اتحاد الأطباء النفسانيين العرب
1975 ١٩٧٥
ARAB FEDERATION OF PSYCHIATRISTS

المجلة العربية للطب النفسي

المجلد الثالث ـ العدد الأول ايار (مايو) ١٩٩٢

تصدر عن
إتحاد الاطبّاء النفسانيين العرب

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in the management of acute psychoses

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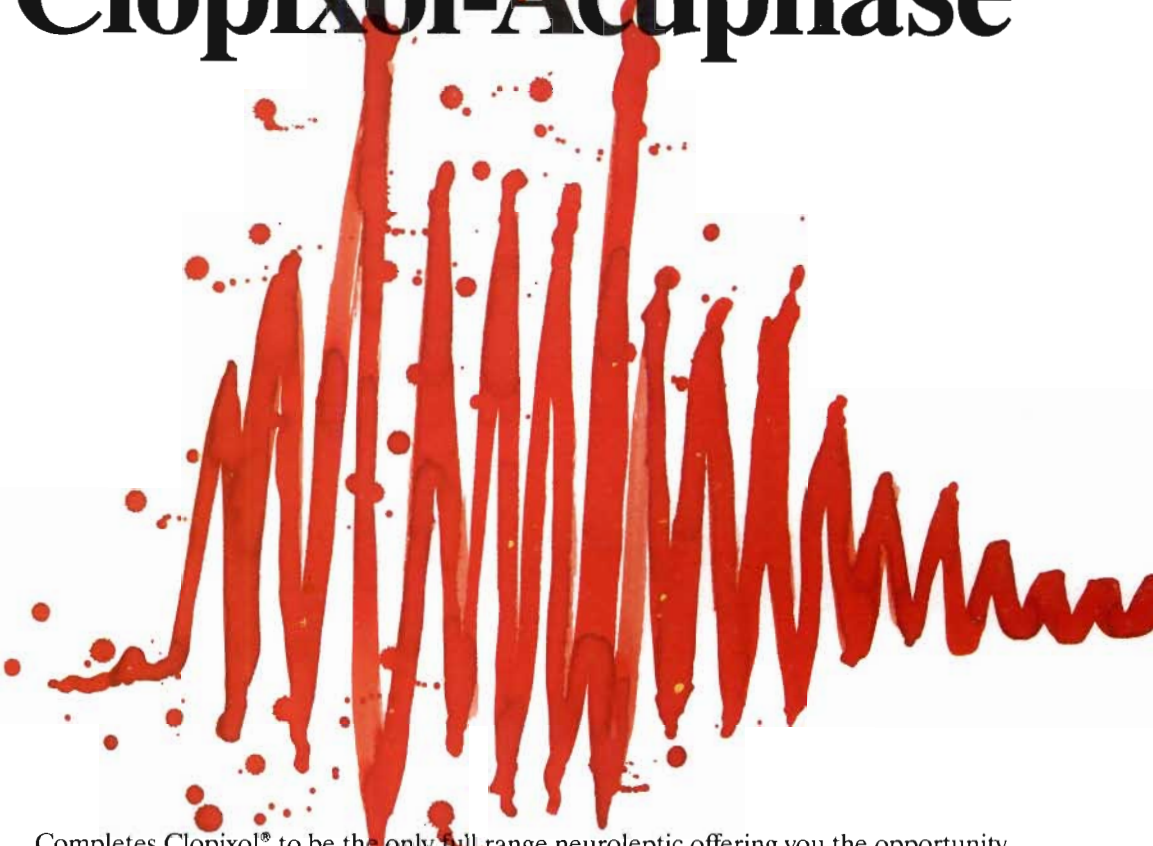

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المجلة العربية للطب النفسي

المجلد الثالث ـ العدد الأول أيار (مايو) ١٩٩٢

تصدر عن
إتحاد الأطباء النفسانيين العرب

شعبة إتحاد الأطباء العرب

٦١٦,٨٠٥
مجل المجلة العربيـة للطب النفسي / اتحاد الأطباء النفسيين العرب. ـ عمان، ع١، تشرين ثاني، ١٩٨٩
٩٠ ص
ر.ا.ع ٠١٠ (١٩٨٩/٦/٣٤٥)
١ ـ الطب النفسي ـ دوريـات أ ـ اتحاد الأطباء النفسانيين العرب

(تمت الفهرسة بمعرفة دائـرة المكتبات والوثـائق الوطنية)

Design, Artistic Layout, and Follow up:
Siham Al-Wahoush, Center for Educational Development for Health Personnel, University of Jordan

طبـع في شركة الشرق الأوسط للطباعة ـ تلفون ٨٩٤٩٤٠ ـ ٨٩٤٩٤١ ـ ص.ب ١٥٢٨٦ ـ عمّان ـ الأردن ـ ماركا الشمالية

رسالة المحرر

الزميل الكريم

مع صدور العدد السادس لمجلتنا، أبعث لكم جميعاً بالتحية والاحترام والشكر على الدعم المتواصل، ولا زالت هيئة التحرير تطمح بالمزيد من المشاركة والدعم من كافة الزملاء في الأقطار العربية وفي مختلف انحاء العالم، لقد تبلورت فكرة المجلة في المؤتمر العربي الثالث في عمان عام ١٩٨٧، وخرجت للوجود مع المؤتمر العربي الرابع في صنعاء عام ١٩٨٩، ونحن الآن على أبواب المؤتمر العربي الخامس في الدار البيضاء هذا العام، وأملنا كبير أن يأتي هذا المؤتمر وقد تعزّزت مكانة المجلة، وأصبحت مقبولة للنشر والترفيع من كافة الجامعات العربية، وهذا يتطلب من الزملاء العمل الدؤوب كل في بلده لتحقيق ذلك.

هيئة التحرير تودّ أن تسمع الكثير من النقد البنّاء، والتوجيه والتنبيه، والتعاون الايجابي، وسيكون مؤتمرنا القادم في الدار البيضاء مناسبة جيدة لمناقشة وتقييم المجلة.

أيار ١٩٩٢ — المحرّر

معلومات هامة للناشرين

يصدر اتحاد الاطباء النفسانيين العرب المجلة العربية للطب النفسي مرتين في السنة.

وتستقبل المجلة من الزملاء البحوث العلمية والمقالات العلمية ودراسة الحالة في جميع حقول الطب النفسي على أن لا تكون قد قدمت للنشر في أي مجلة أخرى وتقبل النصوص في اللغات العربية والانجليزية والفرنسية ويرفق بالبحث ملخص لا يتجاوز (١٥٠) كلمة على ان يضم ترجمات له في اللغتين الاخريتين.

ملاحظات هامة لمقدمي الأبحاث:

تهتم هيئة التحرير بوضوح التعبير والصياغة الجيدة ويجب ان تكون مطبوعة بمسافات مزدوجة بين الاسطر وبوجه واحد من الورقة وبهوامش واسعة ويفضل حجم الورقة ان يكون ٢١ × ٢٨ سم، ويجب ترقيم الصفحات ابتداء من صفحة عنوان المقال بشكل متسلسل، ويجب ان يكون العنوان قصيرا وذو دلالة لمحتويات البحث ويكتب في الصفحة الاولى اسم الكتاب، اسماءهم ودرجاتهم العلمية وعنوانهم الكامل ويرسل الباحث ثلاث نسخ من المقال الى محرر المجلة.

المراجع:

يعمل قائمة بالمراجع في نهاية البحث مرقمة حسب اولوية ورودها في النص الاصلي. وتشمل اسم العائلة للكاتب والحروف الأولى من اسماءه الاخرى. سنة البحث وعنوان البحث بالاضافة الى اسم المجلة او الكتاب ورقم المجلد ورقم الصفحة.

(١) **مثال: م، س، عبد الجواد وعرفة، م. (١٩٨٠) دراسة عبر ثقافية لاغراض الكآبة المجلة المصرية للطب النفسي، ٣:٣٢ ـ ٣٧.**

أما الصور والجداول والاشكال فيجب ان تقدم بأوراق منفصلة مع تفاصيل عن ماهيتها وبيان موضعهامن البحث ويجب الرجوع الى المرجع المتعلق بالابحاث المقدمة للمجلات الطبية Br. Med. J. 1988; 296:401-405 للتقيد بشروط تقديم الصور والجداول والاشكال. آخر موعد لتقديم الاوراق ٣٠/٩ و ٣٠/٣.

★ **يرسل للباحث عشر نسخ من المقال بدون مقابل.**

★ الاشتراكات ان الاشتراك في اتحاد الاطباء النفسانيين العرب يهيىء للمشترك استلام المجلة مجاناً

★ الاشتراك السنوي (٢٥) دولاراً أمريكيا / (٤٠) دولارا امريكيا لغير الاطباء النفسانيين العرب

★ ثمن العدد الواحد (٢٠) دولارا أمريكيا

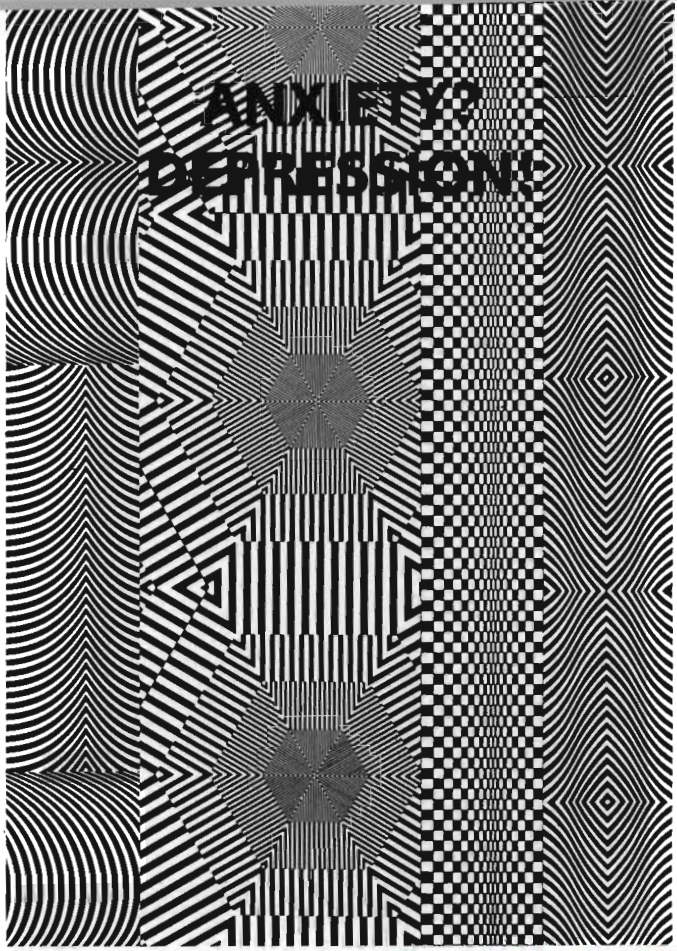
★ يرسل الاشتراك للبنك الاهلي الاردني/ جبل عمان ـ عمان ـ الاردن.
رقم الحساب ١٢٠ **يُرسل الاشتراك بحوالة بنكية فقط**

★ عنوان المجلة المحرر المسؤول ـ الدكتور عدنان التكريتي ص ب (٥٣٧٠) عمان، الاردن

THE ARAB JOURNAL OF PSYCHIATRY

المجلة العربية للطب النفسي

هيئة التحرير



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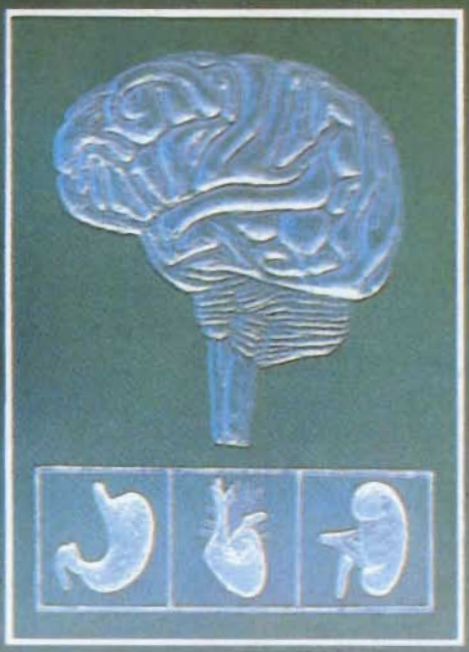

Xanax™ Tablets
(alprazolam)

to calm the somatic symptoms of anxiety and anxiety with depressed mood

- *Palpitations*
- *Tension*
- *Chest Pain*
- *Vertigo*
- *Pruritus*
- *Fear*
- *Nausea*
- *Diarrhoea*
- *Headache*
- *Sweating*

a triazolobenzodiazepine with a measurable difference in effectiveness and tolerance

effective in a broader range of patients than traditional anxiolytics

PRODUCT INFORMATION

Indications

Anxiety.

Contraindications

Known hypersensitivity to benzodiazepines.

Warnings and Precautions

Xanax Tablets should not be used by patients with impaired renal or hepatic function; by children under 18; by nursing mothers or by pregnant women because there is a risk of congenital malformations. Additive CNS depressant effects may occur when taken along with alcohol or other CNS depressants. Caution patients about possible drowsiness or dizziness when driving or doing other dangerous tasks. Habituation and emotional/physical dependence may occur. Use particular caution when prescribing benzodiazepines to patients prone to abusing drugs, eg. alcoholics or drug addicts. To discontinue treatment with Xanax, reduce dosage by no more than 0,5 mg every three days. An even slower dosage reduction may be necessary. Withdrawal symptoms have occurred following rapid decrease or abrupt discontinuation. These can range from mild dysphoria and insomnia to a major syndrome including abdominal and muscle cramps, vomiting, sweating, tremors, and convulsions. Withdrawal seizures have also been reported with rapid decrease or abrupt discontinuation. Use appropriate precautions when prescribing for severely depressed or suicidal patients.

