PONEX®
tipsychotic agent

esentation
zapine
blets (scored): 25 and 100 mg
apoules (2 mL): 50 mg for i.m. injection

dication
izophrenia in patients who are non-sponsive to or intolerant of classical uroleptics. See full product information.

sage
.5 mg (1/2 tablet 25 mg) once or twice the first day, 25 or 50 mg on the se-nd day, followed by stepwise dosage in-ases up to 300–450 mg p.o. (in some tients 600 mg) per day in divided do-. Maximum oral dose: 900 mg/day. For intenance treatment lower doses may ffice. See full product information; also intramuscular dosage.

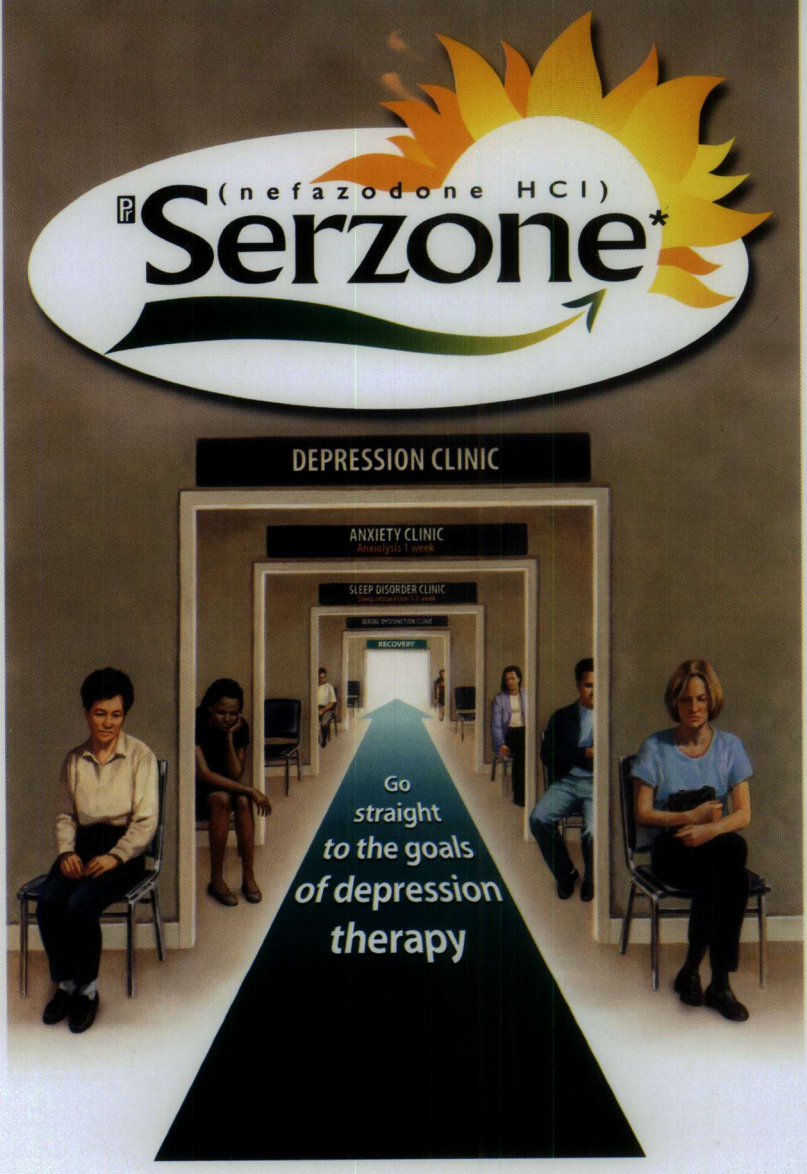
ntraindications
persensitivity to the drug; history of g-induced granulocytopenia/agranu-ytosis; impaired bone marrow function; controlled epilepsy; alcoholic and other ic psychoses, drug intoxication, coma-e conditions; circulatory collapse; CNS pression; severe hepatic, renal, or car-c disease.

ecautions
ponex can cause agranulocytosis. Its e should be limited to treatment-resist-t schizophrenic patients who have nor-l leucocyte findings, and in whom the ndatory white blood cell counts (week-during the first 18 weeks, at least nthly thereafter) can be performed. ncomitant use of drugs with a substan-l potential to depress bone marrow func-n and of long-acting depot antipsycho-s should be avoided. For instructions on w to proceed in the event of infection d/or granulocytopenia, see full product ormation.
ution when patients drive a vehicle or erate machinery; with patients with a tory of seizures; in the presence of car-vascular, renal or hepatic disorders, ostatic enlargement, narrow-angle glau-na; in children and in elderly patients; ring pregnancy and lactation.

eractions
ohol, MAO inhibitors, CNS depres-nts, narcotics, antihistamines, benzo-zepines, anticholinergic drugs, antihy-tensive agents, adrenaline, drugs with piratory depressant effects, warfarin d other highly protein-bound drugs, ci-tidine, phenytoin, carbamazepine, fluo-ine, fluvoxamine, lithium. See full pro-t information.

e effects
nulocytopenia, agranulocytosis, throm-cytopenia, eosinophilia, leucocytosis, wsiness, fatigue, sedation, dizziness, dache, confusion, restlessness, agita-, delirium, EEG changes, myoclonic s, seizures, rigidity, tremor, akathisia, y rarely neuroleptic malignant syndro-; dry mouth or hypersalivation, blurred on, disturbances in sweating and tem-ature regulation; tachycardia, postural otension, hypertension, in rare cases ulatory collapse, respiratory depres-n or arrest, ECG changes, isolated es of cardiac arrhythmias, pericarditis, ocarditis, rare cases of thromboembo-; dysphagia, aspiration, nausea, vom-g, constipation, ileus, weight gain, he-ic dysfunction, rarely cholestasis or te pancreatitis; urinary incontinence retention, in a few cases priapism, iso-d cases of acute interstitial nephritis; ign hyperthermia, hyperglycaemia, K elevation, skin reactions; isolated re-ts of unexplained sudden death; isola-cases of leukaemia and tardive dyski-ia have been reported.

ks
untry specific



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معلومات هامة للناشرين

لقد صدرت المجلة العربية للطب النفسي عام ١٩٨٩ من قبل اتحاد الأطباء النفسانيين العرب، وينشر في المجلة أبحاث علمية أصيلة، مراجعات علمية ومقالات تهتم بالعمل السريري. ويمكن أن تكتب المقالة باللغة العربية أو الإنجليزية مع ملخصين باللغة العربية والانجليزية. ويتم قبول الأوراق العلمية التي تتمشى مع أخلاقيات القوانين المحلية والدولية. ويمكن أن ترسل المقالات إما الى رئيس التحرير أو نائبه أو المحررين المشاركين. وتقيّم كل الأوراق من قبل محكمين دوليين.

المقالة: ترسل بنسختين مطبوعتين بمسافات مزدوجة على صفحات A4 بحواشي ٣ سم. ويجب أن لا تزيد العناوين الفرعية عن ثلاث مستويات ويراعى عند كتابة المقال أن تخصص الصفحة الأولى لعنوان الورقة باللغة العربية والإنجليزية مع أسماء المشاركين بها دون ألقاب بما لا يزيد عن ٤٠ حرف.

الصفحة الثانية: ملخص باللغة العربية لا يزيد عن مائتين وخمسين كلمة منظم حسب أهداف الدراسة وطريقتها والنتاج ثم الخلاصة.

الصفحة الثالثة: تحتوى على أسماء المشاركين وعناوينهم وعناوين المراسلة.

يمكن أن تخصص صفحة للشكر للأفراد والمؤسسات التي دعمت البحث.

أما الملخص باللغة الإنجليزية فيفضل أن يكون على صفحة منفصلة بعد المراجع.

الجداول: يجب أن تطبع الجداول بمسافات مضاعفة وعلى صفحات خاصة وترقم وأن يكون لها اسم مختصر.

الإيضاحات: كل الإيضاحات من صور أو رسومات يجب أن تكون ضعف الحجم الذي ستظهر به بالطباعة حتى يمكن تصويرها.

قائمة المراجع: يجب أن يتبع أسلوب فانكوفر بحيث تظهر المراجع حسب الترتيب الذي ظهرت به في المقالة وليس حسب الترتيب الأبجدي. ويفضل كتابة أسماء المشاركين في المرجع إلا إذا زاد العدد عن ستة فيكتفي بكتابة (وجماعته et al).

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ملاحظة: على الكاتب إرسال النسخة النهائية من الورقة أو المخطوطة على قرص قياس ٥ر٣ متوافق مع IBM-Microsoft World

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Introduction to the Psychiatry of Ancient Iraq

Walid Abdul-Hamid

مقدمة في طب نفس العراق القديم

د. وليد خالد عبد الحميد

الملخـــص

بلاد الرافدين (Mesopotamia) هو الإسمُ اليونانيُ للأرض بين النهرين العظيمين دجلة والفـرات بمـا يُكوّن اليوم أرض العراق.هذه الأرض كانت مهد الحضاراتِ الأولى في تأريخ الإنسان. ففي سنة 3200 قبل الميلاد وفي أوروك في جنوب العراق كُتب أول نص مكتوبَ في تاريخ البشرية باسـتعمال الكتابـة المسمارية. ولقد وصلتنا حوالي نصف مليون لوح مسماري كتبها العراقيون القدماء في مختلـف الفنـون والعلوم والآداب1. أن بضعة آلاف من هذه الرقم الطينية تتصل بالنصوص الطبية. هـذه الالنصـوص الطبية تتضمّن بشكل رئيسي إرشادات للأطباء ومجموعة وصفات.

من ضمن المئات من النصوص الطبية المسمارية التي وصلتنا والتي تتضمّن معلومات تشخيصية وتنبؤية وعلاجيّة وُجدت العديد من رُقم طينية طبية التي تعنى بالأمراض النفسية. لقد حاولت أسـتعراض هـذه الرُقم وما تحويه من وصف نفسي مرضـي (psychopathology) لإضـطرابات نفسـية و سـلوكية لدراستها ومقارنتها مع الإضطرابات التي يعالجها الطبيب المعاصر بالأضافة إلـى دراسـة الممارسـة التشخيصية والعلاجية آنذاك.

لمحة تاريخية

عاشت في العراق القـديم شـعوب عديـدة ومختلفة ربما كان السومريون اقـدمها[2]. و السومريون أقوام لسنا متأكدين مـن أصـلهم كانوا قد نزحوا من جنوبي شرق دجلـة إلـى جنوب حوض مابين النهـرين فـي حـوالي منتصف القرن الاربعين قبل الميلاد وهـؤلاء بنوا أول المراكز الحضرية المتمثلة بالمـدن الكثيرة التي منها كيش واريدو والوركاء ونفر ولارسا وأور وماري وغيرها من أولى مراكز الحضارة الإنسانية . اللغة السومرية كانت لغة غير سامية رغم احتوائها على مفردات سامية. واستطاع السـومريون بنـاء قواعـد مهمـة لحضارة وادي الرافدين في العلـوم والفنـون والآداب أثرت على حضارة ما بين النهـرين حتى انقراضها في أواخر القرن الخامس قبـل الميلاد. وفي حوالي منتصف الألف الثلاثـين قبل الميلاد ظهر الأكديون وهم أقوام سـامية هاجرت من الجزيـرة العربيـة واسـتوطنت منطقة أكد الواقعة شمال الأراضي السـومرية وقد تغلب ملكهـا سـرجون الاكـدي علـى السومريين وضم أراضـيهم إلـى مملكتـه. وحافظت المملكـة الأكديـة علـى ملامـح الحضارة السومرية وطورتها. وفـي حـوالي العام 1955 قبل الميلاد ظهر الملك حمورابي السامي من سلالة العمورين الذين نزحوا مـن الجزيرة العربية إلـى الشـام أولا. وجعـل حمورابي عاصمته في بابل التي ازدهرت فيها في عهده الحياة الاجتماعية انتعشت التجـارة والأعمال الزراعية ويعتبرعصـر حمـورابي ازهـى عصـور بابـل وأقواهـا وارقاهـا حضارة[3]. ويعتبر حمورابي أول مشرع فـي التاريخ وتسجل مسلته أولى القوانين البشـرية والمحفوظة في متحف اللوفر في باريس.

العراق القديم

عددت مقدمة المسلة مفاخر حمورابي الكثيرة في البناء وإرساء العدل الاجتماعي.ينسب إلى هذه المسلة النص (العين بالعين والسن بالسن) الذي قبلته الإنسانية مذ ذاك. كما إن هذه المسلة حوت فقرات لتنظيم الممارسة الطبية في ذلك العهد.

وفي حوالي القرن التاسع قبل الميلاد انحدرت من شمال ما بين النهرين أقوام سامية إستولوا على بابل وضمّواها إلى أمبراطوريتهم الآشورية. وقد توسعت هذه الإمبراطورية في عهد الملك ناصربال (844-859 قبل الميلاد) حتى شملت الممالك الفينيقية. ومن أشهر ملوك الآشوريين الملكة شامورامات التي سماها اليونانيون سمير أميس ،اعتبروها من الآلهة.

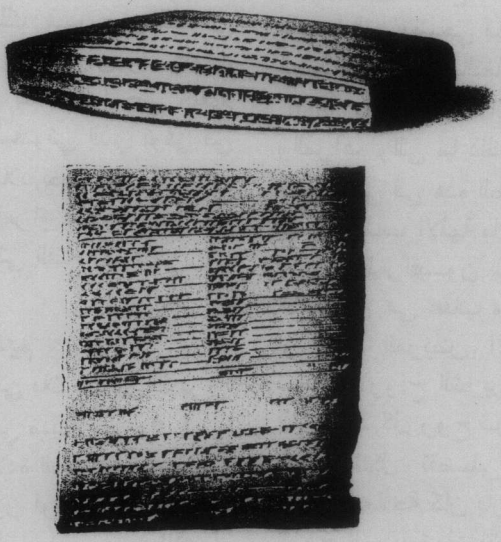
وأحد حكام الآشوريين المشهورين هو آشور بانيبال (668-625 قبل الميلاد) وهو الذي وسع مملكته لتشمل بلاد الشام. وكان محبا لنشر العلوم والفنون وجمع الكتب من الألواح و الرقم الطينية[2]. أن مكتبته قد زودت البشرية بمعظم المعلومات التي نعرفها عن الحضارة الآشورية وما قبلها من حضارات في وادي الرافدين بما في ذلك المعارف النفسية والطبية موضوع البحث.

وفى حوالي سنة 625 قبل الميلاد ظهرت في بابل سلالة الحكام الكلدانيين الذين أطاحوا بالآشوريين أسقطوا نينوى عاصمتهم سنة 612 قبل الميلاد وأشهر ملوكهم هو نبوخذنصر(605-561 قبل الميلاد) الذي

أسقط مملكة يهوذا وهدم هيكلها وساق اليهود أسرى إلى بابل.
أسقط حكم الكلدانيين الملك قوروش الثاني الاخميني الذي قدم من بلاد فارس واستولى على بابل.وبقي الفرس يحكمونها حتى خلفهم على حكمها الاسكندر المقدوني الذي توفى في بابل سنة 323 قبل الميلاد حيث حكمها من بعده السلوقيون وظل العراق مسرحا للحروب بين الفرس والرومان حتى الفتح الإسلامي.

الطب في العراق القديم

منذ أن اكتشفت الكتابة في بلاد ما بين النهرين في 3200 قبل الميلاد في مدينة أوروك في جنوب العراق وحتى ولادة السيد المسيح فإن هناك حوالي نصف مليون لوح مسماري كتبها العراقيون القدماء ووصلتنا منهم لحد الآن [1].
أن هناك من العلماء الآثاريين من يعتقد أن هناك المزيد الذي لم يكتشف لحد الآن. أن هناك بضعة آلاف من هذه الرقم الطينية تغطي النّصوص الطّبية [4]هذه النّصوص الطّبية تتضمّن بشكل رئيسي على إرشادات للأطباء ومجموعة وصفات من نّوعين رّئيسيين.أحدها المقصود منه أن يكون مستعمل من قبل الأطباء العمليين والآخر للاستعمال من قبل المعالجين الروحانيين [5].
لقد كان الطب في العراق القديم متقدم جدا بالنسبة إلى عصره فلقد وصلتنا مصادر مكتوبة بأن الأطباء عراقيون كانوا يرسلون لمعالجة الملوك الفراعنة المصريون وكذلكالملوك الحيثيين في الأناضول[2].الأطباء كانوا جزء من الطبقة الاجتماعية المتوسطة المثقفة في المجتمع البابلي. أن هذه الطبقة تضم أصناف عديدة من الحرف مثل المنجم "tupsharru " الذي يعطي الطالع من دراسة حركة الكواكب. ثم أن هناك العراف "baru" الذي يعطى الطالع اعتمادا على دراسة أحشاء الكبش التي يضحي بها، الأشيبو "ashipu " أة المعالج الروحي بالتغاويذ والأدعية ثم الأسو "asu" والذي يعالج المرضى بالأدوية والمراهم والى ما ذلك. يلي الأسو في السلم الاجتماعي في هذه الطبقة المغني "kalu" الذي يهدّئ غضب الآلهة بالأناشيد [6].
لقد كان العراقيون القدماء يعتقدون بأن الأمراض هي عقاب من الآلهه بسبب خطيئة أو عيوب المريض. الآلهة بدورها هي التي تسمح للأرواح الشريرة بأن تتلبس الشّخص المريض. كل روح شريرة تهاجم بعض أجزاء الجسم بشكل تفضيلي (Roux,1980). أن هدف المعالجة كان بأن يجبر أو يغري المعالج الروح الشرّيرة بأن تترك جسم مريض. هذه لربما القاعدة الأصلية للفصد و المسهلات المستعملة للتطهير في الطب اليوناني ومن ثم في لقرون الوسطى في الطب الإسلامي والأوروبى[3] هذه الفكرة أيضا ليست غريبة عن المعالجة التّحليلية النفسية التي تهدّف إلى جلب النزاعات النفسية من اللاوعي إلى العقل الواعي }. هذه المعالجة تتضمّن عادة معالجة فيزيائية طبية من جهة ومعالجة روحية دينية من جهة أخرى. المصادر المسمارية توضح أن ممارسة المهنتين المختلفتين يتم بأن يؤدّيا النّوعان من معالجة بما يكمل أحدهما الآخر[5].
الأشيبو "ashipu " كان هو المعالج الرّوحي الذي يميّز الروح الشريرة المعينة من بعد قراءة قائمة الآثام، التي قد أرتكبها المري كمثال، في حالة تلبس شخص ما بالروح الشريرة لامتشو 'Lamashtu' التي تقتل النساء الحبالى والأطفال الصغار



فإن الأشيبو عادة ما يحاول رشوة هذه الروح الشريرة من خلال عروض بتزويدها بالزاد والماء لرحلتها عبر الصّحراء [3].

