأى أصحاب المدرسة العقلية أن إضطرابات اللغة عند الفصاميين دليل وتعبير عن إضطراب التفكير وبالتالي هذه الإضطرابات في تشخيص الفصام، ومن أقطاب هذه المدرسة (إيميل كربلين)، الذي أطلق وصف اللغة غير المنسجمه [4] (Schizophasia) على مجموع إضطرابات اللغة عند مريض الفصام، وكما رأى أن هناك فقدان للقدرة على التنظيم والترتيب في الأفكار [5]. كما نجد أيضاً (إيجاد بلولر) قد أشار في عام 1911، إلى فقدان التداعيات عند الفصامي وأعتبرها إنعكاس غير مباشر لإضطراب مجرى التفكير. كما رأى بلولر أن الفصامي يعبر عن أفكار مرتبطة بطريقة غير منطقية لتكوين فكرة جديدة [6]. وانتقد أصحاب هذه الدراسة هذا التحديد كون إضطراب التفكير يوجد أيضاً في مرضى الزهو أو الهوس وإضطرابات ذهانية أخرى.

ورأى أصحاب المدرسة التحليلية وخاصة المحلل الفرنسي (جاك لاكان) أن كلام الفصامي يشهد إنزلاقاً مستمراً على صعيد السلسة المدلول عنها، ويظهر المريض كأنه يهرب من العالم الواقعي ليلجأ إلى عالم خاص به و هناك تصبح فيه للكلمات دلالة لا يدركها إلا هو [7] وإعتبر أصحاب المدرسة المعرفية أن اللغة هي المكان المفضل لظهور الإضطرابات المعرفية عند مريض الفصام، لقد بينت البحوث التي أجريت على اللغة عند مرضى الفصام أن الخلل لا يكون بأحد مكونات اللغة بشكل خاص ولكن هناك إضطراب في الأداء اللغوي وليس في الكفاءة اللغوية. وقد أقترح (شابمان) ومن معه عام 1976، فرضية مفادها أن الفصاميين يعانون من إضطراب في معالجة السياق الدال على المعنى، حيث يسود عندهم المعنى الغالب للكلمات الغامضة دون ربطها بسياقها التي توجد فيه.

لقد قامت الباحثة أندريانسن سنه 1979 بتنظيم سلم لقياس إضطرابات اللغة عن الفصاميين وسمته (سلم التفكير واللغة و الإتصال) ويرمز له بالحروف TLC ويحتوي هذا السلم على 18 بنذ وتوصلت إلى أن الفصاميين يتميزون بكلام مقتضب وفقر واضح في مضمون كلامهم [8] وقد انتقد هذا السلم لأنه لا يميز بين مختلف المرضى مثل مرضى الفصام والهوس.

ونظراً لتنوع الفصام تختلف إضطرابات اللغة لأن هذه الأخيرة تترجم أعراض الفصام المختلفة، فإذا كان مريض الفصام بأعراض إيجابية ولدية أعراض واضحة في لغته مثل الربط الغير منطقي للأفكار والرموز، وقد ترتبط الأفكار فيما بينها بواسطة كلمات متناغمة لكن لا معنى لها، أو بواسطة تداعيات غير منسجمة تسمى سلطة لفظيه[9] ، وإذا كان الفصام بأعراضه السلبية ظهر عند المريض فقر في اللغة حيث تختزل الإجابات وتكون قصيرة وفارغة وذلك تبعاً لضعف القدرات المعرفية[10] . وإن كان الفصام تخشبياً أو جامودياً ظهرت عند المريض أعراض الصمت وإن كان زورياً ظهرت أوهام الإضطهاد والعظمة والغيرة، وإن كان الفصام مفككاً لوحظ على المريض عدم

إنسجام في تفكيره وعدم وضوح التوهمات[11].

4 - تساؤلات البحث:

يمكن صياغة الإشكالية على شكل أسئلة وهي كالتالي:

- ما هي الإضطرابات التي تصيب خطاب مريض الفصام؟
- هل يضطرب مجرى تفكيره؟

وهل يعاني من فقر الخطاب؟ وكيف تكون التداعيات عنده؟ وهل يفقد البعد التصوري للغة؟

- هل يخطط الفصامي لفعله ويعالج السياق الدلالي بصوره سويه؟
- كيف يعالج نواياه ونوايا الآخرين؟
- هل يضطرب عنده الإنتباه الإنتقائي؟

5 - الفرضيات:

1 - فرضية عامة أولى: يعاني مريض الفصام من إضطراب في الخطاب.

1-1 فرضية إجرائية 1: يعاني مريض الفصام من فقر الخطاب.

1-2 فرضية إجرائية 2: يعاني مريض الفصام من خطاب غير منظم.

1-3 فرضية إجرائية 3: يعاني مريض الفصام من فقدان للبعد التصوري للغة.

2 - فرضية عامة ثانية: يعاني الفصامي من إضطراب في تخطيط الفعل ومعالجة السياق الدلالي.

2-1 فرضية إجرائية 4: يعاني مريض الفصام من عجز في بدء الفعل القصدي.

2-2 فرضية إجرائية 5: يجد مريض الفصام صعوبة في معالجة السياق الدلالي.

2-3 فرضية إجرائية 6: لايعالج مريض الفصام النوايا الخاصه به.

2-4 فرضية إجرائية 7: لايعالج مريض الفصام نوايا الأخرين.

3 - فرضية عامة ثالثة: يوجد عجز عند مريض الفصامي في القدر الإنتباهية .

3-1 فرضية إجرائية 8: يوجد إضطراب في الإنتباه الإنتقائي عند مريض الفصام.

6_ المنهج وعينة الدراسة وحدود البحث وأدوات البحث.

6-1 المنهج وعينة الدراسة

لقد طبق الباحث في هذه الدراسة المنهج الإكلينيكي الذي ينظر إلى السلوك من منظور خاص، فهو يحاول الكشف عن مكنون الفرد وشعوره في موقف معين، كما يبحث عن مدلول هذا السلوك والبحث عن سبب الصراعات النفسية.[12]

ويعد المنهج الإكلينيكي المنهج الأنسب الذي يحاول إكتشاف مختلف الإضطرابات اللغوية التي تظهر في خطاب مرضى الفصام الزوري، حيث قام الباحث بإجراء مقابلات مع أخصائين في الطب النفسي، وراقب مرضى الفصام وطبق عليهم الإستبيان الذي قام بتصميمه لهذا الغرض وقد تمت الدراسة على مرحلتين:

<u>المرحلة الأولى (الدراسة الإستطلاعية)</u>

قام الباحث بتصميم أداة بحثه و تطبيقها على عينة سوية (ليست فصامية) وحاول اكتشاف الصعوبات التي وجدها المفحوصين الأسوياء في فهم هذه الأداة .

لقد ساعدت الدراسة الإستطلاعية على:

- الإحتكاك والتفاعل مع أفراد عينة الدراسة بغية تسهيل الإتصال معهم .
- تحديد الوقت الذي تستغرقه دراسة كل حالة من الحالات(تطبيق الإستبيان عليها).
- اكتشاف الأخطاء والنقائص التي احتوتها أداة البحث.

- معرفة الصعوبات التي وجدها المفحوصين ومحاولة حلها.
- إستيحاء أفكار أخرى عن موضوع البحث .

المرحلة الثانية (الدراسة النهائية)

و فيها تم تطبيق أداة الدراسة على مجموعة البحث،المتكونة من 10 فصاميين ،لقد طلب من الأطباء النفسيين المعالجين لهم تصنيف أهم الإضطرابات اللغوية التي صادفوها عند هؤلاء المرضى أثناء ممارساتهم الإكلينيكية .

هؤلاء الأطباء يعملون بمستشفى الرازي للأمراض العقلية بولاية عنابة في الجزائر.

2-6- حدود البحث:

* **الحدود الزمنية :**أجريت الدراسة التطبيقية من كانون ثاني (يناير) 2007 إلى غاية كانون ثاني (يناير) 2008

*** الحدود المكانية :**

طبق الجانب الميداني على مستوى مستشفى الرازي للأمراض العقلية بولاية عنابة – الجزائر -

يقع مستشفى الرازي للأمراض العقلية – عنابة- بحي الصفصاف وهي مؤسسة جهوية واستشفائية جامعية تغطي خمس ولايات هي : عنابة، و قالمة، و تبسة ، والطارف وسوق أهراس.و لقد دشن يوم 1نيسان/أبريل 1982 . وهو هيكل على شكل أجنحة يمتد على مساحة 7.5هكتار.