Adverse Reactions

Side effects usually occur at the start of treatment and diminish or disappear with continuation or dosage reduction. The most common complaints were drowsiness and lightheadedness/dizziness. Less common adverse reactions were blurred vision, headache, depression, insomnia, nervousness/anxiety, tremor, weight change, memory impairment/amnesia, coordination disorders, various gastrointestinal symptoms, and autonomic manifestations. Stimulation, agitation, concentration difficulties, confusion, hallucinations or other adverse behavioural effects, dystonia, irritability, anorexia, fatigue, slurred speech, jaundice, musculoskeletal weakness, changes in libido, menstrual irregularities, incontinence, urinary retention, abnormal liver function, and increased intraocular pressure have been reported.

Drug Interactions

Concomitant administration raised blood levels of imipramine and desipramine; clinical significance is not known. Interaction with other drugs also occurs, eg. clearance of benzodiazepines is slowed in patients taking cimetidine. The clinical significance is not known.

Dosage

Dosage must be individualised. Dose must be increased or decreased cautiously to minimise adverse effects. Patients who have not previously taken psychotropics will require lower doses.

Usual starting dosage :

0.75 to 1.5 mg daily, in divided doses.

Usual dosage range :

0.5 to 4.0 mg daily, in divided doses.

Geriatric patients :

0.5 to 0.75 mg daily, in divided doses. Increase gradually if needed and tolerated. Use lowest effective dose to avoid ataxia or oversedation.

Availability

Xanax Tablets are available as 0.25 mg (white), 0.5 mg (peach), and 1 mg (lavender) scored, ovoid-shaped tablets in blisters of 30.

(Not all sizes available in all areas)

PRODUCT OF Upjohn

المحتويات

المجلة العربية للطب النفسي ١٩٩٢ المجلد ٣ عدد ١ صفحة 65 - 64

مكتبة المجلة

سيكولوجية الارهاب السياسي

تأليف الدكتور خليل فاضل

صدرت في القاهرة الطبعة الأولى من هذا الكتاب لأحد الأطباء النفسيين العرب النشيطين في حقل الكتابة والبحث العلمي. يقع الكتاب في ثلاثمائة صفحة من القطع الكبير في ستة فصول.

يبحث الكتاب في موضوع شائك صعب ابتعد عنه الكتاب العرب لحساسيته، وقد حاول الدكتور خليل في كتابه أن يفتح أبواباً ونوافذ كثيرة على هذا المجال، وقد يكون أكثر منها، ولكن الهدف هو أن يضيء طريق البحث في هذا المجال الصعب. ولذلك بدت بعض المواضيع مبتورة وكان القصد منها التنبيه اليها اكثر من بحثها.

في الفصل الأول تعرض للارهاب السياسي كظاهرة معاصرة، وتطرق لأسبابه، وموضوع الرهائن وعلم دراسة الضحايا ودور الاعلام في إثارة الارهاب ومكافحة الارهاب والتصدي له، وتعرض إلى لمحات من حياة الارهابيين واسلوبهم في صنع القرارات.

في الفصل الثاني تناول رؤية الارهاب السياسي بشكل عام معرفا ومفسراً متطرقاً للبعد الشخصي وعلاقة الطب النفسي في الموضوع، وتناول النظريات التحليلية في التوتر والارهاب على الضحايا.

في الفصل الثالث تناول الهوية الشخصية كمفهوم تنظيمي وراء الفرد الارهابي، موضحا بعض الامثلة لأفراد وحركات في مصر وقد حاول ربط ذلك بنظريات اريكسون في التطور النفسي الاجتماعي.

في الفصل الرابع تناول البعد الاجتماعي للجماعة الارهابية لمحاولة فهم اسس التنظيم الارهابي من منظور نفسي اجتماعي. واستغرب لماذا يستعمل الكاتب كلمة سوسيولوجي فكلمة اجتماعي كافية وافية. في هذا الفصل يبحث البدايات الوظيفية للعمل الارهابي السياسي، الوازع، والضمير، ويذكر مثالا لأحد رجال الميليشيات اللبنانية ويصل في تحليلاته الى ان الانخراط في العنف يسلب من الانسان الاحساس بالذنب، ويتطرق لثقافة الارهابي وابطاله.

في الفصل الخامس يتطرق الى ارهاب الدولة وهنا يصعب التفريق بين الحرب بين الدول وما سماه الكتاب ارهاب الدولة، ويتطرق لبعض المشاكل بين الدول

العربية التي اعتقد انها اكبر من ان توصف بهذا الوصف البسيط، وقد تكون من الامور الصعبة في تشريحها على طاولة العلوم النفسية والاجتماعية.

في الفصل السادس يتطرق بشيء من التفصيل للارهاب الصهيوني كمثال واضح على ممارسة الدولة للارهاب مستعرضا مجزرة المسجد الاقصى وآثارها، مقتل كاهانا، مجازر صبرا وشاتيلا وامثلة ايمن حافظ وسليمان خاطر وتطرق للانتفاضة وجيلها، وآثار ذلك على الاطفال الفلسطينيين واخذ موضوع اقحام الطب النفسي في الصراع العربي الاسرائيلي باهتمام.

وختم كتابه بفصل عن توتر ما بعد الصدمة على اعتباره اكثر الحالات النفسية شيوعا بعد الارهاب مستعرضا اعراضها وعلاجها. وقد ضمن الكتاب ملاحق عديدة ووثائق تدعم القصص الواردة عن الارهاب السياسي، وضمنها صور عديدة للتوضيح.

لقد كتب الكتاب بأسلوب بسيط واحتوى الكثير من المعلومات، وان كان ربط كل هذه الاحداث بالارهاب السياسي، وهي المهمة الشاقة التي اخذها الدكتور خليل على عاتقه فقد وفق في ذلك الى حد ما، وقد يجد من يخالفه الرأي في كثير من التفاصيل.

باعتقادي ان هذا الكتاب هو فاتحة لمجال جديد لم يطرقه الاطباء النفسيين وعلماء النفس العرب ويجدر بهم ان يلتفتوا إليه الآن، فنحن نعيش في عالم كله مشاكل وحروب وارهاب، شكري للدكتور خليل على الجهد الهائل الذي تكبده لجمع كل هذه المعلومات وتهنئتي له على هذا العمل الذي يضيفه إلى سجله الحافل، ونحن بانتظار المزيد يا دكتور خليل.

المجلة العربية للطب النفسي ١٩٩٢ المجلد ٣ عدد ١ صفحة 63 - 62

تفكير الأطفال ـ تطوّره وطُرق تعلّمه

تأليف الدكتور يوسف قطامي

صدرت الطبعة الأولى من هذا الكتاب عام ١٩٩٠ عن الأهلية للنشر والتوزيع في عمان، ويقع الكتاب في أكثر من ثمانمئة صفحة من القطع الكبير في سبعة عشرة فصلاً.

يعتبر موضوع الكتاب من أكثر مواضيع علم النفس صعوبة وتعقيد، وقد ابتعد الباحثون العرب عنه ولذلك فان مراجع تفكير الطفل قليلة في المكتبة العربية، ولذلك فقد تكبد الدكتور يوسف عناء كبيرا ومشقة في جمع المعلومات وتصنيفها وتحليلها وربطها بالواقع الأردني والعربي، ومع ذلك لم يتخلى الكاتب عن اسلوبه البسيط السهل الذي يجعل قراءة الكتاب متعة بحق.

في الفصل الأول والثاني تناول أساليب التفكير وطرق تعليمها مستعرضاً عدداً كبيراً من النظريات المعروفة في هذا المجال مستخلصاً منها تطبيقات عملية للنمو المعرفي، وفي الفصل الثالث تناول الاتجاهات السلوكية في التفكير وطرق تدريب التفكير الارتباطي وانتقل للاتجاهات المعرفية في الفصل الرابع والتدريب على الاستقصاء في الفصل الخامس. اما الفصول الستة التالية فقد افرد كل منها لأحد النماذج التي قدمها كبار العلماء المعروفين في هذا المجال وهم برونر، أو سوبل، متسوري، فروبل، ستالوزي واخيرا اتجاه هيلدا تابا الاستقرائي في التفكير، وفي الفصل الثاني عشر تناول باسهاب اسلوب الحوار والمناقشة في تنمية التفكير معطياً نماذج تدريبية عملية بسيطة، اما التفكير المنطقي والحدسي والتحليلي لدى الاطفال فقد خصص له فصلاً تناوله باسهاب، وتناول اسلوب تفكير حل المشاكل وعلاقته بالتعليم والتعلم، وخصص فصلاً لمعالجة المعلومات تم تناول الابداع وأساليب تطويره والألعاب الاجتماعية والذهنية ولعب الدور في تطوير التفكير، كل هذه في منظور التعليم وتطويره.

كل هذه المواضيع طرقت بتفصيل محبب والتزام علمي دقيق في اسلوب سهل، واستعمل الملخصات والمربعات لابراز النقاط الهامة، واورد العديد من التدريبات والانشطة والتطبيقات العملية المفيدة للمدرسين والامهات والآباء.

أعتقد ان هذا الكتاب مرجع ممتاز لطلاب علم النفس والتربية والعلوم الانسانية والطبية، كما انه قراءة مفيدة للانسان العادي الذي يود زيادة ثقافته عن تطور الطفل واساليب مساعدة التفكير والتعليم، ولا بد لكل من يدرس الاطفال ان يقرأه ويحتفظ به في مكتبته، وهو يلبي طلب كثير من المتعلمين والمهنيين الذين يشعرون انهم غير قادرين على فهم اطفالهم.

لا بد لي من ان أسجل التهنئة للدكتور يوسف قطامي الباحث الاردني المعروف في مجال علم النفس، على هذا الانجاز الرائع، وابارك للمكتبة النفسية العربية بهذه الاضافة الجديدة، واتمنى ان يكون هذا الكتاب فاتحة لمزيد من الدراسات والبحوث في هذا الميدان.

الدكتور/وليد سرحان

FORTHCOMING EVENTS

■ Annual Meeting 1992

The Royal College of Psychiatrists is holding its meeting in Dublin between 24th and the 27th of July 1992.

Further informations:

Deborah hart

Royal College of Psychiatrists, 17 Belgralve

Square London SW1X 8PG

Tel. 071 235 2351 , Fax 071 2451231

■ First International congress of Islamic Medical Association of Malaysia

Theme: Towards The ultimate in Health

An Islamic Perspective

Kuala Lumpur, MAMAYSIA 11-15 September 1992

For correspondence:

The Secretariat

c/o Faculty of Medicine

University Kebang saan Malaysia

Jalan Raja Muda Abdul Aziz

50300 Kuala Lumpor

MALAYSIA

Registration Forms are available at The A.J.P office in Amman.

P.O.Box 5370.

■ Fifth Panarab Congress on Psychiatry

25 - 27 Nov. 1992, Casablanca, Morocco under the auspices of the Arab Federation of Psychiatrists.

Information: Prof. D. Moussaoui

Contre Psychiatrique universitaire Ibn Rochd

Rue Tarik Ibn Ziad, Casablanca, Morocco

Tel. (212) - 2 - 204102 Fax (212) 2 - 294707.

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gender. Although the case was diagnosed as atypical psychosis DSMIII-R, the short duration of the episode, the accompanying panic and the rapid remission without relapse may suggest phobic reaction.

As fertility and masculinity are highly praised among the Saudis, the delusion of losing one's penis may reflect an inner conflict over worth and usefulness. There are no available epidemiological data regarding sexual disorders in Saudi Arabia. The author presume from his own clinical experience in different medical centres in this country that the complaint of small sexual organs is a rather common one. The majority of those subjects have average organ size.

Although Mr (A) firmly denied any current homosexual orientation, his complaint might have been a symbol of latent homosexuality.

Oyebode et al 1986 demonstrated that anxiety which accompanies Koro can cause reducation in the blood flow to the extremities causing actual reduction of the penile circumference. Which means that the belief of penile shrinkage may not be utterly delusional.

In a proposal for DSM IV (Ruth et al 1990) considered the complaint of genital retraction as a physical symptom for which there are no demonstrable organic finding and which is presumed to be of psychogenic origin. Therefore they included it under the somatoform disorders. They further subclassified it into genital retraction disorder, culture specific (Koro) which occurs in single and epidemic forms and genital retraction disorder, which is not culture specific.

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with strong belief that his penis was smaller than average. this belief made him visit various clinics seeking help in treating his imagined defect. Inspite of assurance by many physicians that his sexual organ was quite normal, he continued to ask for treatment, Fantasies during masturbation were heterosexual.

After reading an article on hermaphrodism, he started to feel his penis shrinking into the abdomen. he became bewildered, apprehended and stayed awake for several nights just grasping his organ in an attempt to stop it's shrinkage. In a weektime he was delusionally convinced that his gender was changing as he developed a womb in his pelvis and a vaginal entrance at the site of his shrinking penis. When seen at the psychiatric OPD Mr (A) was very tense and almost in a state of mania. He was able to speak coherently and relevantly he denied any hallucinatory experience.

