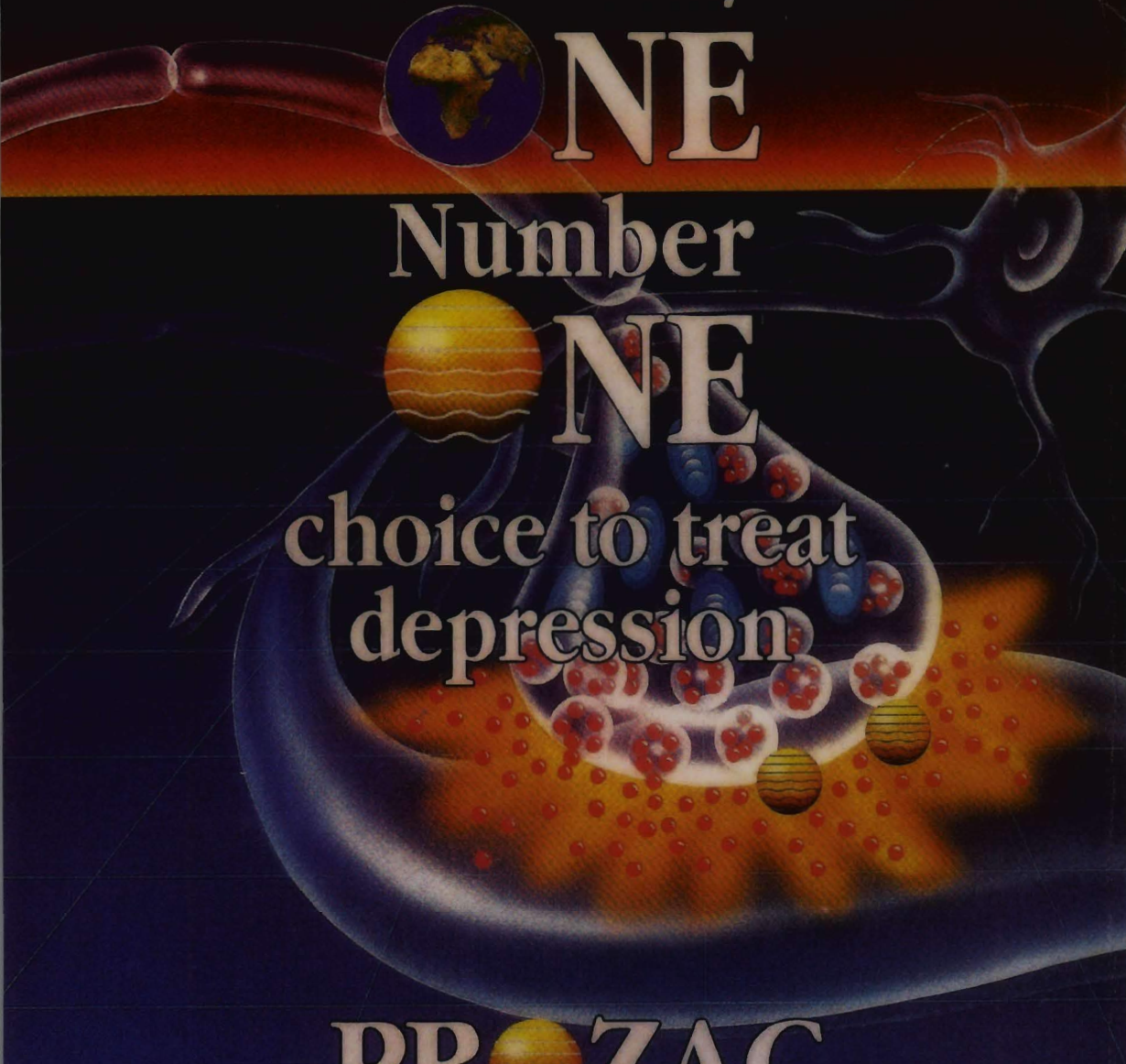

ABBREVIATED PRESCRIBING INFORMATION "PROZAC" (FLUOXETINE HYDROCHLORIDE) Presentation Capsules containing 20mg fluoxetine hydrochloride. Liquid containing 20mg fluoxetine Hydrochloride per 5ml syrup. **Uses** *Depression:* Treatment of the symptoms of depressive illness. *Bulimia nervosa:* For the reduction of binge-eating and purging activity. **Dosage and Administration** (For full information, see data sheet.) For oral administration to adults only. *Depression - adults and the elderly:* A dose of 20mg/day is recommended. *Bulimia - adults and the elderly:* A dose of 60mg/day is recommended. Because of the long elimination half-lives of the parent drug (2-3 days) and its major metabolite (7-9 days), active drug substance will persist in the body for several weeks after dosing is stopped. The capsule and liquid dosage forms are bioequivalent. *Children:* Not recommended. *Patients with renal and/or hepatic dysfunction:* See "Contra-Indications" and "precautions" sections. **Contra-Indications** Hypersensitivity to fluoxetine. Prozac should not be administered to patients with severe renal failure (GFR <10ml/min.) *Usage in nursing mothers:* Prozac should not be prescribed to nursing mothers. *Monoamine oxidase inhibitors:* At least 14 days should elapse between discontinuation of an MAOI and initiation of treatment with Prozac. At least five weeks should elapse between discontinuation of Prozac and initiation of therapy with an MAOI. Serious, sometimes fatal reactions (including Hyperthermia, rigidity, myoclonus, autonomic instability and mental status changes that include extreme agitation, progressing to delirium and coma) have been reported with concomitant use or when fluoxetine had been recently discontinued and an MAOI started. Some cases presented with features resembling neuroleptic malignant syndrome. **Warnings** *Rash and allergic reactions:* Angioneurotic oedema, urticaria and other allergic reactions have been reported. Upon appearance of rash, or of other allergic phenomena for which an alternative aetiology cannot be identified, Prozac should be discontinued. *Pregnancy:* Use of Prozac should be avoided unless there is no safer alternative. **Precautions** Prozac should be discontinued in any patient who develops seizures. Prozac should be avoided in patients with unstable epilepsy; patients with controlled epilepsy should be carefully monitored. There have been rare reports of prolonged seizures in patients on fluoxetine receiving ECT treatment. A lower dose of Prozac, eg, alternate day dosing, is recommended in patients with significant hepatic dysfunction or mild to moderate renal failure (GFR 10-50ml/min.). Caution is advisable when Prozac is used in patients with acute cardiac disease. Prozac may cause weight loss which may be undesirable in underweight depressed patients. In diabetics, fluoxetine may alter glycaemic control. There have been reports of abnormal bleeding in several patient but causal relationship to fluoxetine and clinical importance are unclear. *Drug interactions:* Increased (with lithiu toxicity) or decreased lithium levels have been reported. Lithium levels should be monitored. Greater than 2-fol increases of previously stable plasma levels of cyclic antidepressants have been observed when Prozac has bee administered in combination. Agitation, restlessness and gastro-intestinal symptoms have been reported in a sma number of patients receiving fluoxetine in combination with tryptophan. *For further information, see data she* **Adverse Effects** Asthenia, fever, nausea, diarrhoea, dry mouth, appetite loss, dyspepsia, vomiting, headach nervousness, insomnia, drowsiness, anxiety, tremor, dizziness, fatigue, decreased libido, seizures, hypomania o mania, dyskinesia, movement disorders, neuroleptic malignant syndrome-like events, pharyngitis, dyspnoe pulmonary events (including inflammatory processes and/or fibrosis), rash, urticaria, vasculitis, serum sickness anaphylactoid reactions, hair loss, excessive sweating, sexual dysfunction. The following have been reported i association with fluoxetine but no causal relationship has been established : aplastic anaemia, cerebral vascul accident, confusion, ecchymoses, eosinophilic pneumonia, gastro-intestinal haemorrhage, hyperprolactinaemi immune-related haemolytic anaemia, pancreatitis, pancytopenia, suicidal ideation, thrombocytopeni thrombocytopenic purpura, vaginal bleeding after drug withdrawal and violent behaviour. Hyponatraemia (includi serum sodium below 11mmol/l) has been rarely reported. This appears to be reversible upon discontinuatio **Overdosage** On the evidence available, fluoxetine has a wide margin of safety in overdose. Since introductio reports of death, attributed to overdosage of fluoxetine alone, have been extremely rare. One patient who reported took 3000 mg of fluoxetine experienced 2 grand mal seizures that remitted spontaneously.
Date of Preparation or Last Review May 1993.

References 1. Harris B, et al, data on file, Eli Lilly. 2. Data on file, Eli Lilly. 3. Judd F. JAMA SEA 1991; (Dec. Suppl.) 31-33. 4. Hindmarch I, Human Psychopharmacology 1987; 2: 171-185. 5. Fairweather DB, Kerr JS, Harrison DA, press. 6. Cooper GL, Br J Psych 1988; 153 (Suppl. 3): 77-86. 7. MIMS December 1992. MIMS April 1993. "Prozac" is Eli Lilly trade mark.

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1) IMS Midas 1992, referring to days of therapy

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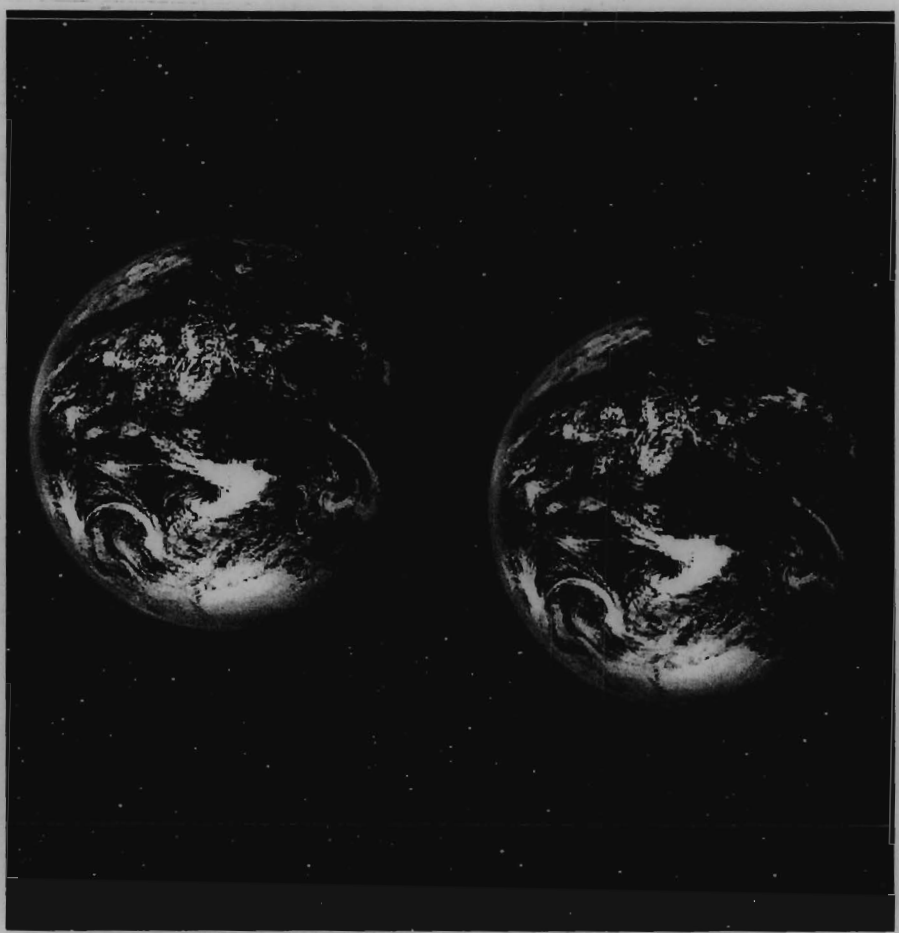

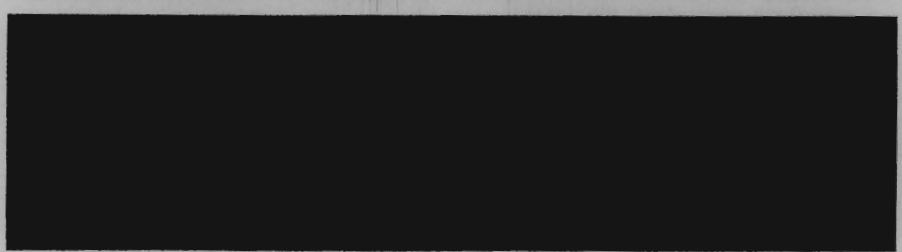

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The Arab Journal of Psychiatry (1997) Vol. 8. No. 1

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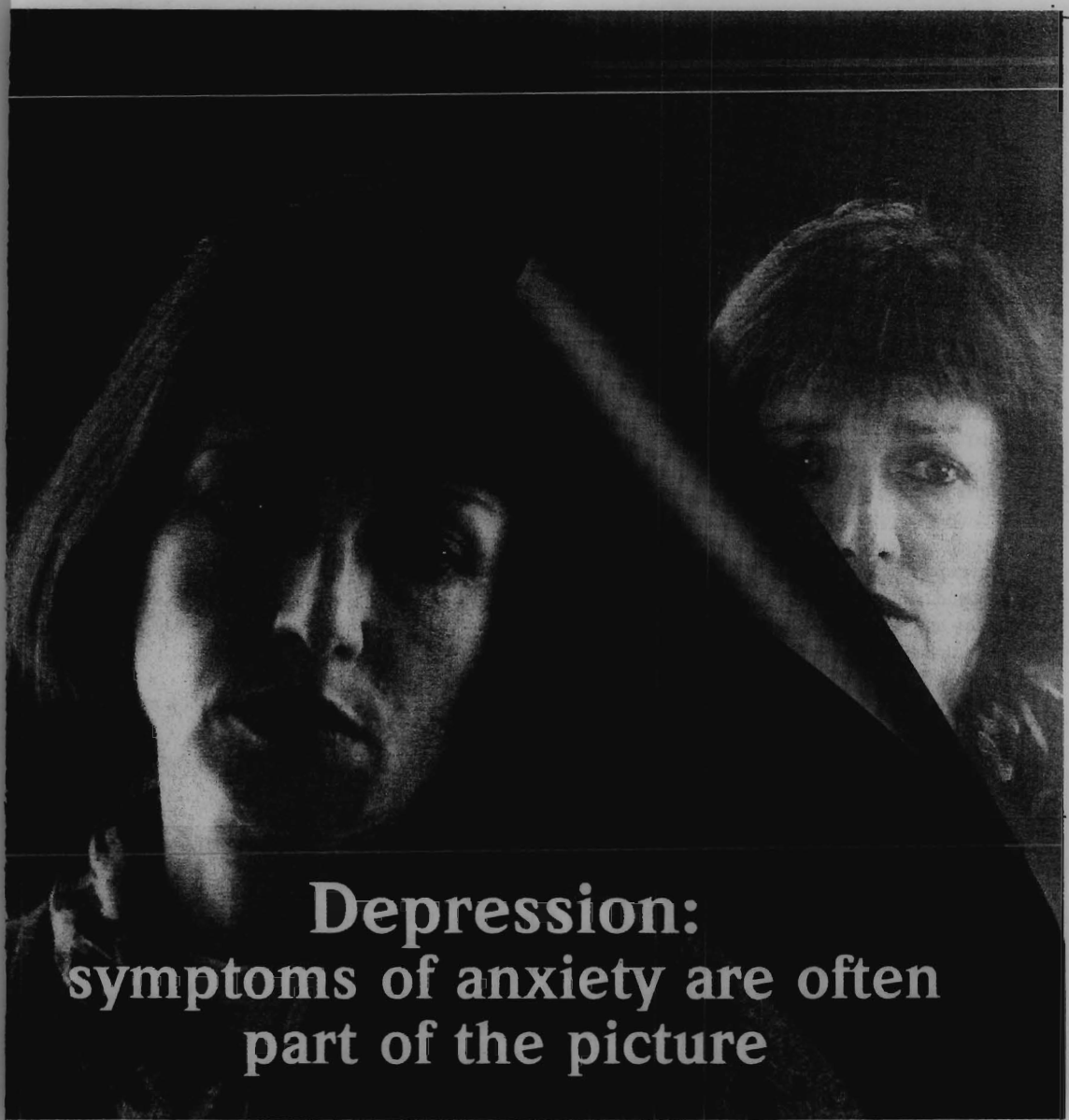
1. Zeigler FJ, Imboden, JB, Meyer E. Contemporary conversion reactions: a clinical study. Am. J. Psychiatry 1960; 116:901-10.
2. Mosey AC. Occupational therapy. Configuration of a profession. New York: Raven Press, 1981.
3. Gotesman KG. Behavioural aspects of physical illness. In: Ohman R, Freeman H, Holmkvist AF, Nielzen S, editors. Interaction between mental and physical illness. Needed areas for research. Berlin: Springer Verlag, 1989:120-34.



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. Fawcett, J., Kravitz, H.M. *J Clin Psychiatry 44*(8), 8-11 (1983) 2. Angst, J., Dobler-Mikola, A. *Eur Arch Psychiatr Neurol Sci 235*, 179-186 (1985) 3. Degruy, F. *Am Family Phys 49*(4), 860-866 (1987) . Kasper, S. et al. *Drugs 43*(Suppl 2), 11-23 (1992) 5. Anderson, I.M., Tomenson, B.M. *J Psychopharmacol 8*(4), 238-249 (1994) 6. Ottevanger, E.A. *Br J Clin Res 2*, 125-132 (1991) 7. Wilde, M.I. et al. *Drugs 45*(5), 895-924 (1993) 8. Ottevanger, E.A. *Eur J Clin Res 1*, 47-54 (1991) 9. Montgomery, S.A. *Drugs 43*(Suppl 2), 24-31 (1992) 10.Chabannes, J.P. et al. Data presented at the VIII World Congress of Psychiatry, ctober 1989, Athens 11. Wakelin, J.S. *Adv Biol Psychiatry 17*, 70-83 (1988) 12. Lapierre, Y.D. et al.: Treatment of major affective disorder with fluvoxamine. *J Clin Psychiatry 48*, 65-68 (1987) 3. Wakelin, J.S., Coleman, B.S.: Fluvoxamine; a multicentre placebo and imipramine controlled study in depression. Data on file, Solvay Duphar, Weesp, The Netherlands. 14. Palmer, K.J., Benfield, P. *CNS Drugs 1*(1), 57-87 (1994) 15. Leonard, B.E. *Drugs 43*(Suppl 2), 3-10 (1992) 16. Wagner, W. et al. *Int Clin Psychopharmacol 9*, 223-227 (1994) 17. Lecrubier, Y. *Drugs 43*(Suppl 2), 1-2 (1992)

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Review Article

Postpartum Psychiatric Illness in Arab Culture

Mohamad T. Abou-Saleh

الاضطرابات النفسية بعد الولادة في المجتمع العربي

محمد طموح أبو صالح

ABSTRACT

There have been numerous studies of the prevalence of postpartum psychiatric illness and its risk factors in Western Europe and North America but very few studies from developing countries including the Arab world.
Studies that were carried out in the Arab world are reviewed including recent studies from the UAE which show similar prevalence rates to rates reported from industrialized countries but with a few unique social risk factors.