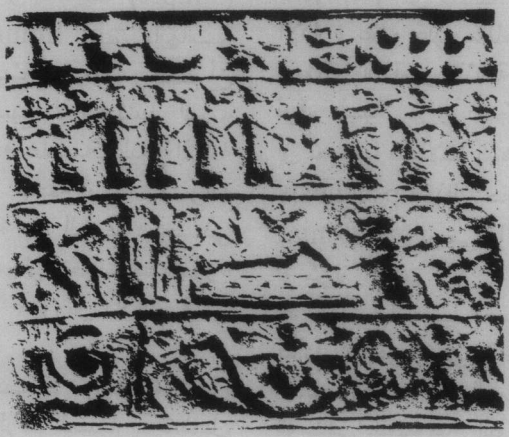
أما الأطباء الممارسون في العراق قديم فقد كانوا يدعون بالآسو "asu". والآسوا هو جزء من الطبقة المتوسطة العليا في المجتمع البابلي والآشوري. وهو عادة ما يكون خريج مدرسة يتعلم فيها العلوم الأساسية لذلك العصر يدخل بعدها إلى معهد متخصص بتعليم مهنة الطب[2].

إن التّشخيص يحتل دورا مهما في الممارسة الطّبية ومعالجة الأمراض في العراق القديم. في رسالة كتبها طبيب اسمه لوردي-نامو إلى الملك الآشوري يقول فيها: "الملك يسألني بشكل مستمر لماذا أنا لم أصل إلى تشخيص المرض الذي يعاني منه ، ولا أعددت العلاج الملائم له لحد الآن. إنه لحقيقة أنة ورغم أني تكلّمت في السّابق إلى شخص الملك فأنا عاجز بأن أميّز طبيعة مرضه "[1] إنه من الواضّح و من خلال هذا النّص بأن الطبيب يصل إلى التّشخيص من خلال رؤية المريض وفحص الأعراض.

أما بالنسبة إلى العلاج الطبي الذي كان يمارسه الآسو فأن المصادر من الرقم الطينية المسمارية حفظت لنا قوائم من الأعراض والتشخيصات لأمراض عديدة و الوصفات الطّبية المناسبة لمعالجة هذه الأمراض.

عادة ما تتبع هذه المصادر تسلسل منطقيّ عادة ما يبدأ بعبارة " إذا عاني شخص من" تتليها قائمة من الأعراض والعلامات المرضية والتي تؤدي إلى تشخيص بدوره يحدد التوجيهات المحددة إلى الأطباء باستعمال الأدوية المناسبة[5].ولو أن تشخيص كان متأثرا بالاعتقادات الدّينية السائدة آنذاك فأن العلاج كان علم يتبع الملاحظة الدّقيقة والقواعد العلمية المعروفة في حينه.لقد حفظت لنا الرقم الطينية المسمارية أقدم دستور للأدوية عرف

لحد الآن من مجموعة من الوصفات التي تعود إلى السلالة الثالثة من العهد السومري في أور. وقد تضمّن هذا الدستور تحضيرات أدوية في شكل مراهم ، وشرابات من مزج مواد معدنية ونّباتات أستمر استعمالها في الصيدليات الأوربية حتى ثلاثمائة سنة مضت[2].



أذن فقد كان علاج الأمر أضفي العراق القديم مكونا من جزأين أساسيين الروحي-الديني و الفيزيائي-الطبي. والنص الطبي التالي عن معالجة الحمى يصوّر هذا خير تصوير:" إذا المريض عنده ألم في صدغيه بدون توقف خلال اليوم، فأن ذلك بسبب تلبس شبح (التشخيص). بعدما يكمل الأشيبو عمله (المعالجة الروحية) عليك أنت (طبيب) أن تدعك المريض بمرهم (المعالجة الجسمية) يصنع كالتالي:ألخ.

طب نفس بلاد الرافدين

في تلك الثروة من المصادر والسجلات التي بوثق المعرفة الطّبية للعراق القديم ومن ضمن العديد من مئات من النّصوص الطّبية المسمارية التي تتضمّن معلومات تشخيصية وتنبؤية وعلاجّية وجد العالم الآثاري البريطاني البروفسور كنير ولسون رقم طينية طبية محفوظة في المتحف البريطاني تعنى بالمرضى النفسيون[7] و كون هذه النصوص وجدث كجزء من النصوص الطبية ولكونها تتضمن وصفا نفسيا مرضيا (psychopathology) لاضطرابات نفسية أو سلوكية فأن كنير ولسون قد كرس بحوثه لحل رموز هده الرقم الطينية ومقارنة معلوماتها مع الممارسة التشخيصية الطبية النفسية الحديثة[8].

الأمراض النفسية المترافقة مع مرض الصّرع المعروف باللغة البابلية بالمكتو 'miqtu' أو مرض السّقوط كانت محل دراسة أطباء العراق القديم. فبالإضافة إلى وصف نوبات الصرع التوتري"tonic-clonic "، وصرع الفص الصدغي " temporal lobe epilepsy" . كما وصفوا أورة الصرع "aura" وحالة ارتباك ما بعد النوبة postictal confusional[7].كذلك وصفت

الإختلالات العقلية الصرعية مثل الاضطراب الذهانية في أحد هذه الرقم المسمارية و كما يلي:

" إذا كان الرجل يعاني من نوبات صرعية كبيرة (grand mal) أو بسيطة (simple) وقامت روح شريرة ' alu limnu ' بإيهامه ب (أفكار) إضطهاد بحيث أنه يقول رغم أن لا أحد يتفق معه إن إصبع الإدانة تشير اليه وراء ظهره وإن الآلهة غاضبة عليه؛ إذ إنه يرى تخيلات مروّعة و مخيفة أو فاسدة وأنه (لذلك) في حالة مستمرة من الخوف؛ يعاني من فقدان السيطرة وإنفجار الغضب بصورة دّورية ضد الآلهة، فهو مهووس بأوهام في عقله"[7].

الأوهام الإضطهادية كانت قد درست من قبل الطب البابلي ففي أحد الرقم المسمارية تسجيل لحالة مريض يشعر بأنّه قد اتّهم "بأني فتحت بوّابة المدينة أدخلت العدو لكن أمام سيدي (الملك) أقسمت بأني ماعملت هذه الأشياء ". لكن هذا المريض كان قد أُخذ إلى الطّبيب بدلا من الحاكم أو القاضي إذ لا أحد قد وجه الاتهام ضده. و في رقم طيني آخر نجد وصف لظاهرة السلبية (passivity phenomenon) من مجموعة واحدة، مجموعتان أنت تحرق وتشعل بكل غضب.

وهناك وصف لمريض آخر بأعراض ذهانية أكثر شدة قد تنطبق عليها الأعراض التشخيصية لمرض الفصام (schizophrenia) حسب أعراض شنايدر (Schneider). حالة هذا المريض تتميز بالأواهم والهلوسة السمعية " إذا كان الرجل معه مدبر الشرور"bel lemutti " يضطهده بالألسنة العدوانية، تنشر الإشاعات، وتخبر بالأقاويل وتفتري عليه؛ إذا ماكان كل من يتكلم معه لا يتكلّم إلا بالكذب؛ وإذا و بدون معرفته يصوب اليه السحر والنوبات والتعويذات أو المكائد الشريّرة (الأخرى) توجه إليه؛ وإذا الإله أو الملك،أو العظماء أو الشّيوخ، أو أي ضابط في بلاط القصر أو الإدارة عنده عليه مظلمة أو غاضب معه. (يؤدّي الطقوس التّالية) "[7]. إن هناك وصف لرقم طينية أخرى تسجّل أعراض نفسية يمكن أن تصنف كحالات الذهان الهوسي manic psychosis وكذلك حالة فصام جامودي (catatonia) يسمى بالأكدية da-bi-dib-ka أو كزاز الفك.

لقد كانت ملنخوليا الحبّ والتي لا تستعمل حاليا كتشخيص في الطبّ النفسي واحدة من أهم الأمراض النفسية في العصور الوسطى[9].لنصوص الطّبية العراقية القديمة تذكر هذا المرض وتسميه بداء الحب[1] وتصفه كالآتي:

" عندما المريض يجد غصة دائمة في حنجرته و غالبا ما يجد صعوبة في إيجاد الكلمات؛ ويتحدّث دائما لنفسه عندما هو وحيد ويضحك أحيانا دون أي سبب في زوايا الحقول، هو مكتئب بشكل دائم، حنجرته تضيّق، ولا يجد لذة في أكل أو شرب، و يكرّر بشكل لانهائي، بتّنهدات عميقة، ' آه! يا قلبي التعيس': فأنه مصاب بداء الحب" .

أما بالنسبة للأمراض العصابية فهناك دراسة حالة وصفت شخص يعاني من "خوف مرضي من الأسرّة و الكراسي و المناضد والمواقد المضاءة والقناديل. . الخ (وتجنّبها). كذلك فأنه يتجنب مدينة معينة، أو بوّابات المدينة أو دار معينة أو شارع أو هيكل أو طريق ". وهذه الحالة لربما لحالة تشخيصها هو الرهاب غير المحدد مع رهاب الساح agoraphobia. وهناك حالة أخرى من المرض العصابي كما

ورد في دراسة السيرة التالية :" يكون حّل اللّغز في ذلك الذي لا يعرف لماذا هو مرغم أن يأخذ الأشياء و أن يخفيها. بأن يؤشر بالإصبع على الآلهة المحمية وأن يطأ الدّم أو يمشي حول المكان الذي سفك فيه الدم. عنده خوف مرضي من الالتقاء بشخص الملعون أو أن الشخص الملعون يقابله، أو من نوم في سّرير،والجلوس على كرسي، أو الأكل على منضدة أو الشرب من كأس شخص ملعون ". هذه الحالة تثبت أن الاضطراب الوسواسي القسري (obsessive compulsive disorder) كان معروفاً في العراق القديم.

وفي حين أن بعض الأطباء النفسانيين الحديثين يجادلون بأن اضطراب الشّخصية (personality disorder) ليست بالمرض النفسي فأن الأطباء العراقيين القدماء سجلوا هذا النوع من الأضطرابات في أحد الرقم المسمارية الطبية وكما يلي:

" ليكون اللّغز محلولا في ذلك الذي يفعل كذا وكذلك ولا يعرف إن ذلك خطأ: عندما يعطي مقياس أصغر(عند البيع). ويستعمل ميزان باطل ويأخذ الأموال بشكل غير شرعي. يضع حجارة حدود باطلة ويدخل دار صديقه، ويضاجع زّوجته ويسفك دمه ويسرق ملابسه. عندما فمه يقول نعم قلبه يقول لا ومهما يقل فهو عار من الصحة دائما، عندما يهتزّ ويرتعد(من الغضب)، يحطّم (الأشياء)، يرميها خارجا (من الدّار) أو يجعلها تختفي؛ أنه يتّهم و يجرّم، و ينشر الإشاعات، يسيء و يسرق أو يحرّض الآخرون على السرقة". قائمة طويلة تتشابه كثيرا مع معايير تشخيص اضطراب الشخصية اللاإجتماعية antisocial personality disorder.

ومثلما لا زال الطب النفسي في وقتنا الحاضر يحاول جاهدا معرفة العوامل المسببة للاضطرابات النّفسية فعل الأطباء في العراق القديم. ورغم أن تفسيراتهم كانت تتناغم مع المعرفة النفسية والروحية آنذاك ألا إنها ظلت مشابهة للتفسيرات السائدة للأمراض النفسية في الطب الأوربي حتى بداية القرن العشرين. وهذه التفسيرات تتضمن بأثيرات "السحر،والرقى السحرية وطرق شريّرة أخرى ". كما في النص المسماري التالي[8]:

" هن (الساحرات) قد جعلنني آكل طعام مسحور؛ هن قد جعلنني اشرب ماء مسحور؛ هن قد غسلنني في ماء الغسل القذر؛ هن قد دهنني بمراهم صنعت من عقاقير شّريّرة ".

هذا النّص يسجل بالإضافة إلى الأوهام الإضطهادية؛ الظاهرة السلبية passivity phenomenon والتي هي أحد أعراض شنايدر لداء الفصام.

أما المعالجة التي أستعملها الأشيبو فكانت تتضمن الإحراق أوالتذويب البطيء لصورة أو رمز للشّخص المضطهد للمريض. هذا بالإضافة إلى اقتراح مجابهة

" أنا شوك أجمة الورد، لا تتجاسري وتدوسي عليّ؛ أنا لدغة عقرب، لا تتجاسري و المريض للسّاحرة التي سببت المس بما يشابه العلاج السلوكي التعرّضي. كما ورد في النص المسماري العراقي القديم[8]:

تمسّيني؛أنا جبل وعر، تأكدي بأنّ سِحرُكِ، ومس سِحرُكِ ومكائدكِ الشريّرة لا تقترب مني".

Abstract

Mesopotamia is the Greek name of the land between the two great rivers Tigris and Euphrates which constitute present-day Iraq. It was the cradle of major early civilizations in human history. It was in 3200 BC and in Uruk in southern Iraq that the first text was ever written. From then till the birth of Christ the ancient Iraqis kept almost half a million cuneiform tablets.

Several thousands of these tablets covered medical texts. These medical text were mainly consisting of handbooks and collection of prescriptions. Some of these medical text contained information on the diagnosis and treatment of psychiatric disorders. I have tried to explore the psychopathology detailed in these text to compare with current diagnostic practices in Psychiatry.

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مراجعة كتاب

المخدرات والمسكرات والمهدئات
مدخل عام الى الإدمان والعلاج والتأهيل
للدكتور أنطوان لطيف الله البستاني

صـــدر فـــي مطلع هذا العام عن دار النهضة في لبنان، وكاتبه أحد رواد الطب النفسي العربي واللبناني وله باع طويل في معالجة الإدمان. جاء الكتاب في ثلاثمائة صفحة من القطع المتوسط وبـــدأ الكاتـــب بالـــتعريف والتصـــنيف وكذلك المفاهيم المتعلقة بالموضوع، ثم تناول الحشيش، الأفيونات، المنبهات، المهدئات، الكحول، المهلوسات، التبغ وعالم التهريب والمهربين.

جـــاء الكـــتاب في لغة عربية سلسة وبأسلوب واضح وحمل كماً هائلاً من المعلومات والخبرات، وتناولها بالرصانة العلمية والعمق الفكري، وأثراها بالخبرات اليومية الهائلة التي يحملها الكاتب في جعبته.

إن هـــذا الكـــتاب مفيد للدارسين والأطباء والعاملين في الرعاية النفسية والإجتماعية وفي ميدان مكافحة الإدمان وعلاجه، كما أنه قراءة رائعة للمدمنين والعابثين بعقولهم، فهو خلافاً لكثير من الكتـــب التي صدرت في هذا المجال يصلح أن يقرأه كل من يقرأ لغة الضاد، وهو أحد الأساليب الفعالة في نشر الوعي بين الشباب العربي حتى يتجنب الوقوع بآفة الإدمان.

وإن تطرق الدكتور أنطوان للكحول والقات والكافيين جاء في المكان المناسب ليربط كافة أشكال الإدمان والتعود معاً. إن هذا الكتاب إضافة ثمينة للمكتبة النفسية العربية.

وليد سرحان

إبـــن ســـينا الملقب بالشيخ والرئيس وأطلق عليه المعلم الثالث بعد أرسطو والفارابي، وله ٢٧٦ كتاباً في مختلف العلوم، والقانون هو أشهرها وفيه خلاصة الطب اليوناني والعربي، ومن كتبه ٤٣ كـــتاباً فـــي الطب والباقي في اللاهوت والفيزياء والفلسفة وعلم النفس الذي خصص له ٢٣ كـــتاباً، والمـــنطق والرياضيات وتفسير القرآن الكريم، وتحدث ابن سينا عن الجراحة والتخدير، وتحدث بإسهاب عن كسور الجمجمة، واختلافها عن باقي عظام الجسم بأنها لا تلتئم.