Physical examination revealed no abnormality, his organ was of average size. Psychometric testing showed high psychotic scores, an average IQ and no signs of organicity. Premorbid personality was of sensitive, insecure and schizoid type. No family history of mental illness could be detected. Mr (A) was given Trifluperazine (stelazine) 5mg and Benztropine (cogentine) 2mg orally twice daily.

The family braught him again after three days reporting no noticeable improvement. Admission to the in-patient was arranged and dose increased to stelazine 30mg and cogentine 4mg daily. After 4 days Mr (A) reported disappearance of all his symptoms, and insisted on going home against medical advice. He was diagnosed as a case of atypical psychosis DSMIII-R.

Contact had been made with the patient and his father 6 months and 2 years following his discharge. They reported disappearance of all symptoms without relapse. Now he holds a permanent job and does not visit doctors or receive any treatment what so ever.

DISCUSSION

It should be emphasized that the belief of ghosts attempting to resume human life through obtaining genitals of humans is not known in Saudi Arabia. Mr (A) had no contact with any Chinese person or culture by anyway. He, like other non Chinese cases studied by Berrios & Morley 1984 showed incomplete Koro symptomatology as he did not believe that he would eventually die at the end of his experience. he was rather delusional about the change of his

La nature de Koro comme limite culturelle a été discutée l'auteur pense que le Koro classique existe seulement chez les chinois et les cultures avoisinantes. Quand l'apparition se fait en debors de cette localité géographique l'image est soit incomplète, soit greffée sur d'autres conditions psychiatriques.

Koro, a Malay word, means head of the turtle. It describes a syndrome that occurs among Chinese and Southeastern Asians in both sporadic and epidemic forms[3]. Classically the patient believes that his penis is shrinking into the abdomen, leading to his eventual death. To prevent this happening he may tie, clamp or keep grasping his organ[2]. It is believed in some South Asian areas that ghosts of dead do not possess genitals, and those who wish to return to human life need to obtain genitals. Consequently the feeling of one's organ shrinking creates intense anxiety and may lead to panic in the local native who expects the fatal end of his experience[6]. Sporadic cases have been reported in Great Britain, France, USA, India, Nigeria and some other places. There has been no general Agreement on the nature of Koro as it has been considered by different researchers as depersonalisation disorder, obsessional disorder, acute anxiety, acute castration fear, psychotic episode or hysteria[1,7].

The place of culture bound syndromes in the international classification of Psychiatric disorders (DSMIII-R and ICD 10) is still controversial.

CASE REPORT

Mr A was escorted to Riyadh's psychiatric hospital by a private urologist who requested help to the patient who attended his clinic more than once every day for the past 5 days, and who finally refused to leave the clinic unless he gets curative treatment for his shrinking penis. Mr A was 20 year Saudi national, single and unemployed. He finished (A) level education, left school due to repeated failure and could not hold down any full time job. He was 5th eldest of 8 healthy siblings, his delivery and early childhood were normal. He admitted to having two homosexual experiences at the ages of 11 and 14, being the passive partner on both occasions. He also reported late puberty at the age of 16

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Koro Like Symptoms in Saudi Patient

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عرض حالة مريض سعودي مُصاب بأعراض شبيهة بالكورو

هاني منتصر

ملخص:

يقدم الباحث حالة مريض سعودي ظهرت عليه أعراض شبيهة بالكورو، ناقش هذا المرض كمتلازمة مرتبطة بالثقافة، يعتقد الباحث ان الكورو معروف فقط في الصينيين والحضارات القريبة منهم، وعندما تظهر خارج هذه المنطقة الجغرافية فعادة ما تكون الصورة غير مكتملة أو ضمن احد الاضطرابات النفسية الأخرى.

Abstract

A case of young Saudi who manifested Koro like symptoms is presented. The nature of Koro as culture bound syndrome is discussed. The author believes that classic Koro exists only in Chinese and other related cultures. When it appears outside of this geographical locality the picture is either incomplete or grafted on other psychiatric conditions.

Résumé

Koro Like Symptome Chez un Patient Saoudien

Un cas d'un Jeune Saoudien qui a développé un Koro-like symptôme est présenté.

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seizures[8,11]. On the other hand, 9 patients were refered for E.E.G. solely on the ground of being violent. Unexpectedly, 6 out of them showed significant E.E.G. abnormalities which were consistent with temporal lobe seizures. This is inconsistent with the majority of previous studies which indicated the rarity of such association[11,10,12,13]. Nevertheless, unexplainable violence or unprovoked aggression seems still to influence the clinicians to relate them to epileptic seizures, Hindler (1989) reported an unusual case of homicidal act which was ruled out as being due to epileptic activity and had suggested few criteria which he had extracted from previous studies to be met before such violence is accepted as being due to epileptic activity. The criteria he forwarded were:-

(1) A past history of unequivocal epileptic attacks.
(2) The violence is out of character with the previous personality.
(3) The violence is motiveless and unpremeditated.
(4) E.E.G. findings are compatible.
(5) Total or subtotal amnesia for the act[15].

Another important finding was that 13 out of 32 patients referred with the diagnosis of psychogenic fits were found to be epileptic in nature. This confirms the continuously highlighted difficulty in differentiating such cases on clinical grounds only and emphasizes the role of E.E.G. in such cases.

Conclusion:

Psychiatric clinics in developing countries are still receiving a substantial portion of epileptics with or without psychological problems. Not a few of them may wrongly be diagnosed as functional disorders to receive inappropriate treatment. This mere fact overemphasizes the role of E.E.G. in psychiatric clinics and makes it a necessary investigatory tool among these patients.

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implications. The majority of the patients (57.1%) who showed epileptiform activity in their E.E.Gs. were in the age range 11 - 30 years, compared to only 20% in the age range 31 - 60 years. (Chi square 15.8,$P<0.05$). This reflects the cumulative effect of chronic epilepsy which has the highest prevalence rate in this age group.[18] The percentage of patients showing epileptiform activity in the study is much higher than reported before. 55.3% of males and 45.6% of females showed such an activity compared to only 5.8% of the patients studied by Linda et al 1985. This high difference may be due to the nature of our patients who are highly selected ones being attending especialized clinics. However, considering the percentage of epileptiform activity in normal population which doesn't exceed 3.8% in most studies[16,17,14]. This high incidence lends more support to the repeatedly reported high incidence of psychological morbidity among epileptic patients regardless of their sociocultural background. As had been indicated previously, partial complex seizures originated in temporal lobes was found to be over-represented among our patients. 92 patients (59%) were found to have temporal lobe foci, and moreover, they showed the highest correlation with the provisional clinical diagnosis they were refered with. The poorest correlation in this respect was among patients who were refered as suffering from petit mal epilepsy. None of them showed the diagnostic pattern of 3 spike/wave activity, and moreover, four out of the 7 showed temporal lobe foci. This finding highlights the difficulty encountered in the diagnosis of petit mal epilepsy in adulthood and also confirms the close resemblance of such attacks with the brief attacks of psychomotor epilepsy originated in temporal lobes to add to the aforementioned difficulty which can only be resolved with the help of E.E.G. Such differentiation is essential for therapeutic implication.

In symptomatology, disturbed behaviour with or without aggression was found to be the third commonest complaint for which E.E.G. was sought. It was superceded by only convulsions and altered consciousness which are frank epileptic manifestations. 22 patients who were refered because of deterioration in their social behaviour, were found to be epileptics and needed active treatment. This is in keeping with the known personality and behaviour changes that had been repeatedly reported, particularly, with temporal lobe

Table (IV)

MAINS SYMPTOMS IN PATIENTS REFERRED FOR E.E.G.

SYMPTOMS	T.L.E. 92		G.M.E. 42		2
	No.	%	No.	%	
1. Bouts of altered conciousness	28	30	15	36	
2. Fits	27	29	30	71	4.6
3. Bouts of violence and/or aggression	19	21	3	8	1.96
4. Headache	12	13	1	2	
5. Bouts of fear	8	9			
6. Dysphoric mood	5	5			
7. Fugues	5	5			
8. Involuntary movements	4	4			
9. Personality changes	4	4	2	5	
10. Absence attacks	3	3			
11. Hallucinations	14	15			

Chi square 36.7 $P<0.05$

Discussion:

Epilepsy and psychosis have enjoyed for many years an intriguing relationship which though has been the focus of attention of many investigators, its qualitative nature has not yet been clearly identified[1]. The issue is even more complicated in the developing countries where a significant number of people still believe that epilepsy is a functional disorder which is most commonly related to some superstitious or supernatural powers. Quite understandably, such a belief makes the majority of epileptics attend the psychiatric rather than neurology clinics, thus creating an extra burden on the already congested ones. In addition, if we consider the high incidence of psychological disorders associated with epilepsy, in particular temporal lobe disorder, the imperative role of E.E.G. in psychiatric clinics, in the developing countries, in particular will be clearly evident.

Compared to previous studies, this study shed the light on few but albeit significant points which may have important clinical

found to have abnormalities consistent with temporal lobe seizures. Hence, only 48 patients (34.3%) were found to correlate correctly to their provisional diagnoses. 13 patients out of the 32 (40.6%) who were refered with provisional diagnosis of psychogenic pseudoepileptic fits were found to have grossly abnormal E.E.Gs., consistent with epileptic seizures and needed regular anticonvulsant drugs. 6 out of the 9 patients who were refered with bizare conduct disorder showed significant abnormalities in their E.E.G. which warranted active antiepileptic treatment. [table (III)].

Table (III)

CORRELATION RATE BETWEEN CLINICAL DIAGNOSES & E.E.G. FINDINGS

Clinical diagnosis		E.E.G. RESULTS					
		–ve results		+ve results			
				same type		other type	
	No.	No.	%	No.	%	No.	%
G.M.E.	87	39	45	26	29.9	22	25.3
T.L.D.	46	24	52	22	48		
P.M.E.	7	3	43			4	57
Total	140	66	47	48	34.3	26	18.5

Chi square 21.98 significant $P<0.05$

(3) Symptomatology:-

Symptoms which most commonly led the psychiatrist to seek E.E.G. help in diagnosis were altered consciousness, convulsions and disturbed behaviour with or without aggression. (table IV).. Altered consciousness and convulsions were more frequent amongst patients suffering from grand mal epilepsy, while disturbed behaviour and hallucinatory experience were the most frequent symptoms among patients diagnosed as suffering from temporal lobe disorder.

Table (II)

MAIN CLINICAL DIAGNOSES REFERRED FOR E.E.G.

	CLINICAL DIAGNOSIS	No.	–ve	+ve			
				T.L.D.	G.M.E.	Focal	Non Specific
1.	Grand Mal epilepsy	87	37	19	26	3	2
2.	Temporal lobe disorder	46	24	22			
3.	Psychogenic fits	32	19	10	1	2	
4.	Fits for investigations	27	9	9	7	2	
5.	Psychosis	20	14	4		2	
6.	Organic Brain Syndrome	17	5	4	1	5	2
7.	Headache	13	8	3		1	1
8.	Mental Retardation	12	6	1	4		1
9.	Disturbed consciousness	12	7	5			
10	Conduct disorder	9	3	6			
11.	Personality disorder	8	5		3		
12.	Petit Mal Epilepsy	7	2	4			1
13.	Neuroses	6	2	4			
14.	Nocturnal Enuresis						
	Total	300	144	92	42	15	7

focal lesion warranting further investigations in 15 cases (9.6%), and non-specific changes in only 7 patients (4.5%). In total 156 patients were found with significant abnormalities in their E.E.Gs. Among them, by far the highest correlation between the provisional clinical diagnosis and the E.E.G. diagnosis was found among patients diagnosed as temporal lobe disorder. 22 out of 46 patients were positively correlated (47.8%) while only 26 out of 87 patients (29.9%) were correlated among Grand Mal epilepsy and the poorest correlation was found among patients diagnosed as petit Mal epilepsy with non of the 7 patients referred with this diagnosis showing the diagnostic 3c/s activity in their E.E.Gs., and moreover, four of them were

E.E.G.. Of them 109 males & 47 females were found to have significant abnormalities in their E.E.Gs. These abnormalities were either epileptiform activity or dominant slow delta wave activity. For the purpose of this paper, epileptiform activity is defined as spike or/and sharp wave/slow complexes only. The ages of the patients range from 1 year to over 70 years. 212 patients (70.7%) were in the age range of 11 - 30 years; 121 of them (57.1%) showing positive E.E.Gs.. compared to only 20% (4 out of 20 patients) in the age range of 40 - 60 years, (Chi square 15.8P<0.05). [table(I)].

Table (I)

Age of patients in relation to +ve E.E.G. findings

Range	No.	−ve		+ve		Z test
		No.	%	No.	%	
1 - 10	24	10	41.7	14	58.3	
11 - 20	105	42	40	63	60	2.9
21 - 30	107	49	45.8	58	54.2	
31 - 40	40	25	62.5	15	37.5	2.2
41 - 50	15	12	80	3	20	3.3
51 - 60	5	4	80	1	20	1.8
61 - 70	4	2	66.6	1	33.3	

Chi square 16.8 significant < 0.05

(2) Clinical diagnoses and the E.E.G. findings:-

The provisional clinical diagnoses with which patients were referred for E.E.G. were widely variable. The most common diagnoses were:- Generalized epilepsy (Grand Mal type) in 87 patients (29%), partial epilepsy originated in temporal lobes 46 patients (15.3%), psychogenic fits 32 patients (10.7%), and undifferentiated fits for investigations in 27 patients (9%) [table (II)].