تحتوي المصلحة الإستشفائية الجامعية للطب العقلي على أربع وحدات بقدرة إستيعابية تصل إلى 264 سرير(1987) موزعة كالتالي:

- وحدة الإستعجالات (رجال ونساء) 60 سريراً.
- وحدة الإستشفاء والعناية (رجال) 60 سريراً .
- وحدة الإستشفاء والعناية (نساء) 60 سريراً .
- وحدة الطب العقلي للأطفال والمراهقين: 40 سرير طفل، 40 سرير مراهق

يتكون الطاقم الطبي من 34 شخص يشغلون الوظائف التالية:

- أستاذ تعليم عالي –بروفسور-
- 4 أساتذة مساعدين
- 5 أطباء نفسيين
- 1 جراح أسنان
- 1 طبيب عام
- 16 طبيب مقيم- طب نفسي.
- 4 أخصائيين نفسانيين عياديين
- 1 نفساني رئيسي

ويتكون الطاقم الطبي المساعد من 128 شخص

أما السلك الإداري والتقني فيحتوي على 192شخص

وبهذا يكون عدد الموظفين على مستوى الرازي: 354 شخص

7- أدوات البحث

صمم الباحث أداة تدرس اللغة عند الفصامي وسماها: "تعداد اللغة عند الفصامي" ،ويحتوي هذا التعداد على 148 بند (عبارة) إختار منها الباحث 60 بنداً لإختبار فرضياته.

8- نتائج الدراسة :

8-1 تصنيف إضطرابات اللغة عند الفصامي:

لقد قمنا بتصنيف إضطرابات اللغة عند الفصامي حسب ترتيب التكرارات التنازلي أي من الأكثر شيوعاً إلى الأقل شيوعاً.

وقد جاء المتغير في الرتبة الأولى البند "قولبات لفظية" حيث بلغ تكراره 45، وفي الرتبة 16 البندين "يعتقد أن له إتصال (علاقة) مع كائنات غير بشرية و "يرى أن مصدر أفعاله خارجية" ودرجة كل منهما 31 والرتبة 41 للبند "ألفاظ مجردة" وكانت درجته 14... (أنظر الجدول -1-).

2-8 ا لإضطرابات اللغوية الأكثر شيوعا عند الفصامي:

إن ا لإضطراب الأكثر شيوعا هو "القولبات اللفظية" وكانت درجته 45 ونسبته 11,56% ، ثم في المرتبة الثانية إضطراب "التوقف" ودرجته 44 ونسبته 11,31% ، والمرتبة الثالثة لإضطراب: "تداعياته غير الشائعة" وكانت درجتها 43 ونسبتها 11,05% ، وفي المرتبة الرابعة نجد اضطرابين: الوظووبيه و"الخطاب المبهم" ولكل واحد منهما 39 درجة ونسبة 10,02% .

وفي المرتبة السابعة "التفكير الغامض"ودرجته37 ونسبته 9,51% وفي المرتبة الثامنة "الإجابات الخارجة عن السياق" ودرجتها 36 ونسبتها 9,25% ، وأخيراً في المرتبة التاسعة نجد اضطرابين هما: "خطاب غريب" ، و"عبارات غير مفهومة" ، ولكل واحد منهما الدرجة 34 والنسبة8,74% . (أنظر الجدول - 2- والشكلين 1 و2).

الجدول (1) تصنيف اضطرابات اللغة عند الفصامي

البنود	ترتيب البند
1-إجابات فارغة	21
2- الإنتقال من فكرة إلى أخرى بدون رابط	22
3- خطاب غريب	09
4- تفكير متسرع	25
5- يقدم تداعيات مختلفة لنفس المثير	26
6- إجابات وجيزة	22
7- تداعيات غير شائعة	03
8- تفكير غامض	07
9- خطاب متصنع	45
10-التوقف	02
11- يغير في تداعياته	06
12- إجابات قصيرة	22
13-خطاب مبهم	24
14- فقر مضمون الخطاب	38
15- ميل إلى التجريد.	45

16-لا توجد علاقة بين الكلمات (المثير والإستجابة)	45
17- تفكير مماسي	45
18- تفكير بطيء.	45
19-ألفاظ مجردة	41
20-إجابات خارجة عن السياق	08
21-يعتقد أن له إتصال (علاقة) مع كائنات غير بشرية	19
22-ألفاظ مقولبة	55
23-يكفي تفكيره أو رغبته في الشيء ليصبح حاضراً	45
24- عبارات غير مفهومة	09
25- اعتقاده بقدرته على قراءة أفكار الآخرين	38
26--ألفاظ غير منطقية	12
27-ألبراغماتية- أو الوظوبيه-	04
28-عدم وعيه بما يريد	32
29-قولبات لفظية	01
30-لا يستطيع تفسير ما قيل له	43
31-لا يعالج نواياه - مقاصده -	29
32- كثرة الإستجابات العشوائية	344
33- إستجابات غير منسجمة	09
34- يرى أن مصدر أفعاله قوى غريبة	16
35- زيادة التداخل أثناء المعالجة الفورية للمعلومات	45
36- لا يأخذ السياق بعين الإعتبار	12
37- عدم الإنتباه	20
38- فشل إستعمال إستدلالات لإزالة الغموض	43
39- يعتقد أن تفكيره له مصدر خارجي	18
40- إستدلالات خاطئة عن نوايا الآخرين	18
41- لا يعالج نوايا الآخرين	29
42- صعوبة تمييز المعلومة الملائمة	45
43- سوء تنظيم السلوك	45
44- يعتقد أن خطابه له مصدر خارجي	29
45- ألفاظ غير مكيفة للسياق	32
46-إضطراب تكييف الخطاب للمعلومات السياقية الملائمة (الإنتاج)	55
47- صعوبة تثبيط البنود المتداخلة	36
48- سوء تنظيم الألفاظ	26
49- يرى أفعاله غريبة	55
50- إجابات غير ملائمة	28

51- عدم القدرة على تهجئة كلمة-برتقال- من الأخير إلى الأول	41
52- التدفق:خطاب كثيف و ثري	38
53- عدم القدرة على إهمال المثيرات غير الملائمة	11
54- صعوبة إدراكه لنواياه – مقاصده -	45
55- عدم القدرة على التركيز على منبهات حاسمة (مهمة)	36
56- يعتقد أن إنفعالاته لها مصدر خارجي	15
57- الشرودية	12
58- فرط تمييز كل مثيرات المحيط - الإنقطاع عن العالم –	34
59- الاستجابة بكلمات أحادية المقطع .	55
60- ليس بإمكانه أن يحسب ابتدءاً من 100 مع حذف 7 في كل مرة	60

الجدول (02) الاضطرابات اللغوية العشرة الأكثر شيوعا عند الفصامي

ترتيب البند	البنـــد	الدرجة	النسبة المئوية
01	القولبـات اللفظية	45	11,568
02	التوقف	44	11,311
03	تداعياتـه غير شائعـة	43	11,053
04	(الوظوبيه) أبراغماتية	39	10,025
04	خطاب مبهم	39	10,025
05	يغير تداعياته	38	09,768
07	تفكير غامض	37	09,511
08	إجابات خارجة عن السياق	36	09,254
09	خطاب غريب	34	08,740
09	عبارات غير مفهومة	34	08,740
المجمـوع	×	389	100

3-8- نسب تحقق الفرضيات:

أ) نلاحظ أن نسب تحقق الفرضيات متباينة من فرضية إلى أخرى فقد جاءت فرضيتا "الخطاب غير المنظم" و"عدم معالجة نوايا الذات" في المرتبة الأولى وحققت كل واحد منها نسبة 57,14% ، وفي المرتبة الثالثة جاءت فرضيتين أخريين هما: فرضية "فقدان البعد التصوري للغة" وفرضية "عدم معالجة نوايا الآخرين" وكانت نسبة كل منهما 50,00% .

وفي المرتبة الخامسة نجد فرضية "العجز في بدء الفعل القصدي" بنسبة 44,44% .

وفي المرتبة السادسة فرضيتين هما: "صعوبة معالجة السياق الدلالي" و"إضطراب الإنتباه الإنتقائي" وكانت نسبة منهما بـ 40,00% ، وفي المرتبة

الثامنة والأخيرة جاءت فرضية "فقر الخطاب" بنسبة بـ 33,33% .
ب) كانت معدل نسب تحقق الفرضيات يقدر بـ 46,50% مما يجعله قريب من المتوسط.
ج) هناك أربع فرضيات كانت نسبة تحقق كل واحدة منها يفوق 50% وأربع فرضيات أخرى أقل من 50% . (أنظر الجدول -03-).

8-4- التحليل العام:

يعاني الفصامي من تناذر "التفكك"، حيث يظهر خلل في تماسك الحياة العقلية للفصامي في ذهنه (فكره)، ووجدانيته وسلوكه.

يظهر تفكك الحياة العقلية عند الفصامي من خلال:

- التناقض: إظهار المظهر الموجب والسالب للأفعال النفسية في آن واحد.
- الغرابــة: في السلوك والكلام.
- عدم إمكانية فهمه
- الإنفصـال: حيث يلاحظ عليه الإنزواء وفقدان الإتصال الحيوي مع الواقع والانطواء وعدم قدرته على إستثمار قدراته في مواضيع حب أخرى (النرجسية).