كتاب القانون بقي يدّرس في أوروبا وكانت آخر كلية طب تدرسه هي كلية مدينة لوفان البلجيكية فـــي منتصف القرن الثامن عشر، وقال عنه الطبيب الإنجليزي الشهير السير وليام أوسلو (كان الإنجـــيل الطبي لأطول فترة من الزمن)، ويحتوي الكتاب على مليون كلمة ويقول إبن سينا أنه يـــتوخى الإيجـــاز؟! يشمل كتاب القانون على خمسة كتب من ضمنها الأمراض العصبية، وقد خصـــص الفن الأول من الكتاب الثالث في أمراض الرأس والدماغ في خمس مقالات تكاد تشمل كل العلوم العصبية المعروفة حديثاً يسهب الكاتب في ما ورد في هذا الكتاب عن العلوم العصبية إذ فـــيه كم هائل يثير الدهشة والحيرة في قدرة الطبيب العبقري على معرفة كل الطب من خلال الملاحظات والخبرات السريرية، ويزيد الإستطراد في هذا المجال عن الستين صفحة.

ينـــتقل الكاتـــب للطب في الأندلس ويخص عائلة إبن زهر التي توارثت الطب عبر ستة أجيال، ويركز على كتاب (التصريف لمن عجز عن التأليف) للزهراوي الذي يقسم أمراض الرأس تسعة عشـــر مرضـــاً، تشـــمل الأمراض العصبية والنفسية، وقد خصص الزهراوي المقالة الثلاثون للجراحة والتي جعلته يعرف كجراح عظيم في تاريخ الطب.

وينتقل الكاتب للحديث عن إبن طفيل الذي له أرجوزه في الصداع وإبن القف الكركي الذي كتب (عمدة الإصلاح في علل الجراح) وكتاب (جامع الفرض في حفظ الصحة ودفع المرض)، وهذا الطبيب تطرق للتفصيل في تشريح الدماغ والنخاع الشوكي وأجهزة الجسم المختلفة.

إســـتعرض الكاتـــب بإسهاب التعليم الطبي عند العرب والمسلمين وما حظي به من إهتمام يفوق التصور، وبناء المستشفيات الذي كان الخليفة الأموي الوليد بن عبد الملك أول من أنشأ مستشفى فـــي الإســـلام، وتـــلاه الحجـــاج والخليفة العباسي المهدي، ثم هارون الرشيد، وكانت تسمى المستشـــفيات (البيمارســـتانات) وهـــي كلمة فارسية، في حين أمر الملك فيليب ملك فرنسا سنة ١٣١٣م بحـــرق المرضـــى المصابين بأمراض مزمنة لتخليص الناس من شرهم، ثم تحدث عن العلاقة الحميمة بين الحكام والأطباء وأجور الأطباء والأخلاق الطبية في الإسلام.

يركـــز الكاتب على عظمة الحضارة العربية الإسلامية بشكل عام وفي ميدان الطب بشكل خاص والعلـــوم العصـــبية تحديداً، ويحاول أن يذكرنا بتاريخنا وأننا لم نكن دائماً في تأخر علمي، ولا يجوز أن نبقى كذلك، ويبعث الأمل في نهضة علمية عربية حديثة.

إن هـــذا مـــن الكتـــب القليلة التي ظهرت مؤخراً في تاريخ الطب، وينفرد في توسعه ومراجعه وشـــموليته، وبإعتقادي أن أي طبيب عربي يجب أن يحمله معه، ولا تخلو منه مكتبة طبية أو مستشـــفى، وأملـــي أن تـــأخذ منه كليات الطب بعض الأجزاء لتدريسها لطلبة الطب، والكتاب قراءته ممتعة حتى لغير الأطباء، وإضافة ثمينة للمكتبة العربية.

وليد سرحان

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مراجعة كتاب

دور العرب والمسلمين في العلوم العصبية (٥٠٠ – ١٥١٦)

أ.د. أشرف الكردي

صـــدر هذا الكتاب القيم عن مركز الأبحاث التابع لمستشفى الملك فيصل التخصصي في المملكة العربية السعودية، والكاتب هو من أعلام طب الأعصاب العرب المعروفين، وقد بذل جهداً جباراً في إخراج هذا السفر، كما سماه مقدم الكتاب الدكتور عبد السلام المجالي، فهو من القطع الكبير ويقـــارب الخمســـمائة صفحة ولا يمكن أبداً إعتباره كتاباً عن دور العرب والمسلمين في العلوم العصـــبية، بـــل هو مرجع في تاريخ الطب القديم والإسلامي والعربي، ومن خلال هذا الباب الواسع دخل الى مساهمات العرب والمسلمين في مجال العلوم العصبية.

يســـتعرض الدكـــتور أشـــرف الطب الفرعوني وطب ما بين النهرين، والطب الصيني والهندي والفارســـي واليوناني، ويصل الى طب ما قبل الاسلام ومساهمة الأطباء اليهود والمسيحيين في الجزيـــرة العربية، الى أن يصل الى الطبيب العربي الحارث بين كلدة الذي قال عنه النبي صلى الله عليه وسلم (إن ابن ثقيف من أطباء العرب في زمانه)، وكان يأمر من كانت به علة أن يأتيه فيسأل عن علته، وينتقل بعد ذلك للطب النبوي في فجر الإسلام وما زخر به من معرفة ونصائح طبية.

يخصـــص الكاتـــب الحديـــث عن الطب في العصر الأموي والعباسي، ويستعرض عائلات من الأطـــباء مـــثل عائلـــة بختشيوع التي توارثت الطب جيلاً بعد جيل وانتقل أطباءها مع الخلفاء، واستعرض الترجمة للعربية ومن العربية لليونانية والسريانية بتوسع كبير.

يـــتطرق الكتاب لأطباء كثيرين مستعرضاً انجازاتهم ويربطها بالعلم الحديث، من الطبري الذي تحدث عن أمراض الدماغ في (فردوس الحكمة)، ويورد الطبري ثلاثة عشر نوعاً منها، وستة أنواع من الصداع وأربعة أنواع من تهيج المزاج، وما جاء عن ثابت بن قرة الحراني في أنواع الصداع والشقيقة والفالج والتشنج والرعشة والماليخوليا والفزع والسبات.

ويمر بالعديد من الأطباء التي تذهل القارىء قدرتهم في الوصف والتصنيف السريري.

أمـــا الرازي فيحظى بما يستحق من إهتمام، فقد ألف نحو مائتي كتاب نصفها بالطب، وأثارت دهشة أطباء الغرب، وترجمتها الجامعات الأوروبية وظلت المعتمدة لمدارس أوروبا عن البحوث الطبية مدة طويلة، وله كتاب اشتهر بين الناس أسماه (طب الفقراء)، وكتاب (برء الساعة)، ثم موسوعته الطبية الحاوي التي تشمل كل ما في الطب، وقسّم الرازي الصرع لثلاثة أنواع، وفي رسالة في طب الأطفال وصف إستسقاء الدماغ الداخلي، وفي الحاوي أسهب الرازي في السكتة واللفوة (إلتهاب العصب السادس)، والصرع والرعشة والصداع والسرسام وهو إلتهاب السحايا، أمـــا كتاب المنصوري فهو أول كتاب في الطب الوقائي، وفيه يقول أن الأعصاب هي التي تنقل الحس والحركة من الدماغ للأعضاء، ويصف تجاويف الدماغ.

Book Review

Mad in America

(Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally ILL)
By Robert Whitaker, published by perseus publishing in USA, 2002

The writer is a journalist whose articles on the mentally ill and drug industry have won several awards, Including George Polk award for medical writing, and the National Association of Science Writers award for best magazine article.

The book is three hundred pages of medium size, divided in four parts, part one: The original Bedlam (1750-1900) in 40 pages, in which he describes the wards of Pennsylvania Hospital that was opened in 1756, by physicians who carried the ideas from Great Britain, Mr. Whitaker is very critical of the way the patients were described, and the claims of the doctors at the time that they could cure 9 out of 10 patients, by drowning, bleeding, freezing and exhaustion, with the intention to protect the society, the writer is wandering about the better prognosis of Schizophrenic patients in the third world countries, that is still standing until today.

Part two: the darkness era (1900-1950) in one hundred pages, in which he criticize the Mendelian Madness, and the Compulsory sterilization of the severely mentally ill, insulin therapy, electroshock and prefrontal lobotomy.

Part three: Back to Bedlam (1950-1990s) 110 pages in 5 sections, started with the introduction of chlorpromazine and the phenothiazines that were supposed to be insecticides in the nineteenth century.

Mr. Whitaker went on to describe the side-effects of neuroleptics, and the era of drug industry that started to control medicine and science, he is very critical of the clinical studies and FDA approval system, he cited several patients report of their experiences, and criticize president kennedy move towards moral and community treatment, in fact as a clinical psychiatrist, I would agree with some of his comments, but definitely not with the notion that nothing is good about psychiatry and psychiatric treatment, in some statements his hostility reaches a pathological intensity, but nevertheless every psychiatrist should be a ware of such views that could be shred by decision makers, patients and their families.

Part four: Mad medicine today (1990s-present) fifty pages started by statements made by the American joint commission on mental illness and mental health 1961. (This is a field where fads and fancies flourish, Hardly a year passes without some new claim, for example, that the cause or cure of schizophrenia has been found. The early promises of each of these discoveries are uniformly unfulfilled, successive waves of patients habitually appear to become more resistant to the newest "miracle" cure than was the group on which the first experiments were made). The rest of this part carries very harsh criticism of atypical neuroleptics and consider the whole story of atypicals specially risredonce is a joke.

This book has brought out a lot of the antipsychiatry movement on the surface specially in USA, one would not agree with everything he said, but I am sure it is a valuable reading for everybody interested in mental health.

Walid Sarhan

Discussion

SSRI.s have been used in the treatment of patients who developed irritability and aggression following closed head trauma[2] Sertraline has been shown to be effective in the treatment of impulsive aggression in patients with personality disturbances[3]. It has been claimed that the effectiveness of Sertraline can be explained by the sedative effect of the drug[4,5].

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Case Report

Specific Serotonin Reuptake Inhibitors in Organic Personality Disorder

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تقرير حالة:
إستعمال مثبطات إعادة قبض السيرتونين النوعية في إضطرابات الشخصية العضوية

روز لزك

Introduction

It has been found that a significant improvement in personality disturbances of paranoid personality, borderline personality and avoidant personality types, as a response to SSRI specially Sertraline[1]. The serotoninergic disturbed functions with the central nervous system could be the basis of impulsive aggression and self – destructive behaviour expressed by patients with personality disorders[3]. Several studies have shown good response to SSRIs . Specially irritability and aggression developed as consequence closed head trauma[2], This result were replicated by others[1,3].

The case

Male patient J.S. aged 37 years. At age 23,he was involved in a car accident and sustained a serious head injury which he never received any psychiatric treatment . He was hospitalized and was unconscious for 48 hours. Brain concussion and contusion were then diagnosed although his CT scan and MRI were normal, conservative treatment was given for two weeks His birth and milestones were uneventful, family and school life were good, after school he worked in a bank happily until now. Fourteen years later the patient developed personality changes as confirmed by the author, Mr.S became very irritable verbally aggressive, which has influenced his psychosocial adaptation badly.

The psychiatric evaluation of the patient revealed personality disorder of post-traumatic type. This diagnosis was confirmed by testing the patient[1] by the Swedish version of structured clinical interview for personality disorders, also the diagnosis was confirmed with partially structured open scale of aggression[3]. According to DSM-III –R criteria the diagnosis of personality disorder was confirmed, No other diagnosis on axis I on . No family history of psychiatric disorder.

Laboratory investigations were within normal including ECG , neurological examination was free, EGG showed sharp wave activity and intermittent scattered that waves . The patient was treated with individual psychotherapy and Sertraline up to 75 meg 1 with satisfactory remission of the symptoms.

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فروق دالة بين الطلبة الجيدين في مستوى القلق والطلبة الممتازين والضعفاء. ولقد قام الباحث في ضوء نتائج الدراسة بصياغة عدد من التوصيات والمقترحات.

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The probable explanation of this result can be summarized into three points:

1- This result supports the findings of previous studies[19,17,18]; which showed a negative correlation between anxiety and academic achievement. Anxiety in this case represents a painful conscious experience, which may develop by the student's perception of academic performance and parental high expectations as a threat to his self-efficacy.

2- For the excellent students the results were in general consistency with the findings of many studies [19,17,18], which affirm the theoretical trend that low level of anxiety in students reflects positively on their achievement at school. Students who have good parental treatment at home exhibit a higher degree of relaxation and reassurance, which are needed to perform well in schools or other fields for that matter.

3- In regard to the weak students it was surprising to the researcher to find out that there was a positive correlation between low anxiety and low academic achievement which contradicts the mainstream in educational and counseling psychology. However, in spite of the fact that this group represents a small portion of the study sample (7%) it is possible to say that these weak students may have experienced a great deal of sustainable maltreatment by their parents to the extent that they exceeded the threshold needed to maintain some levels of objective anxiety to motivate and stimulate these underachievers to have an accepted academic performance in school and self-worth at home. In light of the findings of the present study some recommendations could be drawn as follows:

1- An increase in quantity and quality of school counselors is needed to help in the development of specific educational and counseling programs and services to fulfill the guidance and counseling needs of the adolescents.

2- School counselors must implement preventive and therapeutic techniques that enhance the students' abilities to cope with stress and anxiety.

3- School counselors could coordinate efforts to educate parents on the characteristics and modes of child rearing, treatment and socialization of children and adolescents.

الملخص

تهدف هذه الدراسة إلى الكشف عن العلاقة بين اضطراب القلق وبعض أساليب المعاملة الوالدية. أيضاً تحاول الدراسة الحالية معرفة مدى وجود فروق دالة بين طلبة المرحلتين المتوسطة والثانوية في مستويات القلق يمكن أن تعزى للمرحلة التعليمية أو المعدلات الأكاديمية. لقد تم تطبيق أداتي الدراسة على ٣٣١ طالباً في ست مدارس حكومية بمدينة الرياض وقد أظهرت المعالجات الإحصائية وجود علاقة إرتباطية إيجابية دالة بين القلق وأساليب القسوة والحماية الزائدة والإهمال الوالدي كما أظهرت وجود علاقة سلبية دالة بين الأسلوب السوي الأبوي واh لقلق. أيضاً فقد كشفت الدراسة عن عدم وجود فروق دالة بين القلق والمرحلة التعليمية ولكن هناك

Discussion

The results of the current study will be discussed with reference to the findings of other studies. The results of the present study lend support to previous studies' findings indicating the importance of the parental treatment styles in the development and maintenance of anxiety in adolescents.

Testing the first hypothesis revealed a significant positive relationship between anxiety and the parental style of cruelty. This result supports the findings of AL-Suwaigh's study, which showed that parents who practiced cruelty with their children resulted in the creation of many psychological disturbances and behavioral problems.

Consistent with Wenar and Kerg's (2000) study findings, examining the relationship between anxiety and overprotection, it was found that the occurrence of anxiety among students has been significantly correlated in a positive way. The premise here is that parental overprotection results in the individual becoming less self-dependent on therefore would lack the skills needed to deal with new experiences that may lead to anxiety. Rape (1997) pointed out that many studies dating back to the 1950's found that parents of anxious children had practiced control and overprotection.

Also, the findings revealed a significant positive relationship between the parenting style of negligence and the existence of anxiety in their adolescent sons. This result agrees with Attahan's (1992) study findings about the role of parenting negligence in the development of anxiety among youngsters. Also, consistent with this, Viovona (2000) concluded in his study of parental attachment styles of late adolescents that securely attached adolescents manifested uniformly positive attachment and low levels of anxiety and worry compared to insecurely attached adolescents.

In regards to normal treatment it was revealed that there is a significant negative correlation between anxiety and the fathers' normal treatment. Therefore, it is expected that the levels of anxiety will be decreased with the son's perception and experiences of their parent's normal treatment. As for the mother's normal treatment styles it was negatively correlated to anxiety but not to a significant level. The findings of this study are similar to the results of Attahan's (1992) study, which exhibited the important role of fathers in the treatment and socialization of youth. Consistent with these results are the findings of Chang's (2002) study, which revealed that the father's treatment style is more effective on sons.

By and large the results of this study replicate earlier studies. As far as the differences between the intermediate and secondary school students are concerned, the second hypothesis did not reveal significant differences between the two groups in their anxiety levels. These findings are consistent with the trend of the majority of theoretical orientations in educational and counseling psychology regarding the characteristics and conditions of early and late adolescence periods.

With regards to the final hypothesis the results showed significant statistical differences among the students in their levels of anxiety in relation to their grade point average. The Bonferroni test of multiple comparisons revealed that the good students have higher mean ratings of anxiety and differ significantly from the excellent students and the weak students.

calculated with an accompanying value of .0073, which means retaining the hypothesis. Table (5) displays a summary of ANOVA findings.

Table (4): T-test of the Differences between Intermediate and Secondary Schools' Students

School	N	Mean	Stan. Dev.	T-Value	Sig.
Intermediate	139	2.213	.486	-1.52	.130
Secondary	183	2.125	.539		

D- The Third hypothesis: There are significant differences among students in their levels of anxiety, which can be referred to their different grade point average. One way analysis of variance was utilized to test the research hypothesis. An F value of 4.084 was calculated with an accompanying value of .0073, which means retaining the hypothesis. Table (5) displays a summary of ANOVA findings.

Table (5): One Way Analysis of Variance for the Differences According to the GPA

Source	Sum. Squ	D.F	M. Squ	F	P
Between groups	2.97	3	.99	4.084	.007
Within groups	75.12	310	.24		
Total	78.09	313			

The Bonferroni test of multiple comparisons was used to the mean ratings to uncover the source of variance among the four groups. Table (6) shows that the good students differ significantly in their levels of anxiety from the excellent and week students.

Table (6): The Bonferroni Method of Multiple Comparisons of GPA Means

#	GPA	Means	1	2	3	4	N
1	Excellent	2.06					52
2	V. Good	2.17					142
3	Good	2.29	*			*	106
4	Weak	1.98					23

Results and Findings

In this section, the hypotheses will be tested and the results will be displayed in tables.