The E.E.G. findings were consistent with partial epilepsy originated in temporal lobes in 92 patients (59%), generalized epilepsy (Grand Mal) in 42 (26.9%), focal epilepsy which was thought to be due to a

one of the higher cognitive functions. Typical clinical cases, indeed, seldom present diagnostic difficulties, but albeit, the atypical cases, which by no means rare, may escape attention and their epileptic nature may not be detected and hence a functional psychiatric disorder is usually more likely to be suspected. In these cases, electroencephalogram (EEG) plays a central role to help identifying their epileptic nature. And despite the fact that interictal E.E.G. changes are usually not diagnostic, such findings, undoubtedly, give a strong support to the clinical impression. Such support comes primarily from the demonstration of epileptiform activity on their E.E.Gs. If we consider this problematic relationship of epilepsy with psychosis and the wide variability of epileptic manifestations itself, the role of E.E.G. in these patients would become clearly evident.

The aim of this study is three folds:-

First one is to know the proportion of the epileptic patients among the psychiatric patients attending our clinics since most people in developing countries still consider epilepsy as a psychiatric condition. Second, to assess the role of E.E.G. in these patients and to find out the correlation between the clinical diagnosis and the E.E.G. findings. Third and the most important one is to identify the symptoms and complaints which most commonly attract the attention of the psychiatrist to seek help of E.E.G. in diagnosis.

Method:-

A retrospective thorough review of all the E.E.G. records in the E.E.G. department at Jeddah Psychiatric Hospital revealed a total of 300 patients attending the department in a period of one year. (1.1.1990 to 31.12.1990). All of them were refered by the psychiatrists working in the hospital to have E.E.G. done for either a further support for their clinical impressions or to exclude an underlying organic lesions. At the time of referral neither the psychiatrist nor the E.E.G. interpreter were aware of this study is taking place. All patients were referred in a standard form which was specifically designed for E.E.G. request. It included all necessary sociodemographic as well as medical data relevant to epilepsy.

Results:

(1) Sex and age:-

A total of 2015 male and 1311 female patients attended the out-patient clinics in the hospital during the same period. Only 197 males (9.8%) and 103 females (7.9%) a total of 300 patients were referred for

over-represented and showed the highest correlation with the provisional clinical diagnoses for which E.E.G. was sought.

Fits, altered consciousness and deterioration in social behaviour came as the main complaints for which E.E.G. was requested. In developing countries, epileptics are still constituting a significant portion of patients in the psychiatric clinics.

Résumé

Le rôle délectroencéphalograme chez les malades psychiatriques dans les pays développés

Nous avons étudié 300 E.E.G. chez les malades soignés à l'hôpital psychiatrique de Jeddah, en cours d'une année afin de savoir la proportion des malades épileptiques, le diagnostic et le symptômes principals qui attirent l'attention du psychiatre pour le diagnostic. les atteintes des lobes temporaux sont les plus frequentes et demontrent une corrélation entre le diagnostic initial et le diagnostic basé sur E.E.G.

Les symptoms principaux aigent l'E.E.G. ont été l'altération de la conscience la détérioration du comportment social.

L'étude démontre que dans les pays developpés le nombre des malades epileptiques qui viennent pour consulter dans les cliniques psychiatriques est élevé.

The relationship between epilepsy and psychosis attracted the attention of many clinicians as well as researchers for over 150 years. While most of the early clinicians suggested an antagonistic relationships between the two disorders[1], the majority of the contemporary psychiatrists noted an affinity between them[2,20,3,5]. Nevertheless, the relatively high incidence of psychiatric morbidity associated with epilepsy, in particular with temporal lobe disorders, is well recognized[9,6,2,4,7]. Moreover, epileptic seizures themselves may present in a variety of ways to pose formidable difficulties in diagnosis. The manifestation may be a typical motor seizure, an abnormality of perception, a disorder of behaviour or an impairment of

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The Role of Electroencephalogram In Psychiatric Patients in Developing Countries

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ملخص:

قمنا بدراسة ٣٠٠ تقرير كامل عن نتيجة رسم الدماغ الكهربائي للمرضى المترددين على عيادات مستشفى الصحة النفسية بجدة خلال فترة عام كامل في محاولة لتحديد نوعية الصرع الذي يعانون منه وطبيعة الاعراض المرضية التي تثير انتباه الاخصائي المعالج لطلب رسم الدماغ الكهربائي لمساعدته في التشخيص. حالات الصرع الصدغي كانت اكثر الحالات بين هؤلاء المرضى كما انها اظهرت علاقة ايجابية كبيرة بين التشخيص المبدئي والتشخيص المبني على وجود ذبذبات صرعية في رسم الدماغ. الاعراض الرئيسية التي ادت الى طلب رسم الدماغ الكهربائي كانت النوبات التشنجية ـ تغيير حالة الوعي وتغيير كبير في السلوكيات أو العلاقات الاجتماعية. هذه الدراسة تبين ان هناك نسبة كبيرة من مرضى الصرع لا يزالون يترددون على العيادات النفسية وتحتم ضرورة مراعاة ذلك في التشخيص في الدول النامية.

Abstract

We studied 300 electroencephalograms (E.E.G.) for patients attending Jeddah Psychiatric Hospital in a period of one year in an attempt to know the proportion of epileptic patients attending the psychiatric clinics and their diagnoses and main symptoms which generate the interest of the psychiatrist to seek E.E.G. help in diagnosis. Temporal lobe seizures were

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Comparison between the six sub-groups in relation to the severity of symptoms has failed to find differences amongst different diagnostic categories, These results are not consistent with previous studies[8,17] which showed differences in severity of panic symptoms among different diagnostic groups, especially panic disorder and agoraphobia sub-groups in which more severe and frequent symptoms are present. The results of this study are in line with some other previous studies which did not find differences in severity of panic symptoms amongst different panic sub-groups[18,13], bearing in mind the different methodology used in those studies.

In relation to cognitive symptoms, this study showed that the bulk of the sample exhibited fear of dying (78%), while the fear of losing control was present in only 21% which reflects that the ideation of panic patients were preoccupeid with the misconception about dangers related to health. These results are consistent with the cognitive model of panic[16]. Clark affirmed that catastrophic misinterpretation of anxiety symptoms, (palpitation interpreted as heart attack) are the essential component which provoked the panic attack. This evidence needs to be elaborated in a more systematic controlled studies.

This preliminary study with retrospective data could only be considered as paving the way for more parsimonious, systematic and controlled studies using standardized tools of research, with more representative samples of the general population and hospital data.

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order is significantly longer when it is associated with agoraphobia. This fact confirms previous studies which denotes that avoidance behaviour reinforces the panic disorder and renders it difficult to manage[14,15].

The absence of precipitating factors in a given fraction of the panic patient population needs an explanation. Since the onset of the majority of the panic patients attacks were precipitated by either psychosocial or somatic stimuli was suggested that patients might have had a precipitant for their panic that they were not aware of. Cognitive events may have played a role which might be consciously or unconsciously motivated[16].

The present study showed that panic is not a homogeneous disorder. The presence of other clinical entities in conjunction with panic disorder resulted in dividing the subjects into six panic sub-groups. Heterogeneity of the panic disorder has been found in other studies[8,20]. The present results must enhance further research in this area to elucidate the nature of this co-morbidity, whether the associated disorder antecede, co-exist or precede the panic disorder. since this knowledge must contribute to the management of various symptoms. For instance the presence of avoidance in the agoraphobic-panic group, and the presence of depressive symptoms along with panic disorder pose management problems.

The highest duration of panic attacks found amongst panic with agoraphobia sub-group may denote that avoidance behaviour could be implicated since reinforcement of agoraphobic symptoms become vicious, thus perpetuating the panic disorder.

Results of correlation between the severity of panic symptoms associated categories and precipitating factors provided some evidence about panic symptoms and associated categories. It was shown that the severity of panic symptoms were associated with generalized anxiety and simple phobia. This denotes that within the panic groups the severity of symptoms could be the result of generalized anxiety or visa versa. The absence of significant correlations between the precipitating factors and the severity of panic symptoms might denote that the nature of panic disorder is not adequately defined in relation to etiology whether the disorder has a purely psychological, biological or a combination of both causative factors.

Table (10)

Precipitating Factors Across Six Panic Subgroups

	Panic Subgroups					
Precipitating Factors	PD AGO N 18	PD Social PH N 16	PD DP N 39	PD Simple PH N 23	PD GAD N 28	PD Disorder N 26
Somatic	6.30	7.00	5,90	6.20	6.20	6.30
	3.9	3.6	3.9	3.8	3.8	3.9
Psychosocial	4.70	5.70	5.40	4.70	5.00	5.70
Stress	3.5	3.6	3.3	3.5	3.5	3.6

Table (11)

Cognitive Symptoms of Panic Disorder

Idiation	Number of Subjects	Percentage
Fear of Dying	119.00	78.00
Fear of Losing Control	31.00	21.00
Fear of Illness	50.00	33.00

Discussion

The aim of this study was to examine the prevalence, and analyze the clinical variable in panic disorder seen in a private psychiatric clinic dealing with general psychiatry in Jordan.

The results revealed interesting data about the prevalence of panic disorder amongst the anxiety disorders. Results suggested that panic disorder is a common problem amongst the different categories of depression and anxiety disorders (14.5%). These results give an important indication to the extent of the problem in Jordan. Therefore, such results must stimulate research workers in Jordan to carry out further exhaustive studies.

A much higher prevalence of the disorder was found amongst women than men which is consistent with many other studies[2,3].

It was found that the duration of the dis-

Table (9/A)

Severity of Symptoms Across Six Panic Subgroup

	Panic Subgroups					
Symptoms	PD AGO N 18	PD Social Ph. N 16	PD DP N 39	PD Simple Ph. N 23	PD GAD N 28	PD Disorder N 26
Shortness Of Breath	1.05	1.50	1.60	1.75	2.83	1.57
Dizziness	2.05	2.00	2.13	1.40	1.78	1.93
Palpitation	1.73	1.83	1.93	2.20	1.57	1.95
Trembling	1.76	1.42	1.65	1.93	1.59	1.60
Sweating	2.00	1.00	1.53	1.60	1.87	1.50
Chocking	1.70	1.87	2.21	2.25	1.93	1.78

Table (9/B)

Severity of Symptoms Across Six Panic Subgroups

	Panic Subgroups					
Symptoms	PD AGO N 18	PD Social Ph. N 16	PD DP N 39	PD Simple Ph. N 23	PD GAD N 28	PD Disorder N 26
Nausea	1.63	1.33	1.40	2.33	1.66	1.28
Chest Pain	2.00	1.80	1.63	2.86	1.86	2.07
World Unreal	1.77	2.00	2.00	1.50	1.40	1.00
Numbness	2.00	1.25	1.74	2.16	1.81	1.50
Hot Flushes	1.75	1.87	2.05	2.00	2.00	2.00
Fear of Dying	2.29	2.00	2.10	2.18	2.13	2.09
Fear of Going Crazy	2.33	2.00	2.37	1.83	2.00	1.67

Table (7)

Duration of Panic Disorder

Across Six Panic Subgroups

Panic Subgroups					
PD AGO	PD Social Ph.	PD DP	PD Simple Ph.	PD GAD	PD Disorder
N 18	N 16	N 39	N 23	N 28	N 26
M 41.7	M 13.4	M 10.7	M 14.3	M 25.4	M 16.1
SD 55.8	SD 15.8	SD 16.7	SD 19.0	SD 35.1	SD 24.1

F = 3.44 (144) = , P<.005)

S.NK =>2,3,4,5,6

5>2,3,4,6

Table (8)

Associated Disorder Within

Different Panic Subgroups

Groups	Associated Disorder			
	GAD	DP	Simple Ph.	No.
P.D With Agoraphobia	10	10	5	18
P.D With Depression	4	—	3	39
P.D With Social Phobia	2	—	—	—

have similar effects to precipitating factors at the onset of the disorder.

Results are summarized in (Table 9).

Cognitive symptoms in panic groups:

The results of different ideation showed that fear of death was the highest frequency 78%, while fear of losing control and insanity were 21% and fear of disease (cancer, paralysis, fainting and coronary) were 33%. This indicated that panic patients were more preoccupied by fears about their health, lives and existence rather than becoming insane.

See Table 10

Table (6)
Differences in Sex Across
the Six Panic Subgroups

Variable	Panic Subgroups				
Sex	PD AGO	PD Social Ph.	PD DP	PD Simple Ph.	PD GAD
Male	N 5 % 27.8	N 6 % 37.5	N 12 % 30.8	N 4 % 17.4	N 5 % 17.9
Female	N 13 % 27.2	N 10 % 62.5	N 27 % 69.2	N 19 % 82.6	N 23 % 82.1

$X = 3,65\ (5) = P,ns$

agoraphobia. Ten of them reported having generalized anxiety and depression, also five of the agoraphobic patients presented with generalized anxiety, depression and simple phobia in addition, while four patients of the subgroup consisted of panic disorder associated with depression and showing generalized anxiety. A further three of them had simple phobia. Only two of the panic patients with social phobia have experienced generalized anxiety.

These results clearly indicate that it is the combination of panic disorder with agoraphobia that show evidence of co-existence of further clinical entities such as generalized anxiety, depression, social phobia and simple phobia which denotes the complexity of the agoraphobic disorder.

See Table 7

Additional analyses were conducted to determine whether there were differences in severity of panic symptoms among the different sub-groups. One-way ANOVA were conducted and followed by post-hoc Newman-Keuls analyses, revealing no differences in the average of severity scores among all symptoms, which indicate that the different diagnostic groups had similar severity of panic symptoms.