لوحظ أن اضطرابات اللغة عند الفصامي تظهر في مختلف مراحل المرض: سواء مرحلة البداية أو مرحلة المرض والشكل (1) يقدم حصيلة عامة لهذه الإضطرابات.

توجد مفارقة غريبة عند الفصامي حيث تبقى القدرات العقلية على حالها لكن مع عدم الإستطاعة على إستغلالها بشكل جيد.

إن تداعي الأفكار يؤدي إلى آليات غير مفهومة ويأخذ التفكير طابع فوضوي (كارثي)، ويضطرب التفكير في آن واحد في آليته المعتادة وإيقاعه. ويكون إيقاع الكلام سريعاً حيناً، وراكداً حيناً آخر.

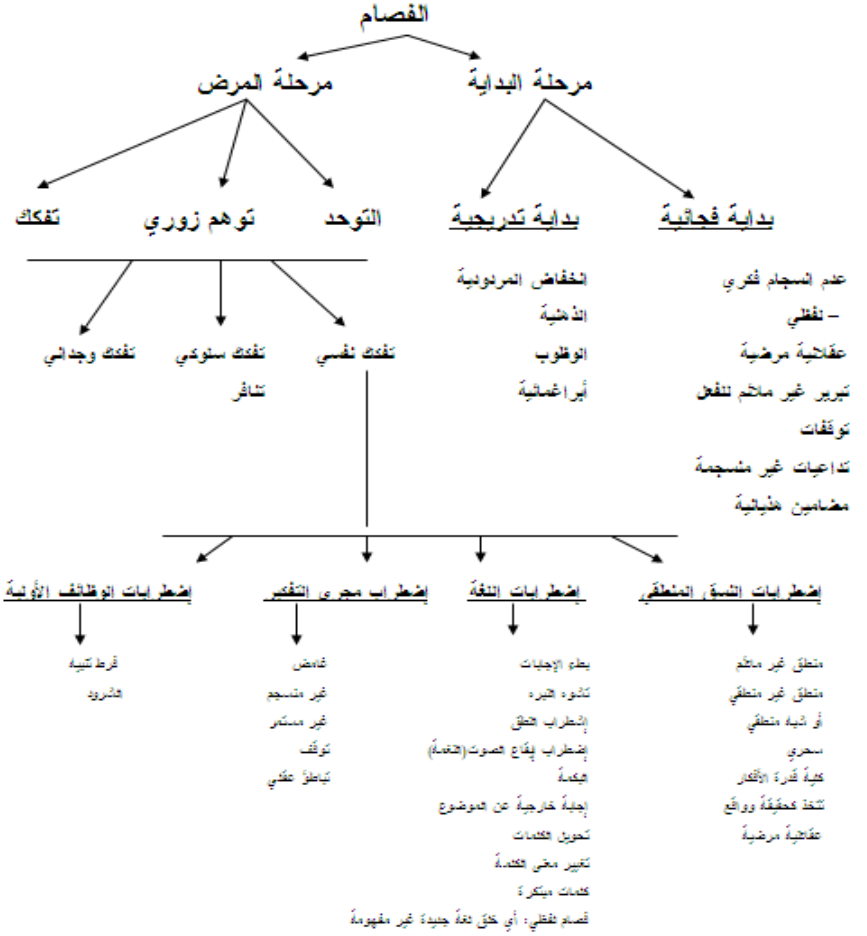
تضطرب اللغة على مختلف الأصعدة: فعلى صعيد الحصيلة اللغوية: ينتج الفصامي كلمات مبتكرة، وفي الحالات القصوى ينتج لغة جديدة مبهمة، كما تفقد اللغة قيمتها كأداة للاتصال، وعلى الصعيد النحوي قد يظهر عنده أسلوب تليغرافي أو أسلوب شبه شعري.

جدول (03) نسب تحقق فرضيات الدراسة

ترتيب الفرضية الإجرائية	مضمون الفرضية	متوسط حسابي	نسبة تحقق الفرضية (%)
01	يعاني الفصامي من خطاب غير منظم	24,57	%57,14
01	لا يعالج الفصامي نواياه الخاصة به	22,57	%57,14
03	يعاني الفصامي من فقدان البعد التصوري للغة	23,62	%50,00
03	لا يعالج الفصامي نوايا الآخرين	23,00	%50,00
05	يعاني الفصامي من عجز في بدء الفعل القصدي	24,22	%44,44
06	يجد الفصامي صعوبة في معالجة السياق	25,4	%40,00

	الدلالي		
06	يعاني الفصامي من اضطراب في الانتباه الانتقائي	18,00	%40,00
08	يعاني الفصامي من فقر الخطاب	29,5	%33,33

الشكل 01 إضطرابات اللغة في مختلف مراحل الفصام



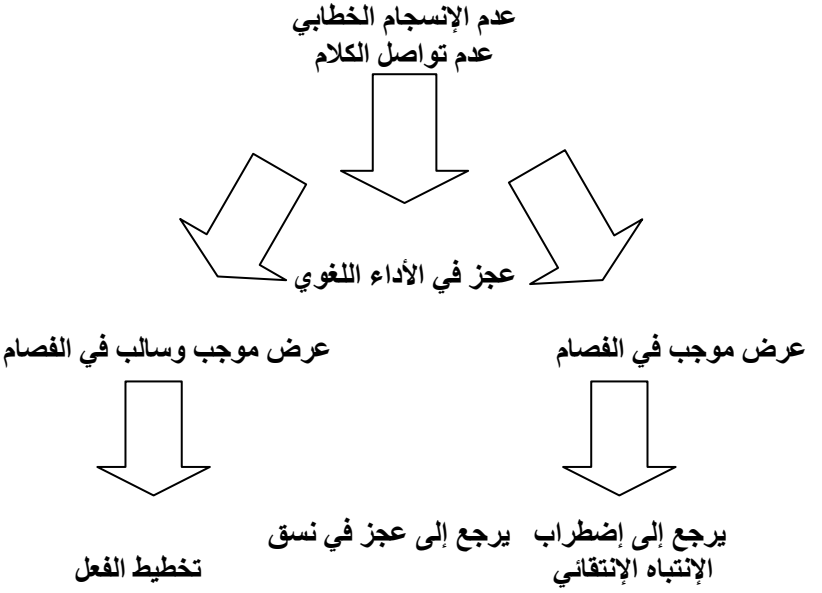
يعاني الفصامي من جملة من الإضطرابات الخطابية فقد تضطرب دينامية الخطاب فيصبح خطاب الفصامي لا يؤدي وظيفته الإتصالية كناقل للمعلومات، فقد تظهر في خطابه إندفاعات لفظية وقد يقدم خطاب أحادي ، وقد يحس بوجود مخاطبين

خياليين، وقد يفتقر مضمون الخطاب فلا يصبح إخبارياً ، ولا يستعمل كأداة إتصال متبادل، فقد يكون خطابه متدفقاً لكنه فقير على مستوى المضمون، وقد يصبح خطاب الفصامي غير مفهوماً شكلا ومضموناً حيث يبدو غير مرتب، وغامض، ومشوش، وغير منطقي، وغالباً ما يحتوي على رطانة لا يفهمها سوى المريض نفسه، وقد يصل الحال بالفصامي إلى خلقه للغة جديدة يسميها العلماء المختصون "الإبتكار اللغوي".

إلى جانب هذه الإضطرابات في الخطاب اهتم العلماء خاصة باضطراب آخر أعطوه أهمية وأولوية في دراستهم هو: "عدم إنسجام الخطاب" أو عدم تواصله.

يرجع العلماء "عدم إنسجام الخطاب" إلى عجز في الأداء اللغوي وليس إلى عجز الكفاءة اللغوية ، ويرى البعض منهم أن "عدم الإنسجام الخطابي" هو عرض موجب في الفصام مصدر إضطراب الإنتباه الإنتقائي، والبعض الآخر يرى أنه عرض موجب وسالب في آن واحد وفي هذه الحالة يكون مصدر عجز في نسق تخطيط الفعل (أنظر الشكل - 02-).

الشكل 04: مصدر عدم انسجام الخطاب عند الفصامي



الخاتمة

منذ التوصيفات الإكلينيكية الأولى الذي أجرها (كرابلان) سنة 1919 حول الفصام كان هناك تلميح إلى وجود تدهور معرفي عند الفصاميين، واعتبر هذا التدهور آنذاك كإضطراب ثانوي مصدره الهلوسات أو وجود المريض داخل المؤسسة الإستشفائية العقلية. ومع تطور البحوث في الفصام بينت الدراسات الوبائية أن ما يفوق 85% من الفصاميين يعانون من إضطرابات معرفية تظهر عندهم منذ الأعراض الأولى للمرض.

إن التقييم العصبي-النفسي للوظائف المعرفية أظهرت أن الفصاميين يعانون من صعوبات الذاكرة والإنتباه، والتعلم ومعالجة المعلومات لكن يبقى الإضطراب المركزي هو إضطراب تخطيط الفعل. المسؤول عن سوء تنظيم الخطاب.