The relationship of motherhood and psychiatric illness has been extensively studied in recent years. This is related to remarkable advances in the (nosology) of psychiatric disorders, the rapidly accumulating knowledge on their etiology and the introduction of effective treatments. The spectrum of postpartum psychopathology ranges from the common blues (prevalence 50-70%) through depressive illness (prevalence 10-15%) to psychosis (prevalence 0.1-0.2%). Although the etiology of these disorders is largely unknown, recent studies have highlighted the importance of hormonal factors in the pathogenesis of postpartum psychosis and the predominant role of psychosocial factors in the etiology of postpartum depression.

There have been numerous studies of postpartum depression, its nature, prevalence and risk factors, whether psychosocial or biological one. O'Hara and Swain (1996) undertook a meta-analysis of the results of a large number of studies to determine the average prevalence rate of non-psychotic postpartum depression and the effects of a number of putative risk factors, measured during pregnancy for postpartum depression. The average overall prevalence rate in 59 studies was 13% with a small 95% confidence interval (12.3 to 13.4%). Prevalence estimates were marginally greater in self-report based studies (14%) than in interview (diagnosis) based studies (12%). Moreover, estimates were greater in studies that used a wider window (e.g.

first eight weeks) than a narrow one (e.g. first 4 weeks) and the postpartum period under evaluation made the largest contribution to the prediction of prevalence estimates, accounting for 17% of the variance. Importantly, the number of days postpartum when assessment was completed and the country in which the study was conducted did not significantly predict prevalence estimates.

The majority of these studies were European/North American based and only one was carried out in a semi-rural setting in Uganda[3] reporting in a series of 183 women, a prevalence of 10% depression (ICD-8) assessed in context of the Goldberg interview within three months from childbirth. Interestingly, this rate was similar to the rate obtained in a series of Scottish women (13%) using the same methodology.

Kumar (1994) in a critical review of the literature of trans-cultural aspects of postpartum psychiatric illness has shown the scarcity of studies done outside of Western Europe and North America and commented on the surprising similarities of rated of postpartum depression in the few reported cross-cultural comparative studies. These studies had important limitations: reliance upon self-report questionnaires, description of prevalence rather than incidence rates, uncertainty about the relevant time frame, the lack of detailed comparisons of symptomatology and the lack of availability of methods that allow sensitive and yet reliable comparative analysis of aetiological factors as well as of the course, nature and outcome of postpartum depression. The study of postpartum psychiatric illness in a range of cultures offers a unique opportunity to examine the socio-cultural differences in presentation, etiology and hence the care and prevention of these disorders.

The first study of postpartum psychiatric disorders was carried out in Egypt and reported a prevalence of 4.3% comprising maternal blues 8%, shizophreniform disorders 5%, mania 21%, depression 11% and organic disorders 5% using DSM-III criteria[9]. Women with blues had impaired cognitive function and depressed women had a negative attitude towards their babies and their husbands. There was however a discrepancy between the subgroup of normal women from the obstetric wards who had a high prevalence rate of psychiatric disorder (25%) and the two subgroups of psychiatrically ill women admitted to the hospital who had delivered within the six months previous to admission, 1.4 and 4.3% respectively which is related to selection factors. The second study reported a prevalence rate of maternity blues of 38% which were associated with somatic symptoms, depression, phobic, anxiety symptoms, history of premenstrual tension and maternal ill health during pregnancy[4].

We have recently undertaken a retrospective study of the incidence and characteristics of severe postpartum psychiatric illness following childbirth in the city of Al Ain[1] United Arab Emirates. The incidence of postpartum psychiatric admission was 0.55 per 1000 deliveries and the incidence of psychosis

was 0.32 per 1000 deliveries. These rates are concordant with the lower incidence reported from Saudi Arabia[10] and Japan[9] when compared with the incidence in Western Europe and North America. However, the diagnostic breakdown showed a similar rate (47%) of affective and schizoaffective psychosis to the rates reported from developed countries.

We have then carried out a prospective study involving 95 women admitted to the New Dubai Hospital in Dubai for childbirth. All subjects were assessed in the postpartum period using clinical and sociocultural instruments: the Self Reporting Questionnaire (SRQ) at day 2, the Edinburgh Postnatal Depression Scale (EPDS) at day 7, the Present State Examination (PSE) at week 8±2 and week 30±2 after delivery.

The prevalence rate of psychiatric morbidity was 24.5% by SRQ, 17.8% by EPDS and 15.8% by PSE. A number of psychosocial factors emerged as putative risk factors for postpartum depression: marital problems before and after delivery, polygamy, life events in the last 6 months, previous psychiatric illness, first child and baby's ill health. These risk factors except for polygamy are consistent with the findings of the meta-analysis of previous studies[7]. The impact of polygamy was mediated by marital problems. The most powerful risk factors for the occurrence of postpartum depression in the first few weeks after delivery was early depressive symptoms occurring within the first week from delivery: patients who were cases on the EPDS in the first week were the ones who suffered from full-blown depressive illness many weeks after delivery. Of note is that all those with PSE case depression recovered at 8 months after delivery when very few new occurrences were found (4.2%) indicating the self-limiting nature of postpartum depression.

Our results could be compared to the findings of Cooper et al (1988) who used the PSE and compared the prevalence rate of non-psychotic psychiatric disorder after childbirth (8.7%) to the rate in a general population sample of non-puerperal women (9.9%) and found it no greater. The rate of PSE-cases of 15.8% is lower than the rate obtained in a community-based survey of psychiatric morbidity in women in Dubai using the same method of PSE-CATEGO ID level 5 (22.7%). This is probably related to the higher mean age and the inclusion of divorced, separated and widowed (postmarital) women in the community sample who as a subgroup had a PSE case rate of 39.4%. The diagnostic breakdown, however, was similar with 39.7% having endogenous depression (296.1), 17.6% with anxiety states (300.0) and 13.2% with neurotic depression (300.4).

We are currently examining the impact of postpartum maternal and potential psychiatric illness on child development in view of the reports of adverse effects of postpartum psychiatric illness causing cognitive and behavioural problems in infants and young children respectively[6].

All in all, the findings of these Arab studies show that the prevalence of postpartum psychiatric morbidity and its

psychosocial correlates are similar to the results obtained in studies from Western Europe and North America. The portrait of postpartum psychiatric disturbance is a woman who has suffered previous psychological problems with marital problems, other life stresses, concerns about the pregnancy and the newborn child, and who shows signs of distress early in the puerperium.

الملخـــــص

هناك شحة نسبية في دراسات الاضطرابات النفسية بعد الولادة في المجتمع العربي بالمقارنة مع عدد كبير من الدراسات المماثلة في البلدان الأوروبية وشمال أمريكا. لقد بينت الدراسات المماثلة ومنها دراسة أجريت في دولة الإمارات أن معدل انتشار هذه الاضطرابات مقارب لمعدل انتشارها في الدول الأوروبية مع اختلاف في الأسباب الاجتماعية والثقافية لهذه الاضطرابات.

References

1. Abou-Saleh, M.T., Karim, L, Ghubash, R. (1996) Postpartum Psychiatric admissions in Al Ain. Annals of Saudi Medicine, 16:355-356.
2. Cooper, P.J., Campbell, E.A., Day, A., Kennerley, H & Bond, A. (1988). Nonpsychotic psychiatric disorder after childbirth: a prospective study of prevalence, incidence, course and nature. British Journal of Psychiatry, 152, 799-806.
3. Cox, J.L. (1983) Postnatal depression: A comparison of African and Scottish women. Social Psychiatry, 18, 25-28.
4. El-Akabawi, A.S., Khattab, T.Y., Amin, Y., Sayed, S, Khater, U.M. (1988). The Nature and Associates of "Maternity Blues" in and Egyptian Culture. Egypt. J. Psychiat, 11:57-80.
5. Kumar, R. (1994) Postnatal Mental Illness: A Transcultural Perspective. Soc Psychiat and Psychiat Epidemiology 29:250-264.
6. Murray, L. and Cooper, P.J. (1996) The impact of postpartum depression on child development. International Review of Psychiatry, 8, 55-63.
7. O'Hara, M.W., Swain, A.M. (1996). Rates and risk of postpartum depression a meta-analysis. International Review of Psychiatry, 8, 37-54.
8. Okana, T., Koshikawa, N., Nomura, J., Tatsunuma, T. Cross-Cultural study of maternity blues and postpartum depression. Paper presented at 6th International Conference of the Marce Society, Edinburgh 1992.

9. Okasha, A., Younis, N., Youssef, I., Khalil, A.H., Demerdash, A. (1987) The Postpartum Psychiatric Disorders: A Descriptive and Epidemiological Study. Egypt. J. Psychiat, 10:161-174.

10. Shoeb, I.A., Hassan, G.A. (1990) Postpartum psychosis in the Assir region of Saudi Arabia. Br J of Psychiatry, 1990:157,427-430.

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The Factorial Structure of the 17-item Hamilton Depression Rating Scale

Tewfiq Daradkeh, Mohamad Abou-Saleh, Lina Karim

التركيبة المعولية لأداة هاملتون لقياس شدة مرض الاكتئاب

توفيق درادكة، محمد أبو صالح، لينا كريم

ABSTRACT

The Hamilton Depression Rating Scale was applied to 73 depressed inpatients diagnosed using the Psychiatric Diagnostic Interview. The first 17 items of the scale were factorized using the hierarchical factor analysis and were clustered using agglomerative hierarchical cluster analysis. Five primary and one secondary factor, accounting for 61% of variance were extracted. The extracted factors represent insomnia, depression, anxiety-hypochondriasis, guilt, and genital symptoms (libido). Three simple interpretable clusters that represent depression, associated symptoms and some melancholic features were found. A weak general factor of the scale was found.

Key words : structure, rating scale, depression.

Introduction

The Hamilton Depression Rating Scale is a standardized scale for the measurement of severity of depression (103). The scale consists of 21 items (the total score is based on the first 17 items) rated on either 3- or 5-point scales. The factorial structure of HDRS-17 has been investigated by a number of investigators[4]. Recent reports have indicated that the HDRS is a weak measure of depression severity because it does not define a unidimensional depressive state and does not correlate well with clinical assessments[5]. Thus, it would be a worthwhile exercise to explore the validity of the scale. In this paper we describe the structure and psychometric properties of the scale, and in a second report the predictive validity of the total score will be presented in a different sample of patients. The structure and psychometric properties of the HDRS presented in this report is a part of a brain imaging study on patients with severe illness.

Material and Method

Seventy-three (n=73) consecutively admitted patients with DSM-111-R diagnosis of major depression were assessed with the Hamilton Depression Rating Scale. The sample was selected from the in-patient population with clinical diagnoses of depression. Patients were then assessed with a highly structured diagnostic interview, the Psychiatric Diagnostic Interview - PDI-R[6], that yields DSM-111-R diagnosis. The first 17 items of the scale were subjected to hierarchical factor analysis with varimax rotation. Screen test was used to determine the number of factors[7]. Some authors have discussed in some detail the concept of oblique (non-orthogonal) factors in order to achieve more interpretable (simple) structure. Specifically, computational strategies have been developed to rotate factors so as to best represent clusters of variables without the constraint of orthogonality of factors. However, the oblique factors produced by such rotations are often not easily interpreted. A new computational strategy has been elaborated in which the programme first identifies clusters of items and rotates axes through those clusters; next the correlations between the oblique factors are computed, and that correlation matrix is further factor-analysed to yield a set of orthogonal factors that divide the variability in the items into that due to shared or common variance (secondary or general factors), and unique variance due to the clusters of similar variables in the analysis (primary factors). The HDRS (total and extracted factors were then subjected to item analysis in order to calculate the internal consistency (reliability) of the total scale and subscales. Subscales whose reliability is equal or better than the reliability of the total scale are more likely to be valid and meaningful. On the other hand, subscales with low reliability cast doubt on their validity. To avoid the problems that may result from improper solution achieved by factor analysis, cluster analysis of variables was carried out to explore the structure of the HDRS. Hierarchical Cluster Analysis of variables does not require multivariate normal distribution of variables, nor a linear relationship between variables. Similarity as a cluster measure was employed to group variables into different clusters. Extracted clusters were also subjected to item (reliability) analysis to calculate the reliability of subscales.

Results

The sample comprised 31 male and 42 female patients. The mean age of patients was 35.1 years, ranging from 18 to 58 years. The mean total Hamilton score was 27.5, (SD=4.8). Hierarchical factor analysis yielded 5-factor (primary) solution and a general (secondary) factor accounting for 61% of variance (Table 1). Ten items of the HDRS were loaded on the general factor (loadings > 0.3) and loadings ranged from 0.35 to 0.57 which indicates a moderate level of loadings for the general factor. The items or symptoms were as follow: depressed mood, guilt, initial insomnia,

middle insomnia, late insomnia, psychic anxiety, somatic anxiety, gastrointestinal somatic symptoms, general somatic symptoms and loss of libido. The symptoms can be grouped under three clusters: psychological (cognitive), sleep, anxiety and somatic component. This factor seems to be a better indicator of severity than the total scale as its reliability (alpha coefficient = 0.75) was higher than the reliability of total scale (alpha coefficient = 0.60). First primary factor was markedly loaded form middle, late, and initial insomnia and was moderately loaded for psychic anxiety. Loadings ranged from 0.38 to 0.67. Its internal consistency (alpha) was found to be 0.71. Second primary factor was markedly loaded for depressed mood, loss of weight and suicide and was moderately loaded for agitation. Loadings for this factor ranged from 0.46 to 0.77. Its internal consistency was 0.64. Third primary factor was markedly loaded for loss of interest/work (negative) and was moderately loaded for hypochondriasis and anxiety. Fourth primary factor was markedly loaded for loss of weight, guilt, and was moderately loaded for retardation. Fifth primary factor was markedly loaded for loss of libido and was moderately loaded for somatic items. Reliability coefficients for extracted components were as follows: 0.71 and 0.64 for first and second primary factors. The rest of the factors exhibited low reliability coefficients. Cluster analysis classified the 17 variables of the HDRS into 3 groups (Fig. 1). First cluster represents depressed mood, loss of weight, suicide and agitation. The reliability of this cluster was 0.64. Second cluster represents anxiety, somatic symptoms, loss of interests and insomnia. The reliability of this cluster was 0.71. Third cluster represents guilt, retardation, loss of insight, loss of libido and hypochondriasis. The reliability of this cluster was 0.37.

Discussion

We have described no more and no less than an "internal construct validity" evaluation of the HDRS. The findings reported here represent more than a revision of the HDRS guided by clinical validators. Our analysis rests on a belief that the psychometric properties of any psychological measure must be well-defined and consistent with the definition of the target construct. The comparison between different factor analyses of HDRS presents many difficulties[4]. First, there are many versions of the Hamilton Depression Rating Scale. Second, not only does patient inclusion and exclusion criteria vary but also the level of depression and the diagnostic criteria used. Third, variation in methods of factor extraction and factor loading vary from one study to another. Factor analysis and cluster analysis yielded only two meaningful primary factors and two clusters respectively. The second primary factor corresponds exactly to the first cluster that included depressed mood, suicide, loss of insight and agitation. The

findings that limited number of symptoms were loaded on depressive factor accord with previous observations. Hamilton[8] reported that depressed mood, guilt, suicide and agitation represented the depressive factor. Bech et al[9,11] reported that depressed mood, guilt, work/interest, and psychic anxiety constituted the depressive factor. Risking et al in 1987[12] found that depressed mood, suicide, work/interest and loss of libido constituted the depressive factor. Factor analysis revealed that the secondary or the general factor was different from the depressive factor. First, more items were loaded on the general factor than the depressive factor. Second, the internal reliability of the general factor was higher than the reliability of the depressive factor. Third, we expected that the general factor loading on depressed mood would be the highest but it was not. The limited number of the HDRS items loaded on this factor, the moderate level of loading and the moderate level of alpha reliability suggest that this factor, although better than total scale, is not a terribly good index of severity of depression. Despite these differences certain factors are common to different HDRS-17 analyses. The insomnia factor covering all 3 insomnia items appears in several analyses[13,15]. The higher correlation between the insomnia variables compared with the depressed mood with the general factor can be explained by the fact that our patients may be less psychologically oriented and therefore the complaints of sleep disturbances were expressed easier than the anguish of depressed mood. One of the most important findings of our study is that a powerful general factor was not found. Two possible explanations for the latter observation are possible: either a general factor for HDRS does not in fact exist, or if such a factor does exist, the small range of severity of illness in our patients allows the general factor to diminish in size, and by rotating the factor to a simple structure elimination of such factors is a likelihood possibility. The extracted factors in our study have also been reported by other investigators[4,8] but with different variables and different loading. The findings of cluster analysis are rather more simple, meaningful and interpretable. First cluster describes the psychological component of depression; second cluster describes more or less the associated symptoms of depression and the third cluster partly describes some of the melancholic features of depression (guilt, retardation and loss of weight). Taking into consideration the results of both factor and cluster analyses it seems unlikely that the HDRS is a unidimensional scale[16] and subsequently its total score is also unlikely to be an optimum index for severity of depressive illness. The relatively low internal consistency of the scale (alpha = 0.6) supports the questionable validity of the total score as an index of severity of depressive illness. It is interesting to find that the low internal consistency of the HDRS was also noted by other investigators[17]. It would be of interest to find out how the total score correlates with other measures of severity and

whether the total scores predict the overall clinical severity. The above two points will be discussed in our second report which will follow soon.