Insert Table 8 right here

Comparisons were made between each precipitating factor amongst the six sub-groups. One-way ANOVA with post-hoc Newman-Keuls were used to explore whether there is any significant effects in between them. The results did not show any significant differences in somatic, and psychosocial precipitating factors. These results indicate that all panic sub-groups

Associated disorders:

This study showed a certain pattern of association between panic disorder and the other diagnostic categories. Six subgroups were emerged. Namely panic disorder alone (17.3%), or panic disorder with one of the following psychiatric categories: agoraphobia (12%), social phobia (10.6%), depression (26%), simple phobia (15.3%) and generalized anxiety (18.6%) as presented in Table 5.

The result of analyzing age patterns did not reveal significant differences between the sub-groups (one way ANOVA ($F=1.56$ (144), ns). Also there was no sex differences between subgroups (Chi-square $X=3.65$ (5),ns).

Results presented in Table 5

Significant difference was found in the duration of panic attacks between the sub-groups. Panic with agoraphobia showed the longest duration ($F=3.44$ (144), $p<.005$), while all other subgroups did reveal significantly shorter duration of the disorder. These results indicate that avoidance behaviour could possibly perpetuate the disorder.

Results were presented in Table 6.

Table (5)

Distribution of Psychiatric Categories

Associated with Panic Disorder

Diagnosis	No. = **150**	%
P.D+Agoraphobia	18	12.00
P.D+Social Phobia	16	10.60
P.D+Depression	39	26.00
P.D+Simple Phobia	23	15.30
P.D+With GAD	28	18.60
P.D+Alone	26	17.30

It was speculated that using this questionnaire might indicate that those categories classified as panic with different associated disorders will show differences in frequency and severity of panic symptoms versus panic disorder with no association with other clinical entities.

The frequency of other clinical categories associated with panic disorder were mainly found among panic with

Table (3)

Precipitating Factors at the Onset of Panic

Precipitating Factors	No.=150	%
Somatic Sensation	51.00	34.00
Psychosocial Stress	82.00	54.70
Spontaneous Panic	26.00	16.00

cipitating factors, severity of panic symptoms and associated disorders, parson product moment correlations were calculated for the whole panic group. The results showed that within the panic group, genetalized anxiety found to be correlated with the total mean severity score of panic symptoms ($r=.48$, $p<.01$). These results revealed a significant correlation between the severity of panic symptoms and the presence of generalized anxiety. A further significant correlation was found between simple phobics and generalized anxiety ($r=.50, P<.01$), while no correlation was found in panic, depression and mean score of severity of symptoms. No significant correlation was found with or without the presence of precipitating factors (somatic and psychosocial) with other factors.

See Table 4

Table (4)

Correlation Between Precipitating Factors, Severity of Panic Symptoms and Associated Disorders

Variable	Somatic	Psychosicial Stress	Severity of PD SYMPTOMS	GAD	DP	Simple
Somatic S.	—	—	—	—	—	—
Psychosocial	0.44	—	—	—	—	—
Severity of PD	0.14	0.15	—	—	—	—
GAD	0.09	0.04	.48*	—	—	—
DP	0.41	0.07	0,20	0.09	—	—
Sim. Phobia	0.02	0.25	0.24	.50*	0.02	—

* = $P < .01$

Appendix 1

PANIC SYMPTOMS QUESTIONNAIRE

Case No..... Code No.....

Name: Sex M F

Age: Marital status

Duration: 1 - Married 2 - Single 3 - Divorced

Associated Disorder

* Agoraphobia
* Social phobia
* Depression
* Others.....

Precipitating factors

* Internal factors (somatic sensation)
* Life event (psychosocial stress)
* Others

Episode of panic last week

Episode of panic last month

SYMPTOMS RANGE 1- MILD 2- MODERATE 3- SEVERE

1. Shortness of breath ( )
2. Dizziness, unsteady feeling or faintness ( )
3. Palpitation ( )
4. Trembling or shaking ( )
5. Sweating ( )
6. Choking ( )
7. Nausea or stomach distress ( )
8. Chest pain or discomfort ( )
9. Feeling that you or the world unreal ( )
10. Numbness or tingling in any part of your body ( )
11. Hot flushes or chills ( )
12. Fear of dying ( )
13. fear of going crazy, or doing something uncontrolled ( )

Others:- .....

Table (2)

Panic Disorder

Demographic Data (Sex, Mean Age)

Sex	No.=150	%	Mean Age	SD
Male	40.00	26.60	30.33	8.60
Female	110.00	73.40	31.80	12.30

subjects to indicate age, sex, marital status and the duration of panic. The second section included two parts. The first part contained the association disorder (agoraphobia, social phobia, depression, generalized anxiety and others). The second part included the precipitating factors which contained two items namely psychosocial stresses, (e.g death of relatives, witnessing an accident or an epileptic fit, marital conflict and internal stimuli, e.g dizzy feeling, chest pain, flu, fever. Section three contained the number of episodes of panic the previous week and month, and the thirteen panic symptoms along with a three point severity scale (1=Mild, 2=Moderate, 3=Severe).

RESULTS

Prevalence of panic disorder and precipitating factors

The results showed that the prevalence of panic disorder according to DSMIII-R criteria was (7.4%) among the whole patient population (2017) patients, and (14.5%) among the neurotic patient population. It also showed that mean duration of panic attacks was (1.5 years), ranging from two months to thirteen years, which denoted that most of these patients were short termed.

The results of frequency of precipitating factors among panic patients at the onset of the disorder showed that the highest number of precipitating factors were psychosocial stress (82, 54.7%). Fifty one (34%) patients had somatic or internal stimulus as precipitant for the initial attack, while 26 (16%) patients did not experience any precipitating event. Their panic attacks were spontaneous (out of the blue). These obsevations indicated that the psychosocial factors are the most common and prominent events among patients with panic disorder in this sample. (See Table 3).

To test the relationship between pre-

two years. One hundred and fifty patients met the DSMIII-R and the rest were eliminated from the study (see Table 1) for details regarding the incidence of neurotic patient across the whole patient population. The sample consisted of 110 females and 40 males, age ranged between 18 and 50 years (Mean=31 y). The majority of subjects 84=54% were single, 61=40% married, 4=2.75% divorced, 1=1.5% widowed as have been in Table 2.

Procedure

The patient population who were diagnosed as panic disorder were subjected to a semi-structured interview. Each subject was asked to complete the Panic Attack Questionnaire (PAQ, Ahmad, 1989)[19] (See appendix 1). The questionnaire is one of the packages used by the authors as a diagnostic criterion to meet the requirement of DSMIII-R The PAQ consisted of three sections. The first section asks the

Table (1)

Psychiatric Patient Population

Psychiatric Categories	Number of Patients	
Whole Patient Population		2017
Patients with Neurotic Disorders	Sub-Categories	1036
I. Depressive Disorders		290
II. Anxiety Disorders		570
Panic Disorder	132	
Panic with Agoraphobia	18	
Social Phobia	29	
Simple Phobia	58	
OCD	75	
GAD	258	
III. Dissociative Disorders		33
IV. Somatoform Disorders		143
Hypochondriasis	52	
Somatisation Disorder	71	
Conversion Disorder	20	

reported three to four panic attacks. In addition those non clinical panickers reported more depression, and phobic anxiety.

Few studies have examined the prevalence of panic disorders in psychiatric clinics, and none has been done in Jordan. Therefore, one of the main purposes of this study is to investigate the prevalence of panic disorder seen in a private psychiatric clinic dealing with general psychiatry in Jordan. This sample of patients could reflect preliminary results as far as prevalence of psychiatric disorders concern.

Panic disorder has been recognized as a clinically significant problem for a long time. The diagnostic differentiation of panic disorder as a distinct clinical entity from other disorders such as generalized anxiety, depression, simple phobia, avoidance behaviour as well as hypochondriasis has been recently researched[1]. The association between panic disorder and other associated psychiatric categories have to be explored.

Comorbidity of such disorders has to be determined whether such disorders precedes, coincides or antecedes the panic disorder. Previous studies showed controversial results in this respect[8], and have reported that panic disorder is usually associated with generalized anxiety. Uhde, Roy-Byrne, Vittone, Boulenger, and Post (1985)[9] found that the majority of their patients have developed pathological degrees of generalized anxiety after, rather than before the onset of the panic attack.

Similarly, many studies have revealed that amongst the majority of panic with agoraphobic patients they developed avoidance behaviour after they had experienced panic attacks[10,11,5].

While other studies have showed that some panic patients do not develop agoraphobia even though they had been suffering from panic for as much as ten years[12,13].

The present study aims to reveal the pattern of association between panic disorder and the other diagnostic categories. It also aims to explore different diagnostic variables such as severity of symptoms, duration, sex, age, and precipitating factors in connection with the above mentioned association.

METHOD

Subjects

Two hundred and eighty patients diagnosed as panic were picked out of 2017 consecutive patients interviewed for the first time in a private psychiatric clinic over

cas d'association avec dautres maladies cependant la correlation entre la severité des symptômes et les facteurs favorisants était faible.
Le côté cognitif de cette étude a été discuté. Certaines suggestions pour des recherches d'avenir ont été formulées.

Introduction

Panic disorder has been the focus of attention of many studies, and it has been noticed that a high percentage of patients each year seek help for what is broadly construed as anxiety or nervousness most of which complain of panic attacks[1].

Panic disorder is characterized by sudden episodes of intense anxiety accompanied by a number of predominantly somatic and cognitive symptoms such as tachycardia, dizziness, breathlessness, trembling, sweating, fear of dying and losing control[2]. Two main types of panic are recognized; spontaneous or non cued and situational or cued panic attacks.

Panic attacks are common conditions which are not limited to panic disorder, but are prevalent in a wide variety of anxiety and affective disorders. Epidemiological studies indicated varied prevalences which could be shown by studying different periods and using different criteria. In Weissman's study[3] using the Diagnostic Interview Schedule (DIS) in six month prevalence showed that panic without agoraphobia ranged from 0.6% to 1.0% and for panic with agoraphobia from 2.7% to 5.8%. Panic disorders are more common among women than men. Joyce, Bushnell. Oakley-Browm, Wells, and Hornblow, (1989)[4] found that the life time prevalence of panic disorder was 2.2%. Brier, Charney and Heninger (1985)[5] estimated that panic amongst depressed population ranged from 30 to 80%. Raskin, Peeke, Dickman, and Pinsker, (1982)[6] comparing 17 panic disorder patients with 16 generalized anxiety disorder patients found that previous depressive episodes were twice as common in the panic disorder patient (15 vs 7). Angst, 1991 (20) in his recent review of the natural history of anxiety disorders found that generalized anxiety, and depression are commonly associated with panic disorders. Even amongst general the population, Norton, Harrison, Hauch and Rhodes (1985)[7] who studied 186 normal young adults, 34.4% of these subjects reported two or more panic attacks in the past year, while 11.3%

psychiatric clinic. They were diagnosed according to DSM-III-R criteria. The results showed that the prevalence of panic disorder among anxiety disorders is rather high (14.5%).

This study showed a certain pattern of association between panic disorder and the other diagnostic categories. Six subgroups were emerged. Namely panic disorder alone (17.3%), or panic disorder with one of the following psychiatric categories: agoraphobia (12%), social phobia (10.6%), depression (26%), simple phobia (15.3%) and generalized anxiety (18.6%).

The results confirm the comorbidity with other diagnostic catagories.

The results of comparison between the six sub-groups in relation to the severity of symptoms has failed to find differences among different diagnostic categories. However, The correlation between the severity of symptoms and precipitating factors was weakly supported.

The Cognitive component of the study was discussed. Suggestions for future research were made.

Résumé
Trouble de la Panique Etude clinique

Cette etude concerne l'aspect clinique et demographique des roubles de la panique chez 150 patients examinés dans une clinique psychiatrique privé. Ils ont-été diagnostiqué selon les critères D.S.M.IIIR.

Les resultats ont demontré que la prevalence des desordres de la panique parmi les desordres d'anxieté est relativement élevé (14.5%). L'etude a demontré une certaine forme d'association entre le trouble de la panique et d'autres troubles psychiatriques six sous groupes ont été mis en evidence. Trouble de la panique seule (17.3%). Trouble de la panique en association avec d'autres troubles psychiatricques: agoraphobic (12%). Phobie sociale (10.6%) depression (26%) phobie simple (15.3%) Anxieté generalise (18.6%). Les resultats ont confirmé la coexistance avec les autres categories.

L'etude a échoué à prouver que la severité de la panique augmente en

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Panic Disorder
A clinical study

Adnan Y. Takriti and Tayseer F. Ahmad

اضطـــــراب الـــفـــــــزع
دراســـــة ســـريريـــة

عدنان التكريتي وتيسير احمد

ملخص:

تركز هذه الدراسة على النواحي السريرية والديموغرافية للفزع. وقد فحص ماية وخمسون مريضا في عيادة نفسية وكان مقياس التشخيص هو DSMIII-R. وقد وجد ان نسبة اضطراب الفزع الى مرض اضطرابات القلق مرتفعة حقا (١٤,٥٪).

كما ظهر من الدراسة ان هناك نمط معين لوجود اضطراب الفزع مع الاضطرابات النفسية الاخرى. وقد اظهرت الدراسة وجود ستة مجموعات. الفزع لوحده (١٧,٣٪)، والفزع مع واحدة من الاضطرابات التالية: رهاب الساح ١٢٪، المخاوف الاجتماعية ١٠,٦٪، الكآبة ٢٦٪، المخاوف البسيطة ١٥,٣٪، والقلق الشامل ١٨,٦٪.