A- The alternative hypothesis stated that there is a significant relationship between anxiety and the four parental treatment styles of cruelty, overprotection, and negligence and normally as perceived by the sons.

A partial correlation coefficient was performed to test the research hypothesis. Table (3) showed that the partial correlation coefficient between anxiety and the parental cruelty was .38 for the fathers and .37 for the mothers, which reveals a positive relationship with a statistical significance at.01 level.

Table (3): Partial Correlation Coefficients of Anxiety and the Four Parental Styles

Parental Style	Cruelty		Overprotection		Negligence		Normality	
	Father	Mother	Father	Mother	Father	Mother	Father	Mother
Anxiety	.38**	.37**	.33**	.37**	.34**	.34**	-.17**	-.08

** Significance at the level of .01.

Also table (3) displayed that the partial correlation coefficient between anxiety and the parental overprotection was .33 for the fathers and .37 for the mothers which shows a positive relationship with a statistical significance at .01 level.

For the parental negligence, table (3) displays that the partial correlation coefficient was .33 for the fathers and .37 for the mothers which shows that there is a significant statistical positive relationship between anxiety and the parents negligence of their son's anxiety and the normal parental treatment style as perceived by the sons. Finally a partial correlation coefficient was performed to test the research hypothesis.

Table (3) displays that the partial correlation coefficient was -.17 for the fathers and -.08 for the mothers, which shows that there is a significant negative relationship between the father's normal style and anxiety at.01 level of significance. This means that normal treatment by the fathers decreases the levels of their sons' anxiety. On the other hand, there was a negative relationship between mothers' normal style of treatment and anxiety but it was not statistically significant.

B- The second alternative hypothesis: There are no significant differences between intermediate and secondary school students in their levels of anxiety. A T-test was applied to test the null hypothesis. Table (4) presents a summary of T-test results, which revealed that the null hypothesis could not be rejected. This means that there were no significant differences between the intermediate and secondary school students in their levels of anxiety.

C- The Third hypothesis: There are significant differences among students in their levels of anxiety, which can be referred to their different grade point average. One way analysis of variance was utilized to test the research hypothesis. An F value of 4.084 was

Table 2: Reliability and Internal Consistency of the Four Subscales of Parental Treatment Styles

Cruelty					Overprotection					Negligence					Normality				
Father			Mother		Father			Mother		Father			Mother		Father			Mother	
Item	Corr.	Sig.	Corr.	Sig.	Item	Corr.	Sig.	Corr.	Sig.	Item	Corr.	Sig.	Corr.	Sig.	Item	Corr.	Sig.	Corr.	Sig.
4	.,61	..01	.,65	.,01	2	.,49	..01	.,45	.,01	5	.,49	.,01	.,50	.,01	1	.,58	.,01	.,49	..01
7	.,64	..01	..72	..01	3	..53	..01	.,61	..01	10	.,49	.,01	.,56	..01	8	.,66	.,01	.,62	..01
11	.,50	..01	.,52	.,01	6	.,54	..01	.,64	..01	16	.,48	..01	.,49	..01	12	.,63	.,01	.,58	..01
13	.,63	..01	..73	..01	9	.,52	..01	.,54	..01	17	.,39	.,01	.,47	..01	14	.,55	.,01	.,57	..01
15	..71	..01	.,59	..01	25	..53	..01	.,50	..01	26	.,54	..01	.,43	..01	18	.,56	.,01	.,53	..01
20	.,54	..01	.,56	..01	29	..38	..01	..38	..01	28	.,41	..01	.,31	..01	19	.,55	.,01	.,53	.,01
21	.,69	..01	..72	..01	30	..36	..01	.,46	..01	31	.,43	..01	.,45	..01	23	.,42	.,01	.,29	..01
22	.,53	..01	.,67	..01	32	..53	..01	.,49	..01	35	.,49	..01	.,43	..01	24	.,57	.,01	.,45	..01
34	.,63	..01	.,54	..01	33	..54	..01	.,47	..01	36	.,61	..01	.,50	..01	27	.,54	.,01	.,51	..01
37	.,56	..01	.,55	..01	39	.,47	..01	.,48	..01	41	.,50	..01	.,57	..01	42	.,59	.,01	.,48	..01
38	..71	..01	.,65	..01	44	..58	..01	.,42	..01	45	.,51	..01	.,37	..01	48	.,59	.,01	.,60	..01
40	.,66	..01	.,64	..01	47	..58	..01	.,47	..01	49	.,55	..01	.,49	..01	52	.,58	.,01	.,44	..01
43	.,34	..01	.,34	..01	50	.,60	..01	.,40	..01	51	.,46	..01	.,57	..01	57	.,61	.,01	.,60	..01
46	.,57	..01	.,54	..01	53	.,60	..01	.,52	..01	54	.,52	..01	.,49	..01					
										55	.,51	..01	.,43	..01					
Reliability Coepicients		..84	..87		..84			..80		..83			..81		.,89			..82	
Total Alpha:			Father: .,91					Mother: .,90											

Table (1): Internal onsistency of Taif Anxiety Scale

Item#	Correlation item x total	Sig.	Item#	Correlation item x total	Sig.	Item#	Correlation item x total	Sig.
1	.,32	.,01	11	.,54	.,01	21	.,43	.,01
2	.,48	.,01	12	.,45	.,01	22	.,52	.,01
3	.,44	.,01	13	.,54	.,01	23	.,54	.,01
4	.,47	.,01	14	.,42	.,01	24	.,48	.,01
5	.,55	.,01	15	.,42	.,01	25	.,34	.,01
6	.,53	.,01	16	.,58	.,01	26	.,50	.,01
7	.,47	.,01	17	.,55	.,01	27	.,61	.,01
8	.,68	.,01	18	.,49	.,01	28	.,61	.,01
9	.,52	.,01	19	.,43	.,01	29	.,62	.,01
10	.,46	.,01	02	.,57	.,01	03	.,34	.,01
31	.,21	.,01	37	.,20	.,01	43	.,45	.,01
32	.,54	.,01	38	.,33	.,01	44	.,36	.,01
33	.,34	.,01	39	.,41	.,01	45	.,25	.,01
34	.,31	.,01	40	.,20	.,01	46	.,54	.,01
35	.,22	.,01	41	.,46	.,01	47	.,48	.,01
36	.,20	.,01	42	.,28	.,01	----	----	.,01

Data Analysis:

The two instrument items require that the students express their perceptions or opinions on a Likert Scale. Taif Anxiety Scale used: always =3 sometimes =2, rarely =1 and never =0. For the Parental Treatment Styles Scale, the response categories are always =2, sometimes =1 and never =0. For the analysis of the data collected, SPSS was used to obtain frequencies, percentages, means, standard deviations, T-test and analysis of variance.

that there was a negative relationship between academic achievement and anxiety among two hundred students in the United Arab Emirates. Moreover, Kadhem (1973) found in her study that excellent and good students have less anxiety in comparison with weak students.

Methodology of the study:

1- Sample of the study :

The subjects of this study consist of 140 ninth grade students and 191 eleventh grade students. These 331 students represent six intermediate and secondary schools in Riyadh city. The average age of the students is 16.7 years. The sample was geographically limited to the city of Riyadh and to the male youth.

2- Instruments of the study:

Two instruments were implemented in this study:

First: Taif Anxiety Scale:

The researcher and others developed this instrument in 1994. This instrument that contains 47 items was applied to 4156 individuals of the Saudi population in twenty-seven cities. Face validity, factorial validity and concurrent validity were obtained. For the reliability of the scale, an Alpha Cronbach of .92 was calculated, which reflects high reliability coefficient. For the present study, table (1) shows the high correlation coefficients using the internal consistency validity. An Alpha Cronbach was implemented and it revealed a high rate of reliability of .91.

Second: Parental Treatment Styles Scale

Mohammed S. Assohaimi designed this instrument in 1993 for the purpose of measuring four parental treatment styles in Saudi Arabia. This tool consists of 57 items. It was applied to students in intermediate and secondary schools in Riyadh city. Content and construct validity were obtained. The reliability was found using Spearman-Brown and Cronbach, which showed high coefficients. For the current study, table (2) shows the high correlation coefficients using the internal consistency validity for the four parental treatment styles. Also table (2) displays high reliability coefficients for both fathers and mothers versions using Alpha Cronbach.

Data Analysis:

The two instrument items require that the students express their perceptions or opinions on a Likert Scale. Taif Anxiety Scale used: always =3 sometimes =2, rarely =1 and never =0. For the Parental Treatment Styles Scale, the response categories are always =2, sometimes =1 and never =0.

For the analysis of the data collected, SPSS was used to obtain frequencies, percentages, means, standard deviations, T-test and analysis of variance.

2- Are there significant statistical differences between secondary and intermediate schools' students in their levels of anxiety?
3- Are there significant statistical differences in anxiety among the students referred to their grade point average?

Importance of the Study

Anxiety disorders are the most common psychological problems reported by children and adolescents. Estimation for prevalence of childhood anxiety disorders in the population range from 1% to 21%[7].

It is anticipated that the findings, conclusions and recommendations of this study may assist in the following:

1- More formal and official attention will be given to improving mental health services in schools and clinics.
2- Increasing the quantity and quality of school counselors to screen, diagnose and treat such cases in early stages.
3- Development of new educational, developmental, preventive and therapeutic programs to deal with the psychological problems of childhood and adolescence.

Review of Related Literature :

This section presents a review of the literature relevant to the purposes of the study. McClure and others (2001) stated that recent studies have shown significant associations between perceived parental psychological control and the presence of both anxiety symptoms and clinical anxiety disorders in children. AlSuwaigh (1997) found in her study of three hundred boys and girls in the elementary level in Saudi Arabia that the parental treatment styles mostly used by the parents were the cruelty, overprotection, temperament and negligence. Attahan (1991) found out in a study of 338 high school students in the United Arab Emirates that a significant positive correlation exists between anxiety and parental negligence. He specified that the fathers' style is more determinant in the appearance of anxiety among the students. Ashara'ah (2000) revealed in his study of 263 Jordanian college students that there is a significant negative correlation between parental democratic and acceptance styles and anxiety. Salamah (1987) concluded in her study of some Egyptian children that there is a positive relationship between fear and parental rejection. Also, Crick and Ladd (1993) in a study of the third, fourth and fifth grades' students emphasized that those who are rejected by their parents expressed feelings of psychological loneliness and anxiety. In regards to the parental style of cruelty and its psychological impact on the children, Morsee (1988) found a positive correlation between anxiety and the perceptions of King Saud University students of their parents' cruelty. He concluded that anxiety trait as behavioral disposition grew with children's perceptions of parental refusal or acceptance. Settler and Brandon (1967) specified that there was a positive correlation between children's anxiety and parental treatment style of cruelty. Wenar and Kerig (2000) concluded that there is evidence that parental over-protectiveness and maladaptive support contributes to the maintenance of anxiety. As for the relationship between anxiety and academic achievement, Spielberger and Katzenmayer (1974) indicated a negative correlation between anxiety and academic achievement among children, adolescents and adults. Also, Agha (1988) concluded in his study

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The Relationship Between Anxiety And Some Parental Treatment Styles

Fahad Abdullah Addelaim

العلاقة بين القلق وبعض أساليب المعاملة الوالدية كما يدركها الأبناء

فهد عبدالله الدليم

Introduction

Anxiety disorders are the most common psychological problems reported by children and adolescents, with up to 20% of children being affected and 8% at a level of severity[1]. Approximately half the children with an anxiety disorder will have a diagnosable disorder eight years after its onset. The chronicity of childhood anxiety is related to their associations with some psychosocial d
ifficulties .

Prior to 1950, only two books had been written about anxiety, one being Freud's "the Problem Of Anxiety" and Kierkgardis" The Concept Of Dread"[2]. However, at the start of the second half of the last century a wide range of experimental studies and field research were carried out, especially after Janet Taylor published The Manifest Anxiety Scale.

Many theoretical approaches tried to explain the concept of anxiety. Freud (1959) believes that anxiety is an inevitable aspect of the human condition and it refers to the fear that one's inner impulses cannot be controlled. Horney (1945) thinks that anxiety is created by social forces rather than by the human predicament itself. Specifically, she believes a variety of negative conditions in the environment could produce insecurity entailed in basic anxiety, conditions such as overprotection, parental dominance and discord, hostility and inconsistent behavior.

These conditions could be seen clearly in the familial environment where the lack of appropriate parental fostering and socialization may leave children with feelings of frustration , fear and insecurity[2].

Developmental psychologists have been interested in the role of parenting and how it may affect the success or failure of socialization.

Baumrind (1990) classified the parental treatment into four styles: indulgent parents, authoritarian parents, authoritative parents and uninvolved parents.

The present study tries to define the nature of the correlations between anxiety and parental treatment styles of their adolescent sons.

Statement of the Problem

Anxiety in the psychoanalysis orientation is a central concept like Freud and Homey. Sullivan conceives of anxiety as any painful feeling or emotion that may stem from organic needs or social insecurity [2].

The present study tries to explore the potential role of the family environment in the development of anxiety among adolescents by examining the relationship between anxiety and the sons' perceptions of their parents' treatment styles. Specifically, this study aims at answering the following questions:

1- Is there a relationship between anxiety and some parental treatment styles as perceived by the sons ?

NCCN® Practice Guidelines in Oncology – v.1.2002

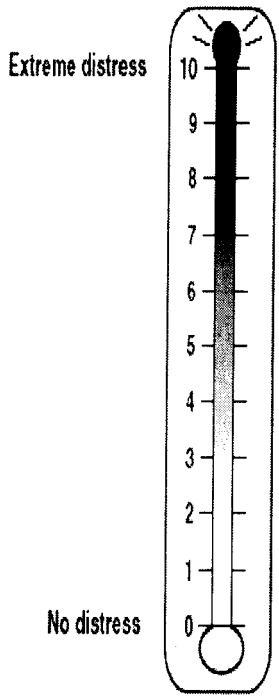
Distress Management

Guidelines Index
Distress Management TOC
MS Referencer

Figure 1

Screening tools for measuring distress

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a cause of distress in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Housing
❑	❑	Insurance
❑	❑	Work/school
❑	❑	Transportation
❑	❑	Child care

		Family Problems
❑	❑	Dealing with partner
❑	❑	Dealing with children

		Emotional Problems
❑	❑	Worry
❑	❑	Fears
❑	❑	Sadness
❑	❑	Depression
❑	❑	Nervousness

		Spiritual/religious concerns
❑	❑	Relating to God
❑	❑	Loss of faith

YES	NO	Physical Problems
❑	❑	Pain
❑	❑	Nausea
❑	❑	Fatigue
❑	❑	Sleep
❑	❑	Getting around
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Mouth sores
❑	❑	Eating
❑	❑	Indigestion
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Changes in urination
❑	❑	Fevers
❑	❑	Skin dry/itchy
❑	❑	Nose dry/congested
❑	❑	Tingling in hands/feet
❑	❑	Feeling swollen
❑	❑	Sexual

Other Problems: _____

_____

_____

مـركـز الحسـين للسرطـان

قسـم الصحـة النفسـية والرعـايـة الاجتماعيـة

الاسم ..... الجنس: [] ذكر [] أنثى
العمر ..... الحالة الاجتماعية: [] أعزب [] متزوج [] مطلق [] أرمل
المستوى التعليمي :.....المهنة .....
العنوان: .....التليفون.....
.....
التشخيص: ..... تاريخ التشخيص:.....
نوع العلاج : [] جراحة [] كيماوي [] اشعة []علاجات اخرى تاريخ بدءالعلاج:.....
[] داخل المركز [] خـــــارج

المركز

عزيزي حدد درجة تأثير المرض على حياتك

١ يتسبب في ضيق شديد

يتسبب في ضيق متوسط

يتسبب في ضيق محدود

لم يتسبب بضيق إطلاقا

أ) عزيزي هل تعاني من مشكلة في:
- ❑ السكن
- ❑ نفقات العلاج
- ❑ العمل /الدراسة
- ❑ المواصلات
- ❑ العناية بأولادك
- ❑ التعامل مع زوجتك/زوجك
- ❑ التعامل مع الآخرين/أولادك

ب)هل تشعر ب :
- ❑ القلق
- ❑ الخوف
- ❑ الحزن
- ❑ الكآبة
- ❑ العصبية و التوتر

ج)كيف ترى المرض:
- ❑ قضاء و قدر
- ❑ لماذا أنا؟

هل تعاني من:
- ❑ الألم
- ❑ الغثيان
- ❑ الإجهاد
- ❑ اضطراب النوم
- ❑ صعوبة الحمام و اللبس
- ❑ صعوبة في التنفس
- ❑ تقرحات بالفم
- ❑ اضطراب الشهية
- ❑ عسر الهضم
- ❑ الإمساك
- ❑ الإسهال
- ❑ صعوبة التبول
- ❑ الحرارة
- ❑ مشاكل جلدية
- ❑ سيلان في الأنف
- ❑ خدران في الأطراف
- ❑ تورم و انتفاخ
- ❑ مشاكل جنسية

د)إضافات أخرى:.....
.....

هاتف: ٠٦-٥٣٥٣٠٠٠ فاكس: ٠٦ - ٥٣٤٢٥٦٧ ص.ب ١٢٦٩ الجبيهة - عمان ١١٩٤١ الأردن

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far from our results as in our case we didn't use the sub categories:
Moderate global level of distress (3.5-6.5)
Low level (0-3.5)
High level (7-10).