الملخـــــص

لدراسة التركيبة المعولية لأداة هاملتون لقياس شدة الاكتئاب تم قياس شدة الاكتئاب لـ ٧٣ مريضاً مصاباً بالمرض ومشخصون حسب التصنيف الأمريكي الثالث المعدل. وبعد التحليل المعولي لعناصر أداة هاملتون أظهرت الدراسة وجود خمسة عوامل رئيسية وعامل ثانوي واحد. وتمثل هذه العوامل الأعراض المرضية التالية: اضطراب النوم، الشعور بالكآبة، القلق والخوف من المرض، الشعور بالندم والضعف الجنسي. وبعد التحليل العنقودي أظهرت الدراسة أيضاً أن عناصر أداة هاملتون تتكون من ثلاث مجموعات منفصلة من الأعراض المرضية مثل الشعور بالكآبة، الأعراض المصاحبة وألاعراض السوداوية. وبشكل عام لم تظهر الدراسة وجود عامل مشترك واحد لجميع عناصر أداة هاملتون مما يدل على أن أداة هاملتون قد لا تكون الأداة المثالية لقياس شدة الاكتئاب.

References

1. Hamilton M. A rating scale for depression. J Neurol, Neurosurg Psychiatry 1960: 23: 56-62.
2. Fava G, Kellner R, Munari F, Pavan L. The Hamilton depression rating scale in normals and depressives: a crosscultural validation. Act Psychiatr Scand 1982: 66: 26-23.
3. Knesevich J, Biggs J, Clayton P, Ziegler V. Validity of the Hamilton rating scale for depression. Br J Psychiatry 1977:131:49-52.
4. Fleck MPA, Poirier-Littre MF, Guelfi J-D, Bourdel MC, Loo H. Factorial structure of the 17-item Hamilton Depression Rating Scale. Act Psychiatr Scand 1995:92:168-172.
5. Gibbons RD, Clark DC, Kupfer DJ. Exactly what does the Hamilton Depression Rating Scale measure? J. Psychiat Research 1993:27:259-273.
6. Othmer E, Penick EC, Powell BJ, et al. The Psychiatric Diagnostic Interview. revised by Penick EC, Los Angeles, CA, Western Psychological Services 1988.
7. Cattell RB. The scree test for the number of factors. Multivariate Beh Research 1966; 1:245-276.
8. Hamilton M. Development of a rating scale for primary depressive illness. Br J Soc Clin Psychology 1967:6:278-296.

9. Bech P, Gram LF, Dein E, Jacobsen O, Vitger J, Golwing TG. Quantitative rating of depressive states: correlation between clinical assessment, Beck's self-rating scale and Hamiltons's objective rating scale. Acta Psychiat Scandinavica 1975; 51:161-170.
10. Bech P, Allerup P. The Hamilton Depression Scale: evaluation of objectivity using logistic models. Acta Psychiat Scandinavica 1981;63:290-299.
11. Bech P, Allerup N, Reisby N, Gram LF. Assessment of symptom change from improvement curves on the Hamilton depression scale in trial with antidepressants. Psychopharmacology 1984;84:276-281.
12. Riskind JH, Beck AT, Brown G, Steer RA. Taking the measure of anxiety and depression: validity of the reconstructed Hamilton scales. J Nerv Ment Disases 1987;175:474-479.
13. Brien KP, Glaudin V. Factorial structure and factor reliability of the Hamilton rating scale for depression. Acta Psychiatr Scand 1988:78:113-120.
14. Xheng Y, Zhao J, Philips M, Jianbai L, Cai M, Sun S, Huang M. Validity and reliability of the Chinese Hamilton depression rating scale 1988:152:660-664.
15. Ramos-Brieva JA, Cordero-Villafafila A. A new validation of the Hamilton rating scale for depression. J Psychiatr Res 1988:22:21-28.
16. Baumanu U. Methodische Untersuchungen zur Hamilton Depression-Skala. Arch Psychiatr Nervenkr 1967:222:539-375.
17. Bech P, Rafaelsen OJ. The use of rating scales exemplified by a comparison of the Hamilton and the Bech-Rafaelsen Melancholia Scale. Acta Psychiat Scandinavica 1990;62 (suppl. 285):128-131.

Table 1: Hierarchical Factor Analysis of the HDRS-17

17-item HDRS		Primary Factors					
		1 (22.2%)	2 (13.3%)	3 (10.6%)	4 (8.0%)	5 (6.9%)	General Factor
5	Middle insomnia	0.62					0.56
4	Early insomnia	0.38			0.37		0.57
6	Late insomnia	0.66					0.46
7	Work and activities			-.73			
1	Depressive mood		0.68				0.36
16	Weight loss		0.77				
3	Suicide		0.65				
9	Agitation	0.44	0.46	0.30			
10	Psychic anxiety	0.48		0.49			0.41
12	Gastrointestinal somatic					0.31	0.45
13	General somatic					0.44	0.41
11	Somatic anxiety			0.34		0.44	0.57
8	Retardation	-0.38			0.35		
14	Genital symptoms			0.33		0.62	0.34
2	Guilt				0.64		0.43
17	Insight				0.72		
15	Hypochondriasis		-.45	0.52			
Internal consistency (alpha)		0.71	0.64	0.45	0.38	0.55	0.75

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The Assessment and Treatment of Adolescent Substance Misuse: Some Special Considerations

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تقييم وعلاج سوء استعمال العقاقير لدى اليافعين

حارث سوادي

ABSTRACT

While substance misuse among adolescents is globally on the increase, prevention remains the main approach. This paper highlights some relevant clinical issues of recent interest. It provides some aspects which could help in the clinical assessment of referred adolescents and how these differ from adults. Some pointers in relation to clinical managements and treatment approaches are highlighted. Finally, the case for setting up specialist services for adolescents who misuse psychoactive substances is made.

Keywords: adolescents; substance misuse, assessment.

Introduction

Although North America and Britain have taken the lead in the table of countries most affected by, and reporting an increase in substance misuse among adolescents is increasing, it is extremely difficult for any nation to deny that it has been showing similar trends to varying degrees. Like Britain and many other European countries, there are hardly any organised treatment services for adolescents in the Arab world. Instead, there is almost a total emphasis on prevention despite the fact that there is no universal agreement on what prevention can achieve. This approach also overlooks the fact that a growing number of adolescents fail to respond to preventative measures in any form.

Why treat adolescents?

A point of contention is whether or not we should concern ourselves with treatment. is it not possible that adolescents may just grow out of the habit of using psychoactive substances? It is argued that we should, because:

1. While it is true that most will eventually stop substance misuse, some will not. They, will make the future substance dependent adults. One report found that 92% of drug dependent adults start to use around the age of 15-18 years[1].
2. Drug misuse has an epidemic character through peer influence.
3. It is associated with psychosocial and health risks[2]. A prospective

4. study over 22 years found that about 2% of opiate addicts die each year mostly (72%) of drug-related causes and mainly in the young age group[3].
5. It is possibly more likely to be treated successfully in adolescence than in adulthood, given that their substance use is not usually associated with the features of dependence.
6. The preventative value of treating adolescent substance misusers can be realised through a reduction on the demand for adult substance misuse services and the associated reduction in HIV and AIDS morbidity.

The most likely sources of referral are families, social welfare agencies, the legal system, schools and primary health workers Very few adolescents come voluntarily for treatment[4]. A proportion of referrals are made for reasons other than substance use (usually behavior problems) which tends to emerge later in the assessment process as a main problem.

Types of substance use among adolescents

Unlike adult addicts who mainly use psychoactive substances just to feel normal, adolescents use psychoactive substances in many different contexts. It is very important to determine the context of use as it has a very large bearing on the intervention process. There are five different clinical contexts of involvement[5].

1. Exploratory or Experimental

The primary motive in this type is curiosity and risk-taking. The mood altering effects are secondary to the adventure of use. Using takes place mostly with others. The user may try more than one substance, but usually not more than a handful of times. The key factor is "Curiosity". The adolescent is experimenting with the mood swing caused by drugs.

2. Social

The context here is strictly social e.g. parties, friends' houses, car parks etc.. The primary motive is social acceptance. Peer group plays a large role. Substances are shared freely or sold at cost. The purpose is to fit in with the crowd and to loosen up. The keyword is "Acceptance". The adolescent is usually still experimenting with the mood swing.

3. Emotional or Instrumental

In this context, the adolescent learns through a process of trial and error, and modelling, to use substances purposefully to manipulate feelings, emotions and behavior, i.e. to elicit or to inhibit certain behaviours and feelings. The keyword is "Seeking". The adolescent is generally seeking the mood swing.

There are two types of instrumental use:

a. Generative/Hedonistic where the purpose is to seek pleasure and to have fun. It is characterised by binges motivated by the desire to get high or to disinhibit behaviour (e.g. shyness) or both. It is directed to elicit pleasurable

feelings or to explore new feelings or emotions.

b. Suppressive/Compensatory where the purpose is to cope with stress and uncomfortable feelings. The goal is suppression of negative and distressing emotions such as shame, anger, sadness, confusion and loneliness. Mostly, use is solitary but can also happen with the peer group.

4. Habitual

Typically the frequency of use is more alarming and begins to show a characteristic of compulsiveness and pre-occupation. Life style becomes gradually centred around drugs. Former relationships, activities and friends start to dissipate and new substance related ones develop. Sleep and concentration difficulties begin to appear. Withdrawal symptoms appear occasionally especially after periods of heavy sustained use. Craving and tolerance may appear and he/she begins to think about use most of the time. More behavior problems appear and school performance becomes seriously affected. The key word is "Accommodation". The adolescent is pre-occupied with the mood swing.

5. Dependent or Addictive

This is the stage where physical and psychological addiction become the main feature. Tolerance, craving, withdrawal symptoms and the compulsion to use are the main features. The adolescent is completely pre-occupied with use and life centres around the substance and the next 'fix'. The adolescent takes substances only to feel normal.

Adolescents in the first two categories of use (Exploratory, Social) are primarily involved in lower tariff substances such as volatile substances, cannabis and amphetamines whereas those using habitually could be involved in a variety of substances including opiates and crack cocaine.

Psychopathology

Psychopathogy is increasingly emerging as a very influential risk factor, not only in relation to initiation but also in relation to response to intervention and outcome. It represents a risk factor that we may be able to recognise and do something about. Conduct problems have long been recognised as associates of substance misuse. The strong links with emotional problems are now being recognised. Consistently, reports indicate that affective symptoms predominate in females while conduct problems are more common in males. Swadi[4] stressed on the need to be aware of the existence of mood disorders among substance users as they are easy to miss particularly when associated with conduct and anti-social behavior. Substance misuse is related to increased suicidal ideation and attempted suicide[6]. Many adolescents who 'overdose' do so while under the influence of alcohol or other drugs. A major risk factor for completed suicide after parasuicide in adolescents is substance misuse[7,8]. In one study more than half the suicides in

adolescents had a principal diagnosis of substance misuse[9].

Young substance misusers also show higher rates for psychosomatic complaints, anxiety, relationship problems and social dysfunction. Adolescents with poor coping skills tend to use psychoactive substances to deal with stress[10] and as a means of emotional self regulation. There is also an emerging link between eating disorders (both anorexia and bulimia) and substance misuse particularly in relation to alcohol use in women[11,12]. American literature consistently reports strong links between Attention Deficit-Hyperactivity Disorders and substance misuse in adolescents[13]. This is not a view shared by British and European researchers because of differences in the diagnostic criteria of Attention Deficit-Hyperactivity Disorders.

Treatment Options

The main criteria for the need for treatment depend on the stage of involvement and the degree of impairment or handicap caused by substance use. Therefore, problematic substance use can be defined as that which has resulted in demonstrable or documented evidence of sustained adverse consequences, with evidence of continued use despite these consequences, in areas related to education (e.g. being expelled or having left school prematurely), delinquency (e.g. being arrested, or getting involved in theft), intra-familial relationships (e.g. running away from home, violence towards family members) and psychiatric symptomatology (e.g. severe conduct problems, depressive symptoms).

Substance misuse in adolescents is, on the whole, very different from that in adults. The aetiological factors, the patterns of use, the context of use, and the therapeutic approaches are different:

1. In adults attending substance misuse clinics, drug use is primarily a need to counter the effects of not taking drugs, i.e. the effects of the dependence syndrome. Adolescents take drugs because they get something, they perceive as positive. Dependence is quite rare among adolescents.
2. Multiple drug use is the rule rather than the exception in adolescents and the idea of a favourite substance is rather uncommon in adolescents. They are less likely to be involved in higher tariff substances and rarely inject. They are more involved in binges and are affected by the consequences of acute intoxication rather than chronic use. They use substances in a variety of contexts unlike adults who use in a very narrow context.
3. Motivation regarding treatment is more likely to be an adult characteristic. Adults are particularly motivated by severe adverse consequences. Adolescents are usually reluctant customers and help-seeking behavior is rarely their characteristic. They usually have less adverse consequences and less motivated for change.

4. Developmental differences make it necessary to take a different approach. Adolescents are still in the process of shaping their values and attitudes and have different coping strategies from adults[14]. For example, experience in handling stress, dealing with interpersonal conflict and negotiating change are more likely to be adult characteristics. Many adolescents have great difficulties in relationships, personal and social skills issues which almost always have to be addressed. Choice and decision making are skills that have not yet fully developed in adolescents.
5. Adults substance misusers often present to services at the later stages of the addiction process; usually physical and/or psychological dependence. Adolescents are usually referred before that. Therefore, detoxification is rarely needed in adolescents while rehabilitation is often needed as substance misuse would have seriously affected the development of many basic life skills, education, social relationships, employment skills etc...

A thorough assessment should enable the clinician to plan a treatment programme that is specifically tailored to the needs of the individual adolescent. It also aims at identifying his assets and the deficits that need to be addressed (such as social skills and life skills deficits, family communication problems, educational difficulties etc.). The treatment process should have a well defined and realistic goal and should address the therapeutic needs of the adolescent as a whole including substance misuse problems. The main issue is matching patients with treatment. The main factor in deciding this is the degree of handicap, the level of use and the adolescent's circumstances. For example, less affected individuals, with a relatively short period of use and less severe or absent psychopathology respond better to cognitive-behavioural approaches than their counter-parts with anti-social problems who respond better to interactional therapy particularly group therapy. Those using socially often need less intensive treatment where family intervention or individual counselling may suffice. Individual counselling, group psychotherapy and family therapy are often utilised in one combination or another. Since most adolescents' use is not addictive in nature, there is little role for pharmacological methods of treatment[5]. However, when addiction is a feature, its treatment usually follows those for adult addicts.

Individual Counselling

A recent development in individual counselling is the use of brief intervention techniques. This began with the use of simple advice in primary care settings and reported significant reductions particularly in relation to alcohol use. However, a major new approach is that which is based on the theory of change[15]; motivational interviewing[16]. This approach is

becoming increasingly popular and has added a new and exciting dimension to therapeutic intervention. The cycle of change identifies 5-6 stages in change. Intervention begins with identifying where at this cycle the person is, and depending on that a plan of action is devised. The objective is to help the young person move along from one stage to another through increasing motivation. This approach is particularly useful with resistant clients (such as adolescents). Different stages required different approaches.

Family Work (Therapy)

Families can be helpful in the process of therapy. They can also be obstacles. Families and family dynamics have been shown to be influencial in the process of moving from experimentation to chronic use. Most recovered addicts report family systems being very helpful in their recovery. Family therapy can take the form of individual family work or group family work. It can also take the from of structural, strategic or behavioural work.

The family can help improve compliance with treatment which involves medication. Treatment should be time limited and goal oriented, especially goals identified by the family. Family tasks are very useful in this sense. The therapist should keep the issue of drug use alive and avoid getting into other red-herring issues. If the family wish to discuss other issues they should be advised that they may wish to discuss that after the 'current' goal is achieved. Parents roles should be enhanced and given a major advisory and decision making role viz-à-vis the treatment process.

Group Work (Therapy)

This can take the form of substance abuse oriented or non-substance abuse oriented. The latter can deal with social skills, relationships and can have an element of education and catharsis. Group therapy particularly that which involves peer confrontation seems to be effective for adolescents, at least in the short term[17]. However, most substance abuse oriented work has really been based on the AA (12-Steps) model. The basic objective is self-help and relapse prevention. However, although this model of work can be beneficial for adults, it has some problems with adolescents. The concept of self help has to be modified to make into account the adolescent development.

External Support Network, Education and Employment

For adolescents in treatment, abstinence is a major change in lifestyle, and needs support to be maintained. Once treatment is completed, it is important for the adolescent, in order to function satisfactorily and 'stay off' drugs, to be able to return to an environment that will support such a need. It is important that the nature of and degree of support is explored as part of the continued review and assessment process. Such support will inevitably involve opportunities for adequate accommodation, education, training, and employment. Often it is also useful to

provide psychological support either on a regular or on an ad-hoc basis. Most well developed treatment programmes include an element of extended day or community follow-up and support.

Treatment Outcome

Research evidence from America suggests that there are some promising pointers. Alford et al[18] described an inpatient treatment programme for adolescents aged 13-19, based on the Alcoholics Anonymous (12 steps) model, claiming some short-term success especially among girls. The 3-month programme involved individual counselling, group psychotherapy and family work. They reported that 6 months after discharge, 71% of males and 79% of females who completed treatment were 'abstinent' or essentially abstinent'. At 24 months, 40% of males and 61% of females were 'abstinent' or 'essentially abstinent'. This favourable but unsustainable outcome suggests that an aftercare component of treatment is essential. This should take the form of relapse prevention strategies and/or an enhanced social support network.

Recovering adolescents need to have coping skills to maintain abstinence. A method widely used in treating adult addicts is relapse prevention which takes a cognitive approach to help generate mechanisms to cope with situation of high risk for elapse. Social pressure is the most important high risk situation for adolescents. A recent investigation showed that, 6 months after the end of treatment, abstinence was directly related to the ability of the adolescent to develop coping strategies to deal with social pressure. The most successful strategies were those characterised by a behavioural-cognitive approach such as avoiding high risk situations, refusal and engaging in alternative activity[19].