وقد أيّدت الدراسة تواجد الفزع مع الامراض الاخرى. وقد فشلت الدراسة في اثبات ان شدة الفزع تزداد مع تواجد الفزع مع الامراض الاخرى. كما ان العلاقة بين العوامل المرضية وشدة الاعراض ليست قوية.

وقد نوقشت الناحية المعرفية للدراسة كما نوقشت بعض الاقتراحات للابحاث المستقبلية.

Abstract

This Study is concerned with the clinical and demographic aspects of panic disorder. One hundred and fifty patients were interviewed in a private

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tolerated to express dissatisfaction with undesirable behavior. Special skills will be required to avoid over-involvement and weakling of ego boundaries.

9 - Medications might be used in a symbolic rather than pharmacological way. They thus give an image of "treatment" and strengthen compliance with appointments.

CONCLUSION:

Psychotherapy as it is outlined and structured in the current literature reflects a point of view of a culture different from the one in which we are living. Therefore, a specific modifications and changes in the general roles and rules and the principles of psychotherapy are needed to fit this culture. We can only do this exchanging ideas and thoughts; this article is presented in order to invite other Arab scholars to participate in this project.

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the Western literature. It should be replaced by dependency versus interdependency principles, where the society boundary should be taken into consideration, and the individual responsibility should not conflict with the society, unlike most of the inner personal problems encountered in the Western psychotherapy, where patients are seen as more dependent and they should be taught to be independent. Our goal is usually to teach the patient how to be interdependent and feel comfortable in the society.

7 - The use of religion in therapy; although realistic, can not be a prerequisite for every psychotherapist to use Islamic teachings in his treatment since it requires an adequate knowledge and scholarly ability in use of Sheria Law. It is feasible for some therapists to use Islamic principles to facilitate the psychotherapeutic processes. Several examples could be given where patients or families believed that an evil eye or jinn has played a role in the affliction they have. Although the fact "Jinn" and "evil eye" are mentioned in Qur'an, there is absolutely no evidence that this was causing the problem with the patient and, therefore, a knowledge of medicine and psychiatry is needed to identify these problems. Patients with obsessive disorder have been shown in some studies, to be suffering mostly from a religious type of obsession. Patients could be taught that religious obsession is not caused by weakness of faith "Iyman". He would not have a religious obsession of the derogatory type caused by an evil force to weaken his faith, if he had a weak faith, since there would be no role for the devil to play in such a case. This proved to give a degree of satisfaction and confidence to facilitate the treatment afterwards. Religion could also be used as a culturally acceptable cognitive restructuring model, where patients are taught to have goals in life and to extend their horizon within its teachings such as patients with hysterical conversion disorders who might have something more to look for to replace their sense of bewilderment. In some studies[10], religion has been shown to be beneficial in treating patients with addictive disorder.

8 - Transference could be used occasionally to facilitate change by directly expressing eagerness to see changes, putting an acceptable amount of pressure on patients when appropriate and

of ambivalence, and consequently, guilt.

SOME ASPECTS OF A PROPOSED CULTURALLY ORIENTED TECHNIQUE OF PSYCHOTHERAPY

Acknowledging the fact that we cannot in a single article propose a thorough and comprehensive technique for psychotherapy, we identify certain aspects that need to be expanded in consequent publications, that we feel are culturally relevant for the technique of psychotherapy.

1 - The therapist needs to be assertive and directive and might take advisory role addressing the emotional, as well as the cognitive component of the patient's conflict and personality.

2 - A therapist needs to evaluate and constantly reevaluate the needs of the patient, who is in the position of a learner, teaching him problem-solving techniques, taking into consideration the different social aspects and therapeutic experiences within his community.

3 - The therapy might take the form of condolence (Arabic = "Muwasat"). Unloading the burden of the patient-problem by talking out, strengthens patient-therapist relationship and relieves patient from some of the stresses of the problem, however, decision making should always be by the patient himself.

4 - Learning and relearning will always go through the security of the therapeutic experience. The therapist is expected to express more of his own personal emotion that might be in Western oriented psychotherapy. Most of the changes is expected to come from the nature of the relationship rather than from the interpretative process and the explorative psychotherapy. It also applies in cognitive oriented psychotherapy where the relationship itself will play the role of identifier of the false function and practice, rather than its recognition by the patient himself.

5 - The learning experience is teacher-based rather than student-base. We have assumed as in the Western model that the learning experience should be student based and that a patient had to do most of the active work. Not so in this culture where some modification is required, an active manipulation of the patient's environmental personality and behavior and sometimes thought-orientation, by the therapist is needed to achieve change.

6 - Dependency versus independency principles can not be accepted, as from

tions are false, therefore, they must be false, rather than I now can identify these false assumptions".

THE ROLE OF CULTURE AND RELIGION

It is as difficult to perceive the Arab culture without Islam as it is to perceiving the Islamic culture without Arab influence. from that point of view, a real knowledge of the culture and the influence of religion is a prerequisite for successful psychotherapy. The positive effect of religion on shaping the personality and the psychological coping mechanism of an individual should not be overlooked. It has long been recognized that people who have faith and believe in the life hereafter, are better able to tolerate stresses in this life and to cope with misfortune. It also influences them in a way that failure as an end product of a long struggle and work, is not so devastating, and might not effect the self-esteem or weaken the ego, since the reward may not be seen in this life. Therefore, nothing is perceived as wasted, and no effort is made without a return of a similar nature, good will brings a positive return, bad will brings a negative one.

Religion, if misperceived, can lead to negative aspects; these might be summarized on two levels, first, on a cognitive level and second, on an emotional level. Cognitively, it can lead to inflexibility and at times a "tunnel vision" dividing things into good and bad, or black and white i.e. complete splitting of perception. At times this splitting leads to conflict and production of guilt. The guilt here might take a different nature, as it is known in the Western culture, when a person feels bad for something he has done himself that he is to be punished for, it might take a form of fear from punishment from outside (the highest being). Fears of punishment from God, about something that could have been done, rather than something that could have been done wrong, will be equated as guilt. On the emotional level, the over-perception of religious rituals might lead to an obsessive disorder, the dilemma of the magic nature of words when the patient perceives uttering ideas or words will be the same as doing the deeds, intensifies guilt feeling. A patient who is quoting words with action might find it difficult to express his anger about people whom he should respect e.g. parents, therefore, it will lead to strong defenses and suppression of emotions. The serenity that religion can give an individual could conflict with the sense of having not done enough and expectation of punishment, a situation which can lead to a sense

trust makes the patient more reluctant to express and expose his weaknesses. Another reason may be the embarrassment the patient feels, stemming from the rules of patriarchal society. The third, and most intriguing cause has its roots deep in the history of the Arabs and their cherished heritage of poetry. The exceptional value Arabs place on poetry has given it a special role in their life, where the announced words have a great effect and influence in the people. Arab history tells us about great men threatened by statements from a poet, and big kings have given a lot for a few praising words. It is assumed, therefore, that patient exploration of his inner forbidden desires and wishes will make these spoken words a magical reality, that in turn could be very destructive. And finally the process of the explorative psychotherapy is in itself a revolutionary concept, with its aim to strengthen the ego and the individuality of the patient, and this in itself is threatening the society as when an ego is strengthened it shakes the social structure, and it is done at the expense of the culture. It was also observed that even if exploration was achieved and some of those defenses were broken, the material spoken was quickly forgotten and not talked about in consequent sessions.

COGNITIVE PSYCHOTHERAPY

Cognitive therapy has been chosen by many Arab psychotherapists as the preferred modality to treat patients for the main reason that it by-passes the vagueness and the abstraction of the explorative and insight oriented therapy. It is characterized by its clarity and its identification of the altered cognitive distortions that maintain symptoms, and it is more suitable to this culture due to its directive role. It is structured and somewhat authoritarian, assigning homework and behavioral technique; it concretely identifies a rational belief and automatic thoughts. It is based on correction of certain attitudes and assumptions that underlie negative thoughts. A specific characteristic of cognitive therapy shapes its place, as it is conducted with Arab patients. He is unable to deal with the technique of identification of rational beliefs, automatic thoughts , attitudes and false assumptions on his own. He can reach the same goal, however, as identified by using a particularly personalized relationship with the therapist i.e. the relationship itself is helping to identify the faulty assumptions rather than the patient spontaneously and independently identifying and acting upon them. In other words the patient's position here is explained by the statement, "IF you believe these assump-

relashionship may take a different form. As the therapist is seen as a father figure, the patient will take a passive position, seeing the therapist as strongly omnipotent, intimidating and highly respected. Although socially this is an accepted position, it can be very counter-therapeutic. Putting the patient in a position where he perceives the therapist as a father will make him uncomfortable and embarrassed, that in turn will affect the explorative style in the insight oriented type of psychotherapy. Furthermore, there is an intriguing phenomenon observed in Arab patients or individuals in general, and that is the passive position. Patient perceives that he is being done to, rather than himself doing things. A product of group oriented culture creates a self-concept of passively receiving orders, directions with a series of social norms to follow. Elders should be respected and obeyed, young should be taken care of, and traditional values should be adhered to and followed even at the expense of individual personal needs. The patient will assume a similar attitude in the therapy setting, not accepting the responsibility of his action, not accepting the responsibility of his behavior and consequent emotional adjustment. He will not be responsible for taking action to change this behavior, because it has never been perceived as his responsibility. In a classical setting of psychotherapy in the Western style a patient is expected to take responsibility for his action, for his behavior and even for his emotions, to take charge of his life and to be motivated for change that he himself initiates.

PATIENT INTOLERANCE TO INSIGHT

Arab psychotherapists and psychiatrists have observed that the Arab patient is intolerable to emotional exploration and to inhight oriented model. The patient is seen in general as very resistant, and heavily defended, using all kinds of mental mechanisms to guard himself against inner exploration of his psyche. Interviewing the patient under effect of amytal injection intravenously, sometimes called "abreaction", is a frequently needed modality with Arab patients, to break these defenses. There have been instances where exploration and expressions of insight have led to an extreme sense of anxiety rather than the expected therapeutic outcome. Several reasons have been proposed as cause for this phenomenon one probably stemming from the old historical reality, of Arabs living in a harsh desert environment causes them to be on guard, and unwilling to bend the influence of others. This feeling of dis-

as an independent person. Each individual has to follow a set of rules, traditions and values, sometimes at the expense of his own individuality. This has been given as an explanation of the increased incidence of social phobia in this culture[9]. An individual who has to follow a predetermined and prestructured life-style will have little autonomy. So the concept of autonomy in a Western culture, meaning a state of individualization, would not apply in this culture since it could not be achieved without alienation of that individual from that society making his life adjustment even more difficult.

The patriarchal culture has some influence on shaping the personality structure. It strengthens family ties and provides broad social support for the individual, and thus a strong base of security. It also identifies the role of each individual in his family, in the community, and in the society at large. A clear and well defined role which reduces stress on the individual, since it spares his struggle to identify himself and his roles. The role of the patriarch is well defined so as to facilitate the solving of any conflict, thus minimizing finding environmental stresses.

A patriarchal culture affects the mode of psychotherapy in two ways. First, it dictates the type of interaction between the therapist and the patient, and the child-parent interaction would be the model followed as the therapist assumes the parent position, being more directive, advisory, and caring and at times critical. This will negate the type of therapy where adult interaction is encouraged and explorative-reflective technique is used. A therapist cannot assume an observant position, he has to use an active manipulation of the cognitive processes of the patient and shaping of behavior. Second, a patriarchal culture would affect the outcome of psychotherapy where a therapist can only function within the norm of culture. His only goal will be change of behavior from one culture norm to another, more suitable to the needs of the patient. A state of complete autonomy or individuation or dependence as in Western culture is not desirable and is replaced by a type of individuation in which the position and the function of the individual in that culture is a knowledge. Meanwhile independence has to be replaced by that state of interdependece, i.e. the patient has to understand that his independence is only accepted if he acquires the interdependency of individuals whithin the society. The effect of a patriarchal society on therapist-patient

tic category. Patients fitting the classical model of explorative therapy will be primarily non-psychotic i.e. diagnoses of anxiety disorder, depressive disorder, adjustment disorders and difficulty in adjusting to the developmental stages in their lives.

THE ABSTRACT QUALITY OF PSYCHOTHERAPY

Most psychotherapy techniques involve an abstract concept. The non-directive model, the free association technique, the insight-oriented psychotherapy, all are abstract concepts, and the ability of the patient to comprehend and integrate formal operation-thinking, is necessary in this kind of psychotherapy. The theory of the cognitive development of culture indicates that cultures grow cognitively on levels similar to those outlined by Piaget, where the stage of concrete operation precedes the stage of formal operation during which abstract conceptions are integrated within the framework of mental operation[7,8]. In other words, we are assuming that the present developing Arab culture may be still functioning at a pre-formal operation stage and abstract concepts are not dealt with adequately. That probably explain the tendency of many Arab psychotherapists to use cognitive psychotherapy and supportive psychotherapy models for most of their patients, since both of these types of therapy by-pass the abstract ability of the patient, especially the latter. Specifically the cognitive model employs a technique where the therapist assumes a more direct and explanatory role and the patient is a more passive receiver. Similarly with the supportive type of therapy, a model that would fit a patriarchal culture since in this type of therapy the parent-child interaction is more important than the adult-adult interaction, which also characterizes many other types of therapy, especially the explorative and reflective types.