Conclusion

The Majority of adult in-patients in KHCC suffer from significant distress due to psychosocial and somatic factors. Major components of the distress are anxiety, fears, pain, sadness, sleeplessness and fatigue. It has been our hope through this study to be able to address such problems correctly and to provide the most comprehensive biopsychosocial intervention. We will be proactive in as much as that all our patients will be screened for quality and quantity of distress using the modified thermometer and each will be managed accordingly.

As part of our intervention, a letter will be addressed to all new patients to provide insight, knowledge about illness and treatment, hope, telling them that we "the whole KHCC team" will be always there for them to help through fear, anxiety, uncertainty and sadness and to reassure them that care and follow-up will be extended past their discharge.

In the next few months we hope to perform a follow-up longitudinal study to assess the effects of our intervention on all parameters established by our modified scale.

Important issues that will need to be studied in greater detail in future work include the assessment of intervention strategies. Placebo-controlled trials to assess the efficacy of our modified screening scale versus the traditional consultation can be part of future designs.

Important issues is to be addressed, and still we don't have definite answer for are

1- Whether professional psychiatric intervention should be carried on the bases of the level determined by distress screening, or consultation should be asked by the team, or help is to be asked by patient?
2- Should psychiatric intervention be a part of the management process or still a special consent is needed?

الملخـــص

هــذه دراسة مراجعة سجلات المرضى تهدف لإكتشاف نوعية وحجم الإزعاج المرافق للسرطان فـــي مرضى مركز الحسين للسرطان في الأردن، وذلك بإستعمال الشكل العربي المطوّر لميزان حـــرارة الإنزعاج الذي يتم تطويره من قبل شبكة السرطان الوطنية الشاملة في الولايات المتحدة الأمريكية، لمعرفة طبيعة الإنزعاج لمئة مريض خلال فترة ستة أسابيع . أظهرت النتائج بأن ٧٠ % مـــن المرضـــى يعـــانوا مـــن إنزعاج مهم يزيد عن درجة ٥ على ميزان الحرارة ، وكانت العناصـــر الرئيسية للإنزعاج هي القلق، الخوف، الألم ،الحزن والإرهاق ، إن نتائج هذه الدراسة تشجع على إستعمال هذا الميزان لكافة مرضى السرطان قبل التقييم السريري النفسي.

Table 10: Major problems in patients diagnosed 2003: 27 patients out of 42= 64%

Total	Fatigue	Nausea	Pain	Fears	Anxiety	Problem
27	26	22	25	26	27	No of affected
100%	96.2%	81.1%	92.5%	96.2%	100%	%

Table 11: Social causes of distress

Dealing with other	Dealing with spouse	Problem
51	25	No
92.7%	45.4%	%

Table 12: Distress in relation to age

total	>70	61-70	51-60	41-50	31-40	20-30	<20	Age
70	2	12	13	12	14	14	3	No
100	%2.9	%17.9	18.5%	%17.1	20%	20%	4.4%	%

Table 13: Sex distribution in distress

G.total	Female	Male	Sex
100	57	43	Total
70	46	24	Distressed
70%	65.7%	34.2 %	%

Discussion

Overall level of distress was higher than the reported levels. "Numerous studies suggest that 25% to 50% of cancer patients have psychological distress and at least a quarter of cancer patients suffer depression[5]". But most of the studies did not explain the state of patients, whether in or out patients or they were under active treatment; i.e. currently receiving chemotherapy or radiotherapy or neither. Our population consisted of:

1. All in-patients.
2- All were in active phase of illness and/or under active treatment.

This might explain our rather high results. Another possible reason for the discrepancy in rates might have been due to methodological differences in interpretation of the distress thermometer, our inclusion for high versus low level of distress were the cut off point 5, while other studies[6] revealed different results. The majority (51%) identified moderate global level of distress (3.5-6.5); (26%) a low level (0-3.5) and (23%) a high level (7-10). However if we sum those who scored above 5 "our cutoff sign" we might be dealing with 51% + 26 i.e. >70 which is not

Table 7: Distress according to type of cancer

%	Distressed i.e.>5	No	Type
82.1%	23	28	Breast
100%	1	1	Pancreas
50%	1	2	Prostate
54.5%	6	11	Blood
55.5%	5	9	Endocrine
50%	1	2	Testes
66.6%	2	3	Ovary
66.6%	4	6	Bone
62.5%	5	8	Lung
62.5%	5	8	Cervix
50%	1	2	Skin
60%	3	5	Colon
100%	1	1	Brain
100%	1	1	Kidneys
66.6%	4	6	Stomach
66.6%	2	3	Bladder
100%	1	1	Liver
100%	2	2	Larynx
100%	1	1	Neurological
70%	**70**	**100**	Total

Table 8: distress scores > 5 according to treatment

radiation	chemo	surgery	Type
18	55	57	NO
25.7%	78.5%	81.4%	%

Table 9: Major causes of distress in patients diagnosed before 2003: 42 patients out of 58 = 72%

Total	Fatigue	Nausea	Pain	Fears	Anxiety	Problem
42	35	39	37	35	35	No of affected
100%	83.3%	92.8%	% ^^	83.3%	83.3%	%

Table 5: the problems causing distress

NO	Nature of problem
23	Housing
16	Cost
50	Work/study
43	Travel
50	Care of children
31	Deal with spouse
67	Deal with others
98	Anxiety
91	Fear
84	Sadness
61	Depression
60	Nervousness ,irritability
91	**Accepting illness" Gods well"**
35	Why me?
88	Pain
68	Nausea
80	Fatigue
84	Sleeplessness
26	Difficulties in toilet
44	Difficulty in breathing
22	Ulcers
78	Loss of appetite
37	Indigestion
59	Constipation
13	Diarrhea
22	Dysurea
46	Fever
25	Skin problems
10	Running nose
53	Numbness
25	Edema
17	Sexual problems

Table 6: distress level

total	9	8	7	6	5	4	3	2	1	**Distress level**
100	1	3	12	25	29	18	8	4	0	No

Results

Table 1: distribution according to gender

No	Sex
40	Male
60	Female
100	**Total**

Table 2: distribution according to treatment

Other	Radio-	Chemo-	Surgery	Rx
1%	25%	77%	73%	No

Table 3: distribution of the type of cancer

NO	Type
28	Breast
1	Pancreas
2	Prostate
11	Blood
9	Endocrine
2	Testes
3	Ovary
6	Bone
8	Lung
8	Cervical
2	Skin
5	Colon
1	Brain
1	Kidney
6	Stomach
3	Bladder
1	Liver
3	Larynx
1	Neurological

Table 4: the year of the diagnosis

2003	2002	2001	2000	Before99	Year
42	27	18	8	5	NO

common, averaging a point prevalence across studies of about 25-30%[2,4]."

"Psychological or psychiatric conditions, usually anxiety and depression are common in patients with cancer[4,5,6]. At least 25% of hospitalized cancer patients are likely to meet criteria for depression or adjustment disorder[3]. One multi-centre prevalence study showed that 51% of patients had symptoms consistent with a psychiatric diagnosis[7]. Patients at highest risk of depression are those with a history of affective disorder, with advanced cancer, poorly controlled pain and treatment with medication or concurrent illnesses that can produce depressive symptoms[3]. Psychological disturbance frequently occurs following a diagnosis of breast cancer. Research shows that 24 - 38% of patients with breast cancer suffer from clinical levels of anxiety and/or depression[6,8]. A similar proportion experiences a decline in quality of life due to psychosocial effects, such as role changes, loss of functional ability and problems with social relationships[3]."

"The Distress Thermometer (DT), a self-administered assessment, is adapted from that developed by the National Comprehensive Cancer Network[7]. This tool has two sections. The first asks patients to indicate the highest global level of distress experienced in the previous week on a 10-integer scale in the shape of a thermometer, marked in + point intervals. The second section asks patients to choose the domains of their distress from a list selected by the panel to reflect the constitutional symptoms of cancer and the common side effects of treatment. Physical, emotional, social, practical and spiritual items are represented[4]."

Method

We used the distress thermometer developed by the National Comprehensive Cancer Network[7].

Initially we translated it into Arabic then we validated it to suit the Jordanian cultural and social norms.

Then we added items to the thermometer to extend the data gathered to help to form a comprehensive study such as age, gender, date of diagnosis, treatment, type of cancer and marital status. We had wide range of results regarding the type of cancer, nature, type of distress, relation to gender and age, relation of distress to type of cancer and type of treatment. Nature and components of distress in relation to date of diagnosis and duration of illness.

We considered 5 as a cutoff mark, so scores above are considered distress.

After that we interviewed the patients to fill the thermometer i.e. it was not fully self-administered, as we had to explain the nature and the aim of the questionnaire. We interviewed every patient admitted to KHCC "new or re-admission" in addition to those we were consulted upon.

We used the thermometer with the intent of management rather than study, and then we studied results retrospectively.

We studied the first 100 files during the period from June to July 2003; all patients admitted through that period were included regardless of any other factor.

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Distress in cancer in-patients in KHCC
A study using the Arabic-modified version of Distress Thermometer in the King Hussein Cancer Center

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الإنزعاج في مرضى السرطان الداخلين لمركز الحسين للسرطان
دراسة في إستعمال الشكل العربي المطور لميزان حرارة الإنزعاج في مركز الحسين للسرطان - الاردن

ج.خطيب ر. صالحي ج. عوض

Abstract

This is a case review study exploring and examining the quality and quantity of distress associated with cancer in patients at the King Hussein Cancer Center in Jordan using a modified version of the Distress Thermometer developed by the National Comprehensive Cancer Network (U.S.A). The aim is to examine the nature of distress in 100 patients over a 6 week period. The results showed that as many as 70% of the patients are suffering significant distress > 5 on the thermometer. The major components are anxiety, fear, pain, sadness and fatigue. The results of this study encourage the use of the distress thermometer for all cancer patients prior to clinical evaluation of all the cancer patients.

Introduction

Distress is defined as "an unpleasant experience of an emotional, psychological, social or spiritual nature that interferes with the ability to cope with cancer treatment. It extends along a continuum, from common normal feelings of vulnerability, sadness and fears, to problems that are disabling, such as true depression, anxiety, panic and feeling isolated or in a spiritual crisis[1]."

"Research has repeatedly revealed a high prevalence of psychosocial distress in a variety of populations of cancer patients, and has been reviewed in several publications[2-5]. In one of the earliest and most widely-cited studies by Derogatis and colleagues, the point prevalence of DSM-III diagnoses were assessed: over one-third of a randomly selected sample of cancer patients from three cancer programs met diagnostic criteria for Adjustment Disorder with Depressed or Anxious Mood[6]. An additional 7% were diagnosed with a current Major Depressive Disorder. Overall, 47% of these patients were diagnosed with a DSM-III Axis I disorder. Reported rates of depression in patients with cancer ranged widely -- from 1-53%, depending on the population of patients and the diagnostic criteria used[7]. The most commonly reported point-prevalence rates of major depression are in the 20-25% range, increasing with higher levels of physical disability, advanced illness and pain[4]. Adjustment disorder is also very

٥ر٢% اســتعملوا الحشــيش، و ٣ر٣% استعملوا الأفيون، و ٦ر٢% استعملوا المنشطات، و٠٢% استعملوا البنزهكسول، و٢٩% مدخنين ولم يكون هناك أحد استعمل الكوكائين.

أظهــرت الدراســة أن هناك بعض عوامل الخطورة التي تؤدي الى استعمال مواد الإدمان مثل البحث عــن القبول من قبل الرفاق، تشجيع الرفاق، وجود صديق يتعاطى هذه المواد وصعوبة التواصل مع العائلة.

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higher than the Lebanese survey which found a rate of 1.6%, but it is lower than the US rate at 9% for the same age group[14]. Cannabis, the most widely used illicit drug in the West[15], had a self-reported use rate of 2.5%. This is lower than the Egyptian survey, which found a 5% rate, but close to the Lebanese survey, which found a 2.2% rate. In this respect, the same American age group showed that 50% had used cannabis at least once during the previous month, and 13% defined themselves as current users[16]. Opioids were used least of all, with a rate of 0.9%. This is higher than the Egyptian survey rate of 0.6% and lower than the Lebanese survey rate of 3.8%. It is worth mentioning that none of the surveyed group used cocaine unlike 0.05% of the Egyptian survey and 0.5% of the Lebanese survey.

The low rates of use of the more dangerous substances could be due to lesser availability in the market, high price and knowledge of the dangerous consequences of their use. Risk factors for substance abuse in the study group were an important factor of the current study.

In conclusion, a pattern of risk factors was found to be common to all abuse substances while others were substance-specific. The risk factors included:

- Friends' acceptance and encouragement of the behavior.
- Lack of communication between families and the abuser member
- Living in an area where substance abuse is common.
- Psychological instability.
- Low school achievement
- Growing up outside Jordan was specifically related to alcohol and cannabis use.

The above risk factors may help policy makers and educationalists to implement policies and take precautions that could help to prevent young population, especially those at risk, from being involved in substance use activities.

الملخـــــص

هدفـت هـذه الدراسة المسحية التي بدأت في شباط عام ٢٠٠١ الى استقصاء مدى انتشار وأنواع مواد الإدمان بين طلبة الجامعات والكليات المتوسطة الأردنية.

الطـريقة: اشـتملت عيـنة الدراسة على ٥٠٦٤ مشارك تراوحت أعمارهم بين ١٨ الى ٢٥ سنة تم اختـيارهم عشـوائياً وتمت مقابلتهم أجابوا على استبيان طور خصيصاً لغايات الدراسة بعد التأكد من صـدقه وثـباته حيـث تتـناول الجوانب الشخصية، العاطفية، العلاقات الاجتماعية خاصة مع الأهل والأصـدقاء والجـيران، وكذلك تناول المواد الشائعة بسوء الاستخدام، حيث كان الاستبيان بدون اسم وسري.

النـتائج: أظهرت النتائج أن العينة تتكون من ٢٧٨٠ من الإناث (٩ر٥٤%) و ٢٢٨٤ (١ر٤٥%) من الذكـور وعـند سؤالهم عن المواد التي أساؤا استخدامها على الأقل مرة واحدة خلال الشهر، تبين أن

Discussion

Surveys of drug use by questionnaires are a common method for obtaining information, especially amongst school aged samples. This method has many advantages: it can ascertain the level of many substances of abuse at a single point in time, it can present unbiased reports relating to the subjective need for treatment or involvement with crime, and it is an efficient means to collect data rapidly. Surveys, however, have some inherent problems as they assume honesty of the respondent, which cannot always be relied upon especially when the subject of the survey is of a contentious nature.

Despite the limitations of self-report methods, studies have shown a high reliability and validity of surveys for use of illicit drugs[5], especially if the data provided are anonymous or confidential, as it is the case in our study.

The results of our study provided information relating to the type of abused substances and the rate of their use by the sample during the month prior the conduction of the study. This procedure, though not ideal, may give an indication of the extent of the drug use among the studied population.

The results of substance use among the group showed that tobacco was the highest at (28.7%), which is higher than both the current percentage of adult smokers in the United States which stands at 22%[11], and the Lebanese university students' survey[12] which found 20% of them to be current smokers. This could be due to the fact that smoking is a widespread habit among Jordanians generally.

Sedatives and anti-anxiety drugs were also used widely with self-reported use standing at 12.5%. Again, this is higher than 9.3% which was found in Lebanese university students survey and much higher than 4% which was found in university students survey in Egypt[13]. It is suggested that this could be due to a high availability of these medications in Jordan. The common use of these drugs is likely to be due to the fact that their use is more socially acceptable than alcohol and other drugs.

The alcohol use rate was 11.8%. This is lower than the rate of the Egyptian survey (16%) and the Lebanese survey (14%) which may be due to availability and absence of restrictions on its purchase, and very much lower than a similar US age group where 51% are current alcohol users, a difference that is most likely due to religious and social factors.

The volatile substance use rate was 3.3%. This percentage is higher than that found by a US survey for the same age group, which found 2.7% to have used inhalants at least once during the prior month[12]. This is probably due to the fact that these substances are easily available, are inexpensive, and socially more acceptable than other substances in Jordan.

As for the anti-cholinergic and antiparkinsonian drug Benzhexol, which abusers in Jordan use as stimulant, the rate was 2.8%. In this regard, easy availability may have played a role in its common use.