Conclusion

There is no doubt that adolescence is the genesis of the adult addictions. Prevention is a legitimate goal. In the Arab world this has taken the method of public awareness and education campaigns. Western experience has proved prevention to be not the most effective answer, and treatment remains to be necessary. The case for setting up services for the treatment of adolescent substance misusers is clear and derives it's strength mainly from the prevention of the onset of adult-type addictions. Sub-stance misuse in adolescents can be associated with high psychiatric morbidity which can easily be overlooked and which makes treatment a necessary course of action. Adult treatment services are by nature and design not suitable for adolescents. It is high time for the establishment of treatment services for adolescents which recognise their particular vulnerabilities and special needs.

الملخـــــص

بينما تزداد نسبة اليافعين الذين يتعاطون المواد المؤثرة عقليا، لا تزال الوقاية تمثل الاتجاه السائد في التدخل. تلقي هذه المقالة الضوء على بعض الجوانب السريرية المثيرة الاهتمام حديثاً وتوفر بعض المؤشرات التي تساعد في تقييم حالة اليافعين الذين يتعاطون المواد المؤثرة عقلياً وكيف يختلفون عن البالغين. وتوفر هذه المقالة الأسباب والحجج لإنشاء خدمات خاصة بعلاج اليافعين الذين يتعاطون المواد المؤثرة عقلياً.

References

1. Sheehan, M. Oppenheimer, E. & Taylor, C. Who comes for treatment: drug misusers at three London agencies. British Journal of Addiction, 1988, 83, 311-320.
2. Hansel, S. & White, H. Adolescent Drug Use, Psychosocial Distress, and Physical Symptoms. Journal of Health and Social Behavior, 1991, 32, 288-301.
3. Oppenheimer E., Tobutt, C., Taylor, C., & Andrew, T. Death and Survival in a cohort of heroin addicts from London Clinics: a 22 year follow-up study. Addiction, 1994, 89, 1299-1308.
4. Swadi H. Psychiatric Symptoms in Drug Abusing Adolescents. Drug and Alcohol Dependence, 1992, 31, 77-83.
5. Nowinski, J. Substance Abuse in Adolescents and Young Adults: A Guide to Treatment. 1990, (Norton, New York).
6. Felts W, Chenier T & Barnes R. Drug Use and Suicidal Ideation and Behavior among North Carolina Public School Students. American Journal of Psychiatry, 1992, 82, 870-872.
7. Bukstein, O., Brent, D., Perper, J., et al Risk factors for completed suicide among adolescents with a lifetime history of substance abuse: a case control study. Acta Psychiatrica Scandanavica, 1993, 88, 403-408.
8. Hawton, K., Fagg, J., Platt, S. & Hawkins, M. Factors associated with suicide after parasuicide in young people. British Medical Journal, 1993, 306, 1641-1644.
9. Fowler, R., Rich, C., & Young, D. San Diego Suicide Study: Substance Abuse in Young Cases, Archives of General Psychiatry, 1986, 43, 962-965.
10. Labouvie, E. Alcohol and marijuana use in relation to adolescent stress, International Journal of the Addictions, 1986, 21, 333-345.
11. Lavik, N. & Onstad, S. Drug use and psychiatric symptoms in

adolescence, Acta Psychiatrica Scandanavica, 1986, 73, 437-440.
12. Lavik, N., Clausen, S. & Pedersen, W. Eating behavior, drug use, psychopathology and parental bonding in adolescents in Norway. Acta Psychiatrica Scandanavica, 1991, 84, 387-390.
13. Wilens, T., Biederman, J., Spencer, T. & Frances, R. Comorbidity of attention Deficit Hyperactivity and Psychoactive Substance Use Disorder. Hospital and Community Psychiatry, 1994, 45, 421-435.
14. Blum, G. Current Perspectives on substance abuse in youth. Journal of the American Academy of Child & Adolescent Psychiatry, 1987, 28, 151-162.
15. Prochaska, J., & DiClemente, C. Transtheoretical Therapy: Toward a more integrative model of change. psychotherapy: Theory, Research and Practice, 1982, 19, 276-288.
16. Miller, W. & Rollnick, S. Motivational Interviewing: Preparing People to Change Addictive Behavior. 1991, (Guildford Press, New York).
17. Wheeler, K., & Malmquist, J. Treatment approaches in adolescent chemical dependency. Pediatric Clinics of North America, 1987, 34, 437-448.
18. Alford G, Koehler R, & Leonard J. Alcoholic Anonymous-Narcotic Anonymous Model Inpatient Treatment of Chemically Dependent Adolescents: A 2-year Outcome Study. Journal of Studies on Alcohol., 1991, 52, 118-126.
19. Myers, M. & Brown, S. Coping Responses and Relapse Among Adolescent Substance Abusers. Journal of Substance Abuse, 1990, 2, 177-189.

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Management of Post Traumatic Stress Disorder Using the Technique of Debriefing

V. Eapen, G. John

تدبير عقبى الكرب الرضحي بواسطة أسلوب التفريغ

فالسا ايبان، ج. جون

ABSTRACT

A comprehensive treatment programme for Post Traumatic Stress Disorder (PTSD) using the technique of "debriefing" is presented. "Debriefing" attempts to prevent the development of the initial response pattern of the individual to "symptoms" and then into a "disorder". The individual usually perceives their "experience" following the traumatic event as "abnormal reactions", and in debriefing, this is reframed as "normal reactions" to an abnormal event. The emphasis on the reactions as normal, prevents cognitive re-appraisal of oneself as abnormal when they experience the symptoms. The primary aim is to reduce the negative impact of the event and to speed up the recovery process.

Introduction

Stress is a well known component of day to day living. This could take the form of acute stresses, or in some cases, it may be chronic. Sometimes when this has been present for long duration, individuals may not even recognise that they are suffering from chronic stress, as they get used to it and do not feel the difference any more. Clinical experience following the Vietnam war was influential in initiating research interest in Post Traumatic Stress Disorder (PTSD). Rosser & Dewar (1991) highlighted issues such as the heterogeneity of treatment response, the problems associated with the reluctance of the survivors to take the "role" of patients, the need for a planned service and the benefits of providing information to the victims about psychological symptoms.

The essential components or PTSD as outlined in DSM 111 R (APA 1987) include the following:

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone.

B. The traumatic event is persistently reexperienced in at least one of the following ways:
   1. recurrent intrusive recollections of the event
   2. recurrent distressing dreams of the event
   3. sudden acting or feeling as if the event were recurring a) sense of

reliving, illusions, hallucinations and dissociative flashback episodes)
4. intense psychological distress on reexposure to events that symbolise or resemble the traumatic event including anniversaries

C. Presistent avoidance of associated stimuli or numbing of general responsiveness as in at least three of the following ways:
1. efforts to avoid thoughts/feelings associated with the trauma
2. efforts to avoid activities /situations that arouse re-collections
3. inability to recall an important aspect of the event
4. markedly diminished interest in significant activities
5. feeling of detachment/ estrangement from others
6. restricted range of affect (e.g. unable to have loving feelings)
7. sense of foreshortened future (e.g. does not expect to have career, marriage, children or a long life)

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:
1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response
6. physiologic reactivity on re-exposure

E. Duration of the disturbance (B, C&D) of at least one month

If the onset of symptoms was at least six months after the trauma, specify as "delayed onset".

The Treatment Programme

Individuals who have suffered traumatic experiences usually are reluctant to seek professional help. However, most of them experience considerable uncertainty and disorganisation. Any intervention should therefore focus on the following aspects (Hodgkins and Stewart 1991).

1. enabling the individual to make sense of the experience by
   a. ventilation of feelings and reactions about the event
   b. linking events and reactions
   c. decreasing the sense of "uniqueness" or "abnormality" of their reactions and favouring a more "normalizing" attitude
2. helping the individual to achieve cognitive mastery by integrating elements of their new experience
3. identifying aspects that may need further assistance and mobilising appropriate resources
4. prevent the onset of more long term psychological symptoms

DEBRIEFING, a technique originally used with emergency personnel was designed as a form of crisis intervention to minimise the occurrence of psychological suffering (Mitchell 1983). Mitchell developed Critical Incident Stress Debriefing (CISD) to allow immediate processing of the traumatic event and to mobilise the person's own resources and coping mechanisms and thus to emphasise the normality of the

response. Debriefing therefore does not aim to alter the person, but attempt to prevent the development of the initial response pattern of the individual to "symptoms" and then into a "disorder". The individual usually perceives their "experience" following the traumatic event as "abnormal reactions" and in debriefing, this is reframed as "normal reactions" to an abnormal event.

The emphasis on the reactions being normal prevents cognitive re-appraisal of oneself as abnormal when they experience the symptoms. This also prevents distorted interpretations and the development of dysfunctional coping mechanisms. For example, it will help the individual to link the event to reaction and rearrange it in some order thus preventing memories from becoming intrusive and stressing. Although debriefing can be done any time after the event, better outcome is obtained when it is initiated within the first two to three days. Debriefing can be done individually or in groups.

It is a clinician guided group or individual discussion, reviewing the impressions and reactions that survivors experience during or following traumatic events. The aim is to reduce the negative impact of the event and speed up the recovery process. The process can be divided into seven main phases.

1. Introductory Phase

The essential elements include introduction as to who you are, what you are going to do and why. It may be helpful to state that you have used the technique before in similar situations and that it will give him/her a chance to share some of the thoughts and feelings in relation to the traumatic experience and help to appraise these feelings in perspective. The person will have to be informed about the nature of the sessions and the fact that anything that is said in the sessions will be treated as confidential. It may be useful to warn them that they may feel overwhelmed during the session, as they may be getting in touch with painful issues. However, reinforce that this is normal and that part of the process is to be able to confront unpleasant feelings.

2. Gathering Information/Ventilation

Ask the person to tell you, in as much detail as possible, what happened, trying to start from several hours before the event. The first attempt by the person may be disjointed and incomplete but it is better to first allow the person to narrate it without any interruption, and then go over it again trying to establish the missing bits.

3. Cognitive/Thinking Phase

During this phase, an attempt is made to help the person link their thoughts to their feelings. Open ended questions such as "what was the first thing that went through your mind"; "what thought stays with you now"; "what was the worst thing about the event" may be helpful. Beginning with a detailed account of the trauma offers the therapist an opportunity to become familiar with the person's experience, to see their ability to confront it and then to explore the meaning of the event for the person concerned and the extent of

assimilation and accommodation of the

4. Reaction Phase

The emotional processing of the traumatic event takes place during this phase. By so doing, maladaptive and unhelpful thoughts and associated feelings can be identified. their impressions of the event including sensory impressions such as what they felt, saw, heard, smelled and touched are important as most survivors find that these sensory experiences subsequently act as triggers for symptoms by arousing recollections of the traumatic event.

5. The Symptom Phase

This relates to the experiences that followed i.e. how they reacted in the hours or days after the event. In addition to the individual's thoughts, feelings and behaviours, it is important to ascertain the impact it had on family, relationships, social life, work, financial arrangements etc. It is important to empahsise the aspects where they have done well.

6. Normalization Phase

It may be useful to discuss the range and nature of post traumatic responses and the time course of these reactions. Explain that they may experience some of these reactions if they already have not done so, that these may fluctuate from time to time but that they should eventually reduce in frequency and intensity. One of the most important aspect of this phase is to "normalize" their experience and reactions to the "abnormal" event. Discuss their coping strategies and suggest alternatives if appropriate. Some individuals find it helpful to practise relaxation techniques.

experience.

Other behavioural approaches are also effective, for example, progressive desensitisation and flooding, when avoidance behavior is predominant.

7. Closing Phase

This phase should be used to reiterate essential elements from the earlier phase and to discuss future arrangements. It is a useful strategy to check whether there are any urgent issues which they would like to discuss before the next time you meet.

Case Study

'D' an Egyptian child aged 7 years was referred for an evaluation of her "change in behavior and school refusal". At presentation, she was already away from school for the previous 7 weeks, and her family had already tried a change of school thinking this would help. It emerged that the family had spent the summer holidays in Egypt and had returned at the beginning of the school year when the problems started. However, the behavioural change in the form of being withdrawn had been noted even before. On detailed interview, mother reported that the girl had witnessed a fire engulf part of her family home in Egypt. Since then, she was unable to sleep, waking up as often as four times a night with frightened crying. She reported having recurrent nightmares but could not elaborate on the contents in detail, other than that they were "bad ones". For a couple of weeks after the event, on occasions she would scream "fire" which was associated with autonomic arousal

symptoms. There was intense reliving reminding her of the trauma, in that she could not tolerate stereo being played at home nor could she tolerate the intense smell of cooking, especially frying. She also showed intense avoidance of a number of stimuli linked to fire, such as smoking cigarettes and hot objects. There were also significant changes in her temperament and social relating. She had become withdrawn, avoiding eye contact and fact to face interactions. She would not go out to play with other children or attend school. She was reported to be "clingy" and would seek her mothers presence all the time.

Her mother described her as shy and quiet girl who is unduly sensitive. Apart from this, the evidence suggested that until the time of the trauma, she was functioning well overall, and that her development was within the normal range. There was no significant family history, and the rest of the family who witnessed the event were reported to be functioning well.

'D' demonstrated signs and symptoms of PTSD, including evidence of re-experiencing the trauma, recurrent intrusive imagery, marked autonomic arousal, nightmares, as well as avoidance and fearfulness of situations that remind her of the trauma.

Introductory phase: The initial session was used to establish rapport, and to explain about the nature of the forthcoming sessions.

Information gathering/ventilation phase: Initially neutral topics were discussed such as her favourite play activities and her friends. While she was experience in stimulus situations talking about her friends, the topic was gradually directed to her school life. She started to fidget and repeatedly crossed and uncrossed her legs as if to hide her anxiety. I told her that I understood from her mother that she had been having some difficulty in attending the school since coming back from holidays. I also suggested to her that the fire she witnessed while in Egypt may have something to do with her current difficulties. After a long silence and with much encouragement, she nodded her head. I told her that it would be helpful if she would tell me all what she remembers about that day, including things that happened prior to the event. She started to tell me about the event in 'bits and pieces', some of which were incomprehensible and the events didn't have any temporal continuity. I made note of these points for clarification later while allowing her to continue the narrative without interruption.

Cognitive/thinking phase: I asked her "what was the worst thing about the event". She said that it was very frightening and repeated twice about having lost some of her school books; this personal loss seemed to be important for her. She told me that she recovered parts of her school books later from the debris, and that it made her to cry. She also described what appeared to be flash backs of the event, and how frightening this was.

Reaction phase: Based on what 'D' and her mother had told me, I attempted to link the various details of the event to some of her emotional experiences. in

this regard, I linked the autonomic backs/reliving experiences, and the smell of cooking to what she smelled at the time of the fire. One of the vivid memories she had about the events prior to the trauma was that the stereo was playing and the consequent speculation of her family that this was the source of the fire (fault in the electrical circuit) seemed to have exaggerated her intolerance to this stimuli. I explored further her fear and avoidance of school in relation to seeing parts of her school books among the debris (which made her to cry) and suggested that perhaps seeing books may be reminding her of the event. This seemed plausible as her mother reported that she was refusing to study even at home. However, it seemed that she was also experiencing a re-emergence of separation anxiety following the traumatic event which was compounding to her difficulty in attending school This is in keeping with her mothers report that she had become "clingy", seeking her mothers presence all the time, and refusing to go out to play.

The symptom phase: I explored with her how this event had affected her life, especially in the areas of school life and social relationships.

Normalization phase: The various post traumatic responses she had been experiencing were discussed, including the triggers such as perceptual stimuli (stereo playing, smoking, smell of cooking), emotional states (fear, anxiety and autonomic arousal), interpersonal contexts (separation from her mother), and situational cues (school books and arousal symptoms to the flash school). I suggested to her that these were "normal" reactions to an "abnormal" event and that they would eventually reduce in frequency and intensity. Note that her adaptation to these repeated retrieval of the event has included withdrawal and avoidance behavior. We made a programme with the help of her mother and school personnel to help 'D' return to her school as early as possible, and to encourage her to go out to play with other children; initially with her mother being present, followed by her mother gradually withdrawing from the scene.

Closing phase: I suggested that it would be helpful if she would tell me about the event again. From the way she did the narrative this time, it seemed to me that her memory of the event and retrieval was enhanced and modified by the nature of the dialogue we had had during the sessions.

Therapeutic implications include the notion that the perceptual details of the traumatic experience and their psychosocial meaning have been encoded implicitly which are recurrently retrieved in an intrusive manner, and that the "resolution" process need to focus directly on these details. In the sessions 'D' had the opportunity to re-experience painful feelings, to learn to construct a narrative of them, and thereby better integrate fragmented contradictory images and feelings she is experiencing now.

Defusing: is a shortened version of debriefing which can be provided by peers or other trained personnel to

reduce the immediate effects of stress usually done in a one to one setting, preferably within eight hours. It has three parts including Introduction, Exploration and Information, the contents of which are similar to that described under debriefing. This may eliminate the need for formal debriefing or in other instances, help prepare the individual for debriefing.

Guidelines for Case Assessment

There are several areas that need careful evaluation (Scott & Stradling 1992) including a brief account of what had happened, reactions to the event, main presenting problems, the individual's vulnerability, his/her coping skills and how well these were mobilised in relation to the given situation, presence of co-morbid psychopathology and secondary traumatization. Assessment should include characteristic responses, identification of trigger factors for symptom production, presence of guilt or self blame in relation to the event, feeling of helplessness, irrational fear for safety and the need to protect oneself.

General Principles of Management

- Early contact is preferable.
- Debriefing to be initiated whenever possible within a few days of the event.
- In cases of group catastrophe, debriefing session in groups facilitated by a mental health professional is helpful in off loading the emotional impact of the event. In these situations special care should be taken to ensure that all following a traumatic event. This is survivors know about the sessions and have an opportunity to attend.
- Emphasise that it is normal to experience some emotional turmoil after a stressful event, and make information available on commonly experience symptoms.
- Further help should be offered where symptoms are incapacitating, or when pathological coping strategies are already in place.
- Therapy may help facilitation of bereavement for the loss, facilitation of emotional and cognitive processing of the event, and encourage in the restructuring of belief systems to accommodate the event into the persons life experience.
- Empathetic listening is the key factor that enables people to ventilate their traumatic experiences. Emotional expression should be encouraged to help the patient learn that however overwhelming the emotion may be, it can be safely expressed and contained.