ARAB AS PATRIARCHAL CULTURE AND ITS EFFECT ON MODES AND TECHNIQUES OF PSYCHOTHERAPY

Arab culture is strongly patriarchal, the father is dominant. This means that each member of this society has to obey customs dictated by the chief of the clan, who in turn answers to a higher figure, and so up to the absolute authority of that culture. In other words, a patriarchal culture is group oriented rather than individual oriented. An individual is considered a member of a bigger group where the interests of the society are far more important than the interests of the individual. That in turn effects the individual's concept of himself

the principles of psychotherapy could be manipulated to fit the Arab culture, is a question yet to be answered. Papers on psychotherapy authored by Arabs are rare, apart from Rakhawi's book "The Secret of the Game" and his publication on group therapy[2,3]. Although the latter addresses issues in psychopathology, it does not propose modification to psychotherapy, per se, to fit the Arab culture. Some studies were done on the application of cognitive therapy to Saudi Arabian patients[4], and on behavioral management of certain anxiety disorders[5]. The importance of forms of family therapy, and supportive therapy with families of schizophrenics, has also been reported. This article addresses issues pertinent to and suitable for, application of different types of psychotherapy techniques and principles to the Arab culture. Since psychotherapy is not a single entity, it would not be possible for all to be addressed in a single article, we are therefore, only reviewing certain major principles of psychotherapy addressing some specific points as they are relevant to Arab patients.

The main factors thought to effect outcome of therapy and influence change were first, qualities of the therapist, his genuine interest, honesty and, most important, knowledge of the culture and Religion. Second, the social milieu of the patient, his family, the support system, and his therapeutic experiences. Third, the patient's motivation and fourth, the balance of the technique of therapy to provide an interpretative model coupled with didactic counselling, to fit the need of a particular patient within his culture.

CRITERIA FOR PATIENT SELECTION

Many psychiatrists practicing psychotherapy in the Arab world select their patients according to specific criteria to suit the model of psychotherapy. One of these criteria is the patient's education, in that the more educated patient is more able to interpret past experiences. Express his emotion and abstract his ideas and concepts, which is although true in any culture, educated he would be to fit this model. An educated patient is also perceived as more accustomed to the Western concepts of thinking and, therefore, the Western model of psychotherapy would be suitable. Needless to say, this reflects the need for more culturally specific techniques in therapy. Other criteria would include the diagnostic specification with the exclusion of supportive therapy, that would fit any culture and any diagnos-

These intuitive modification, however, have been made on individual level with no clear, stated or published guideline. This paper is calling attention to this need, stimulating hopefully a Pan Arab research in this area where cultural issues are essential in formulating the proper style of the therapy. This paper outlines some problems and makes some preliminary proposals.

Résumé

La psychotherapie chez le patient Arabe

La psychothérapie est une forme de traitement psychiatrique introduit sous ce nom en Europe au 19'Siècle.

Elle est basée principalement sur des conceptions théoriques et sur des techniques dérivées du modèle culturel de l'ouest. Son application dans le monde Arabe a été modifiée par les psychiatres Arabes pour être en harmonie avec le modèle culturel Arabe, cette modification spontanée a été faite à un niveau personnel sans principes bien définis. Cet article attire l'attention sur ce besoin, stimulant la recherche à travers le monde Arabe où les issues culturelles sont essentielles pour develloper les moyens de la psychothérapie.

Cet article souligne certains problèmes et met en évidence certaines propositions préliminaires.

INTRODUCTION:

Psychotherapy is the generic term for a large number of treatment techniques, whose primary means of effecting change is through personal interchange. Psychotherapy is directed toward changing behavior through the reorganization of mental structure. In the process of this reorganization both perception and behavior will change[1]. Psychotherapy is a concept of psychiatric treatment first used in Europe in the 19th century. It was thus designed for that culture. To what extent

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Psychotherapy with Arab Patients, Toward a Culturally Oriented Technique

K. CHALEBY

العـــلاج الـنـفـســـي للمـريـض الـعـربـي

قتيبة الچلبي

ملخص:

العلاج النفسي هو أحد مبادىء المعالجات في الطب النفسي والتي تطورت في أوروبا منذ القرن التاسع عشر. وهو يعتمد على مجموعة من المفاهيم النظرية والأساليب التي طبقت كنموذج للعلاج في الثقافة الغربية.

ان تطبيق هذه الأساليب للمريض العربي قد تعرضت للتعديل من قبل الطبيب النفسي حتى تتلاءم مع النموذج الثقافي العربي. وهذا التعديل الفطري قد تم على المستوى الفردي دون تدوين معلن يستند الى مبادىء واضحة. ان هذه الورقة هي بمثابة دعوة لسد هذه الحاجة من قبل باحثين في مختلف الأقطار العربية أخذت بعين الاعتبار العوامل الثقافية لتطوير أساليب في العلاج النفسي.

وتبحث هذه الورقة أيضا بعض المشكلات وتضع بعض الاقتراحات الأولية في هذا السبيل.

Abstract

Psychotherapy is a concept of a form of psychiatric treatment first introduced under this term in Europe in the 19th century. It is primarily based on theoretical concepts and techniques derived from the Western cultural model. Its application in the Arabs although not formally stated has been always modified by the Arab psychiatrist to fit the cultural model.

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psychotherapy are effective maintenance treatments with a clear trend for the combination to achieve even higher recovery rates. The study has also the important implication that conventional maintenance dose of tricyclic medication are subtherapeutic with the recommendation that patients should be maintained on their acute doses.

The value of cognitive therapy used solely or in combination with drug therapy requires evaluation in a similar study. One such study of the value of cognitive therapy in comparison with supportive psychotherapy in conjunction with lithium versus placebo in the elderly depressed, is near completion (Wilson and Abou-Saleh, unpublished observations).

The efficacy of new antidepressants in the long-term management of unipolar illness should also be established by similar studies before they are recommended for use in accordance with the EEC regulatory authorities[12].

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study on the long-term treatment outcome of recurrent depression is a landmark and provides a major advance[8]. The study evaluated the effectiveness of four treatments in a large series of patients with unipolar depression with a high risk for relapse/ recurrence studied over a period of 3 years: high dose imipramine (200mg per day), interpersonal psychotherapy, combined interpersonal psychotherapy and placebo, combined interpersonal psychotherapy and imipramine and placebo, plus clinical management. The results showed the following success rates for the first year: imipramine 60%, interpersonal psychotherapy 46%, imipramine plus interpersonal psychotherapy 84% and placebo plus clinical management 22%. Success rates after three years maintenance treatment were imipramine 46%, interpersonal psychotherapy 30%, imipramine plus interpersonal psychotherapy 60% and placebo plus clinical management 9%.

In this study, imipramine was used in high doses (200mg per day) for maintenance contrary to the conventional wisdom of using maintenance doses which are 50% to 70% lower than the doses used in acute treatment. This higher dose schedule may have contributed to the higher success rate in this study suggesting that conventional maintenance doses are sub-therapeutic and less effective. There is evidence from acute studies that increasing the dose of tricyclic medication increases the recovery rate by 50%[9].

This study is of high quality in its methods and design and sets a new standard for maintenance studies. Criteria for selection of patients; maintenance of dose regulation and blood levels; standardization of psychotherapy; clear definition of recovery, relapse, and recurrence; and application of survival analysis and relate statistics to the analysis of the data will be expected as protocols for long-term studies[10]. All patients however, received combined imipramine and interpersonal psychotherapy in the acute and continuation phases, which sets it apart from all other maintenance studies. Worthy of note, however, is that the success rate for placebo plus clinical management (20%) over 2 years maintenance treatment is identical to that obtained in the NIMH study[11] and may provide an estimate of outcome under naturalistic conditions.

The results of this study are encouraging and have important implications for long-term management of unipolar depression: high dose imipramine and interpersonal

Depressive illness is a public health problem. One in five individuals will suffer from one form of depression or another, four-fifths of those will suffer further episodes of illness and a fifth will die by suicide or cardiovascular complications.

Depressive illnesses are associated with high degrees of social and occupational morbidity and no less than 2% of the total bill of the National Health Service covers the cost of treating these conditions. Their treatment once the diagnosis is made is often successful and rewarding with the development of specific and highly effective physical and psychological treatments.

A recent study from the National Institute of Mental Health[1] (NIMH) established the efficacy of brief interpersonal psychotherapy in comparison with standard treatment with imipramine plus clinical management, particularly with patients who are more severely depressed and functionally impaired. Cognitive behavioral therapy was found less effective than these two treatments when compared with placebo plus clinical management. This study was the first comparative study of the effectiveness of interpersonal psychotherapy and cognitive behavioural therapy. Its results, however, are disappointing to those who advocate the supremacy of cognitive behavioural therapy for the treatment of depression in general and hospital practice[2], with evidence for its long-term effectiveness in preventing relapses/recurrences of illness[3].

Long-term management occurs in two phases: a continuation therapy phase to prevent early relapses of illness and a maintenance/ prophylactic phase to pevent recurrence. Studies of the value of continuation therapy after recovery have established the efficacy of antidepressants[4] and lithium[5] in preventing relapse in illness. Continuation therapy with drugs appears to reduce the relapse rate by 50% compared to placebo within six to twelve months from recovery from the acute illness. In a number of controlled investigations of variable stringency, tricyclic antidepressants and lithium were shown to substantially reduce the long-term morbidity and mortality of unipolar illness[6]. The results of these studies have, however, been disappointing with only 48% success rate (absence of relapse/ recurrence) in the NIMH study with imipramine maintenance therapy over 2 years. The Medical Research Council study showed a success rate for amytriptline of 32% over a period of 3 years maintenance therapy[7].

The recent publication of the Pittsburgh

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The Long-Term Management of Unipolar Depression:
Grounds For Optimism

M. T. ABOU-SALEH

العلاج طويل الأمد للاكتئاب احادي القطب
أرضيـــة للتفـــاؤل

محمد طموح أبو صالح

ملخص:

يبحث الكاتب في الدراسات المتعلقة بمصير الاكتئاب احادي القطب، موضحا دور عقـار الاميبـرامـين وبعض أنواع العلاج النفسي، ويقترح دراسات لتقييم مضادات الاكتئاب الجديدة في معالجة الاكتئاب على المدى الطويل.

Abstract

The author discusses the literature on the outcome of unipolar depression, Exploring the role of Imipramine and types of psychotherapy, he is suggesting further studies to assess the efficacy of new antidepresants in the long term management of this condition.

Résumé

Traitement au long cours de la dépression unipolaire

L'auteur approfondit les études concernant l'avenir de la dépression unipolaire. En explorant le rôle de l'imipramine et les types de psychothérapie, il propose d'autres études pour évaluer l'éfficacité des nouveaux traitements anti-dépressifs et la conduite à tenir au long cours.

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accepted boundary between healthy emotional concern for a sick family member and emotional overinvolvement is not always easy to define and the effects of critical comments cannot be assessed in isolation from the emotional vehicle (e.g. anger or warmth) in which they are delivered to the patients. Moreover negative expressed emotion could be the family reaction to longstanding prepsychotic and illness-induced abnormal characteristics. In a recent follow up of a sample of schizophrenic patients in India[15] a low level of relatives' expressed emotion was found in those who did not relapse i.e. where the relatives had nothing to criticise or be overinvolved about. In this study relatives received no help to reduce their expressed emotions.

A third explanation for the better outcome of schizophrenia in developing countries could be found in the tolerant sociocultural attitudes of traditional societies in these countries. In tolerant societies minor behavioural abnormalities and temporary withdrawal are likely to be ignored and there are lower expectations of work performance by the mentally ill; the goal is to reintegrate them and it is customary to arrange marriages especially for those with schizoid characteristics. In such societies schizophrenics are less likely to sink into nonivolvement and social isolation.

MANAGEMENT OF SCHIZOPHRENIC PATIENTS

Cultural variations in management of schizophrenic patients determine whether they are ultimately to be integrated into or segregated from, their community. Examples of lines of management which are thought to influence the outcome have been provided in the preceding sections. The arranged type of marriage is prevalent among schizophrenic patients[16,17]. Had it not been for the traditional arrangement of marriages by family elders the marriage rates of schizophrenic patients in Arab communities would have been much lower. Because of their limited interpersonal and emotional resources even prior to illness onset schizophrenic patients are much less likely to embark on love relationships that lead to marriage based on love. However, forcing schizoid or schizophrenic individuals into marriage by family elders on the assumption that marriage has a remedial effect on their solitude is known to lead to precipitation or exacerbation of psychotic symptoms.

more helpful in supervision of patients' medication, social adjustment and leisure-time occupation. The extended family, being more traditionally oriented, helps patients to understand their illness experiences in terms of cultural belief systems once they lose the components that cannot be contained in these systems. Extended family members are unconditionally warm. They are less likely than nuclear family members to call upon the limited social and emotional resources of their schizophrenic patients, and they are more tolerant of their minor behavioural abnormalities and temporary protective withdrawals[11]. As psychiatrists we learned from the extended families and we utilize extended family concepts, attitudes and methods in the management of all our schizophrenic patients.

Supernaturally-centred delusions have been shown to be more likely to remit than environment-centred delusions[6]. In our culture, as patients improve they eliminate the culture-alien features of delusions (e.g. personification of jinn) and reappraise their experiences in culturally acceptable terms (e.g. as intimations of the devil that should be resisted). culturally-shared beliefs act therefore as a repertoire or container in which patients fit their experiences after remission. This contributes to the development of some form of understanding of the experiences which were once non-understandable.