Other drugs were led by amphetamine at 2.6%. This is higher than the Egyptian survey, which found a 1.3% rate, and also

Table 7: Distribution of psychoactive drugs use according to risk factors

Substances	Amph. like		Benztropin		Sedatives		Opiates		Volatile		Hashish		Alcohol	
Risk factors	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Raised abroad	29	4.1	31	4.3	104	14.6	9	1.3	30	4.2	37	5.2	117	16.4
Grades below 60%	16	6.2	15	5.8	51	19.8	8	3.1	20	7.8	19	7.4	62	24.0
Living with non-relatives	67	2.0	79	2.4	398	12.1	21	0.6	90	2.7	71	2.2	390	11.9
Not expressing feelings to parents	39	3.6	40	3.7	159	14.6	17	1.6	56	5.1	42	3.9	163	15.0
Feeling anxious	50	3.0	58	3.5	281	16.8	26	1.6	72	4.3	56	3.3	234	14.0
Parents & friends abusing alcohol	43	4.2	58	5.6	228	22.1	15	1.5	51	4.9	59	5.7	328	31.8
Making quarrels	91	3.2	99	3.5	414	14.6	41	1.4	125	4.4	86	3.0	386	13.6
Feeling depressed	80	2.9	91	3.3	451	16.1	29	1.0	114	4.1	71	2.5	342	12.2
Quarrels with parents	96	2.6	103	2.8	532	14.3	35	0.9	132	3.5	88	2.4	460	12.3
Frequent abuse of alcohol in your neighborhood	85	3.6	100	4.3	413	17.6	32	1.4	101	4.3	102	4.3	476	20.3
Abuse of another drugs in your neighborhood	53	7.0	62	8.2	181	24.0	29	3.8	60	8.0	69	9.2	208	27.6
Acceptance of drugs by friends	--	--	--	--	207	32.8	25	52.1	--	--	36	28.3	217	36.3

Table 6: Risk factors in relation to heroin/opiate use

Risk factors	Total No.	% of use	Chi-square	P.value
Raised abroad Raised in Jordan	704 4360	1.3 0.9	0.6	0.4
Grades below 60% Grades over 60%	258 4788	3.1 0.8	Fisher exact	0.002
Living with non-relatives Living with relatives	3282 1764	0.6 1.5	9	0.003
Easily expressed feelings to parents Not easily expressed feelings to parents	3626 1420	0.5 2.2	30	<0.001
Feeling anxious Not feeling anxious	1657 3398	1.3 0.8	3	0.07
Parents and friends abusing alcohol Parents and friends not abusing alcohol	1031 4015	1.5 0.8	3	0.09
Making quarrels Not making quarrels	2830 2216	1.4 0.3	16	<0.001
Feeling depressed Not feeling depressed	2795 2251	1.0 0.8	0.3	0.6
Quarrels with parents No quarrels with parents	2750 2296	1.3 0.6	6	0.02
Abuse of alcohol in neighborhood No abuse of alcohol in neighborhood	2345 2701	1.4 0.6	7	0.007
Abuse of psychoactive drugs in neighborhood No abuse of psychoactive drugs in neighborhood	754 4292	3.8 0.4	75	<0.001
Acceptance of drug use by friends No acceptance of drug use by friends	217 4829	11.5 0.5	Fisher exact	<0.001

Table 5: Risk factor in relation to cannabis use

Risk factors	Total No.	% of use	Chi-square	P.value
Raised abroad Raised in Jordan	704 4360	5.3 2.1	24	<0.001
Grades below 60% Grades over 60%	258 4788	7.4 2.3	24	<0.001
Living with non-relatives Living with relatives	3282 1764	2.2 3.2	4.4	0.04
Easily expressed feelings to parents Not easily expressed feelings to parents	3626 1420	1.2 6.0	95	<0.001
Feeling anxious Not feeling anxious	1657 3398	4.3 1.7	31	<0.001
Parents and friends abusing alcohol Parents and friends not abusing alcohol	1031 4015	5.7 1.7	53	<0.001
Making quarrels Not making quarrels	2830 2216	3.0 1.9	6.7	0.009
Feeling depressed Not feeling depressed	2795 2251	2.5 2.5	0.01	0.09
Quarrels with parents No quarrels with parents	2750 2296	3.2 1.7	11	<0.001
Abuse of alcohol in neighborhood No abuse of alcohol in neighborhood	2345 2701	4.3 0.9	59	<0.001
Abuse of psychoactive drugs in neighborhood No abuse of psychoactive drugs in neighborhood	754 4292	9.2 1.4	156	<0.001
Acceptance of drug use by friends No acceptance of drug use by friends	217 4829	16.6 1.9	177	<0.001

Table 3: Opiate use according to the route of administration

Route of administration	Gender				Total	
	Female		Male			
	%	No.	%	No.	%	No.
Inhalation	40	4	52.8	19	50	23
Snorting	30	3	30.6	11	29.4	14
Intravenous	30	3	16.6	6	19.6	9*
Total	**100**	**10**	**100**	**36**	**100**	**46**

* of these 6 used sterility precaution and 3 didn't

Table 4: Risk factors in relation to alcohol use

Risk factors	Total No.	% of use	Chi-square	P.value
Raised abroad Raised in Jordan	704 4360	16.1 11.0	17.6	<0.001
Grades below 60% Grades over 60%	258 4788	24.0 11.2	37.4	<0.001
Living with non-relatives Living with relatives	3282 1764	11.9 11.8	0.01	0.96
Easily expressed feelings to parents Not easily expressed feelings to parents	3626 1420	4.5 30.6	66.5	<0.001
Feeling anxious Not feeling anxious	1657 3398	22.0 6.9	240.3	<0.001
Parents and friends abusing alcohol Parents and friends not abusing alcohol	1013 4015	31.8 6.7	492	<0.001
Making quarrels Not making quarrels	2830 2216	13.6 9.6	19.4	<0.001
Feeling depressed Not feeling depressed	2795 2251	12.2 11.4	0.81	0.37
Quarrels with parents No quarrels with parents	2750 2296	12.4 11.1	1.9	0.17
Abuse of alcohol in neighborhood No abuse of alcohol in neighborhood	2345 2701	20.3 4.5	298	<0.001
Abuse of psychoactive drugs in neighborhood No abuse of psychoactive drugs in neighborhood	754 4292	27.6 9.1	208	<0.001
Acceptance of drug use by friends No acceptance of drug use by friends	217 4829	99.1 7.9	1643	<0.001

Table 1: Substance use at least once in the last month (except tobacco) and split according to gender

Substance	P Value	Total No. 5064		Gender			
				Female No.2780		Male No.2284	
		%	No.	%	No.	%	No.
Tobacco	0.00	28.7	1455	9.2	256	52.5	1199
Alcohol	0.00	11.8	598	3.0	83	22.5	514
Hashish / marijuana	0.00	2.5	127	0.7	20	4.7	107
Volatile substances	0.5	3.3	166	3.1	87	3.5	79
Opiates / heroin	0.00	0.9	48	0.4	11	1.6	37
Sedatives	0.00	12.5	632	10.6	294	14.8	338
Benzhexol	0.00	2.8	140	1.4	39	4.4	101
Amph. stimulants	0.00	2.6	133	1.7	47	3.8	86

Table 2: Frequency in days of substance use over the last month

Substance	More than 20 days		Less than 6 days		Ever used	
	%	No.	%	No.	%	No.
Alcohol	1.0	53	8.1	410	16.6	842
Hashish / marijuana	0.1	4	2.0	103	4.6	231
Volatile substances	0.1	3	2.9	146	6.8	343
Opiates / heroin	0.04	2	0.6	28	1.5	77
Sedatives	0.6	30	9.9	503	12.9	652
Benzhexol	0.2	8	2.1	106	3.3	167
Amph. Stimulants	0.1	6	2.0	100	3.0	151

(50%),(see table 3), 140 (2.8%) used Benzhexol, 133 (2.6 %) had used amphetamine-like stimulants, 1469 (29%) had consumed tobacco but none has used cocaine in the group (see table1). All substance use was significantly higher by males (see table2). University students also abused drugs significantly more than community college students did, except for volatile substances and stimulants.

The results also showed that 861(17%) of the sample had used alcohol at least once in life, 405 (8%) had used alcohol for less than 6 days in the prior month, and 51 (1%) had consumed alcohol for more than 20 days in the prior month. This trend was the same to all substances in the study.

The results further showed that 23 (50%) of heroin users used burning and inhaling the fumes method, 14 (30%) used sniffing the nose, and 9 (20%) used intravenous route and observed septic measures. (See table3).

Using (chi-square & p-value)

Using cannabis was significantly related to risk factors identified by the researchers except for feeling depressed, which didn't reach significant value. As for heroin use, it showed a statistically significant correlation with some risk factors such as people in the neighborhood taking psychotropic drugs, poor communication between subject and family, and quarrelsome life style. However, no correlation was found between growing up outside Jordan, feeling depressed/ anxious or having friends/ family who use alcohol or heroin.

The most significant common risk factors to drug abuse were seeking acceptance by friends, encouragement by friends, friends' abusing drugs, and poor communication with family.

It was also found that the attitudes of the participants toward a drug abuser friend varied according to the substance. 962 (19%) would accept smoking, 152 (3%) alcohol, 25 (0.5%) heroin, 35 (0.7%) cannabis, and 202 (4%) sedatives. Regarding encouragement by friends to abuse substances, 304 (6%) went for tobacco, 61 (1.2%) for alcohol and zero percentage for other substances. Encouragement by family showed 40 (0.8%) for tobacco, 15 (0.3%) for alcohol and zero percentage for other substances. As for rejection if offered substance of abuse, 3342 (66%) would reject tobacco without hesitation, 4000 (79%) alcohol and 4811 (95%) heroin. However, those who would find it difficult to reject were 861 (17%) for tobacco, 658 (13%) for alcohol, 35 (0.7%) for heroin or other hard drugs. With respect to how truthful the information the participants had given, 3950 (78%) described the truthfulness as high, 456 (9%) as average and 51 (1%) as low.

Materials and Procedure

A questionnaire was designed for the purpose of this research, which was in line with WHO's population surveys questionnaire. It consisted of four parts: the first included personal data; the second included questions about emotions, and ability to control them, sociability, behaviour; the third included questions about smoking, alcohol and other drugs consumption during the last month; and the fourth section included questions about personality, relationships especially with the family and people in the neighborhood and their own drug use. The questionnaire was anonymous and consisted of seventy-two questions in Arabic. Four Senior Consultant Psychiatrists, all of whom agreed on its ability to assess substance use disorder, assessed the validity of the questionnaire. A pilot study was then conducted on fifty students. The pilot study was also used to train the questionnaire administrators, and to explore any potential difficulties in its application. Results showed that students did not experience any major problems in comprehension. A retest was conducted three weeks later on the same fifty students. The Pearson's product moment correlation coefficient was 0.76 ($p<.001$), which represent a good test-retest reliability.

All participants were assured that all information given would be treated confidentially. Participants were encouraged to answer truthfully by informing them that by answering the questionnaire they would be serving the country and helping others as well.

Results

Analysis of the results showed that the sample consisted of 5064 subjects: 2284 (45.1%)were males and 2780 (54.9%) were females. 4912 (97%) were between 18 and 25 years of age and 152 (3%) of the sample were 25 years or above. 4051 (80%) of the sample were university students and 1013 (20%) were from community colleges.

It was found that 4360 (86.1%) of the sample had grown up in Jordan and 704 (13.9%) outside Jordan. Forty two percent of the samples were high achievers, 25% intermediate and 4% poor academic performers. It was also shown that 65% of the sample lived with adult non-relatives, 20% lived with family and 12% lived with relatives.

As for the emotional state of participants, the results showed that 29% would freely communicate their real feelings to family, 33% would avoid doing so and feel anxious and worried about the future, and 11% would become aggressive if they are irritated.

Asking the participants about their families showed that 62% of the families would like to know the participants' friends and 74% wanted to know where the participants would go. Also, 92% of the participants would like their parents to stop smoking if they smoked.

The results showed that, in the prior month, 126 (2.5%) of the sample (4.7% males and 0.7 females) had used cannabis at least once, 167 (3.3%) had used volatile substances, and 607 (12%) had consumed alcohol. Also, they showed that 633 subjects (12.5%) had used sedatives, 46 (0.9%) for opiates, the most common route among opiates users is burning and inhaling which was used by 23

The majority of illicit drugs currently consumed are derived from plants and are often synthetically modified. A wave of abuse of synthetic amphetamine type stimulants (ATS) has been reported in recent years. Today, some 30 million people abuse ATS. There appears to be a perception, widely spread through the media and directed specifically to young people, that these substances are "fashionable" and safe.

The age of initiation into illicit drug use seems to be falling each year. This is not only a phenomenon of the developed countries. Many developing countries report a similar trend in the growing number of youths abusing cannabis, heroin, stimulants and hallucinogens[4].

Data relating to drug use in most societies is measured by police arrests, medical problems, admissions to drug dependence treatment programs, and surveys, among other methods. These data are subject to a high level of under-reporting. Risk of job loss, stigma associated with excessive use, or common denial of the problem makes further data acquisition more difficult. The search for epidemiological data is further hindered by the problem of defining drug dependence[5].

A large number of studies have examined the role of many factors thought to be involved in drug dependence. The etiology of drug dependence is complex and multifactorial, depending on the interplay of many factors, including genetic, constitutional and environmental factors[6,7,8].

In Jordan, the number of patients treated for drug dependence in the national center for mental health has increased from 27 cases in 1997 to 150 in 1999[9] and continues to rise (personal communication). Also, the number of illicit drug arrests by the police force between 1997 and 1999 has increased from 504 to 720 cases[10]. This could indicate that there is likely to be a drug dependence problem in Jordan in the near future. There has been no large-scale study in Jordan to identify the size of drug dependence problem. Therefore, this is the first large-scale preliminary study to investigate the drug dependence problem in Jordan.

Aim of the study

The study aims to examine the extent of common drugs use among the target group.

Methods

Participants

The study started in February 2001 and data were collected over eight months. The sample consisted of 5064 subjects: 2284 (45.1%)were males and 2780 (54.9%) were females. 4912 (97%) were between 18 and 25 years of age and 152 (3%) of the sample were 25 years or above. Six universities and four intermediate colleges participated from North, Middle and South Jordan. 4051 (80%) of the sample were university students and 1013 (20%) were from community colleges.

The numbers of students who were within the targeted age group and participated in the study were randomly chosen from the list of students who were currently attending the university or collage, and then every tenth student from the list was chosen. If a student declined to answer, the next one on the student list would be chosen.

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Substance Use Among University and College Students in Jordan

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إساءة استعمال المؤثرات العقلية بين طلاب الكليات والجامعات في الأردن

ر. سليمان، م. شريف، س. خرابشة، م. أبو دنون

Abstract

A random survey of 5064 university and community college Jordanian students aged between 18-25 years was conducted in early 2001 to investigate the extent of the impact of common substances of abuse among this population and the subjects' emotional and attitudinal stance toward illicit drugs. Participants completed a questionnaire of 72 questions relating to emotions, behaviors, relationship with family and friends and substance use behavior during the previous month. Results showed the following self-reported substance use: 2.5% cannabis; 3.3% sedatives; 0.9% opiates, with the most common method of opiate consumption being burning and inhaling; 2.8% Benzhexol; 2.6% stimulants; 12% alcohol; and 29% tobacco. None of the sample reported using cocaine. Throughout, substance abuse was significantly higher in male students. Some risk factors were identified for substance abuse in the group as seeking acceptance, encouragement by friends, having friends involved in substance abuse and poor communication with the family.

Introduction

Epidemic drug dependence is a comparatively recent health problem. During the seventeenth century, governments began to express concern over the increasing use of certain substances, including not only alcohol and opium, but also tea, coffee and tobacco. By the eighteenth century, evidence of widespread drug problems became stronger. Some countries passed laws against production or import of psychoactive substances and others imposed tax on their importation. During the nineteenth century, drug dependence became more widespread despite attempts to contain it. Opiate addiction became a widespread problem in China, the United Kingdom and the United States[1].

Currently cannabis is the most widely abused substance in the world, with 140 million consumers or 2.5 % of the global population. Heroin is abused by 8 million people with 13 million people abusing cocaine[2]. Today, it is estimated that more than 200 million people use drugs. Drug use varies from children sniffing glue to adults heavily addicted to heroin[3].

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الملخـــص

ان عقـــار الكلوزابيـــن وهـــو من مجموعة الدايبنزودايزبين المضادة للذهان قد أقر استخدامه في حـــالات الفصام المزمنة والمقاومة ولكن لم يقر استخدامه في حالات الاضطراب الوجداني ثنائي القطب المقاومة بالرغم من أن بعض الأبحاث أشارت الى استخدامه في هذه الحالات .

هـــذه الدراسة تعرض دليلا استقرائيا على مدى خمس سنوات مستخدمة جميع مؤشرات التحسن والاستجابة التي استخدمت سابقا للعقار في نفس المجموعة من المرضى .

تـــم جمـــع احـــد عشر مريضا تم تنويمهم تتابعيا في قسم النفسية بمستشفى الملك خالد الجامعي بالـــرياض والذيـــن لـــم يتحسنوا على الأقل باستخدام اثنين من مثبتات المزاج كل على حده أو مجموعين وواحد منهما هو الليثيوم ولمدة سنتين .

تـــم اســـتخدام مؤشرات الاستجابة التاليه : - مقياس النفسية الموجز، والتقويم الاكلينيكي العام ، ومقـــياس نوعـــية الحياة العامة ، ومقياس الأعراض الجانبية التشنجية ، اضافة الى حالة العمل والمـــيول الانتحارية وعدد مرات التنويم المراجعة وعدد مرات مراجعة الاسعاف وعدد مرات الانتكاسة قبل وبعد العلاج .

ولقـــد ظهر في النتائج أن جميع المؤشرات السابقة تحسنت تحسنا ملحوظا ومهما احصائيا ما عدا مقياس نوعية الحياة العامة .

وبالـــرغم مـــن قلة عدد المرضى الا أن هذه الدراسة تضيف دليلا علميا مقبولا لأهمية استخدام الكلوزابين في العلاج الوقائي الطويل المدى لحالات الاضطراب الوجداني المزمنة والمقاومة .

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Table 2: Comparison of numbers of admissions, A/E attendance and relapses before and after clozapine n = 11

	Mean	P
No of Admissions:		
Before	3.96±2.39	
After	2.01±1.21	0.009
No. of A/E attendance:		
Before	3.48±3.16	
After	1.43±2.13	0.0002
No. of Relapses:		
Before	3.89±2.42	
After	2.11±1.3	0.01

Discussion

Few reports documented the efficacy of clozapine in resistant BAD[10,13,14] but none followed their patients up to five years as this study has. Even though the number of cases in this study is not large, it does show beyond doubt the important role of clozapine in prophylaxis treatment of chronic and resistant cases of BAD. The age range included an adolescent at the start of the study, which also showed as in a previous study[10,12] the advantage of use of clozapine in this age group. The mean illness duration of the study group was 13.2 years, which indicates besides resistance to medication, the chronicity of illness, which is not been considered in other reports[10,11,14].