Drugs

Minor tranquillisers may be needed in some cases immediately following the event. When used, this should be for short term, and with a definite indication; for example to re-establish sleep pattern. Patients should be made aware of the dangers of abusing drugs or alcohol in their attempt to cope. Long term use of minor tranquillisers,

especially those with addictive potential, tranquillisers may be used only when a psychotic reaction has been precipitated. Similarly, antidepressants may be used when biological symptoms of depression are present, or to help reduce the distress produced by panic attacks and intrusive thoughts. Antidepressants remain the most favoured drug, although several other drugs including clonidine, propranolol, lithium and carbamazepine have all been used in the management of PTSD (Silverstone et al 1990).

Follow Up

Eight to ten sessions of active treatment is adequate in most cases. However, long term follow up services are essential. Access to help line or walk in service is usually sufficient for this purpose. This is particularly crucial as most survivors experience difficulties around times of anniversaries and other stressful life events. A more formal follow up session may be desirable about three months after the termination of treatment.

Discussion

It has been shown that a stable and supportive family plays a crucial role in the recovery process. Davidson et al (1991) identified certain factors such as adverse events during childhood, early parental divorce or separation, poverty, family history of psychiatric disorder, should not be recommended. Major past history of conduct disorder and victimization by abuse, as important in the causation and maintenance of PTSD symptoms. Rosser et al (1991) reported on vulnerability factors including the experience of life threat, social disruption, absence of a confidant and problems with litigation and publicity. It is therefore crucial to provide practical help and advocacy in matters relating to income, housing, recovery of possessions, contact with family and employers and legal aid.

Recommendations

Early intervention and a flexible approach are crucial in the management of PTSD. Information for the victim, and liaison with police and emergency services need to be available and efficient. There is little doubt that prompt dissemination of information, together with co-ordinated response including support, induction and debriefing can help reduce the harmful psychological effects, by creating a sense of mastery and control. Effective communication between agencies, and helping individuals, groups and communities to understand the course of recovery following trauma are other essential elements of a comprehensive approach.

الملخـــــص

تطرح الدراسة برنامجاً شاملاً لعلاج اضطراب "عقبى الكرب الرضحي" بواسطة أسلوب "التفريـغ" ، وهـو أسـلوب يهـدف الـى الوقايـة مـن حـدوث الاسـتجابة النمطيـة المبدئيـة فـي صـورة

"أعراض" ثم 'اضطواب"• وحيث أن المصاب يفسر خبرته اللاحقة للإصابة النفسية على أنها خبرة غير طبيعية فان أسلوب "التفريغ" يعيد صياغتها بصفتها تفاعلات طبيعية لحدث غير طبيعي ويؤدي التأكيد على أن ردود أفعال المصاب بشكل استجابات طبيعية الى الوقاية من إعادة التقييم المعرفي لدى المصاب على أنه غير طبيعي حين يعايش الأعراض، وبحيث يصبح الهدف الأساسي هو التقليل من الأثر السلبي للحدث الضاغط والإسراع في عملية الشفاء•

References

1. American Psychiatric Association (1987) Diagnostic and Statistical Manual of Mental Disorders (Third ed. Revised), American Psychiatric Association Press.
2. Davidson JRT, Hughes D, Blazer DG, George LK (1991) Post Traumatic Stress Disorder in the community: an epidemiological study. Psychological Medicine, 21, 713-721.
3. Hodgkins PE & Stewart M (1991) Coping with catastrophe: a handbook of disaster management. Routledtge.
4. Mitchell JT (1983) Development and functions of a Critical Incident Stress Debriefing Team. Journal of Emergency Medicine Services, Vol. 8, 36-39.
5. Rosser R, Dewar S (1991) Therapeutic flexibility in the disaster response. Journal of Royal Society of Medicine, 84, 2-3.
6. Rosser R, Dewar S, Thompson J (1991) Psychiatric aspects of disaster. Journal of Royal Society of Medicine, 84, 4-8.
7. Scott & Stradling (1992) Counselling for post traumatic stress disorder, SAGE, "Counselling in practice" C.
8. Silverstone JM, Sandberg DP, Hales RE (1990) New approaches in the pharmacotherapy of Post Traumatic Stress Disorder. Journal of Clinical Psychiatry, 51 (suppl), 32-38.

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Deliberate Non-Fatal Self Harm in Patients Attending a General Hospital in Saudi Arabia

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ايذاء الذات القصدي الغير مميت في مستشفى عام بالمملكة العربية السعودية

عبد الكريم عثمان، ابراهيم ابراهيم

Background

Though deliberate non-fatal self-harm (DSH) has become a rather common form of non-verbal communication in Western Countries, the impression from the developing countries has been one of being very rare. Arabic countries are among the ones with the lowest reported rates. Our aim in this study is to investigate the patterns of DSH in Saudia Arabia an Arabic country with a strong religious background.

Method

All patients attending the largest general hospital in Jeddah City, with a recognisable self-harm behaviour, were prospectively assessed by the psychiatrist. Their characteristic features and clinical data were analysed using chi square for any significant statistical differences.

Results

Only 55 patients were referred in a period of 9 months with a diagnosis of DSH, 45 females (81.8%) and only 10 males (18.2%). Males were older than females and non-Saudis were significantly more older and presented with more serious high suicidal risk DSH behaviours.

Conclusions

Though DSH rates in Arabic countries may still be considerably low, in comparison to those reported from the western countries, the current indications is that many of these countries may witness a considerable increase, unless they maintain their strong religious affiliations and emphasise the importance of preserving their traditional family structure.

Since early 1960's deliberate non-fatal self-harm (DSH) has become a rather common form of non-verbal communication in the western countries and constituted a serious public and mental health problem[1,5]. In the developing countries, on the other hand, the impression has been one of being very rare, and only recently clinicians have begun to ring the bell of danger that the trend is changing and may be considerably increasing[6,9]. Conspicuous changes in conventional sociocultural values due to relative weakening in religious ties with the associated flexibility in at least some of religious taboos have been implicated for the upsurging trends[9]. Among the developing countries, Arabic countries are among the ones with the lowest rates of DSH[8].

Saudi Arabia with its deeply rooted religious background, and the recent rapid over-urbanization and the concomitant major social transformation, may provide a good example of how these two pertinent factors - religous and social - may influence the changing pattern of DSH in a developing country. Only two studies, to the best of our knowledge, investigated DSH in the country, one in 1988 by Dradkah and El-Zayer[6], which was prior to the current wide scale transforming of the society, and the second in 1990 by Mahgoob et. al.[7] Despite their various methodological deficiencies, and the major drawback of both been on highly selected populations of the Saudi community, their studies, nonetheless, highlighted some significant findings. They reported very low rates and numbers and found the most likely patient to intentionally harm self to be the young unmarried female who reacts rather impulsively to a social distress within the context of disordered interpersonal relationships.

With this background, we designed this study to investigate DSH among patients attending King Fahad Hospital (KFH) the largest general teaching hospital in Jeddah (the second largest city in Saudi Arabia). Jeddah city is a port city with a continuous influx of foreigners mostly from Islamic countries due to their religious affiliation [to visit the Holy places in Mecca]. In result it has the largest concentration of ex-patriots in the Kingdom (1.87 million), according to 1992 census, which constitutes about one third of total population of western region, and about half of the total ex-partriate in the Kingdom[10]. The aim of our study was to determine the incidence of DSH among all the patients attending the accident and emergency (A/E) department in the hospital during a period of nine months, and to identify their demographic as well as their clinical characteristics.

Methods

In a prospective study the demographic and the clinical data were obtained using a computerized database on all patients who were referred to the liaison psychiatrist from the accident and emergency department for further evaluation and treatment.

a) The setting and the patients:

KHF is a large 930-bed teaching hospital that is considered to be the largest secondary care hospital in Jeddah. There are three other state general hospitals and as many as 8 general private hospitals in the same city to provide health services to a population of about 2.5 million. Lack of any defined catchment areas for these hospitals makes them easily accessible for all patients rendering most of the hospital based statistics significantly unreliable and misleading.

However, KFH being the largest general hospital, expectedly received the majority of patients from the inner city areas and that has the busiest A/E department. The hospital policy regarding DSH is that every such patient must be seen and evaluated by the psychiatrist. Unfortunately the majority of such patients who do not need

admission to the hospital or A/E are treated by the ER team and sent home without being seen by the psychiatrist. All patients included in this study were referred to the psychiatrist after their DSH warranted admission to either A/E (stay of up to 48 hours) or to inpatient department. Patients were referred with the diagnosis of "suicidal attempt" or overdose" but we adopted the term DSH[1] for the purpose of this paper and we defined it as "an intentional act in which a person either self administered a drug or a substance in excess with a motive other than therapeutic one, or self inflicted injury in absence of any recognized pleasure or religious satisfying motives". All patients were interviewed by the main author (Osman) and their clinical and demographic data were obtained using a purpose-structured form.

b) Clinical and socio-demographic features.

A two-parts purpose structured form was designed to collect the relevant data. Part A was for the demographic data that included sex, age, education, nationality, and occupation.

Part B was a questionnaire that contained questions regarding details of the DSH and included the method used, the amount of the drug or the other ingested substance, the immediate reason precipitating the act, how long did he or she think about doing it and his real intention and if he had really contemplated killing himself what did stop him from completing it.

c) Data analysis

All the data collected were fed into a data base and statistical significance was assessed using Chi-square analysis of difference between groups using Epi-Info V6.02.

Because of the immediate reason precipitating the act varied widely in different respects .we grouped them into three main classes:

1. a reaction to an acute stress
2. an appeal for others in the context of a long on-going intrafamilial or interpersonal conflict
3. psychiatric or medical illness

The seriousness of the act and its motive or the real intention was as well assessed by the psychiatrist along three levels:

a. serious contemplation with a high risk of suicide

b. impulsive without much thought of the consequence

c. a cry for help with no real intention of harming self

Results:

During a period of 9 months (1/4/1994 to 31/12/1994), a total of 55 patients were referred with the diagnosis of either "overdose" or "suicide attempt" from a total of 47,754 patients admitted to the A/E, 22,787 expatriates and 24,967 Saudi nationals. Of the total, 12,068 were females and 29,446 were males which gave a rate of 0.37% for females and 0.034% for males. Of the 55 patients referred to psychiatrist 45 patients (81.8%) were females (mean age 22.1 years SD 7.24, median 20 years, range 13-43 years); and 10 (18.2%) were males (mean age 32.5

years, SD 7.46, median 34 and range 19-41 years). Table 1 shows their sex and age specific rates.

Considering the multiethnic nature of the composition of the population of Jeddah city, we analyzed the demographic and clinical data according to nationality in Table 2., which shows a total of 36 (65.5%) Saudi nationals and 19 (34.5%) non-Saudi expatriate. Among the latter group Palestinians were relatively over-represented and constituted 5 out of the 19 (26.3%), followed by Egyptians, 3 (15.8%). Other Arabic countries were almost equally represented having between 1-2 patients. The Asians, who by large, constitute a large and important sector among the expatriate, were virtually absent, with only one thirty-eight years old Pakistani male who had seriously burned himself by ingesting a large amount of chemical detergent due to a depressive reaction. Expatriates revealed significant differences in their age groups (significantly older than Saudi nationals $p<0.05$), and were mostly married and tended to be at higher risk of more serious contemplation though reported significantly less previous attempts ($p<0.005$).

Methods, Reasons and Motives:

By and large the commonest method used to inflict self harm was self poisoning. 44 patients (80%), poisoned themselves, 41 by ingesting drugs, the remaining 3 by ingesting chemical detergents (mostly household bleach). Table 3 shows the amount and the type of drugs and the seriousness of the act. The remaining 11 patients (22%), four of them jumped from height, three expatriates and one Saudi and all of them sustained serious orthopedic injuries; three patients cut themselves, two cut wrists and one cut abdomen, three patients swallowed foreign objects (needles or razor blades), and one tried to strangulate himself.

The immediate reason precipitating the act and the motive or intention behind the act with the level of its seriousness are shown in Table 4. Serious act with a high risk of complete suicide was significantly associated more with male gender, older age, presence of previous attempt, and being expartriate. However, 44 patients (88%) denied any real suicidal motive behind their act, mostly on religious reasons. Even among the 9 patients who were rated by the psychiatrist as high risk suicidal patients, 7 of them denied having had any real intention of killing themselves on religious grounds.

Discussion:

Non-fatal DSH is as important as complete suicide, with which it is closely related. As many as 40-60% of suicides are the ultimate result of a series of previous DSH, and 10-14% of those who deliberately harm themselves eventually succeed in killing themselves through a subsequent act[11,12]. However, while national statistics on suicide are carefully collected and reported to WHO, such statistics are virtually absent worldwide on DSH[9]. Although numerous studies have been reported, however, on DSH from different countries the

reliability and validity of their results have to be cautiously conceived. This is due, partly, to the lack of well-defined operational criteria for what basically constitutes as DSH, but most importantly to the under reporting due to various socio-cultural and religious pressures[8,12].

In the developing countries, in addition to the aforementioned reasons, the lack of well-defined catchment areas for health services provision and the virtual absence of reliable record systems render the majority of studies on DSH seriously unreliable and misleading.

Notwithstanding these confounding factors, we still believe that a rate of only 55 patients among 47,754 patients in a period of nine months attending a busy A/E department in the largest general hospital in the city represents a very low rate compared to rates reported from the west and it is highly unlikely that rates of DSH will be any different among attendants of other hospitals in Jeddah city. We believe this low rate reflects a real difference in the incidence rate and may not be only an artifact of underreporting or failure of recognition. As it has been suggested before[13,14,9], we think this low rate among our series may be more likely due to religious reasons as most patients have indicated, as Islam categorically prohibits and condemns any sort of deliberate self mutilation. However, social factors which have been implicated in literature[15,14] may have become more relevant considering the rapidly changing social structure in Saudi Arabia and it's associated socio-economic strains.

Seven patients (77.8%) of the nine who were rated to have been seriously suicidal by the psychiatrist denied such intent despite their complete powerlessness and hopelessness mainly because of their religious faith. 35 patients of the rest (76.1%) also responded to a question of whether they would have really contemplated complete suicide when confronted with serious life events responded by complete denial, the reason being their religious prohibition.

Despite this comparatively low rate of DSH, the characteristic features of our patients did not differ significantly from those reported in the literature. In keeping with the majority of the studies[1,14], the most likely patient to deliberately harm self was a young single female with secondary education, not working and with limited outdoor activities. The most common immediate reason for the act among young females was an argument or a row with a parent or other dominant family member usually over a violation of a conventional social value or a religious taboo such as going out unveiled, talking on telephone to strangers or having a relationship with the opposite sex.

Motivation and real intention for the act in the majority of our patients (50.9%) was fond to be a part of an impulsive behavior without a clearly motivated intent in a context of long on-going intrafamilial discordance. Consistent with the international literature the most common method of DSH was self-poisoning but with few significant differences. The ratio between self-

poisoning and self-injury, which is reported in most of the recent studies to be 2:1[5] was found among our patients to be as high as almost 6:1. We speculate that this may be due to either that self injury is perceived as self mutilation that is religiously highly condemned or due to the strong social stigmatizing effect of DSH in this country which makes people tend to conceal such behaviors by self poisoning rather than self injury. On the other hand, violence breeds violence hence the general lack of violence in Saudi society, may partly explain why self injury-particularly self cutting-is rare among Saudis. This assumption may have some support from the differences that emerged between Saudi self-harmers and expatriates from the other neighboring Arab countries. Expatriates used more violent methods and constituted all cases of self-injury among our patients in this series except one. Although we are not able to give a substantiated explanation to this finding, due first to the small size of our sample and second to lack of knowledge of the pattern of DSH in their respective countries of origin, we believe that the difference is most likely due to the difference in the social pressures expatriates may be exposed to, though it may only reflect the prevailing pattern in their own countries. Drug preference, was the other significant difference. While paracetamole was the commonest drug used in western countries[15,16], ponstan (Mefenamic acid) was the substance used most frequently by our patients.

However, almost all patients who were rated by the psychiatrist to have been highly suicidal used substances other than ponstan, antidepressants, anticonvulsants, and the chemical detergents were the substances most frequently used by this group of patients, (Table 3). Ponstan was the drug of choice for the young attention seeking of impulsive patients. We think that the over prescription of ponstan in this country by the physicians as a pain killer in addition to its availability over the counter makes it easily accessible to self-harmers.

In conclusion though the DSH rates in developing countries may still be considerably low in comparison to those of the western countries, the current indication is that many of these countries are going to witness a sharp increase, in particular among the young generations. As Diekstra 1991[9] puts it the "dramatic changes in values and ways of life as a consequence of over-urbanization, a demographic explosion of young people and its concomitance of an underemployment, instability of traditional family structure and the seduction of substance will inevitably lead to a sharp rise in self-destructive behavior", in many of the developing countries, unless they empahsize the importance of maintaining their traditional family structure and strengthening of their religious affiliation.

الملخـــص

تهدف هذه الورقة دراسة نمط محاولات الانتحار في المملكة العربية السعودية التي تعتبر بلداً عربياً ذات جذور دينية عميقة. وتعتبر هذه الظاهرة التي يعبر عنها في البلدان الغربية على أنها وسيلة غير لفظية للاتصال نادرة في العالم العربي.

وقد خضع لهذه الدراسة جميع المرضى الذين يزورون أكبر مستشفى عام في جدة وقد قيم من قبل الطبيب النفسي جميع الحالات التي تتصف بإيذاء الذات.

وقد حول ٥٥ مريضاً شخصوا خلال فترة تسع شهور. وقد وجد أن الإناث عددهم ٤٥ (٨ر٨١٪) والذكور ٥ (٢ر١٨٪) كما وجد أن سن الذكور كان أكبر. ووجد أيضاً أن المرضى من غير السعوديين كانوا أكبر ومحاولات انتحارهم كانت أخطر.