إن معظم الأفعال وحالات الإتصال تتطلب الإنتباه وأي عجز في انتقاء المعلومات يؤدي إلى سوء تنظيم الفعل والإتصال، إن سوء التنظيم الفصامي راجع إلى عدم إستيعاب المعطيات السياقية الدلالية مما يؤدي إلى سوء تكييف الفعل مع سياقه.

لقد ظهر نموذج معرفي مفسر للفصام، مصمّم من طرف (فريث) وهو يعطي دور مهم لإضطرابات الوعي في ظهور أعراض الفصام، حيث يعاني الفصامي من إضطراب التصور الواعي لأهدافه مما يؤدي إلى إضطراب في:

- التحكم في الفعل: ويظهر ذلك من خلال تقليص وعدم تنظيم الفعل.
- التحكم في نواياه : ويظهر من خلال الأعراض السالبة ونقص التحكم في الخبرات غير السوية.
- التحكم في نوايا الآخرين: ويظهر من خلال الأفكار التوهمية التي تكون أوهام الأشارة للذات أو الإضطهاد.

إن المريض الفصامي لا يعي نيته الأولية في الفعل الذي يقوم به فينسبه إلى الآخرين مما يؤدي إلى ظهور تناذر السكونية وأفكار الأشارة للذات والهلوسات السمعية وإلى جانب نموذج (فريث) ظهرت أيضا نماذج تفسيرية أخرى للفصام منها نموذج "كوهين" و"سارفن-شربير"، الذي يقوم على فرضية أن العجز المعرفي عند الفصامي يظهر في كل مرة تتطلب الإستجابة فيه تكوين أو الإحتفاظ بتصور داخلي للسياق.إن إضطراب التصور الداخلي للسياق قد يفسر لوحده كل الإضطرابات المعرفية التي تظهر عند الفصامي، وأهم الإضطرابات المعرفية التي يركز عليها أصحاب هذا النموذج نجد إضطرابات: الإنتباه، وذاكرة العمل واللغة.

إن الإنتاج الخطابي يستدعي تصور الشخص لمعنى فعله (لهدف منه)، ومعالجة الوضعية سياقياً، وإعطاء مضامين عقلية وانتباهية للآخر (نظرية العقل) بغية تكييف خطابه مع هذا "السياق". يتمثل تصور الهدف، على الصعيد اللغوي، في المعنى الذي ينتجه أو يهدف إلى إنتاجه، إن إضطراب إدراك الفصامي للغاية المقصودة من أفعاله قد يكون مصدر لإضطرابات الإتصال عنده. إن الارتباط بين "وضوح الفعل" والقدرة

على الاتصال، هو ما يجعل أي اضطراب في العمليات المسئولة عن تسيير الأفعال والنوايا يؤثر على القدرة على الاتصال عند الفصامي.

لقد ثبت علمياً أن الاضطرابات المعرفية جزء من الفصام وهي ترتبط بالعجز الوظيفي فيه ، فالأعراض السالبة مرتبطة بنقص الكفاءات الاجتماعية والوظيفية. لقد لاحظ الباحثون أن الاضطراب المعرفي غالباً ما كان مرتبط بالأعراض السالبة للفصام فقط، أي أنهم لم يجدوا ارتباط بين الأعراض الموجبة للفصام والاضطرابات المعرفية فيه. وفي الأخير وجدوا ارتباط بين الأعراض السالبة والموجبة معاً والاضطرابات المعرفية.

إن التعاون بين مختلف العلوم النفسية: خاصة بين "علم النفس المرضي"، و"علم النفس المعرفي" و"علم الأعصاب النفسي"، كفيل بأن يساعد على فهم أحسن للفصام وأعراضه.

10- الاقتراحات والتوصيات:

أ- الاقتراحات: فيما يلي سأقترح مجموعة من المواضيع والدراسات التي يمكن أن يساهم بها الباحث في مجال اللغة والمرض النفسي.

1 - الانسجام الحواري عند المتصل الفصامي.
2 - وظوب الخطاب عند الفصامي.
3 - عدم انسجام الخطاب عند الفصامي.
4 - مقاربة بيثقافية لاضطرابات اللغة عند الفصاميين.
5 - مقاربة معرفية لاضطرابات الذاكرة وتأثيرها على اللغة عند الفصامي.
6 - الأساليب المعرفية واللغة عند الفصاميين.
7 - وظوبية اللغة عند المتوحين.
8 - المؤشرات اللغوية في الخطاب التوهمي عند المتوحدين.
9 - المؤشرات اللغوية الفارقية بين المرضى العقليين: الفصام والتوحد والبارانويا نموذجاً.
10 - الفعل الكتابي عند الفصامي.
11 - الفعل الكتابي عند التوحدي.
12 - الفعل الكتابي عند المكتئب.
13 - المقاربة المعرفية واللسانية لاضطرابات اللغة عند المكتئب.
14 - تصميم مقياس الذاكرة عند الفصامي.
15 - تصميم مقياس الكتابة عند الفصامي.
16 - اضطراب الانتباه الانتقائي وتأثيره على اللغة عند الفصامي.
17 - اضطراب الانتباه الانتقائي وتأثيره على اللغة عند المتوحد.

ب- التوصيات:

هذه بعض التوصيات التي يمكن أن تستخلص من هذه الدراسة:

- ✓ ضرورة إهتمام الباحثين بالإضطرابات اللغوية التي تظهر عند المرضى النفسيين وخاصة الفصاميين والمتوحدين..
- ✓ الإهتمام أكثر بالمدرسة المعرفية في مجال العلوم المعرفية لأن هذه المدرسة ثرية جداً وبوسعها تقديم معلومة جد مفيدة وجديدة عن الاضطرابات اللغوية.

- ✓ إمكانية العلاج المعرفي للفصاميين بالاعتماد على نتائج الدراسات حول الحبسة،وبالأخص بحوث نصيرة زلال (الجزائر) نظراً للتشابه العرضي- المعرفي بين الفصام وبعض أنواع الحبسة.

Abstract:

Language Disorders Among the patients with Schizophrenia.

Bofeleh Bokhmees.

The study is examining the changes in language of schizophrenic patients, reviewing some concepts in the field like C. Frith model which suggests that the process underlying action could be involved in the cognitive abilities, also the basic cognitive disorder is an intention process disorder. While E. Bleuler emphasized the central cognitive mechanisms and thoughts, but Chapmen postulated a deficit in the general function of action planning.

The paper will try to answer the following questions:

1- What are the linguistic problems in schizophrenic patients?
2- Do the schizophrenic patients present (a logia) and (deficit of action planning)?.
3- Can the schizophrenic patients deal with their intentions and the intention of other persons?
4- What is the degree of impairment in their selective attention?

The author has constructed an instrument called (Schizophrenic language inventory) it containes 148 Items, of which 60 items where used in this study.

After the analysis of the results we came to the following conclusions:

- Verbal association problems, verbal stereotypy, thought blocking and perseveration.
- Bizarre and vague language.
- Incomprehensible and illogical expression.
- Deficit in dealing with his intentions and the intention of others.

- A difficulty in selective attention.

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الدكتور بوفوله بوخميس

علم النفس الأكلينيكي

جامعة عنابة – الجزائر

boufoulub@yahoo.fr.

نشرة الإتحاد

المجلد التاسع عشر ، العدد الثاني تشرين ثاني (نوفمبر) 2008

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المحتويـــــــــات

الأخوات والأخوة الأطباء النفسيين العرب

تحية واحترام

لقد عصفت بإتحادنا رياح صيفية أدت لتكرار إنعقاد المؤتمر العربي في القاهرة ودمشق في الصيف الماضي بعد توقف انعقاد المؤتمر لسنوات ، وباعتقادي أن النوايا كانت حسنة ولكن مجموعة من الأخطاء الغير مقصودة أدت لحدوث هذا الانقسام الشكلي ، أما المضمون والجوهر فما زال يحمل الكثير من الخير والطموح والأمل في تطوير هذه المهنة وخدمة أعضاء الإتحاد وخدمة المريض العربي من المحيط إلى الخليج .
ومن منبر المجلة العربية للطب النفسي التي أنهت العشرين عاماً وهي العمل الدائم المستمر المثمر لهذا الإتحاد ، فإنني أوجه الدعوة للقاء القادم في المؤتمر العربي دون العودة للنقاش في ما حصل ومن أخطأ ومن أصاب ، فالمسيرة الكبرى لابد أن تمضي ، ولكن كثرة القال والقيل لن تساهم في أي شكل من الأشكال في تعزيز قوة الإتحاد . وإذا كان هناك من شيء يمكن عمله لمنع تكرار الأخطاء فهو بكل بساطة تطوير النظام الداخلي للإتحاد بالصورة التي تكفل سير أعماله دون إشكالات ، وبدون شك أن تطور عمل الإتحاد سيحتاج دائماً وأبداً لتطوير النظام الداخلي كل بضع سنوات على الأقل .
ولتكن التجربة الأخيرة دافعاً لنا لمزيد من الجهد الموحد لتطوير الإتحاد وتعزيز نشاطاته بكل الوسائل المتاحة والممكنة .