The improvement measures used clearly showed the marked clinical response to clozapine over the period of the study, regarding specific symptoms (BPRS), the global severity change (CGI) and the global improvement (CGI), which is consistent with other reports[10,14]. On the other hand, even though the QLS showed no clear change, other specific measures showed clear improvement in quality of life such as work status and suicidal behaviors. These results are comparable to previous reports [12] and also to effects of clozapine in refractory schizophrenic patients[17,18].

This study also presents new information about long-term efficacy of clozapine in BAD, showing a clear reduction in the number of admissions, the number of Accident and Emergency attendance and of relapses which strengthens the evidence of previous reports to use clozapine as a mood stabilizer in resistant cases of BAD[4,12]. Considering the side-effects, whether extrapyramidal or blood dyscrasias, clozapine proved to be tolerable and safe in this group of patients.

In conclusion, this study, in spite of the small number of patients, provides reasonably strong evidence that clozapine monotherapy is valuable in the long-term management of chronic resistant patients of BAD using the same strict safety system applied to its use in resistant schizophrenic patients.

Using Stat Pac Gold Statistical analysis Package, all the above variables were analyzed and presented.

Results

Only eleven patients, all Saudi nationals, were included in the study with mean age at the start being (34.5± 8.77) years and with a range of (17-45). Other demographic data analysis is shown in Table 1. The mean illness duration for the groups was (13.2±6.65) years and a range of (7-22).

Table 1: Demographic Data n = 11

Character	No.	%
Age: Mean	34.5±8.77	--
Range	17 – 45	--
Sex: Male	6	54.5
Female	5	45.5
Marital Status:		
Single	4	36.4
Married	6	54.5
Divorced	1	9.1
Employment Status:		
Employed	5	45.5
Unemployed	6	54.5

BPRS measure scores were (14.36±9.45) before and (3.73±4.2) after treatment showing a highly significant difference P=0.0002. The CGI severity measure scores were 5.0 before and 2.82 after treatment with P=0.0001 and the CGI improvement mean scores were also significantly changed before (4.8) and after (2.93) with P=0.0002. The QLS scores showed minimal changes, before (mean 28.18) and after (mean 26.55) and was not significant P=0.363.

The work status had also significantly changed after clozapine where x^2=7.103 and P=0.008. Suicidal behavior monitored over the period of the study compared with recorded suicidal behavior before use of clozapine was also significantly reduced where x^2=7.692 and P=0.006. Extrapyramidal Symptom Rating Scale (ESRS) was also analyzed before and after clozapine and there was no significant difference where P=0.10. The WBC values for monitoring blood dyscrasias comparing the first WBC before starting clozapine and the last WBC values and were not significantly different as P=0.17.

The mean number of admissions, A/E attendances and the number of relapses were compared before and after clozapine and were found to be significantly reduced as shown in Table 2.

The mean maintenance dose of clozapine used was (93.75±41.73) and a range of (50-200).

Even though clozapine, an atypical dibenzodiazepine antipsychotic, has been approved worldwide in the treatment of resistant cases of schizophrenia[9], and in spite of previous reports for its efficacy in bipolar affective disorder, still it is not yet approved and this area remains open for more research[2,4].

Previous reports showing efficacy of clozapine monotherapy in BAD had several limitations. Some of these reports recruited a mixed population of patients including schizophrenia, schizoaffective and bipolar patients[10,11]. Another limitation was the chronicity and the resistance to conventional mood stabilizers where patients were mixed, including non-chronic and non-resistant cases[11,12,13]. The period allocated for the study follow up was also a limitation and it rarely exceeded 24 months[2,10-14]. The final limitation is that none of the previous reports used all outcome measures in one setting[10,14]. This study was designed to show the efficacy of clozapine monotherapy in chronic and resistant cases of a Saudi population of BAD and prospectively measuring all possible outcome measures used in previous reports and for a much longer period of follow up.

Methods

Subjects

This study included all consecutively admitted patients to King Khalid University Hospital (KKUH) psychiatric wards over one year starting March 1996, with DSM IV diagnostic criteria of BAD who have relapsed whilst on medication, and were tried on at least two mood stabilizers, separately or in combination, one of them lithium for at least two years. Cases with organic disease, schizoaffective symptoms or of drug abuse history were excluded. All patients were switched to clozapine 25 mg dose at night with a gradual increase according to clinical response. The group was followed up for five years. This study followed the clozapine safety system implemented for the use of clozapine in refractory schizophrenia under the supervision of the Novartis Company in Saudi Arabia, which is a mandatory weekly blood values for 18 weeks and then monthly.

Measures

A data collection form was designed to include all sociodemographic characteristics, treatment history, response to treatment and duration of illness before admission. Comparative parameters such as the number of admissions, the number of attendance to accident and emergency (A/E) and the number of recorded relapses before and after clozapine treatment were also documented.

Assessment of dimensions of improvement was carried using different scales. These were the Brief Psychiatric Reporting Scale (BPRS), which is a clinician-rated tool to assess change in severity of psychopathology[15,16]. The Clinical Global Impression Scale (CGI), which is a standardized assessment tool for estimating global improvement and severity of illness over time[15,16]. The Quality of Life Scale (QLS), which is measuring directly deficit symptoms in chronic disorders[15,16]. The Extrapyramidal Symptoms Rating Scale (ESRS) that measures the presence of extrapyramidal side effects of neuroleptics[16] and the Complete Blood Count (CBC) measuring the White Blood Count (WBC) in consistence with the safety system was performed.

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Clozapine: A Mood Stabilizer in Chronic Resistant Bipolar Affective Disorder

Abdulrazzak M. Alhamad

عقار الكلوزابين كمثبت للمزاج في الحالات المزمنة والمقاومة لمرض الاضطراب الوجداني ثنائي القطب

عبد الرزاق الحمد

Abstract

Clozapine is an atypical dibenzodiazepine antipsychotic drug, which was approved widely for resistant cases of schizophrenia, but as yet not for resistant bipolar affective disorder (BAD), despite some researchers suggesting its use in the long-term treatment of resistant bipolar affective disorder. This paper presents a prospective monitored evidence over a five-year period for this claim, using all previously used outcome measures in the same setting in Saudi BAD patients.

Eleven patients consecutively admitted with chronic BAD to King Khalid University Hospital (KKUH) were tried on at least two mood stabilizers, separately or in combination, one of them lithium for at least two years. Improvement outcome was assessed using the Brief Psychiatric Rating Scale (BPRS), the Clinical Global Impression (CGI), the Quality of Life Scale (QLS) and the Extrapyramidal Symptom Rating Scale (ESRS). Also work status, suicidality, the number of admissions; the number of attendances to accident and emergency (A/E) rooms and the number of relapses were measured before and after treatment.

All above measures showed statistically significant improvement all through the period of the study except the QLS measure.

This report, in spite of the small number of patients studied, presents reasonable evidence for the long-term efficacy of Clozapine monotherapy in chronic resistant BAD patients.

Keywords: Clozapine, chronic resistant bipolar affective, Saudi Arabia.

Introduction

Bipolar affective disorder (BAD) is a life-long mental illness that affects the personal, social and occupational life of the patient[1]. Despite accumulating evidence of efficacy of conventional mood stabilizers such as lithium and anticonvulsants; carbamazepine, valproate and recently lamotrigine in prophylaxis treatment of BAD, still a considerable number of cases show resistance[2]. Clinical trials have suggested several alternative drugs for treating resistant cases of BAD, either alone or as adjunctive to conventional mood stabilizers[2,3,4]. Some reported response to the combination of carbamazepine and lithium, high doses of thyroxine, clonidine and the adjunctive use of clonazepam[5]. Recent reports showed the efficacy of using atypical antipsychotics such as Olanzapine and Resperidone either alone or in combination with conventional mood stabilizers[2,6-8].

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interval in some patients and have some effect on conductivity that could change partial block. Antidepressants' effect on the heart has been stuck in the mind of doctors from the overdoses of those drugs that could lead to cardiac toxicity and death, but those effects have never been shown to be associated with therapeutic doses on normal hearts.

The second generation of antidepressants that include Trazodone which has weak selective effect to block the reuptake of serotonin , it has no effect on other catecholamines, so it has apparent benefit in patients with cardiac disease compared to tricyclic antidepressants[32].

Bupropion is a weak inhibitor of norepinephrine and dopamine reuptake and may cause increase in blood pressure and heart rate, so it has not been considered in studies on cardiac patients.

The third generation antidepressants include the Selective Serotonin Reuptake Inhibitors (SSRIs). Most of cardiovascular side effects of this group are due to the propensity, depending on the agents to interact with other drugs metabolized by the cytochrome P450 enzyme system, which may result in elevated levels of certain antiarrythmics and β-blockers[35,36,37].

It has been estimated that the frequency of cardiovascular effects with SSRIs is less that 0.0003%. The SSRIs have been shown to be very effective in patients without cardiac disease with minimal cardiovascular side effects that are commonly not affecting the course of treatment.

The use of the these drugs in cardiac patient have been studied and shown that Paroxetine, Fluoxetine and Sertraline are safer than tricyclic antidepressants in patients with multiple cardiac disease states, they have no orthostatic hypotension, had minimal effects on conduction and had virtually no effects on ventricular function. Sertraline has proved to be safe and effective in patients with acute myocardial infarction or unstable angina[25].

The comparison of Fluoxetine versus placebo in depressed post-MI patients have shown no difference ECG[30].

Conclusion

Depression has been well established as a risk factor of myocardial infarction and its common in post-MI patients as well as other patients with Ischemic heart disease, the diagnosis of depression needs awareness and screening, and the availability of new drugs that are easier to give with excellent safety profile and effectiveness, have made tremendous change in the care of cardiac depressed patients as well as patients with chronic diseases and multiple pathology.

الملخـــص

تـــراجع الورقـــة هذه العلاقة الهامة بين الإكتئاب وأمراض الشريان التاجي ، وتؤكد على إعتبار الإكتـــئاب عامل خطورة مستقل في حدوث الجلطة القلبي الحادة ، كما أن إنتشار الإكتئاب الزائد في الأمراض المزمنة عموماً قد أصبح أمراً واضحاً وما يعنيه هذا من أثر معالجة الإكتئاب على مآل أمراض الشريان التاجي والأمراض المزمنة ، ومناقشة الجوانب السريرية لهذه الحقائق وكما إستعرضت الورقة إستعمال مضادات الإكتئاب في أمراض القلب بشكل خاص.

years (range-4-32 years), Depression was found to be a significant independent risk factor for the development of IHD morbidity and mortality, and the relative risk mortality, and the relative risk has been adjusted and it is now established that major depression increase the risk 4-4.5 fold and subsyndromal depression increases the risk 1.5-2 fold[24].

Depression in Chronic Diseases

The prevalence of depression in chronic diseases is well established now, Alzheimer's disease 11% , stroke 23% , myocardial infraction 25%, diabetes 27%, cancer 42%, and Parkinson's disease 51%[25,26].

The prevalence rates of major depression in patients with cardiovascular illness have been established as 15-20% in unstable angina, 14-36% in congestive heart failure, 16-20% in myocardial infarction and 15-23% in coronary artery disease[27-30].

Depression and Prognosis of IHD

Depression has a clear effect on the prognosis of myocardial infarction, 11 studies prospectively followed-up approximately 4000 patients diagnosed with recent MI for a mean of 12 months (range, 6-24 months, 17 -9 year in one study). The incidence of major depression was 16-20% and the incidence of depressive symptoms was 17-42%[24]. The subsequent cardiovascular mortality in post- MI patients with major depression has a mean relative risk of 4.1, and much of the mortality risk appears to occur in the first 6 months post-MI, the mortality risk appears to be proportionate to the severity of depression, and in the presence of other risk factors, even minor symptoms of depression contribute to significant additional mortality risk[20,31,32].

The Clinical Perspective:

The evidence is clear on the effect of depression as a risk factor of IHD and as prognostic factor for the outcome, that implicates the need for recognition and treatment of depression. The issue of recognition has to be addressed by increasing the awareness of physicians to the symptoms of depression, the use of screening tools like Beck inventory or Hamilton depression scale, also general scales like the symptom check list 90, and Goldberg health questionnaire are very useful, the involvement of the mental health team in cardiology is of great importance and the emphasis on liaison psychiatry should not be missed.

The Safety of Treatment in Cardiac Patients

Physicians have always seen the treatment of depression as difficult in cardiac patients; this difficulty has been associated with tricyclic antidepressants that have been available for five decades[33,34,35] and known for their wide range of Sid effects. Including the anticholinergic profile (e.g. dry mouth, blurred vision, constipation) and sedation, weight gain, orthostatic hypotension, as well as other cardiovascular effects like sinus tachycardia[36]. Although the tricyclic antidepressants have been shown to be effective in decreasing the frequency of premature ventricular contractions (PVCs) in non-depressed patients with cardiac disease[36,37,38]. There is evidence that tricyclic antidepressant may prolong QRS

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Review Article

Depression and Ischemic Heart Disease

Walid Sarhan
الإكتئاب وأمراض الشريان التاجي
وليد سرحان

Abstract

The paper reviews the topic of the relationship between depression and Ischemic heart disease, depression has been established as an independent risk factor of myocardial infarction. The high prevalence of depression in chronic diseases is becoming more clear, the diagnosis and treatment of depression has great impact on the prognosis of IHD and many chronic diseases, the clinical implication of these findings are discussed with special emphasis on the use of antidepressants in cardiac patients.

Depression is a Risk Factor

Depression is common among patients with ischemic heart disease (IHD) and among patients who are recovering from acute myocardial infraction (MI)[1-5]. The prevalence of minor and major depressive disorders has been reported to be as high as 45% in post-MI patients[6], and 40% in patients with stable IHD[2,7]. The presence of depression is associated with high rates of cardiac complications,[2,5,8-12] death, reinfarction, need for revascularization , and poor adherence to cardiac rehabilitation and medical therapies[2,6,8,10,11,13].

Further, there appears to be a dose-response relation between depression and prognosis. For example, researchers at Montreal heart institution recently demonstrated that mortality during a five-year follow-up was incrementally related to the severity of depression measured by Beck Depression Inventory in post-MI patients[14]. The most consistent biological abnormality in major depression is the increased activation of the hypothalamic-pituitary - adrenal axis, which results in high cortisone level and elevated sympathetic tone. Patients with depression have been found to have elevated plasma norepinephrine, increased heart rate and reduced heart-rate variability[15,16,18] Depressed patients also are found to have increased platelet activity, both at rest and with provocative challenge[17]. Myocardial ischemia can be triggered by mental stress testing in the laboratory, and the mental stress-induced Ischemia is predictive of[19,20-22] poorer outcome in patients with stable IHD. Acute negative emotions such as tension, frustration, and sadness, can also trigger myocardial ischemia during daily living[23].

The traditional risk factors for (IHD) are genetic factors, Diabetes, Hypertension, Thrombocyte dysfunction, Hyperlipidemia ,Smoking and Obesity, but recently depression has been added to the list of risk factors. There are 13 studies that have prospectively followed up more than 40.000 healthy subjects for a mean of 10

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Traditional (collectivist) versus Western (individualist) culture

Factors	Individualists	Collectivists
Attitude	Interactions within relationships and groups occur between independent individuals, and thus, disagreements and conflicts are accepted as a natural and inevitable aspect of social life.	Dislike of social disorganization or disagreements.
Goal Orientation	Strongly oriented toward achieving justice.	More motivated by concern for relationships with others
Goal Attainment	Justice is an instrumental value and not a terminal value	Justice is a terminal value
Tactics	Active, assertive, and confrontational tactics	Passive, collaborative, and avoiding tactics.

In the Arab-Israeli peace process "power" has been used parallel to negotiations. On the Israeli side there continues the expansion of occupation and settlements, bombing of camps and villages, destruction of crops, house demolitions, closure, humiliation by army and settlers, the wall, disregard for UN resolutions etc. For the Palestinians there is suicide bombing and armed resistance. The broker (US) is not neutral in that conflict. It has an interest that goes beyond the success of the negotiations and supports one party while it pressures the other. The social reputation of the process is thus damaged.

Parties involved in Middle East peace negotiations need to be honest about why they negotiate. They have to be held accountable to their answers. Only then might the peace process be able to reclaim its "positive" meaning and be conducive to a solution that is satisfactory to the needs of both negotiating parties.

A psychological obstacle contributing to a failed negotiation is when the resolution is needed by one party more than the other or when the lack of resolution is not as threatening to both parties. A psychological consequence thereof is a reinforcement of animosity, heightened sense of impending danger, reinforcement of stereotype, lack of confidence in future negotiations and of identifying the aggressor with the people, all of which perpetuate and enforce violence.

Conflict resolution requires a long and a gradual process of "peace-building" that must follow the stage of "peace making". There are various examples of peace making as in Northern Ireland; the Israeli-Palestinian conflict, and that of the South African Truth and Reconciliation process which demonstrate that signing agreements between policy makers is not enough[4] .

solutions must conform to the criteria mentioned above.

Stage 4. Evaluation of solutions

This includes a critical analysis of all proposed solutions. Proposed solutions can be adjusted or added to.

Stage 5. Selecting the best solution

Either by an authority or by majority rules. This is best done among a small group.

Stage 6. Testing of selected solutions

Parties should agree on a mechanism to test effectiveness of solutions. Many accounts of conflict resolution processes stop at the stage when the sides reach the peace agreement (peace-making). A conflict does not end by signing agreements.