وقد استنتج الباحث أنه رغم أن نسب محاولات الانتحار في البلاد العربية هي أقل، إلا أنها آخذة بالازدياد ما لم يلتزم الأفراد بعقائدهم الدينية والحفاظ على البنية الأسرية التقليدية.

References

1. Morgan, H.A., Pockok, H., and Pottle, S. (1975). The urban distribution of non-fatal deliberate self-harm. Br. J. 126, 312-28.
2. Hawton & Catalan 1987, Attempted suicide: A practical guide to its nature & management (2nd edn.) Oxford: Oxford University Press.
3. Farmer, R. (1986) Deliberate self-poisoning. Br. J. of Hospital Medicine, 36(6), 437-42.
4. Kreitman, N., and Casey, P. (1988) Repetition of parasuicide: and epidemiological and clinical study. Br. J. Pub. 153, 729-800.
5. Kreitman, N. (1990). Research issues in the epidemiological and public health aspects of parasuicide and suicide. In the public health impact of mental disorders, (eds. D. Goldberg and d. Tantarel) pp 73-82. Stuttgart: Hografe and Huber.
6. Dradkeh, T. K., El-Zayer, N., (1988) Parasuicide in Arab industrial community: The Arabian-American Oil Company experience, Saudi Arabia., Acta-Psychiatr-Scand. 1988 Jun; 77(6):707-11.
7. Mahgoub, O. M., Al-Fareih, H. M., Al-Mohaya, S. A. M., Al-Nahdi, N.S. (1990), Deliberate self-harm in the migrant population in the Eastern Province of Saudi Arabia., Saudi Medical Journal 11(6), No. 1990.
8. WHO (1987): World Health Statistic Annual. World Health Organization, Geneva.

9. Diekstra, R.F. W. (1991). Suicide and parasuicide: A global perspective. In current approaches, Suicide and attempted suicide (e. S. Montgomry and N. Goeting) pp. 1-23. Southampton, Duphar Laboratories ltd.
10. Azzam, H.T. (1995) Population and structure of labor force in the Gulf. At-Tejarah, Magazine, September, 95, 11-14.
11. Egmond, M. and Diekstra, R.F.W. (1989): The predictability of suicidal behavior. The results of a meta analysis of published studies. In Suicide prevention: The role of attitude and imitation, (eds. R.F. Diekstra, R. Moriss, S. Platt and others), Leider, The Netherlands Brill.
12. Diekstra, R.F.W., and Mortiz, B. (1987): Suicide behavior among adolescents, In: Suicide in adolescence. (eds.) R.F. Diekstra, K. Hawton), pp. 7-24, Dordzecht, Kluer Academic publishers.
13. Merrill, J., Owens, J. (1988) Self-poisoning among four immigrant groups. Act-Psychiatr-Scand. 1988 Jan; 77(1): 77-90.
14. McGibben, L.,: Ballard, C. G.,: Handy, S.,: Mohan, R. N.; Silveira, W.R. (1992), Deliberate self-poisoning in Asian and Caucasian 12-15 year-olds., Br. J. Psychiatry. 1992 Jul; 161:110-2.
15. Hawton & Fagg, 1992a, Trends in deliberate self poisoning and self-injury in Oxford, 1976-1989. Br. Medical Journal, 304, 1409-1411.
16. Ott P., DalHof, K. Hansen, P.B. et. al. (1990), Consumption, overdose and deaths from analgesics during the period of over-the counter availability of paracetamole in Denmark-Journal of Internal Medicine, 277, 423-428.

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Table 1: Distribution of Some Study Variables by Age Group and Sex

Age Group / Sex		< 16		16 - 25		26 - 40		41- 45	
		F	M	F	M	F	M	F	M
Reason for attempt	Att. Seek	1	0	6	1	0	0	0	0
	Impulsive	2	0	7	0	1	0	1	1
	A. Stress	2	0	13	1	3	0	0	0
	Psyc. Dis	1	0	5	0	2	6	1	1
Previous Attempt	Yes	0	0	14	1	1	1	1	0
	No	6	0	17	1	5	5	1	2
Method Used	Drug OD	6	0	24	2	3	3	2	1
	Wrist cut	0	0	0	0	1	1	0	1
	Throw FH	0	0	3	0	1	0	0	0
	Poison	0	0	1	0	1	1	0	0
	Hanging	0	0	0	0	0	1	0	0
	Others	0	0	3	0	0	0	0	0
Contemplation	Serious	1	0	7	1	2	5	1	1
	Impulsive	5	0	16	0	4	1	1	1
	Attention Seeking	0	0	8	1	0	0	0	0
	Total	**6**	**0**	**31**	**2**	**6**	**6**	**2**	**2**

Abbreviations:
Att : attention; A : acute; Pscy: psychiatric;
OD : overdose; FH : from height;

Table 2: Patient Demographics in Relation to Some Variables

Variable	Categories	Nationality			
		Saudi		Non Saudi	
		Male	Female	Male	Female
Age P < 0.05	< 16	0	5	0	1
	16 - 25	1	24	1	7
	26 40	3	2	3	4
	41 - 45	0	1	2	1
	Mean	29.7	20.8	34.3	25.5
	SD	5.4	6.3	8.5	8.6
Marital Status (P > 0.05)	Single	3	25	4	6
	Married Divorced	0	7	2	7
		1	0	0	0
Education (P > 0.05)	Illiterate + PRIM	1	2	2	2
	PREP + SEC	3	26	2	10
	Univ & Over	0	4	2	1
Method used (P > 0.05)	Drug OD	3	25	3	10
	Self cut	1	1	1	0
	Throw FH	0	2	0	2
	Poison	0	1	1	1
	Strangulation	0	0	1	0
	Others	0	3	0	0
Previous attempt	Yes	2	15	0	1
	No	2	17	6	12
Contemplation (P > 0.05)	Serious	3	6	4	5
	Impulsive	1	20	1	6
	Attention seeking	0	6	1	2

Table 3: Relationship Between the Method Used and the Seriousness of the Attempt to Self-Harm

Drug Group	Drug Type	Amount	Serious	Impulsive	Attention seeking	Total No. of cases
Analgesics	Ponstan	14- 28	1	4	6	11
	Panadole or Aspirin	20 - 40	2	2	2	6
Antidepressants	Tricyclics-Tofranil	30 - 50	4	1	0	5
Sedatives	Valium	15, 20, 25	1	2	0	3
Polydrugs	2-3 drugs	2- 50	2	4	0	6
Anticonvulsants	Phenytoin	35 - 40	2	2	0	4
Bronchodilators	Theophyllyin	15	0	2	0	2
	Aminophyllin	28				
Antihistaminics	Antihistamines	26 - 30	0	2	0	2
B blockers	Inderal	35	0	1	0	1
Hypoglycemics	Daonil	20	1	0	0	1
Chemical detergents	Clorox	-	2	1	0	3

Table 4: The Psychiatrist's Assessment of Seriousness of the Act

		Serious	Impulsive	Attention Seeking
Age Group	0 - 15	1 (16.7)	5 (83.3)	0 (0.0)
	16 - 25	8 (24.2)	16 (48.5)	9 (27.3)
	26 40	7 (58.3)	5 (41.7)	0 (0.0)
	> 40	2 (50.0)	2 (50.0)	0 (0.0)
Previous attempt	Yes	8 (44.4)	7 (38.9)	3 (16.7)
	No	10 (27.0)	21 (56.8)	6 (16.2)
Past history	Yes	10 (62.5)	5 (31.2)	1 (6.2)
	No	8 (21.1)	22 (57.8)	8 (21.1)
Reason for attempt	Cry for help	0 (0)	3 (37.5)	5 (62.5)
	Impulsive	2 (16.7)	10 (83.3)	0 (0)
	A stress	4 (21.1)	11 (57.8)	4 (21.1)
	Med. Dis	12 (75.0)	4 (25.0)	0 (0)

Abbreviations: A : Acute, Med Dis : Medical Disorder

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Parasuicide in the Klang Valley Marriages

Hussain H., Zafri A.

محاولات الانتحار عند المتزوجين في وادي كلانج - ماليزيا

حسين وظفرى

ABSTRACT

The following study was performed on 146 married couples who were admitted to University Hospital, Kuala Lumpur, due to parasuicide. Patients were mainly young females who were experiencing short term difficulties with either their marriages or extended families. Indians appear to be over represented, comprising of about 46.6% with Malays appearing to be slightly protected against parasuicide. Approximately 51% of the subjects chose overdosage of prescribed drugs while only 17.1% used physical harm. About 60% had been married for a duration exceeding ten years before they presented with attempted suicide and 60% had two or less children. Marriages were mainly based on love not arrangement.

Key notes: Parasuicide, marriages and Klang Valley.

Introduction

Several evidences showed that parasuicide are not uncommonly seen among married couples[1,3]. A recent study performed in Klang Valley on parasuicide also showed that married couples in this area are also at risk to this condition[4]. Since very little is known about this group of parasuicide patients, the main intention of this study is to determine factors which might contribute to their parasuicide tendencies.

This study is significant because there are some indications which showed that parasuicide is a growing problem in this area[5]. Furthermore, the impact of parasuicide is tremendous and can affect not only the individual involved but also other family members of the individual's family. In fact some of these impacts are not only short-term but can be long term also. For instance once a study showed that it can be a factor to make children of the parasuicide to be suicidal as well[6]. Therefore it is timely for clinicians to have more involved information concerning parasuicide among married couples so as to enable them to equip

themselves with some strategies to prevent and minimize parasuicide complications found among married couples.

Method

This study was carried out in the University Hospital, Kuala Lumpur. This hospital is situated in the Klang Valley area with a population of about two million. Three major races which inhabit this area are Chinese (46%), Malays (39%) and Indians (15%). Only patients who voluntarily agreed to participate in this study were selected. Interviews were performed only after the patients had recovered from their medical emergencies. The permission for the study was first granted from the University Hospital Ethical Committee before it was carried out. Semi-structured interview techniques were used for the purpose of this study. Variables analyzed in this study included sociodemographic data, methods use in the attempt, reasons for attempts and data on marital relationship.

Results

One hundred and forty-six married parasuicides were interviewed during a study period from January 1995 to January 1996. Out of the total 78.8% were female, the majority of which were in the age range of 20 to 40 years of age. Comparisons based on racial breakdown showed that Indians seem to be most affected and this is true in both genders (Table I).

Analysis on their marital relationships noted that about 87% were married over the age of nineteen years. About 60% had been married for more than ten years duration. Most of the patients were in their first marriages, with only 7% of the total having suffered failed marriages in the past. With regard to their types of marriages about 73% claimed that their marriages were based on love and only 25% said that their marriages were arranged. In relation to number of children 60% of them had two or less children, while only 3% had more than 6 children (Table II).

About 60% claimed that they had attempted suicide due to problems closely related to family crisis. From this 40% involved difficult relationships with their own spouses. The main outstanding problems were noted to be due to unfaithful husbands who have an extra marital relationship with another woman.

In both genders past historys of parasuicide are noted to be low, with only 23% of the total having a previous history of parasuicide.

The most common methods used in attempts of parasuicide were by the use of medications or poisons. Only 17% used physical methods like hanging or cutting their wrists with sharp objects (Table III).

Table I: Socio-Demographic Data of Parasuicide Couple

Socio-demographic variables	Female n = 115	Male n = 31	Total (%)
Racial Breakdown			
Indian	48	20	68 (46.6)
Chinese	46	8	54 (37.0)
Malays	20	3	23 (15.8)
Others	1	-	1 (0.7)
Age Breakdown			
21 and below	4	1	5 (3.4)
22 - 30	39	7	46 (31.5)
31 - 40	46	9	55 (37.7)
41 - 50	15	9	24 (16.4)
51 and above	11	5	16 (10.9)

Table II: Characteristic of Parasuicide Marriages

Marriages Character	Female n = 115	Male n = 31	Total n = 146
Age getting married			
18 and below	16	3	19 (13.0)
19 - 24	58	7	65 (44.5)
25 and below	41	21	62 (42.5)
Duration of marriage			
1 year and below	14	1	15 (10.3)
2 - 4	26	5	31 (21.2)
5 - 9	12	5	17 (11.6)
10 and above	63	20	83 (56.9)
No. of marriage			
1	111	25	136 (93.2)
2 and more time	4	6	10 (6 .8)
Type of marriage			
love	87	19	106 (72.6)
arranged	26	11	36 (25.3)
both	2	1	3 (2.1)
No. of children			
0 - 2	76	12	88 (60.3)
3 - 5	34	19	53 (36.3)
6 and above	5	0	5 (3.4)

Table III: Clinical Characteristics of Parasuicide Marriages

Clinical variables	Female n = 115	Male n = 31	Total (%) n = 146
Past h/o attempt	27	7	34 (23.3)
Reason to attempt			
Extra marital affairs	38	4	42 (28.8)
Underlying Psy. conditions	22	17	39 (26.7)
Problems due to other family members	19	3	22 (15.1)
Financial problems	10	6	16 (11.0)
Physical illnesses	10	1	11 (7.5)
Spouse abuse	16	-	16 (11.0)
Method used			
Overdose of drugs	67	7	74 (50.7)
Ingestion of poisons	28	16	44 (30.1)
Physical harm	18	7	25 (17.1)
Multiple methods	2	1	3 (2.1)

In relation to DSM III-R diagnosis 67% of cases were diagnosed as adjustment disorder. For those who have major psychiatric disorders 18% were major affective disorders and 8% were due to alcohol dependence syndrome (Table IV).

Table IV: Diagnosis of Parasuicide Marriages

Type of Diagnosis	Female n = 115	Male n = 31	Total (%) n = 146
Adjustment disorder	85	13	98 (67.1)
Major affective disorder	19	7	26 (17.8)
Alcohol dependent syndrome	1	11	12 (8.2)
Schizophrenia	8	0	8 (5.5)
Premenstrual tension	2	0	2 (1.4)

Discussion

This study confirms that the group involved in marital parasuicide are similar to non-marital parasuicide. They were mainly young females, and although Malays were the dominant race, comprising about 40% of the whole population with Indians only comprising about 15%, from this study and others as well it is found that Malays seem to be more protected against this conditions as compared to Indians which seem to be over represented[7, 8]. The differences in risks among races are probably guided by

cultural influences which are well known factors in modifying suicidal behavior among different races[9]. Furthermore Malays, who by religious background are Muslim, may be protected against this behaviour due to Islamic teaching which absolutely prohibits it.

There appeared to be some significant marital characteristics seen among those who attempted suicide. For instance the majority were those with a marriage exceeding more than ten years. This is probably due to an inability for young married couples to cope with either stress or certain problems in dealing with the demands of marital life, as well as the expectations from other family members. This may explain the findings of this study which show that sources of conflict are not only among couples but also involve other family members. Perhaps factors like underlying affective disorders may be another possible explanation, but as seen in this study only about 18% from the study sample were suffering from major affective disorders.

Another interesting finding in this study was in the number of children such couples have. What is obvious is that married parasuicide women were noted to have less than two children or none at all. Evidence from other studies of marriage and parasuicide have suggested that the number of children can act as protective factors against suicidal behaviour[10, 11].

Another probable reason may be due to the rapid development trend which has occurred during the last ten years in Klang Valley. This development trend has led to more women becoming independent and therefore have lost their traditional roles as housewives. Instead their time is spent having to work outside of the home. They therefore can no longer afford to have big families because this would mean having to take more time away from their work. To make matter worse the recent economic boom in Malaysia, especially in the Klang Valley districts, have brought about a shortage of domestic servants which in the past were needed to take care of a working mother's children and their families. Perhaps all these factors may explain why we found such a low number of children among those who were involved in parasuicide. However, this new (life) coping is not without cost. A conflict most probably does arise between the new way of life and the sense of loss of maternal and feminine characteristics outlined by traditional beliefs. Hence, this will further compound the way that the younger generations of Klang Valley will have to adjust with conflicts of development, some of which are known to precipitate parasuicide.

الملخـــــص

أجريت هذه الدراسة على ١٤٦ زوجاً أدخلوا لمستشفى الجامعة في كوالالامبور لمحاولات انتحارية. وكانت معظم العينة من الشابات اللواتي عانين من ضغوط نفسية حادة تتعلق بالزواج أو الاقارب. وقد كان العنصر الهندي ممثلاً بشكل زائد ٦ر٤٦٪ بينما كان الملاويين يمثلون نسباً أقل وقد كانت أداة المحاولة في ٥١٪ من العينة هي تناول جرعة زائدة من العقاقير. كما أن ١ر١٧٪ منهم كانت المحاولة عن طريقة إيذاء الذات. وقد كان ٦٠٪ من العينة متزوجين مدة عشر سنوات أو أكثر كما أن ٦٠٪ منهم لديهم طفلين أو أقل. كما أن الزواج تم عن طريق الحب وليس الزواج التقليدي.

References

1. Janik J; Kavitz HM; Linking work and domestic problem with police suicide. Suicide life threat behavior 1994 Fall; 24(3);267-74.
2. Mac Canley J; Kern DE, Kolodner K; Dill K; Schroeder AF; De Chant HK; Ryden J; Bass FB; Derogatis CR; "The battering syndrome": Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices: Ann Inter-Med 1995 Nov 15 123 (10): 737-46.
3. Smith JC, Mercy ZA; Conn JM; Marital status and risk of suicide. Am J Public Health 1988 Jan 78 (1): 78-80.
4. Hussain H; Ganesvaran T. Agnes LS: Attempted suicide in Kuala Lumpur. Asia-Pacific J of Public Health 1992/1993 Vol. 2: 5-7.
5. Hussain H; Study of eight years pattern of parasuicide admission to University Hospital Kuala Lumpur-not published.
6. Hussain H; Hmann NW. Family psychopathology and childhood experience of the parasuicide admitted to University Hospital, Kuala Lumpur. Ascan J Psychiatry 1994 April 4 (1); 9-16.
7. Yeoh H. Attempted suicide in Penang. Med. J. Malaysia 1981, 36:39-46.
8. Maniam T. Suicide and Parasuicide in Hill Resort in Malaysia. Br J Psychiatry 1988 153:222-5.

9. Fredrick DM. Suicide and the communication of race: across cultural case study. American J of Psychiatry 1968:125:197-205.
10. Veerers JE. Parenthood and suicide: an examination of a neglected variable. Soc. Sci. Med 1973;7:135-144.
11. Hoyer G, Lund E. Suicide among women related to number of children in marriage. Arch Gen Psychiatry 1993;50:134-137.