Schizophrenic symptoms are known to reappear or become worse in vague and complex situations that tax the limited social skills, emotional resources and thinking abilities of schizophrenic patients for example, in relationships with relatives who express their negative emotions in critical, hostile and overinvolved behaviour[12]. The term expressed emotion (EE) should not be taken to indicate that any expressed emotion from relatives might exacerbate or re-precipitate schizophrenic symptoms. The beneficial effects of expressed warmth have been borne out in relation to the outcome of schizophrenia[13]. Though intergenerational conflict is more likely in the extended family, it proved to be a rather 'benign' precipitating factor that could be handled in family psychotherapy by granting individuality to various family members.

The second explanation for the better outcome of schizophrenia in developing countries involves the lower rates of critical comments and emotional overinvolvement (expressed emotions) in families of patients[14]. However the culturally

be physically perceptible by the human senses. Their influence is believed to be communicated internally to human beings in a vague and unspecifiable manner that induces in those with weak faith tendencies or inclinations towards broad behavioural directions, e.g. toward wrong-doing or malevolence. Belief in the influence of these supernatural forces is not culturally accepted as an execuse for waiving the responsibility of an individual who has committed a wrong act or engaged in unacceptable behaviour because human beings should have the strength of faith, will power, and determination to resist and reject implementation of evil feelings and thoughts communicated by these forces.

Delusions and/or hallucinations are diagnosed only when the cultural boundaries were crossed[4]. Failure to define these boundaries may inflate schizophrenic symptomatology with what resembles FRS[5]. Supernaturally-centred delusions arise as pathological deviations of culturally-shared beliefs whereas environment-centred delusions involve the patient's external reality[6].

Defective volition and poverty of initiative have to be carefully assessed against societal background in communities which are neither work-oriented nor achievement-motivated. The acquisition of wealth, with oil discoveries in the Arabian Gulf region, made it possible for members of the indigenous population to obtain salaries for posts which they nominally occupy without doing much actual work[7,8]. The working ability of schizophrenics has therefore to be measured against this background.

COURSE AND OUTCOME

Multicentre studies of schizophrenia pointed to the better outcome of schizophrenia in developing traditional societies than in developed industrial societies[9]. In order to explain this difference it was suggested that transient (psychogenic or schizophreniform) psychoses were over-represented in samples of schizophrenics studied in developing countries whereas in industrial countries schizophrenia has replaced the more transient psychoses. In a sample of Qatari patients schizophrenics were separated from cases of schizophreniform psychoses and their outcome was separately assessed[10]. Both conditions faired better in extended (traditional) than nuclear families. Not only did patients from extended families present earlier for psychiatric treatment but they also received more adequate transactions from members of the extended family who were

cery) by other human beings. Traditional healers collude with this projection which absolves both the individual and family members from blame for disturbed behaviour and they proceed to rituals that are held to reverse the influence of the culprit supernatural forces. Medical treatment for such patients would aim at undoing, and not reinforcing, the projection to help patients to gain insight into their own illness and modify their own behaviour.

The tenth version of the international classification of diseases (ICD-10)[3] relies heavily on Schneider's first rank symptoms (FRS) as criteria for diagnosis of schizophrenia[3]. According to suggested guidelines of ICD-10, schizophrenia is to be diagnosed in patients who display one of groups, I, II, or III, or symptoms from at least two of groups IV, V or VI from the following list:

I. Thought echo, thought insertion or withdrawal, thought broadcasting, and delusional perception.
II. Delusions of control, influence or passivity, or bizarre delusions of other kinds.
III. Hallucinatory voices that give a running commentary on the patient's behaviour or that discuss the patient between themselves or almost any hallucinatory voices that continue for a period of weeks or months.
IV. Apart from the characteristic kinds of delusions mentioned above, delusional ideas of any content may be suggestive of the diagnosis, if accompanied by hallucinations in any modality. However, clearly defind delusions and hallucinations are not always present, particularly in chronic conditions. The diagnosis will then often depend on establishing the presence of negative symptoms as follows:
V. Blunting or incongruity of emotional responses, increasing apathy, and paucity of speech.
VI. Breaks or interruptions in the train of thought. Although these various deficits are equally characteristic of schizophrenia, depression or neuroleptic drugs can sometimes produce a similar clinical picture.

In our culture, where socially shared beliefs about the influence of God's will, the devil, and/or sorcery exist, particular caution has to be exercised in eliciting symptoms in groups II through V in ICD-10 guidelines. The presence of supernatural forces is culturally recognized in an abstract way. They are never expected to

problèmes d'environnement étant donné que les membres de famille trouvent que le premier type est plus facilement cerné par les croyances socio-culturelles.

Schizophrenia occurs in all communities and all races though its prevalence varies from one country to another. Low rate peoples (e.g. Hutterites) are distinguished from high rate peoples (e.g. the western Irish) by preponderance in the former of communalistic rather than individualistic competitive life, a hierarchical structure, strong respect for tradition, fundamentalist religion and disinterest in technological development[1]. Untraditional changes in traditional cultures are thought to play a pathogenic role in increasing the rates of schizophrenia.

Far fewer female schizophrenics than males present to medical services in Arabian Gulf countries and this has been attributed to what has been called 'cultural immunity' of females against schizophrenia[2]. However in most Arabian Gulf countries males outnumber females in the general population and among those attending medical services. Life in extended families made it easy for female family members to help out when a sick woman is unable to participate in household chores until she recovers or improves with family support. On the other hand, males have to continue some form of activity outside the family. Therefore professional help-seeking is more likely for male than female patients in this community.

SYMPTOMS AND COGNITIVE SCHEMAS

Like other psychiatric illnesses in this region, schizophrenic illness may start with bodily complaints and this increases the chance of presentation of patients to medical services by themselves or through relatives. Their diagnosis will be very difficult if they present to physicians whose exclusively biological training in medicine made them unable to take a psychiatric history. On the other hand, if schizophrenic behavioural manifestations are prominent, culturally-shared explanations are likely to be invoked in their appraisal and the help of traditional healers rather than medical professionals may be sought. Family members like the patients themselves, may project the responsibility for schizophrenic disturbances of behaviour onto the devil or jinn or onto evil wishes by others (envy) or harmful employment of evil spirits (sor-

members find the former more easy to contain in their repertoire of culturally-shared beliefs.

Résumé

Transculturel de la Schizophrenie et I.C.D.10

L'etude cosmopolite de la schizophrenie a été prise comme preuve d'origine biologique de la maladie. La variation d'une commun auté a une autre a été prise pour evidence sur la contribution des facteurs environnants et culturels. On pense que les conflits culturels et l'ambiguité jouent un rôle étiopathagenique, il existe une relation étroite entre l'effet de la culture sur les symptômes de la schizophrenie et les consequences.

Les symptômes non naturels, les forces sur surnaturelles sembleraient influencer la vie des êtres humains. Dans la 10² Division internationale des maladies le diagnostic de la schizophrenie depend des symptômes du l'rang de schneider cela entraine la mefiance pour delimiter ces symptômes chez les communautés où les croyances socio- culturelles presentent certaines ressemblances avec les symptômes de l'rang. Les études internationales ont soulignées que les resultats de la schizophrenie ont été meilleurs chez les souétés traditionelles developpées que chez les sociétés industrielles developpées. La raison de cette difference tient à la tendance chez les membres de la famille de diminuer l'expression emotionelle et de l'attitude de tolerance socio culturelles chez les schizophrenes dans les societés traditionelles. Le traitement et la rehabilitation chez les schizophrenes sont aussi influencés par les facteurs culturels. Les malades qui developpent les symptômes de comportement sont orientés vers les "guerisseurs" beaucoup plus que ceux qui presentent des symptômes somatiques.

Il a été demontré aussi que l'involution de la delusion est plus facilement obtenue si elle contienue des sujets supranaturelles beaucoup plus que les

ان علاج وتأهيل مرضى الفصام يتأثر بالعوامل الثقافية، فالمرضى الذين تظهر عليهم اعراض سلوكية هم اكثر عرضة للتوجه للمعالجين الشعبيين من اولئك الذين تظهر عليهم اعراض جسدية، كما لوحظ ان الاوهام المرضية يسهل زوالها اذا احتوت على مواضيع فوق الطبيعة مما لو كانت تحتوي على امور من البيئة، وذلك لأن افراد الاسرة سيجدوا ان النوع الاول يسهل احتواءه في المفاهيم الثقافية السائدة المشتركة في مجتمعهم.

Abstract

The cosmopolitan occurrence of schizophrenia has been taken as evidence of its biological origins and the variation in its prevalence from one community to another as evidence of the contribution of cultural and environmental factors. Cultural conflict and ambiguity are thought to play a pathogenic role in aetiology. The pathoplastic effect of culture on the symptomatology and outcome of schizophrenia is well documented.

Symptoms are noted as abnormal against the cultural background where supernatural forces are believed to influence the life of all human beings. In ICD-10 the diagnosis of schizophenia relies heavily on Schneider's first rank symptoms and caution is necessary in detecting these symptoms in communities where socioculturally-shared beliefs bear a resemblance to first rank symptoms.

International studies documented the better outcome of schizophrenia in developing traditional societies than in developed industrial societies. Reasons for this difference have been sought in a presumed preponderance of schizophreniform attacks, in the tendency to lower expressed emotion of family members and in the tolerant sociocultural attitudes to schizophrenic patients in traditional societies.

The management and rehabilitation of schizophrenic patients are also influenced by cultural factors. Patients who develop behavioural symptoms are more likely to be taken to traditional healers than those with somatic symptoms. It has also been demonstrated that involution of delusions is more likely if they have supernatural than environmental contents as family

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Transcultural Aspects of Schizophrenia and ICD-10

M. Fakhr El-Islam

الأوجه الثقافية في الفصام والتقسيم الدولي العاشر للأمراض

م. فخر الاسلام

ملخص:

لقد تم اخذ الانتشار العالمي للفصام كدليل على الاصل الحيوي للمرض، واختلاف هذا الانتشار من مجتمع لآخر على انه دليل على دور العوامل البيئية والثقافية في حدوثه. يعتقد ان الصراعات والغموض الثقافي تلعب دورا في أسباب هذا المرض، وهناك توثيق جيد للأثر الثقافي في صياغة أعراض الفصام وتحديد نتائجه.

تعتبر الأعراض غير طبيعية على خلفية ثقافية فيها اعتقاد بتأثير القوى الفوق طبيعية على حياة الناس جميعا. في التقسيم الدولي العاشر للأمراض يعتمد تشخيص الفصام على اعراض المرتبة الاولى لشنايدر، وهذا يدعو للحذر في تحديد هذه الاعراض في المجتمعات التي تحمل معتقدات ثقافية واجتماعية قد تتشابه مع اعراض المرتبة الأولى.

لقد وثقت الدراسات الدولية ان الفصام له نتائج افضل في المجتمعات النامية التقليدية من المجتمعات الصناعية المتقدمة، ويعتقد ان السبب في ذلك يعود لكثرة حالات الذهان القصيرة الشبيهة بالفصام، والميل عند افراد العائلة بعدم الاكثار من التعبير العاطفي، هذا بالاضافة ان الاتجاهات الاجتماعية والثقافية تكون اكثر تحملا لمرضى الفصام في المجتمعات التقليدية.

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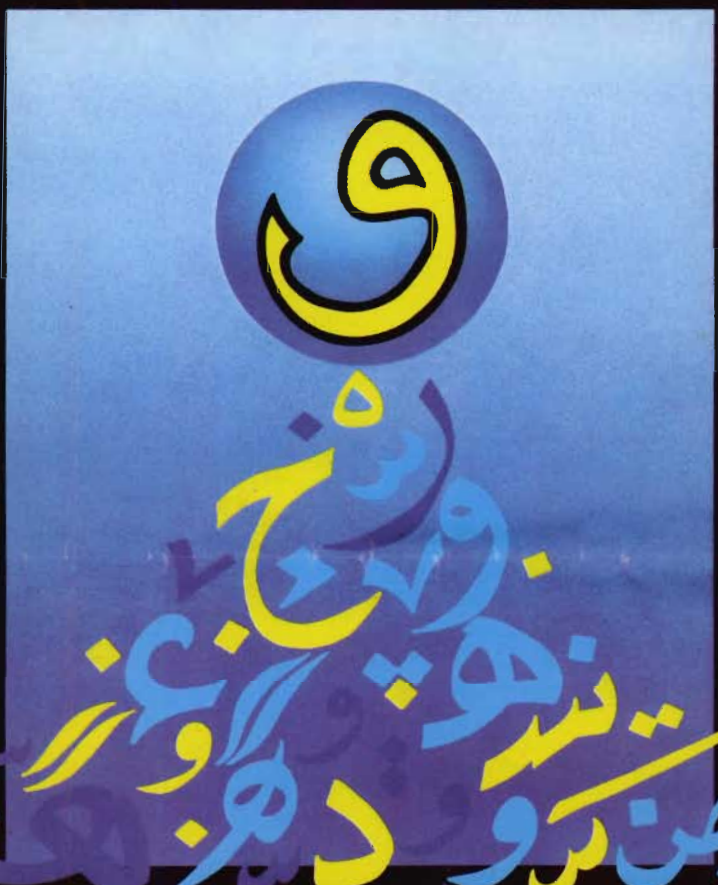

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(1) Gawad, M.S.A. and Arafa, M. (1980):
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The Editorial Letter

May I extend the gratitude of the editorial board, for your participation and support of our journal, The Idea of the journal was initiated in the 3rd pan Arab conference on psychiatry (Amman 1987), and the first issue appeared with the 4th conference (Sana'a 1989), we hope that our 5th conference in Casablanca-Morocco this year will be the venue to assess the journal and support its continuation, the active role of all arab psychiatrists is required to get the accredition of the journal from all the universities in the Arab countries.

May 1992 **THE EDITOR**

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