Impact of Culture

Cultural factors in conflict management in between-culture conflicts are more difficult to resolve than within-culture conflicts. People involved in within-culture conflicts can assume similarities in behavioral dispositions, values, and expectations. On the other hand, people involved in between-culture conflicts cannot make such assumptions and hence have difficulty in adjusting their behavior toward adversaries. Cultural factors affecting conflict management include items such as value systems, nature of tactics and expectations regarding the efficacy of various tactics in achieving the values.

It has been frequently documented that people in individualistic cultures prefer to use active, assertive, and confrontational tactics for resolving conflicts, whereas people in collectivistic cultures prefer passive, collaborative, and avoiding tactics[1].

A schematic overview of such differences is shown in the following table[5].

In the case of the Middle East Conflict, some essential questions need to be addressed:

1- Why do parties negotiate in the first place?

2- Is there a need for the process of negotiation?

3- Does it make sense to negotiate in the Middle East context?

Answers to those questions are of paramount importance for the peace process. In the case of the Middle East Peace Process, negotiations did *not* replace the use of power. This alone throws heavy shadows of doubt regarding the value of the process and gives an impression that negotiations do not make sense in the present context.

Furthermore, the meaning of some terms e.g. negotiations, peace process are not restricted to how they are defined in dictionaries and glossaries, but extend beyond to acquire a meaning and social historical significance of their own. In our case, the repeated failures in the peace process has come to associate the term itself with negative social values such as lack of ability, surrender, weakness and reluctance to face the enemy, especially since the enemy did not stop its aggression[2].

Factors affecting the process of negotiation are:

1. Competition.
2. Legitimacy (what is and what is not allowed?).
3. Risk (bluffing, exaggerating).
4. Diversity of disciplines of the negotiating team.
5. Complementing roles of the negotiating team.
6. Show off of experience.
7. Understanding the other party.
8. Pressing with time, money or energy.
9. Personal relations with the other party.
10. Maintaining social norms to stand out or bypassing them to complement.
11. Past achievements.
12. Insistence to reach resolution.
13. Persistence.
14. Honesty and accountability.
15. Emotional involvement in issues.

Information plays an important role in directing the process of negotiation, whether it is related to the issue of negotiation or to the negotiating persons. A negotiator has to identify the information he/she wants to know from the other party before starting the negotiations, the information he/she wishes to declare and the information he/she wishes to hide from the other party.

Non-cooperative negotiation

The most important information in a process of negotiation is the real minimum, which the other party cannot go beyond. This is what negotiating parties tend to keep from each other and which contribute to a non-cooperative form of negotiation. Mechanisms of blocking information include lying which leads to jeopardy of accountability, and ignoring and shifting to other irrelevant information leading to non progress. Also an open announcement that this is confidential information, which cannot be disclosed, leads to a block of a process.

Collaborative Negotiation

It is form of negotiation that *wants* to solve a particular problem. Information focuses on the needs, interests and wishes of the other party, with a view to each alternative way to satisfy them. A major component of understanding the words used during negotiations depends on the non-verbal expressions surrounding those words or *nonverbal communication.* Nonverbal factors affecting communication in negotiation include elements such as gestures related to time (*Ghronemics*), body gestures (*Kinesics*), factors related to the preparation of the site of negotiation (*Proxemic*), and those surrounding language (*Paralinguistics*)

Stages of Negotiation

Stage1. Defining and analyzing the problem

Parties may have different views or perceptions of the problem leading to an obstruction of the process.

Stage 2. Establishment of criteria for evaluating solutions

The solution can be either a practical one, which would affect material gains or losses, or one based on value, which would follow a goal that reflects image or purpose.

Stage 3. Identify possible solutions

Parties "brainstorm" solutions. It is important to keep in mind that these

Criteria of Success

We negotiate to win over those who are able to grant us a material or moral interest; but who would not do that voluntarily. Negotiations help us achieve what cannot be achieved by force because of physical, moral or legal factors.

Successful negotiations depend on the attitudes and skills of the disputants and of the mediator or arbitrator. Negotiators and mediators should be committed to resolution of the conflict, be flexible, have credibility, be respectful, explicitly acknowledge the needs of the other party, have a positive attitude and have a history of achievements in conflict resolution.

According to the principles of conflict resolution, the only true solution to a conflict is one that attempts to satisfy the needs of all parties involved. It is therefore that successful negotiation should be based on the coexistence of a constellation of factors.

First: A person should have a real cause, something he or she really needs, or else negotiation would lose its meaning. It would turn into a game of negotiation. Motives not conducive to resolution include winning time, testing the other party or diverting the attention of another person or group away from a hidden motive or intention or action.

Second: Parties should have the capacity of achieving the objective of the other or at least help him/her achieve it. Negotiation is unsuccessful if one party does not have such capacity, or if one party realizes that the other cannot actually help in the achievement of the objective. A process of negotiations based on a wrong perception of the issues is most likely destined to fail. So is a process that is undertaken merely to show off importance.

Third: None of the parties should be reluctant to achieve the objective because of moral considerations, economic interests, and historical reasons or otherwise. i.e. issues of negotiation should be really negotiable.

Fourth: Everybody should agree to the process and agenda of negotiation. Also all parties should follow the same behavioral rules. People do not accept to enter into a process of negotiation only to respond to the needs of others, nor if one party shows disinterest or considers that the issue is not negotiable. All parties, whether willingly or not, should accept the idea that the success of the negotiation will benefit them all. Nobody should enter into a process of negotiation unless the other party has agreed to do the same. It is this factor, which differentiates the process of negotiation from the use of power, which is usually based on a unilateral decision.

Fifth: None of the parties should be capable, based on their own material power, to forcing the other to immediately fulfill the objective of the negotiation to their interest.

When negotiating from a position of weakness, the question arises as to how a weaker partner can achieve anything through negotiations. However, even the stronger party usually has objectives that it cannot completely achieve without the cooperation of the weaker party. It is this aspect that makes it worthwhile for weaker parties to enter into a process of negotiation.

process, the impact of culture on negotiation and suggesting that peace negotiations are an ongoing process that has to be enforced and supported beyond the bilateral or multilateral talks.

Definitions

Conflict (from the Latin root "to strike together") is any situation where incompatible activities, feelings, or intentions occur together. Conflict has been the fate of humanity since its very beginning and humans have been accustomed to forcefully settling their conflicts, using a wide spectrum of powers, from physical to economic to military power.

Unfortunately, until this very day, power is the most commonly preferred and chosen means to settle conflicts whether between individuals or groups replacing the process of negotiation, which stands at the top of the list of peaceful means for conflict resolution.

Conflict resolution is the process of defusing antagonism, and reaching an agreement between conflicting parties through some form of peaceful interaction and exchange (negotiation). It is based on the idea that it is better to expose and resolve conflict before it damages people's relationships or escalates into violence. Conflict resolution has developed during the second half of the twentieth century as an alternative to traditional litigation models of settling disputes.

Negotiations

People negotiate all the time and throughout their lives to achieve, for example, a leave from work, an increase in salary, better products at cheaper prices, tax reductions, a higher price for what they sell. They also negotiate to achieve justice, freedom, love, security and social status and everything that is related to it.

In the 1960s and 70s, interpersonal psychology was applied to understand negotiations. This involved studying individual differences between negotiators such as gender, race, age, ethnicity etc. and their impact on the process of negotiation. It also investigated situational and structural variables such as the presence of a wide audience, a third mediating party and the presence or absence of a deadline for the negotiations and their impact on the outcome of the process.

During the 1970s and 80s, cognitive and behavioral psychology were in vogue. It recognized negotiations as a decision making process, where the negotiator is a decision maker.

In the 1990s critics highlighted evident gaps in previous approaches. Interest was drawn to the social and psychological aspects of the process of negotiation. Negotiations themselves were considered a complex structure of decision making where negotiators are faced with numerous choices and processes to decide upon, each according to his/her perception of their mission[8]. Negotiations take place "when the reward of the participants upon agreement is pending on their free choices during the process of negotiation and is not determined in advance by their respective circumstances[7].

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Editorial

Psychological Impediments to the Peace Process in the Middle East

Prof. Ahmed Okasha

المعوّقات النفسية لعملية السلام في الشرق الأوسط

أحمد عكاشة

The World Psychiatric Association produced a statement in May 2002 regarding the escalation of violence in the Middle East and its consequences on mental health. The statement stated that the WPA "has been following with great concern the escalation of violence in the Occupied Territories, in Israel and in the refugee camps in the West bank and Gaza, which represents a new and serious threat to the mental and general health of affected people". The statement acknowledged the psychological trauma being experienced and the psychological consequences to be expected from chronic exposure to violence against civilians both in the Occupied territories and Israel and anticipated an increase in the prevalence of post-traumatic stress disorders and emotional disorders of childhood, in addition to a wide spectrum of stress reactions, both acute and chronic, especially among the most vulnerable groups such as children, women, the elderly and the disabled. In its conclusion the statement appealed to all sides in the conflict to consider the short and long-term psychological consequences of violence and war and to bear their respective responsibility concerning the mental well being of future generations in the region. Less than a year after the issuance of the statement the region witnessed the US military aggression against Iraq, adding yet another conflict to the area which did not only affect the Iraqi people but also spilled over to an accentuation of violence in the Middle East.

The statement was met with a positive response from both Palestinian and Israeli psychiatrists encouraging the WPA to initiate a task force to implement its recommendations and called on its member societies to raise public awareness in their respective countries regarding the psychological hazards of war, trauma and mass killings and to lobby their governments to play an active role to break the cycle of violence in the Occupied Territories and Israel.

In June 2003 WPA cosponsored a meeting in Malta under the theme "The Role of Health and Culture in Conflict Resolution". The meeting was attended by an audience who were interested in Mental Health in the region and who believed that peace and democracy could play a major role in the development of the Arab countries. My contribution to that meeting was a plenary intervention discussing "the process of negotiation" from a psychological perspective, trying to highlight factors that contribute to the success or failure of the

From Risk to Fall...
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ZYPREXA
Olanzapine

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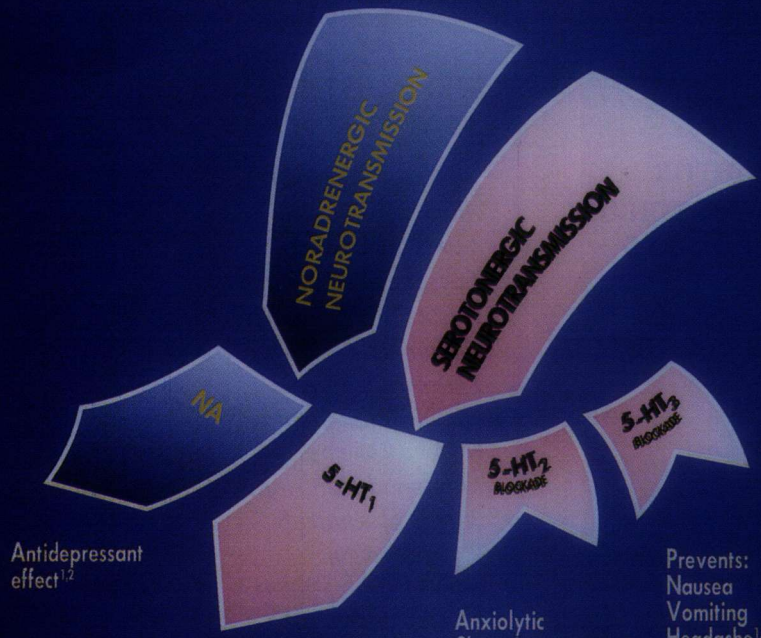

- Once-a-day evening dose[3,4]
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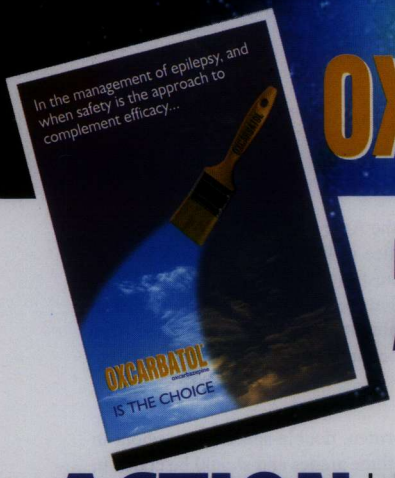

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The Arab Journal of Psychiatry (AJP) has been printed since 1989. It is owned by the Arab Federation of Psychiatrists. Original scientific reports, review articles, and articles describing the clinical practice of Psychiatry will be of interest for publication in AJP. The articles may be written in English or Arabic but must always be accompanied by an abstract in English and Arabic. All papers are accepted upon the understanding that the work has been performed in accordance with national laws and International ethical guidelines. Manuscripts submitted for publication in the Arab Journal of Psychiatry should be sent to Editor in Chief, Deputy Editor or to Associate Editors. All manuscripts are assessed by qualified international referees.

Manuscripts

Manuscripts must be submitted as an original with two copies and must be typewritten, double-spaced throughout in ISO A4 pages with a margin of 3 cm. Sub-heading in the text should be limited to three grades and should be coded in the left margin. Make the approximate position of figures and tables in the left margin.

The first 3 page of the manuscript should contain the following:

Page1: Title, running head (Max: 40 letters), title or article in English and names of authors, without titles or addresses.

Page 2: Abstract in English (max: 250 words). It should follow a structured format (objectives, method, results and conclusion). It should include key words (max. 5).

Page 3: Names of authors, titles, and full addresses and address for correspondence.

Acknowledgment of financial support and persons who have had major contribution to the study can be included on a separate page.

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Tables

Tables should be typed with double-spaced in separate pages. They should be numbered with Arabic (e.g. 1, 2, 3) numerals and have a short descriptive headings.

Illustrations

All illustrations (footnotes and line drawings) should be submitted camera-ready; line drawings/diagrams should be approximately twice the size they will appear in print.

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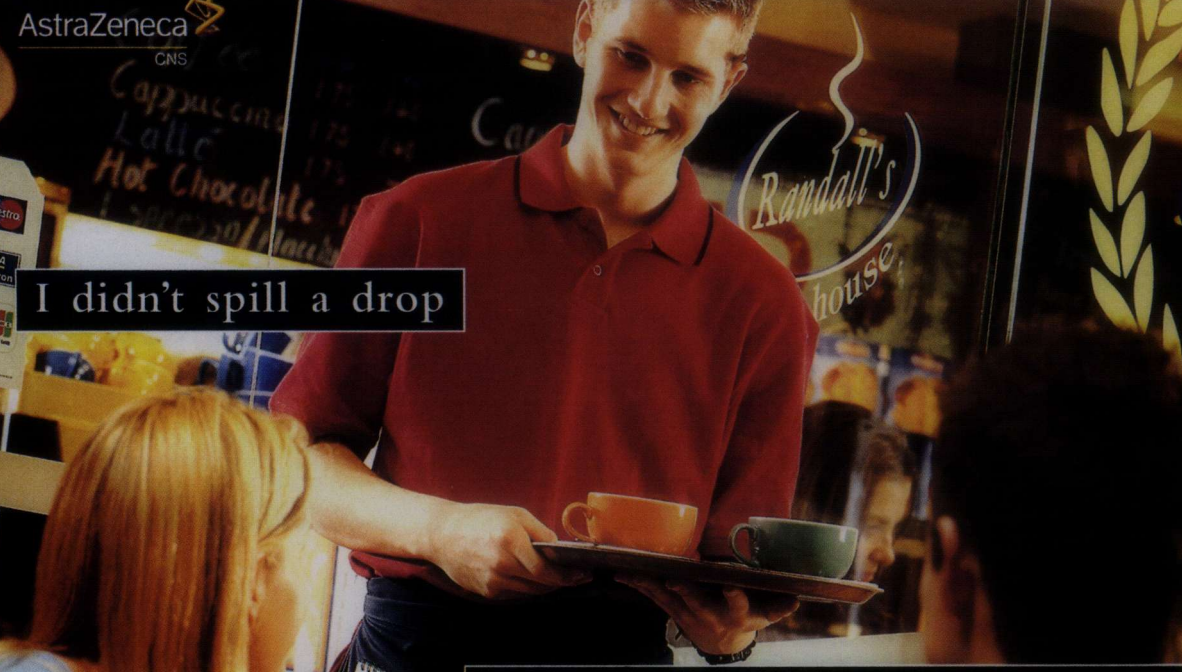

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The incidence of somnolence reported from controlled trials of 'Seroquel' was 17.5%: 'Seroquel' patients versus 10.7% placebo.[6] However, the somnolence experienced with 'Seroquel' is generally mild and typically appears during the first two weeks and disappears with continuation of treatment.[7,8]

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Fluvoxamine: Safety Profile in Extensive Post- Marketing Surveillance

R. Buchberger
W. Wagner

The safety profile of the selective serotonin reuptake inhibitor, fluvoxamine, has been assessed in clinical and post-marketing studies. Post-marketing surveillance provides the opportunity to assess a drug's safety in every day clinical conditions in a much greater patient population than in clinical trials and therefore serves as a useful tool to detect signals for adverse effects with an incidence of less than 1:10,000. The safety profile of fluvoxamine was evaluated based on data from 17 years of global post-marketing surveillance in an estimated 28 million patients exposed to fluvoxamine. A total of 6,658 adverse drug reaction reports received from world-wide sources were reviewed and analysed. Post-marketing surveillance data confirmed the favourable safety profile already observed in clinical and post-marketing studies. A remarkably low level of suicidality, switch to mania, and sexual dysfunction was found. Serotonin Syndrome appeared to be a very rare complication of fluvoxamine treatment. No signals for drug interactions unknown so far were identified. Withdrawal symptoms were observed in everyday clinical conditions, which were generally mild and resolved spontaneously. However, no cases suggestive for drug dependence have been reported. In conclusion, the data presented underlined that fluvoxamine offers a safe and well-tolerated op-

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