واقبلوا مني كل الاحترام والتقدير والمحبة

وليد سرحان

محضر اجتماع الجمعية العمومية
لإتحاد الأطباء النفسيين العرب
المؤتمر العاشر 18-20 يونيو 2008م القاهرة.

عقد الاجتماع العام للجمعية العمومية في فندق سمير أميس انتركونتنتال في القاهرة في قاعة طيبة الساعة السابعة مساءاً من يوم الخميس الموافق 2008/06/19م , وقد حضر ممثلو الدول العربية المختلفة من مصر والسعودية وقطر والأمارات وعمان والأردن والسودان وليبيا وتونس واليمن ولبنان والعراق , وقد افتتح سعادة رئيس المؤتمر ورئيس الاتحاد الأستاذ الدكتور / أحمد عكاشة الاجتماع:

أولاً: قام رئيس المؤتمر ورئيس الاتحاد الأستاذ الدكتور / أحمد عكاشة بتأبين الأستاذ الدكتور طه بعشر (رحمة الله) أستاذ الطب النفسي في السودان والدعاء له بالرحمة.

ثانياً : تم تقديم التهنئة لسعادة الأستاذ الدكتور / أحمد عكاشة بمناسبة حصوله على جائزة الدولة التقديرية في العلوم الطبية.

بعد ذلك تم الترحيب بالحضور وتسجيلهم حيث حضر وفود من اثني عشر دولة عربية سواء من الأفراد أو رؤساء الجمعيات وهم كالتالي: رئيس الجمعية المصرية ورئيس الجمعية العراقية ورئيس الجمعية التونسية ورئيس الجمعية الليبية ورئيس الجمعية اليمنية ورئيس الجمعية السودانية وأفراد من كل من الدول الأخرى لبنان والسعودية والأردن وقطر والأمارات وعمان ويعتبر هذا المؤتمر العاشر لإتحاد الأطباء النفسيين العرب الذي عقد في القاهرة هو أوسع وأشمل مؤتمرات الاتحاد على مدار تاريخه تمثيلاً في الجمعية العمومية.

حيث تعتبر الجمعية العمومية هي الهيئة العليا والسلطة الأولى العليا للاتحاد فهي التي تنتخب المجلس الإداري والذي بدوره ينتخب اللجنة (المجلس) التنفيذي.

وبهذا فقد بدأ الاجتماع بمناقشة جدول الأعمال كما هو محدد واتخذ القرارات التالية:

أولاً : قدم الأمين العام الأستاذ الدكتور عبد الرزاق الحمد تقريره عن الفترة من 2001م وحتى 2008م مبيناً ما يلي:

أ- التأخر الذي حدث جراء عدم انعقاد المؤتمر العام في العراق بسبب الظروف المعنية.
ب- التأخر الذي حدث جراء تأجيل انعقاد المؤتمر العام في الجزائر ثلاث مرات والإجراءات التي تمت لنقل المؤتمر من الجزائر إلى سوريا.
ت- عرض سعادته بالتفصيل الوثائق من الرسائل بما بين بشكل قاطع لا يدع مجالاً للتشكيك بأن سعادة الدكتور أديب / أديب العسالي كان هو السبب في تعطيل المؤتمر في دمشق ونقله إلى القاهرة وكل الوثائق موجودة لمن يريد الإطلاع عليها.

ثانياً: قدم سعادة الأستاذ الدكتور / عدنان التكريتي المشرف على تحرير المجلة العربية للطب النفسي تقريره عن ذلك وأشار إلى ضرورة:-

1) دعم المجلة بالمقالات.

2) دعم المجلة بالاعتراف بها في الجامعة العربية للترقية.
3) اختيار مساعد للتحرير لتهيئته ليكون محرر المجلة مستقبلاً.

ثالثاً: تم تشكيل مجلس الإدارة الجديدة من كل الدول المشاركة وذلك كالتالي:-

السعودية: أ.د. طارق الحبيب (حضر)
د. أحمد الهادي (حضر)
مصر: د. مصطفى فهمي (حضر)
د عارف خويلد (حضر)
لبنان: د. إيلي كرم (حضر)
د. عادل عقل (حضر)
ليبيا: أ.د. علي الرويعي (حضر)
د. عادل الحويرسي (حضر)
اليمن: أ.د. عبدالله عبدالوهاب الشرعبي (حضر)
أ.د. نبيل أحمد نعمان (حضر)
قطر: د. نجلاء الحاج (حضر)
د. ماجد العبدالله (لم يحضر)
السودان: د. عبدا لعزيز أحمد عمر (حضر)
د. عبد الغني الشيخ عبد الغني (حضر)
الأردن: د. عدنان التكريتي (حضر)
د. وليد سرحان (لم يحضر)
الأمارات: د. فاطمة المنصوري (حضر)
د. حسين عطية (حضر)
تونس: أ.د. الحكيم الجدي (حضر)
أ.د. عفيف بوسته (حضر)
العراق: د. محمد لفتا (حضر)
د. جمال عمر (حضر)
سوريا: د. أديب العسالي (لم يحضر)
د. حنا خوري (لم يحضر)
المغرب: د. نادية قدري (لم يحضر)
عمان: د. علاء الحسيني (لم يحضر)
د. مروان الشرباتي (حضر)
الجزائر: د فريد كاشو (لم يحضر)
الكويت: د. علي الزايدي (لم يحضر)
د. عصام الأنصاري (لم يحضر)
فلسطين: د. بسام الأشهب (لم يحضر)

د. عبد العزي ز ثابت (لم يحضر)
البحرين: د. أحمد الأنصاري (لم يحضر)
د. طارق معداوي (لم يحضر)
موريتانيا: لم يستحضر الأخوة أحداً معيناً.
الصومال: لم يستحضر الأخوة أحداً معيناً.

رابعاً: تم اقتراح تعديل قانون الإتحاد بالتصويت على ذلك وتم الاتفاق على ما يلي :-

1) أن يكون في المجلس التنفيذي ممثلا للعلاقات الدولية وآخر للعلاقات العربية.
2) أن يكون هناك منسقين للاتحاد ليسوا أعضاء في المجلس التنفيذي ولكن يتواصلون معه لكل الأطباء النفسيين العرب في أمريكا وأوروبا وغيرها.
3) أن يدخل أعضاء من الدولة الأخرى الغير ممثلة بعدد ثلاثة لكل دورة في المجلس التنفيذي ويكون لهم حق التصويت.

خامساً: تم انتخاب أعضاء المجلس التنفيذي وذلك كالتالي:-

أعضاء اللجنة التنفيذية

أ.د. أحمد عكاشه الرئيس
أ.د. عبد الرزاق بن محمود الحمد الأمين العام
أ.د. ممتاز عبد الوهاب الأمين العام المساعد
أ.د. مصطفى شاهين المستشار المالي
أ.د. الصديق جدى (تونس) مستشار الشئون العربية
أ.د. إيلى كرم (لبنان) مستشار الشؤو ن العلمية
أ.د. طارق الحبيب (السعودية) مستشار المؤتمرات العلمية
أ.د. طارق أسعد (مصر) مستشار التحرير
أ.د. على الرويعى (ليبيا) عضو اللجنة التنفيذية
أ.د. عبدالله الشريعى (اليمن) عضو اللجنة التنفيذية
أ.د. عبد الله عبد الرحمن (السوادن) مستشار الشئون العربية
أ.د. عدنان التكريتي (الأردن) رئيس تحرير المجلة
أ.د. محمد رشيد لافته (العراق) عضو اللجنة التنفيذية
أ.د. يسرى عبد المحسن (مصر) مستشار العلاقات الدولية

تم إختيار منسقين ليسوا أعضاء في المجلس التنفيذي وهم:

أ.د. ممدوح العدل منسق الأطبا ء العرب البريطانيين
أ.د. سهام منتصر منسق الأطباء العرب الأمريكيين
أ.د. البير طانيوس منسق الأطبا ء العرب الفرنسيين

أ.د. جمال التركى منسق الموقع الإلكتروني

سادساً : تمت مناقشة موضوع المؤتمر الحادي عشر العام المزمع عقده في عام 2010 م وقد تقدمت لاستضافة المؤتمر كل من السودان والأمارات (أبو ظبي) والسعودية. وتم الاتفاق بعد التصويت على أن يكون المؤتمر الحادي عشر في السودان في منتصف عام 2010م. وإذا لم يمكن ففي الأمارات (أبو ظبي) وإذا لم يمكن ففي السعودية.

ثامناً: ناقش المجتمعون موضوع الشعب وتطويرها واتفق الأعضاء على أن يترك ذلك للمجلس التنفيذي.