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(Clinical Observation)
Systemic Lupus Erythematosus Presenting with Psychosis

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ذئبة حمامية عامة تسبب ذهان

نظام أبو حجلة

ABSTRACT

A patient with SLE whose disease presented as psychosis is described. The case report shows the possibility of CNS involvement in the form of psychosis to be an early presentation of SLE.

Introduction

SLE is an inflammatory autoimmune disease that may affect multiple organ systems including the brain. Its clinical manifestations are thought to be secondary to the trapping of antigen-antibody complexes in capillaries of visceral structures.

This clinical course may vary from a mild episodic disorder to a rapidly fulminating fatal illness. Before making a diagnosis of spontaneous SLE it is imperative to ascertain that the condition has not been induced by a drug.

Many drugs are implicated but few cause the disorder with appreciable frequency and these include chlorpromazine.

Neurological involvement in SLE could be manifested by psychosis, seizures, organic brain syndrome, peripheral and cranial neuropathies, transverse meylelitis, and stroke.

Severe depression and psychosis are sometimes heightened by the administration of high doses of corticosteroids[1].

Case Report

Mr. I.F.H a 28 year old single male patient presented in October 1994 with dysphoric symptoms and he was shifting from anxiety to depression to agitation.

He attributed his condition to prolonged dissatisfaction with his job as accountant in a drug company.

He was put on a small dose of thioridazine. A few months later he became overtly psychotic with persecutory delusions-believing that his work mates are watching every move he makes and conspiring against him. He became very apprehensive, over-cautious and suspicious. He voiced bizarre

auditory hallucinations and later became agitated and hostile.

Haloperidol 20 mg BID and procyclidine 5 mg. TID were administered orally with good response. Haloperidol was tapered off to be maintained on 5 mg OD.

About 8 months later he relapsed into the same clinical picture and consequently lost his job. Haloperidol 10mg BID was readministered which gave a good response.

This was curtailed to be put on penfluridol (Semap) 20mg tab once a week.

He became so well that he got a job as financial manager of a company.

In May 1996 patient presented with chest pain and joint pains.

He was admitted to a hospital and found to have pericarditis. The rheumatologist diagnosed SLE on the following grounds.

1. Arthritis.
2. Pericarditis.
3. Thrombocytopenia.
4. Positive ANA 1:160.
5. Antibody to native DNA.
6. Nephritis[2].

Beside high ESR, a high CRP and elevated liver enzymes.

Patient was put on:

Prednisolone 60 mg OD.
Immuran 160 mg OD.
Chloroquine 100 mg OD.
Warfarin.

Patient so far remained in a state of remission. Psychological symptoms did not recur since he started on corticosteroids and he could cope well with a highly responsible job, without any psychotropic medication.

Discussion:

Two questions arise from this case:

1. Is it a drug induced SLE?
2. Is the psychosis a part of the SLE?

In answer to the first question, it can be said that it is very unlikely to be a drug induced SLE because the clinical features and most laboratory abnormalities did not revert to normal after withdrawing the psychotropic medication.

On the contrary the disease persisted relentlessly causing pleurisy, pleural effusion and later severe nephritis[3].

In answer to the second question, it can be said, most probably yes, because the psychosis subsided despite stopping psychotropic medication and with corticosteroid therapy patient's psychological status became better and went back to a normal social and occupational functioning.

الملخـــــــص

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references

1. Laurence M Tiery Jr., Stephen J. Mephee, Maxine A. Papadakis, Current Medical Diagnosis & Treatment. Thirty third edition, Prentice-Hall International.
2. Tan EM et al., The 1982 revised criteria for the classification of SLE, Arthritis Rheum 1982:25:1271.
3. Steinberg AD et al., Review of pathogenesis of SLE, Ann Intern Med.1991:115:548.

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15. Hurlock, E, (1981) child development. McGraw Hill series in psychology.
16. Holstein, C. (1976) irreversible step wise sequence in the development of moral judgment.
17. Kholber, L. (1981) Amoral Stages: A current Formultion & a response to critics. Human Development Vol.10.
18. Powers, S (1983) Family interaction & parental development.
19. Rest, J. (1979) Manual for the defining issues test Minnesota Moral research projects.
20. Sethi, A., Gupta P. (1984) moral judgment level & perceived maternal child, learning attitudes of boys & girls. Journal of Psychological researches, 28 (1) (Journal Abstract).

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المراجـــــع

١. اسـماعيل، عـزت (١٩٨٤)، جنـوح الاحداث، وكالة المطبوعات: الكويت.

٢. حباشنة، خديجة (١٩٩١) مستوى الحكم ومفهوم الذات لدى المرأة العاملة مقارنة بغير العاملة، رسالة ماجستير غير منشورة، الجامعة الاردنية، عمان، الاردن.

٣. حجاج، عبد الفتاح احمد (١٩٨٤) النمو الخلقي والتربية الخلقية، حولية كلية التربية، السنة الثانية.

٤. الخطيب، بلال عادل (١٩٨٨) توزيع طلبة الجامعة الاردنية على مراحل النمو الاخلاقي، رسالة ماجستير غير منشورة الجامعة الاردنية، عمان ، الاردن.

٥. الشيخ، سليمان الخضري (١٩٨٢) دراسة في التفكير الخلقي لدى المراهقين والراشدين، الكتاب السنوي في علم النفس.

٦. الهيئة المصرية للكتاب، القاهرة (١٢٣-١٥١).

٧. روبرت دي ب (١٩٧٧) في النظرية السلوكية: ما الذي يقوله ب.ف سكنر حقا (ترجمة جمال الخطيب (١٩٩١)، مكتبة الصفحات الذهبية، الرياض، السعودية).

٨. العواملة، ختام عبد الحليم (١٩٩٢) علاقة انماط الشخصية ومفهوم الذات والذكاء بجنوح الاحداث، دراسة ماجستير غير منشورة، الجامعة الاردنية، عمان، الاردن

٩. نصير راف (١٩٨١) النمو الاخلاقي وعلاقته بالذكاء والمستوى الثقافي للاسرة عند طلاب المرحلة الثانوية في الاردن، رسالة ماجستير غير منشورة، جامعة اليرموك، اربد، عمان.

10. Berk, L (1989) Child development. Allyn & Bacon. U.S.A.

11. Davison L., Robbins, S., Swason, D. (1978). Stage Structure in objective moral judgments. Developmental Psychology Status & I.Q on moral judgement. Dai

12. Gibbs, J. (1977). Kholbergs Stages of moral judgment, a constructive critique. Harvard Education.

13. Hamachelk, D. (1990). Psychology on teaching, Learning & growth Boston Allyn Bacon USA.

14. Hoffman, S. (1977) Intelligence & development of moral judgment in children. The journal of genetic Psychology 130,27-34.

جدول رقم (٣)

جدول تحليل التباين الثنائي لأثر العمر والمجموعة والتفاعل بينهما على علامة النمو الاخلاقي

مصدر التباين	مجموع المربعات	درجات الحرية	قيمة ف
العمر	٩٦٩ر٦٩	٥	١ر٠٨٢
المجموعة	١٢٢٤ر٨٢	١	٦ر٨٣٥*
العمر × المجموعة	٥٤٩ر١٧	٥	٠ر٦٠١٣
الخطأ	٤٣١٨٩ر٦٨	٢٤١	
المجموع الكلي	٤٥٩٥٠ر٦٦	٢٥٢	

* ذات دلالة عند (α = ٠ر٠١)

ABSTRACT

The study purpose was to find out how Jordanian delinquents and nondelinquents distribute among moral development stages according to "Kohlberg theory", and differences in moral development among them.

The sample consisted of (253) juveniles, of which (135) of them were nondelinquents public school pupils, and (118) delinquents residing in the "juvenile rehabilitation center" in Irbid, both groups were in the age group (13-18) year.

Defining issue test (DIT) in it's Arabic version was used to measure moral development stages. Study concluded a higher level of moral development in favor of nondelinquent juveniles.

Findings have not shown significant difference in degree of moral development due to age or interaction between juvenile group and age. The study findings and discussions supported pervious studies held around the theory, also called for further studies to establish Arabic, Jordanian moral development scales in future.

جدول رقم (١)

نسب توزيع الأحداث الجانحين وغير الجانحين على المراحل الاخلاقية

المرحلة الأخلاقية	الجانحين		غير الجانحين	
	عدد	نسبة	عدد	نسبة
١	-	-	-	-
٢	-	-	-	-
٣	٥٦	٤٧ر٥٪	٢٨	٢٠٥ر٧
٤	٣٨	٣٢ر٢٪	٧١	٥٢ر٦٪
٥	٢٤	٢٠ر٣٪	٣٦	٢٦ر٧٪
٦	-	-	-	-
المجموع	١١٨	١٠٠٪	١٣٥	١٠٠٪

جدول رقم (٢)

متوسطات علامات النمو الأخلاقي للأحداث (الجانحين وغير الجانحين) حسب المرحلة العمرية

المجموعة	العمر بالسنوات						الكلي
	١٣	١٤	١٥	١٦	١٧	١٨	
جانحين	٢٧ر٥	٢٨ر٧	٢٧ر٧	٢٥ر٨	٢٧ر٠١	٢٢ر٨	٢٦ر٨
غير جانحين	٣٢ر٥	٣٤ر٦	٣٠ر٥	٢٦ر٠١	٣١ر٩	٣٣ر٥	٣١ر٣
الكلي	٢٩ر٨	٣١ر٧	٢٩ر١	٢٥ر٩	٢٩ر٥	٢٨ر٦	٢٩ر٠٥

بدايتها الى نهايتها، وهي مرحلة انتقالية من فترة الطفولة الى مرحلة الرشد ومن الصعوبة التمييز بين المراهقين بفترات معينة متقاربة وفهم هذه المرحلة يكون من خلال التعامل معها باعتبارها وحدة واحدة، لا كأجزاء كما أشارت دراسة دافيسن (Davison et al 1978).

يلاحظ أن أقل درجات النمو الأخلاقي عند مجتمعين كانت العمر (١٦) سنة، وقد يفسر ذلك بأن هذه المرحلة العمرية تتفرد بخصائص ومميزات معينة إذ يتعرض الفرد خلالها لأزمات نفسية لتحقيق الهوية الشخصية وتحديد اتجاه حياته، ومن المتوقع أن يعطي المراهق الأهمية لذاته ومصالحه مقابل مصالح الجماعة وهنا تنخفض العلامة الكلية للنمو الأخلاقي عند هذه السن (Gibbs 1977) .

ويلاحظ أن الدراسة اقتصرت على الإناث، وذلك لأن أعداد الفتيات نزيلات مراكز الإصلاح قليلة (يقدر بسبع فتيات)، إضافة الى الضوابط الاجتماعية والأمنية المعيقة، وعلى ضوء النتائج المقدمة.

توصي الدراسة :

١. العمل على تطوير الطرق التربوية المتبعة في بيئة الفرد سواء ضمن الأسرة أو المدرسة أو المجتمع الكبير لتحقيق نمو أخلاقي افضل بتشجيع الحوار بين السلطة والفرد مثلا.

٢. الاهتمام بالأحداث الجانحين، والعمل على إعادة تأهيلهم للمجتمع، ووضع برامج إصلاحية وتقديم النماذج الأخلاقية كقدوة حسنة لهم.

٣. التشجيع على إجراء دراسات تكشف الفروق بين الجانحين والجانحات في مستوى النمو الأخلاقي، ودراسات للفئات الخاصة في المجتمع.

٤. العمل على تطوير أدوات قياس أخرى للنمو الأخلاقي بدراسات عربية وأردنية.

إضافة الى المستوى الاقتصادي والثقافي، كما أن طبيعة العلاقات التي يقيمها الفرد في أثناء تفاعله الاجتماعي سواء في المدرسة أو الجيرة أو الرفاق (الشلة)، والذي يتأثر بها لحد كبير، هذه العوامل وأخرى تفسر أسباب التباين في النمو الأخلاقي بين الجانحين والأسوياء (Fleishman 1973)٠

ان نضج الفرد وبالتالي سلوكه المستقبلي يعتمد بشكل واضح على الأسرة التي يعيش بها، فالأسرة ذات الصراع والتفكك العائلي واللامبالاة، ونمط التسلط والرفض، والنبذ والعدوانية نحو الأطفال تفرز تنشئة مرضية تشجع الفرد على استعمال مراحل أخلاقية غير متقدمة، هدفها جلب الرضى من المحيط (Sethi & Gupta 1984) ٠

من ناحية أخرى تشير الدراسات أن الأحداث الجانحين أقل ذكاء من الأحداث الأسوياء (عواملة، ١٩٩٢) والذكاء عامل مهم مؤثر في نمو الفرد النفسي والأخلاقي حيث يقود الذكاء الى تكيف أكبر مع البيئة، ومنها الامتثال الى القوانين الاجتماعية، وقد أشار نصير (١٩٨١) الى ارتباط الذكاء بعلامة إيجابية قوية بمستوى النمو الاخلاقي٠

وفي ضوء نظرية التعلم بالتقليد السلوكي يمكن تفسير تدني مستوى النمو الأخلاقي عند الأحداث الجانحين عن طريق تقليد النماذج في بيئتهم، ففي البداية يكون النموذج متمثلاً في الوالدين المتميزين بصفات أخلاقية سيئة من الإدمان، والكذب، والعدوانية، والشذوذ وعدم احترام القوانين، وكذلك في الأقران ورفاق السوء، وبخاصة إذا عزز سلوك هذه النماذج فيتجه الفرد الى تقليد النموذج السيء، وبالمقابل فالعكس صحيح بالنسبة لنمو الأحداث الأسوياء في بيئة صالحة تحقق مصالحها بتوازن مع قيم المجتمع وقوانينه (روبرت، ١٩٧٧) ٠

أما بالنسبة لعمر الحدث فلم تظهر النتائج له أثرا على درجة النمو الأخلاقي، وقد تعزى هذه النتيجة الى الفئة العمرية التي مثلت مجتمع الدراسة (١٣-١٨) عاما وهذه المراحل العمرية لا تسمح بقدر كبير من التباين في المستويات الأخلاقية، وقد تتقارب السمات والخصائص بين أفراد يختلفون عن بعضهم ببضع سنوات، بالإضافة الى أن هذه الفئة تمثل مرحلة محددة من مراحل النمو الفسيولوجي والنفسي، وهي مرحلة المراهقة، والمتميزة بخصائص معينة منذ

معـايير المجتمـع وتطـرق الـى مثـل هـذا (Holestein 1976) .

تـوزع معظـم الأحـداث الجـانحين علـى المرحلـة الأخلاقيـة الثالثـة فهـم يسـتخدمون تفكير هذه المرحلـة (الولد الطيب- البنـت الطيبـة) ويكـون سـلوكهم مبينـا علـى أسـاس قبـول واستحسـان المحيطين بهـم لإعطـاء فكرة طيبة تتبع من التناسق ما بين السلوك الـذي يحتذونـه ومعـايير المجتمـع والالـتزام الأخلاق، وهي مرحلة تبرز نوعية استعداد شخصية الفرد حيث أن الحكم الـذي يصـدره يمثل وجهة نظر شخصية مستقلة لكنها نابعة من قيم اتفق عليها في المجتمع، ان مثل هذه الذاتيـة والاسـتقلالية والاتـزان فـي بنـاء الاتجاهات والقيم تحتـاج الـى عوامـل ذاتيـة وبيئية سليمة تعتبر أساساً، وهذا الذي يفتقر إليه كثير من الأحداث الجانحين الذين جنحوا أصـلا لعوامـل بيئيـة واسـتعدادات شـخصية أدت الـى تكويـن أحكـام أخلاقيـة أكـثر تـأثرا بالغير وأقل استقلالية، وهـم أقـل قـدرة علـى التكيف والتفاعل الاجتماعي، فسلوكهم يمتـاز بالعدوانيـة والعزلـة والانطـواء والرفـض للتفاعل الاجتماعي، وذلك لتمركزهم حول ذاتهم مما يؤدي الى بطء النمو الـذي يسـبب نحوه، ربما يكون تفكير الحـدث الجـانح أبسط من تفكير نظيره السوي وأقل قدرة وذكـاء، وقـد يكـون سـلوكه موجهـا مـن المحيطين، وليس ذاتيا من ضميره، ولذلك فـان مـن المتوقـع أن يكـون عـدد الأحـداث الجانحين في المرحلة الثالثـة أكـثر مـن عـدد الأحداث الأسوياء.

في المرحلة الأخلاقية الخامسة، وهي الأكثر استخداما لدى الأحداث الأسوياء في حكم عدم القدرة على اسـتيعاب مصـالح الآخرين بتناسـق مـع وجهـة نظرهـم، وهـذه نظـرة أبرزها (Powers 1983) في دراسته.

أما فيما يتعلق بنتائج الفروق بين الأحداث الجـانحين والأسـوياء فـي درجـة نموهـم الأخلاقي:

فلقـد ظهـر فـي الدراسـة أن الفـرق بيـن الأحداث في الدرجـة الكلية للنمو الأخلاقي يعزى لمجموعـة الحـدث ولصـالح الأحـداث غير الجانحين.