تاسعاً: تمت مناقشة موضوع المؤتمر المعلن عنه من قبل الدكتور / أديب العسالي باسم الحادي عشر واتفق الجميع على ما يلي:-

أ- العرض على د. أديب العسالي أن يكون مؤتمره إما استثنائياً بمناسبة أن دمشق عاصمة الثقافة العربية أو فرعياً (امتداداً) للمؤتمر العاشر في القاهرة , ولا يكون المؤتمر الحادي عشر واتفق الجميع على الكتابة لسعادة د. أديب بذلك.

واختتم الاجتماع في تمام الساعة التاسعة والنصف مساءاً.

الأمين العام للإتحاد
أ.د. عبد الرزاق الحمد

رئيس الإتحاد

أ.د. أحمد عكاشة

أسم الشعبة	الرئيس المقترح	E-mail	البلد
القيم و أخلاقيات المهنة	أ.د. محمد رشيد لفتا	muh1215@yahoo.com	العراق
الطب النفسي والأطفال الناشئة	أ.د. أميرة سيف الدين	amira@contact.com.eg	مصر
الطب النفسى و المرأة	أ.د. نادية قدرى	n.kadri@menara.ma	المغرب
الطب النفسى البيولوجي	أ.د. هشام رامى	hishamramy@excite.com	مصر
الطب النفسى المجتمعي	أ.د. أحمد عبد اللطيف	ahlamis_52@yahoo.co.uk	مصر
الطب النفسى القضائى و الشرعى	أ.د. قتيبة شلبى	chaleby@hotmail.com	العراق
الطب النفسى العسكرى	لواء طبيب حسين مرسى	dr_husseinmorsy@yahoo.com	مصر
طب نفس المسنين	أ.د. عبد المنعم عاشور	amashour@hotmail.com	مصر
سوء إستخدام المواد (الإدمان)	أ.د. طارق عبد الجواد	tarekgawad@mac.com	مصر
اضطرابات النوم و اليقظة	أ.د. طارق أسعد	drtarekasaad@yahoo.com	مصر
الأمراض النفسجنسية	أ.د.ممدوح العدل	Mamdouh.ElAdl@nht.northants.nhs.uk	بريطانيا
البحوث العلمية	أ.د. إيلى كرم	egkaram@idraac.org	لبنان

العلاج النفسى	أ.د. عبد الرزاق الحمد	alhamad@ksu.edu.sa	السعودية
الدين و الطب النفسى و الصحة النفسية	أ.د. طارق الحبيب	thabeeb@ksu.edu.sa	السعودية
التدخل المبكر فى العلاج النفسي	أ.د. صديق الجدى	Essedik.jeddi@gmail.com	تونس
التعليم الطبى	أ.د. عماد غز	emadhamdi@doctors.org.uk	مصر
العلوم النفسية والمعلوماتيّة و الاتصالات و النشر الإلكتروني	أ.د. جمال التركى	turky.jamel@gnet.tn	تونس
الطب النفسى و الإبداع و النقد	أ.د. يحيى الرخاوى	yehiatrakhawy@hotmail.com	مصر
الطب النفسى عبر الثقافات	أ.د. فاروق لطيف	vinamoha93@yahoo.com	مصر
التحرير و النشر	أ.د. وليد سرحان	sarhan@nets.com.jo	الأردن

اتحاد الاطباء العرب
الامانة العامة – القاهرة

السيد الأستاذ الدكتور / أحمد عكاشة
رئيس اتحاد الأطباء النفسيين العرب
تحية طيبة وبعد.. وكل عام وانتم بخير

بعد دراسة الموقف الحالي لاتحاد الأطباء النفسيين العرب وفقا للظروف الراهنة من خلال ما ورد لنا من مخاطبات من كلا من:
أ.د احمد عكاشة / الرئيس الحالي لاتحاد الأطباء النفسيين العرب
أ.د سعيدة الدوقي / الرئيس السابق لاتحاد الأطباء النفسيين العرب
فان الإدارة القانونية للأمانة العامة لاتحاد الأطباء العرب تود أن توضح لسيادتكم ما انتهت إليه الدراسة فيما يلي:
خطاب أ.د سعيدة الدوقي قد جاء من غير ذي صفة نظرا لانتهاء فترة رئاستها للاتحاد والمعني بالأمر هو الأستاذ الدكتور / عبد الرزاق الحمد .. الأمين العام لاتحاد الأطباء النفسيين العرب طبقا لنص المادة السادسة من قانون اتحاد الأطباء النفسيين العرب، ومع ذلك فان ما جاء في خطابها غير صحيح ونلخص تصحيحه في الآتي...

1- الدعوة لعقد الجمعية العمومية لاتحاد الأطباء النفسيين العرب بالقاهرة قد جاءت صحيحة لما يلي:
أ_ تعذر إقامتها بدمشق طبقا لما ورد باجتماع الجمعية العمومية للاتحاد بالقاهرة
ب_ لم ينص قانون الاتحاد على ضرورة عقد الاجتماع بنفس الدولة قبل انعقاده بباقي الدول العربية

2_ إن انتخاب أ.د أحمد عكاشة لم يخالف قانون اتحاد الأطباء النفسيين العرب لما يلي:
أ_ نص قانون الاتحاد على انه يجوز عند اقتضاء الحاجة عقد اجتماع في أي وقت بطلب ممثلي ثلاث بلدان على الأقل من أعضاءه على أن يكون بدعوة من الأمين العام للاتحاد وهذا ما حدث.

ب_ لم ينص قانون الاتحاد على ضرورة أخذ رأي أعضاء المجلس التنفيذي السابق للاتحاد في الانتخابات

3_ إن الاجتماع الذي عقد في دمشق غير شرعي لأنه لم يعقد بناء على دعوة أو حضور من الأمين العام الحالي لاتحاد الأطباء النفسيين العرب طبقا لنص المادة السادسة من قانون الاتحاد.

4_ عدم شرعية الانتخابات التي أجريت في اجتماع دمشق لكونه إن كان من المفترض كون الاجتماع صحيح أن يكون الرئيس هو أ.د أديب العسالي من سوريا وليس أ.د ناصر لوزه طبقا لنص المادة الثالثة من قانون الاتحاد.

5_ إن الأمانة العامة لاتحاد الأطباء العرب لم تعرف بوجود كيان لاتحاد الأطباء النفسيين العرب سوى من خلال طلب تسجيل مقدم من أ.د أحمد عكاشة بصفته رئيس اتحاد الأطباء النفسيين العرب بعد استيفائه لأوراق التسجيل وسداد الاشتراك المقرر

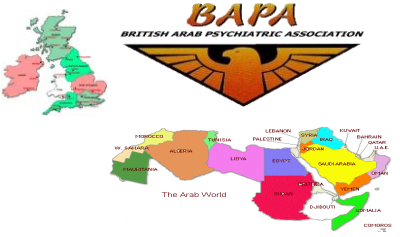
لذلك فإننا نرى الآتي

ان الاتحاد الحالي للأطباء النفسيين العرب هو الرابطة المعترف بها من اتحاد الاطباء العرب برئاسة أ.د أحمد عكاشة والجمعية العمومية المنعقدة في القاهرة لها شرعيتها التامة طبقا لما ورد بنصوص قانون اتحاد الاطباء النفسيين العرب

ولسيادتكم وافر التحية والاحترام

مدير الإدارة القانونية
أ. سامي عبد العليم

تحريرا في 2008/9/29



President:
Dr Saleh EL-Hilu
Consultant Psychiatrist & Clinical Director, Hallam street hospital, West Bromwich, West Midlands B17 4NH, UK.
Tel: Work +44 – 0121 – 6128661
Mob. +44 – 07973273816
Fax: +44 – 0121 – 6128654
Sami.el-hilu@SMHSCT.nhs.uk
smhilu@hotmail.com

Secretary:
Dr Mamdouh EL-Adl
Consultant Psychiatrist,
Campbell House, Campbell Square, Northampton NN1 3EB, UK
Tel: Work +44 – 01604 – 658800
Mob. + 44 – 07713077092
Fax: +44 – 01604 – 658958
mamdouh.eladl@nht.northants.nhs.uk

Treasurer:
Dr Ahmed Mahmoud
mahmoud.s.ahmed@hotmail.com

Scientific Officer:
Dr Ahmed Mahmoud
amah161063@aol.com

Public Relation:
Dr Ahmed Soliman
drasoliman@blueyonder.co.uk

Career Grade:
Dr Adel Sobeih
adelsobeih@hotmail.com

Trainees Rep.:
Dr Dina Munim
dinamunim@yahoo.com

Ex-president:
Dr Tarek El-gohary

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دعوة إلى الوحدة

السادة الأساتذة والأطباء النفسانيين العرب
في العالم العربي وفى المهجر

الأخوة والأخوات– الزملاء والزميلات

عقد مجموعة من الأطباء النفسانيين العرب المهتمين بوحدة الصف اجتماعا في مساء السبت 4 أكتوبر2008
وقد شارك في هذا الاجتماع كل من:

1. د. صالح الحلو – رئيس جمعية الأطباء النفسانيين العرب في بريطانيا – فلسطين
2. د. طارق الجوهرى – رئيس جمعية الأطباء النفسانيين العرب في بريطانا سابقا – مصر
3. ا.د. محمد أبو صالح – أستاذ الطب النفسي – لندن– سوريا
4. د. طارق الكبيسى – استشاري الطب النفسي – بريطانيا – العراق
5. د. أحمد سليمان – استشاري الطب النفسي – بريطانيا – مصر
6. د. محمد عيد – استشاري الطب النفسي – بريطانيا – مصر
7. د. خليل عاجل – استشاري الطب النفسي – بريطانيا– العراق
8. د. ممدوح العدل – استشاري الطب النفسي – بريطانيا – مصر

وقد اتفق الحاضرون على أن من واجب جميع الأطباء النفسانيين العرب أن يضعوا وحدة الصف على أعلى
أولوياتهم. ولهذا اتفق الجميع على أن المؤتمر الشام ل لاتحاد الأطباء النفسانيين العرب الذي يعقد كل سنتين حسب لائحة الاتحاد يجب أن يكون في مكان واحد يجمع عليه الجميع منعا لتكرار ما حدث هذا العام بتنظيم مؤتمرين الأول بالقاهرة والثاني بدمشق مما ترتب عليه آثار سلبية من انقسام والتباس في الرأي والرؤية.
وإذ تؤكد جمعية الأطباء النفسيين العرب في بريطانيا على موقفها المحايد وعلى رغبتها القوية في التعاون والعمل المشترك مع كل أطباء النفس والمتخصصين في مجال الصحة النفسية ومع الجمعيات المناظرة في العالم العربي وخارجه إلا أننا نؤيد انعقاد المؤتمرالعربى الشامل القادم في السودان لتزامنه مع المؤتمر الأفريقي الشامل للطب النفسي المقرر عقده بالسودان في عام 2010 تكريما للسودان واعتزازا بقارة أفريقيا.

وبناء عليه نطالب الجميع ألا يسمحوا بتنظيم أي مؤتمر آخ ر يحمل هذه الصفة إلى أن يتم انعقاد المؤتمر القادم في 2010

وبهذا نأمل أن نحافظ على وحدة صف الأطباء النفسانيين العرب وعلى المصلحة العليا لكل الأطباء النفسانيين والتخصصين في مجال الصحة النفسية العرب ومهنتنا وأمتنا.
ونحن جميعا نتطلع إلى الدعم والتعاون والايجابية والارتقاء لمستوى المسئولية من:

- كل الأطباء النفسانيين العرب في العالم العربي والمهجر.
- كل جمعيات الطب النفسي العربية في جميع البلدان العربية والمهجر.

مع خالص الاحترام والتقدير

ممدوح العدل
الأمين العام لجمعية الأطباء النفسانيين العرب في بريطانيا

All Correspondence to BAPA secretary: Dr M EL-Adl

The 5th International Conference on Psychiatry
"*Challenges in the Outcome of Psychiatric Disorders*"
Intercontinental Hotel, Jeddah, Kingdom of Saudi Arabia,
21 – 23 April 2009

In Collaboration With

Al-Amal Hospital - Jeddah

Egyptian Psychiatric Association

World Psychiatric Association

Institute of Psychiatry Ain Shams University Cairo

Federation of Societies of Biological Psychiatry

Arab Federation of Psychiatrists

الأخوة الزملاء،،،،

أتمنى أن تكونوا قد تمتعكم بعيد سعيد.

لقد اتفقت مع ا.د. عبد الرزاق الحمد على محاولة عقد اجتماع للجنة التنفيذية لإتحاد الأطباء العرب و رؤساء الشعب المتخصصة على هامش المؤتمر العالمي للمستشفى السعودي الألماني في جدة في الفترة من 21–23 إبريل 2009 و قد تكرم أ.د. طارق الحبيب أمين المؤتمرات العلمية بالإتحاد بالتنسيق مع د. محمد خالد سكرتير عام هذا المؤتمر لعمل الترتيبات اللازمة للحصول على تأشيرة السفر إلى السعودية (جدة) وعلى من يريد الاشتراك علميا في هذا المؤتمر من رؤساء الشعب أو من يريد فقط حضور اجتماع اللجنة التنفيذية للإتحاد من أعضاء اللجنة التنفيذية الاتصال بالدكتور محمد خالد على البريد الإلكتروني moh.khaled.hamed@gmail.com و إلى الراغبين في الاشتراك برجاء إرسال صورة من الخطاب المرسل إلى الدكتور محمد خالد إلى رئيس الإتحاد و الأمين العام و أ.د. طارق الحبيب.

مع تحياتي و تقديري

أ.د. أحمد عكاشه

Prof. Ahmed Okasha,
M.D., PhD, F.R.C.P., F.R.C., Psych., F.A.C.P (Hon.)
Prof. and Director of WHO Collaborating Center
For Research and Training in Mental Health
Institute of Psychiatry, Ain Shams University
President Egyptian Psychiatric Association
President Arab Federation of Psychiatrists
Past President WPA
Member of WPA Council
3, Shawarby street , Kasr El Nil
Cairo – Egypt
Tel : ++(202) 29200900 ,1,2,3,4,5,6
Fax: ++((202) 29200907-29200908
E-mail: aokasha@internetegypt.com
Website :www.okashahospital.com

Dear Colleagues

It is our great pleasure to invite you to participate in the 5th International Conference on Psychiatry, organized by Saudi German Hospital (SGH)-Jeddah, Al-Amal Hospital – Jeddah, Saudi Psychiatric Association (SPA) and British Arab Psychiatric Association (BAPA).

Conference theme: "**Challenges in the Outcome of Psychiatric Disorders "**
Venue: Intercontinental Hotel, Jeddah, Kingdom of Saudi Arabia
Date: 21 – 23 April 2009

Mental disorders are highly prevalent, heterogeneous, and of multifactorial etiology. Collectively, they are associated with significant morbidity, mortality, and economic cost. Wellness is the optimal outcome in the management of chronic medical and psychiatric disorders.

Recently there has been a growing awareness of the importance of the outcome in the management of psychiatric disorders.

We aim is to present and discuss comprehensive updated knowledge in the field of psychiatry. We believe this conference is a wonderful opportunity for Arab expertise within the Arab World & across the globe to exchange experience, network & plan for future collaborative activities. We hope to conclude practical achievable directions for improving psychiatric services in our region for the near future.

The conference main speakers will be opinion leaders in the field of psychiatry as well as policy and decision makers. We also welcome new research & submissions from senior colleagues & trainees.

In our three days' conference you will enjoy the Academic, Social & Spiritual aspects of the programme. In addition you will definitely enjoy the well-known Arabic hospitality.

Dr. Mohammed Khaled

Secretary General of conference

Guidelines for abstract submission:

Deadline for submission: 01.01.2009

Registration Fees:

- **Early registration (before 31.02.2009**): 60 $ or 200 Saudi Riyal

- **After 31.01.2008**: 70 $ or 250 Saudi Riyal
- **For each training course (workshop):** 30 $ or 100 Saudi Riyal

Congress Secretariat

Dr. Mohamed Khaled	**Secretary general of the congress**
Tel.	00966-507377541
Fax.	00966-2-6835874
E-mail	psy1.jed@sghgroup.net moh.khaled.hamed@gmail.com

كلمة المحرر

حضرة الزميل العزيز

تستهل المجلة عامها العشرين وهي تواظب على إصدارها مرتين في السنة.

لقد كان هنالك جو من التفاؤل والإصرار على دعم المجلة من قبل الزملاء, خلال انعقاد المؤتمر العاشر للطب النفسي في القاهرة, واعتقد أن المجلة بحاجة إلى هذا الدعم من حيث الكم والنوع, وهناك جهود لمزيد من الفهرسة العلمية حتى تصبح المجلة قادرة على المنافسة العالمية واستقطاب المادة العلمية الجديدة إليها وبالتالي زيادة الأعداد المنشورة سنويا.

ولاشك أن لكل زميل دور في دعم المجلة بالنشر بشتى الأساليب. إن الارتقاء بالمجلة هو فخر لكل زميل بالوطن العربي حتى تصبح في مصاف الدوريات العالمية.

والله الموفق
عدنان التكريتي

رئيس التحرير الفخري
الأستاذ الدكتور أحمد عكاشة
رئيس التحرير: الدكتور عدنان التكريتي
مدير التحرير: الدكتور وليد سرحان

مستشار التحريري الإلكتروني
جمال تركي/ تونس

مستشار الإدمان
محمد أبو صالح/ بريطانيا

مستشار طب الأطفال
جون فياض/ لبنان

مستشار طب المراهقين
أحمد الأنصاري/ البحرين

مستشار طب البالغين
عبد الرزاق الحمد/ السعودية

مستشار العلاقات مع الكلية الملكية البريطانية
ناصر لوزا/ مصر

مستشار التعليم الجامعي
علاء الدين الحسيني/ عُمان

مستشار الدراسات الوبائية
إيمي كرم/ لبنان

مستشار التوثيق العالمي
طارق عكاشة/مصر

مستشار الدراسات الثقافية
محمد فخر الإسلام/ مصر

مستشار الشؤون الدولية
مها يونس / العراق

مستشار طب الشيخوخة
عبد المنعم عاشور/مصر

مستشار الطب الروحي
طارق الحبيب/ السعودية

مستشار العلاقات مع الجمعية الأمريكية
قتيبة شلبي/ أمريكا

مستشار العلاقات العامة
عادل الزايد/ الكويت

مستشار علم النفس
تيسير ألياس/ الأردن

مستشار البحث العلمي العربي
إيلي كرم/لبنان

مستشار الدراسات الفلسفية
يحيى الرخاوي/ مصر

مستشار الدراسات الدوائية
عبد اللة السبيعي/ السعودية

مستشار الامتحانات العربية
فؤاد انطون/لبنان

مستشار التعلم الطبي النفسي
توفيق درادكة/ الأردن

مستشار طب الحروب
نعمان علي/العراق

مستشار النشرة الإخبارية
مهدي القحطاني/ السعودية

المحررون

عصام الأنصاري / الكويت
عفاف حامد / مصر
محمد عبدالعليم / قطر
محمود الشريف / السعوديه

وائل سماره / الأردن
شارلوت كامل / البحرين
أمجد جميعان/ الأردن
عمر الرفاعي/ الامارات

محمد الحداد/ البحرين
ممدوح العدل/ بريطانيا
صباح صادق / السعوديه
صالح الحلو / بريطانيا

اللجنه العالمية للتحكيم

بريان لينارد (ايرلندا)
دافيد شيحان / الولايات المتحده الأمريكية
بيدرو رويز / الولايات المتحدة الأمريكية

نورمان سارتورياس / سويسرا
ماريو ماج / ايطاليا

جوان لوبيز ايبور / اسبانيا

مكتب التحرير

المحرر المساعد: مرام حباشنة
محرر اللغة الإنجليزية: سوزان قعوار
التصميم الإلكتروني: راكان النجداوي
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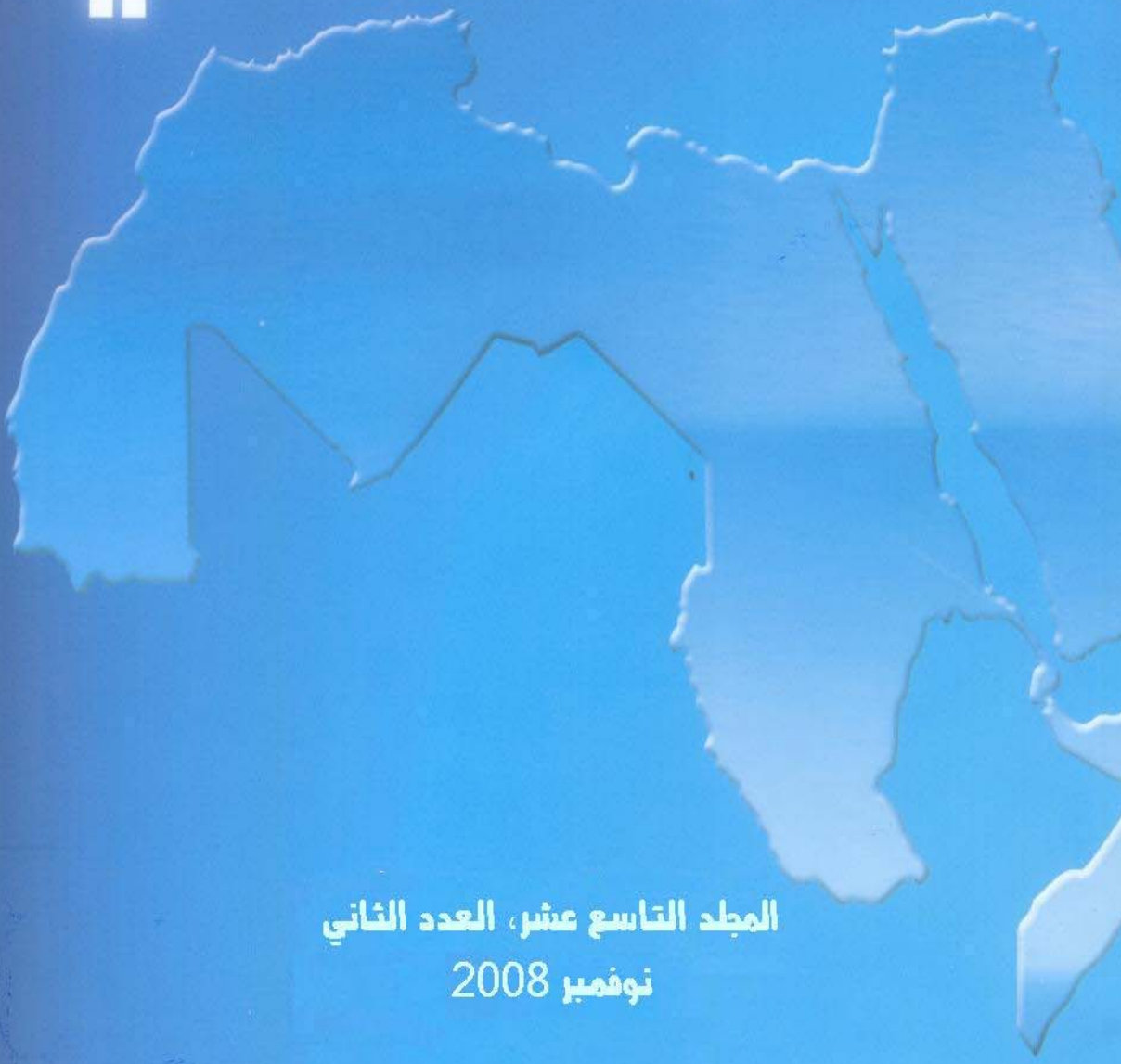
رئيس التحرير الفخري
أحمد عكاشة
رئيس التحرير/ عدنان التكريتي
مدير التحرير/ وليد سرحان

مستشار التحريري الإلكتروني جمال الترك/ تونس	مستشار التوثيق العالمي طارق عكاشة/مصر	مستشار البحث العلمي العربي إيلي كرم/لبنان
مستشار الإدمان محمد أبو صالح/ بريطانيا	مستشار الدراسات الثقافية محمد فخر الإسلام/ مصر	مستشار الدراسات الفلسفية يحيى الرخاوي/ مصر
مستشار طب نفسي الأطفال جون فياض/ لبنان	مستشار الشؤون الدولية أديب عسالي/ سوريا	مستشار الدراسات الدوائية د. عبداللة السبيعي/ السعودية
مستشار طب المراهقين أحمد الأنصاري/ البحرين	مستشار طب الشيخوخة عبدالمنعم عاشورمصر	مستشار الامتحانات العربية فؤاد انطون/لبنان
مستشار طب البالغين عبدالرزاق الحمد/ السعودية	مستشار الطب الروحي طارق الحبيب/ السعودية	مستشار التعليم الطبي النفسي توفيق درادكة/ الأردن
مستشار العلاقات مع الكلية الملكية البريطانية ناصر لوزة/ مصر	مستشار العلاقات مع الجمعية الأمريكية قتيبة شلبي/ أمريكا	مستشار طب الحروب د. نعمان علي/العراق
مستشار التعليم الجامعي علاء الدين الحسيني/ عمان	مستشار العلاقات العامة عادل الزايد/ الكويت	مستشار العلاج النفسي شارل بدورة لبنان
مستشارة الدراسات الوبائية إيمي كرم/ لبنان	مستشار علم النفس تيسير الياس/ الأردن	مستشار النشرة الإخبارية مهدي القحطاني/ السعودية
المحررون		
عصام الأنصاري/ الكويت	عبدالحميدالعلي/ الأردن	محمد الحداد/ البحرين
عفاف حامد /مصر	شارلوت كامل/ البحرين	ممدوح العدل / بريطانيا
محمد عبدالعليم/ قطر	أمجد جميعان/ الأردن	صباح صادق/ السعودية
محمود الشريف/ الأردن	عمر الرفاعي الامارات	صالح الحلو/ بريطانيا
المستشارون		
برايان لينارد (ايرلندا)	وليد شقم (الولايات المتحدة)	جون كوكس (بريطانيا)
. دافيد شيحان (الولايات المتحدة)	آن فارمر (بريطانيا)	بيتر كيندي (بريطانيا)
بدرو رويز (الولايات المتحدة)	كور نيليوس كاتونا (بريطانيا)	سكوت هندرسون (استراليا)

المجلة العربية
للطب النفسي



المجلد التاسع عشر، العدد الثاني
نوفمبر 2008

تصدر عن:
اتحاد الأطباء النفسانيين العرب