وقد تفسر هذه النتيجة من عدة أبعـاد، حيث يتناسق النمو الأخلاقي مع النمو الاجتماعي والمتـأثر بعوامـل أهمهـا شـخصية الفـرد وقدراتـه وميولـه ضمـن البيئـة المحيطـة والأسرة التي تقوم بتربيته بأسلوبها الخاص

المناقشة والتوصيات

مناقشة النتائج المتعلقة بتوزيع الأحداث الجانحين وغير الجانحين على المراحل الأخلاقية: توزع جميع الأحداث على المراحل الأخلاقية الثالثة والرابعة والخامسة. ولم يكن أي منهم ضمن المرحلة الأخلاقية الأولى، أو الثانية، أو السادسة، ولعل هذه النتيجة تأتي مطابقة للإطار النظري وفق نظرية كولبرج في النمو الأخلاقي، إذ استندت نظريته على المراحل العقلية التي تشكل النمو المعرفي عند بياجيه، فهناك توازن ما بين المراحل الأخلاقية عند الفرد، وبين مراحل نموه العقلي والتي بدورها تعتمد على عمر الفرد الزمني ولهذا فان الفرد الأكبر عمرا يكون اكثر تقدما في مرحلته العقلية، وهو الأقدر على استخدام مرحلة حكم أخلاقي ذات مستوى أعلى، إن المرحلة الأولى والثانية من مراحل النمو الأخلاقي تتضمن تفكيرا بسيطا للحكم على المواقف والمعضلات الأخلاقية التي تواجه الطفل، والتي يمكن أن يستخدمها أطفال اصغر عمرا من فئة الأعمار التي تناولها مجتمع الدراسة، أما بالنسبة للمرحلة الأخلاقية السادسة فتعتبر ذروة النمو الأخلاقي عند الفرد، ولا يصل الى هذه المرحلة إلا القليل من الأفراد الذين يؤمنون بمبادئ وقيم مميزه تجعلهم يحكمون على المشكلة الأخلاقية من خلال إيمانهم بحقوق الإنسان وكرامته، وغالبا يكون سنهم ما بعد الخامسة والعشرين، وهذا ما لا يتفق مع عمر فئة الدراسة، إضافة الى ذلك، فان الحدث موضوع الدراسة كان اما طالب مدرسة لا يزال في طور تكوين مبدأ محدد لذاته ويتوافق مع معايير مجتمعه وعامله الأكبر أنه حدث جانح ذو شخصية غير سوية وذو خلفية اجتماعية وأخلاقية متدنية أبطأت في نموه الاجتماعي والأخلاقي كما أيد ذلك (Davison 1978) في دراسته.

لقد كانت هنالك فروق دالة إحصائية على مستوى (٠,٠٠١) في توزيع الأحداث على المراحل الأخلاقية، إن تلك الفروق في نسب الأحداث على المراحل الأخلاقية ربما تعود الى العوامل المكونة لشخصية الحدث فتجعله سويا أو منحرفا، وقد تفسر أيضا بطبيعة المراحل الأخلاقية وخصائصها مع مدى التشجيع أو عدمه من البيئة لاستخدام مرحلة ما للحكم الأخلاقي، ليتناسق مع

ولقد استخدم اختبار كاي تربيع ($\chi 2$) وتبين انه يساوي (٢٠ر٦٨) وهي قيمة دالة إحصائيا على مستوى (٠ر٠٠١) وهي ذات دلالة لمعرفة الفروق في توزيع الأحداث الجانحين وغير الجانحين على المراحل الستة، ويتضح أن غالبية الأحداث الجانحين يحتلون على التوالي المرحلة الثالثة فالرابعة فالخامسة بالتتالي، بينما يتوزع الأحداث الأسوياء على المراحل الأخلاقية الرابعة فالخامسة فالثالثة.

ما هي الفروق في الدرجة الكلية للنمو الأخلاقي للأحداث التي تعزى للعمر (١٣-١٨) أو لمجموعة الأحداث (جانحين/غير جانحين) أو الى التفاعل بينهما؟ الجدول رقم (٢) يبين أن المتوسط الحسابي الكلي لعلامات النمو الأخلاقي للأحداث غير الجانحين (٣٠ر٣١) وهو أعلى مما هو عليه في الأحداث الجانحين (٨ر٢٦)، مما يؤكد المستوى المتقدم في النضج الأخلاقي للأحداث غير الجانحين بالمقارنة مع أمثالهم من الجانحين، وعند حساب المتوسط الحسابي لعلامات النمو الأخلاقي لكلا المجموعتين ولكل مرحلة عمرية يتضح أن المتوسط الحسابي عند الأحداث غير الجانحين أعلى مما هو عليه عند الأحداث الجانحين في كل المراحل العمرية.

ولقد اتضح أن أعلى درجات النمو الأخلاقي للأحداث عامة كانت المرحلة العمرية (١٤) عاما وتساوي (٧ر٣١) وأقل درجات النمو الأخلاقي (٩ر٢٥) كانت في المرحلة العمرية (١٦).

أما فيما يتعلق بالفروق في علامات النمو الأخلاقي الكلية للأحداث حسب مجموعة الحدث (جانح/غير جانح) وحسب المراحل العمرية أو التفاعل بينهما، فان تحليل التباين الثنائي (٢×٦) لمتغيرات العمر وعلى مستويات عمرية من (١٣-١٨) ومتغير المجموعة (جانح/غير جانح) قد وضح أن مستوى النمو الأخلاقي العام للأحداث الجانحين هو أقل مما هو عليه عند الأحداث غير الجانحين جدول رقم (٣)، وأنه لا يوجد تأثير ذو دلالة إحصائية لعمر الحدث على العلامة الكلية للنمو الأخلاقي أو للتفاعل بين العمر ومجموعة الحدث.

إن النتائج تؤكد على أن الفروق في درجة النمو الأخلاقي بين الأعمار (١٣-١٨) والموضحة في الجدول (٣) ليست بمستوى الدلالة الاحصائية.

إجراءات الدراسة والتحليل الإحصائي:

طبق الاختبار على أفراد العينة الأسوياء بشكل جماعي حيث كانت توضح لهم الأسئلة والهدف من الدراسة. وبعد ساعة واحدة يجمع الاختبار من الطلبة، أما بالنسبة للأحداث الجانحين فقد كانت هنالك بعض الصعوبات عند التطبيق ناتجة عن اللامبالاة أو عدم الإلمام بالقراءة والكتابة مما اضطر مطبقي الاختبار الى التعامل معهم وفق مجموعات، فالمجموعة التي لا تقرأ كان يقدم لها الاختبار بشكل فردي ويشرح لها كل سؤال على حدة، ثم تسجل الاستجابة، عند الانتهاء من تطبيق الاختبار تصنف الأحداث حسب العمر والمجموعة.

أما بالنسبة للتحليل الإحصائي، فلقد استخرجت النسب المئوية للأفراد ضمن المراحل، وتم استخراج العلامة الكلية للنمو الأخلاقي لكل فرد، كما استخرجت كاي تربيع (2χ) لمعرفة الفروق في توزيع الأحداث الجانحين والأسوياء على المراحل الأخلاقية، كما استخدم تحليل التباين الثنائي (٢×٦) لمعرفة الفروق الكلية للنمو الأخلاقي بين الأحداث الجانحين وغير الجانحين، وحسب تباين مستويات العمر الستة من عمر (١٣-١٨) عاما.

نتائج الدراسة

- بعد تطبيق اختبار (Dit) وتصحيحه استخلصت نتائج تمحورت حول الإجابة على أسئلة الدراسة.
- هل يوجد فروق في توزيع الأحداث الجانحين وغير الجانحين على المراحل الأخلاقية؟

الجدول رقم (١) يبين أن الأحداث الجانحين توزعوا على المراحل الثالثة والرابعة والخامسة ولم يقع أي منهم في المراحل الأولى أو الثانية أو السادسة، بل أن ٥ر٤٧٪ من الأحداث الجانحين كانوا يستخدمون تفكير المرحلة الثالثة بينما وقع ٢ر٣٢٪ منهم ضمن المرحلة الرابعة للنمو الأخلاقي وكان ٣ر٢٠٪ من الأحداث ضمن المرحلة الأخلاقية الخامسة.

أما ما يخص الأحداث غير الجانحين فقد توزعوا كالتالي: ٦ر٥٢٪ منهم على المرحلة الرابعة و ٧ر٢٦٪ على المرحلة الأخلاقية الخامسة و ٧ر٢٠٪ ضمن المرحلة الأخلاقية الثالثة.

١٩٧٤ وهو ما يعرف باختبار تحديد القضايا، وهو اختبار موضوعي يقيس النمو الأخلاقي عند الأفراد الذين تزيد أعمارهم عن ثلاثة عشر سنة (Rest 1979) ٠يعطي المقياس علامة كلية للنمو الأخلاقي للفرد كما يحدد المرحلة التي يكون بها الفرد، وهو اختبار جماعي، يمكن تطبيقه لفترة زمنية لا تتجاوز الستين دقيقة، ويتكون الاختبار في صورته الأصلية من ست قصص تعبر عن مشكلات أخلاقية تعرض القصص على المفحوص ضمن استبانته ويطلب من المفحوص أن يتخيل نفسه مكان بطل القصة ليقدر أهمية اثني عشر سؤالا يتبع كل قصة لاتخاذ قرار ما لحل المشكلة الأخلاقية من خلال تدرج حماسي يبدأ من سؤال عظيم الأهمية وبعد أن ينتهي المفحوص، عليه أن يختار أهم أربعة أسئلة من وجهة نظره ويرتبها تنازليا وفق أهميتها على النحو التالي: السؤال الأول في أهميته ثم سؤال في الدرجة الثانية، فالثالثة، فالرابعة حيث أن اختيار المفحوص لأسئلة معينة تعكس مرحلته الاخلاقية٠

قام نصير (١٩٨١) بترجمته الى العربية وتقنينه كي يصبح مناسبا للبيئة الأردنية، وفي الدراسة الحالية استخدم اختبار (Dit) المعدل للبيئة الأردنية وبصورته القصيرة أو المختصرة (Short form) والمكونة من ثلاث قصص وبنفس التعليمات والأسئلة وصيغة التقدير والاختيار للأسئلة الأربعة المهمة بعد الترجمة والتقنين٠

صدق الأداه

يرتكز صدق اختبار (Dit) بصورته الأصلية على عدة دراسات، ووجد معامل صدق تلازمي مقداره (٦٨ر٠) بين اختبار (Dit) وأربع قصص من اختبار كولبرج، كما وتمتع الاختبار بصورته المعدلة أيضا بدلالات صدق منطقي بعد عرضه على عدة محكمين يمثلون الهيئة التدريسية في علم النفس في الجامعة الأردنية وجامعة اليرموك (خطيب ١٩٨٨، حباشنة ١٩٩١)٠

ثبات الأداه

هناك معاملات ثبات عالية لاختبار (Dit)، ففي مصر وجد الشيخ (١٩٨٥) أن معامل ثبات الاختبار قد بلغ (٨١ر٠) وفي الأردن وجد نصير (١٩٨١) أن معامل الثبات يساوي (٧٤ر٠) بواسطة إعادة الاختبار٠

توزيعهم على المراحل الأخلاقية حسب نظرية كولبرج، لذا هدفت الدراسة الى تعرف النمو الأخلاقي لدى هاتين الفئتين في الأردن وتوزعهما على المراحل الأخلاقية حسب النظرية المرجعية المذكورة مستخدمة مقياسا معربا ومقننا لتحقيق غاياتها.

الطريقة والإجراءات

حاولت الدراسة الإجابة على الأسئلة التالية :

- هل توجد فروق في توزيع الأحداث (الجانحين وغير الجانحين) في الأردن الى مراحل النمو الأخلاقي كما حددها كولبرج؟
- هل توجد فروق في درجة النمو الأخلاقي للأحداث تعزى لمجموعة (جانح / غير جانح) أو للعمر (١٣-١٨) عاما أو للتفاعل بين المجموعة العمريه؟

١٨) عاما كما هو الحال لأعمار الأحداث الأسوياء، وبهذا تكون العينة شاملة للمجتمع الأصلي بكافة أفراده الجانحين، وكما تكونت العينة أيضا من (١٥٠) حدثا سويا من طلبة المدارس الحكومية للذكور ممن تترامح أعمارهم بين (١٣-١٨) عاما وقد تم اختبار خمس مدارس ضمن محافظة اربد واختيار شعبة من كل مدرسة، وهكذا تكون العينة عشوائية عنقودية للأحداث الأسوياء.

مجتمع الدراسة

يتكون مجتمع الدراسة من الأحداث الذكور الجانحين المحكومين في الأردن حيث يوجدون جميعا في مركز "محمد بن القاسم الثقفي" لإصلاح وتأهيل الأحداث في اربد ويبلغ عددهم (١٣٥) حدثا، كما يتكون من الأحداث الذكور الأسوياء من طلبة المدارس الحكومية ضمن الصفوف التالية: الثامن، التاسع، العاشر، الأول الثانوي، الثاني الثانوي، في محافظة اربد، ويقدر عددهم ب (٨٧٦٠) حدثا، شملت العينة المبدئية للدراسة (١٨٥) حدثا من الأحداث الجانحين والأسوياء بحث كان هنالك (١٣٥) حدثا من الجانحين المحكومين من كافة مناطق المملكة وممن تتراوح أعمارهم بين (١٣-١٨) استثنيت إجابات (٣٢) فردا من أفراد العينة الكلية لعدة أسباب منها عدم إكمال المفحوص للاختبار، أو لأسباب خاصة بالمقياس وتعليماته، ولهذا فالعينة العملية تكونت من (٢٥٣) حدثا، (١١٨) جانحاً و (١٣٥) سوياً.

أداة الدراسة

استخدم في هذه الدراسة مقياس النمو الأخلاقي الذي صممه رست (Rest) عام

١. مرحلة المحافظة على الذات: والسلوك الأخلاقي هنا يتجسد في طاعة الطفل لأوامر السلطة المتمثلة بالوالدين.

٢. مرحلة المحافظة على الذات تبادليا: وتظهر هذه المرحلة تقدما يتجلى في أن السلوك يحقق المصلحة الذاتية ويتعاون في تحقيق مصالح الاخرين.

٣. المحافظة على العلاقات الشخصية: والتعاون هنا يتم بلعب دور تبادلي يجعل العلاقة تستقر وتدوم طويلا.

٤. المحافظة على كيان المجتمع: القانون هنا يتمتع بالعمومية ويطبق دون تمييز ولكل فرد دوره ومركزه والذي من خلاله تتحقق مصلحة المجتمع.

٥. المحافظة على كيان الأفراد باعتبارهم بشراً داخل المجتمع: أساس هذه المرحلة هو بناء قوانين تعكس إرادة الأفراد مع إعطاء الفرصة للتعبير عن الرغبة وينشأ التوازن إذا حققت هذه القوانين حقوق معينة لكافة الأفراد مثل الحق في الحياة والحرية والسيادة.

٦. المحافظة على كيان الإنسان في كل زمان ومكان: وهي مرحلة مثالية للعدل، وتسود عند قلة من أفراد المجتمع (كالفلاسفة مثلا) والعدل ليس مطلقا لكل زمان ومكان ويحصل التوازن إذا قضي على عوامل التمييز بين الافراد.

أثارت نظرية كولبرج اهتمام عدد من العلماء الذين حاولوا دراسة أبعاد متنوعة وعلاقاتها مع النمو الأخلاقي أمثال جبس (Gibbs 1977) حيث درس الثقافة وتأثيرها ووضح التطور المتصاعد للنمو الأخلاقي مع العمر في مختلف أنواع الثقافة، أما دافيسن (Davison 1978) فقد طبق اختبار (Dit) ودعم صحة نظرية كولبرج، ودرس فليشمان (Flishman 1971) تأثير المستوى الاقتصادي على النمو الاخلاقي ووجد الفرق الايجابي لصالح الافراد ذوي الدخل المتوسط، أما سيثي وجوبتا (Sethi & Gupta) فلقد دلت دراستهما على العلاقة الايجابية بين التنشئة الاسرية المتقلبة ومحبة الأطفال، وبين النمو الاخلاقي، كما ايدتها دراسة أخرى وهي دراسة ايزنبرج - برج وباول Eiesenberg - Berg & poul 1978 .

على الرغم من الأهمية الواضحة لموضوع النمو الأخلاقي فلم تتم دراسة الأحداث الجانحين بالمقارنة مع غير الجانحين في

والقاعدة، ويتكون هذا المستوى من مرحلتين هما :

١- مرحلة الولد الطيب - البنت الطيبة The Good byo-Good girt Stage

يبني السلوك هنا على توقعات الآخرين، فالمهم هو إعطاء السلوك الطيب والمتوقع منه، ويهدف السلوك الى إقامة علاقات متبادلة بين الفرد والمحيطين بتقدير مشاعرهم.

٢- مرحلة النظام الاجتماعي والضمير Social System & Conscious Stage

يهدف السلوك هنا الى المحافظة على النظام الاجتماعي، والحكم الأخلاقي يكون قائما على أساس مقدار تنفيذ الفرد للواجبات تجاه المجتمع وقوانينه باعتبارها أولوية وقبل المصالح الذاتية.

ج- ثالثا، المستوى بعد التقليدي (ما يعد العرف والقانون) Post Conventional Level .

وهنا يكون العرف والقانون أساس القيم والمبادئ الأخلاقية، والحكم الأخلاقي الصادر ضمن هذه المرحلة يكون بناء على المبادئ وليس طبقا للأعراف السائدة، وهذا المستوى يتكون من مرحلتين، مرحلة العقد الاجتماعي Social Contract Stage وهنا يحكم الفرد على السلوك من خلال وعيه بنسبية آرائه الشخصية. وان التقيد بالمعايير العامة للمجتمع يعتبر قيمة عامة تم الاتفاق عليها مثل الحرية والكرامة وأما المرحلة الأخرى فهي مرحلة المبادئ الأخلاقية العالمية The Universal ethical principal stage وهذه مرحلة الذروة في النمو الأخلاقي وتتمثل في المبادئ الأخلاقية النابعة من الضمير وهي شاملة وعامة وتستند الى المنطق ويقر بها البشر كافة.

أما وجهة نظر جيمس رست في النمو الأخلاقي فلقد انطلقت من نظرية كولبرج، وقد استطاع رست بناء مقياس يعرف باختبار تحديد القضايا (DIT) The defining issue test حيث استخدم نفس القصص الافتراضية التي استخدمها كولبرج، لكنه اختلف عنه في طريقته بالتقييم، فهو يضع أسئلة محددة، ويطلب من المفحوص أن يجيب عليها (Rest, 1973) ولدى رست منظور جديد بالنسبة الى مراحل النمو الأخلاقي، فهي ستة مراحل:

الأخلاقي إذ أنه يعتقد بأن النمو الأخلاقي يعتمد على التعقل الأخلاقي، والذي يعتمد على النمو المعرفي. ومن ثم فان أي حكم أخلاقي يصدر عن الفرد لا بد وأن يتناسب مع مرحلته المعرفية، وهنا يرى التوازن بين مرحلة الفرد في نمو المعرفي، وبين حكمه الأخلاقي (Berk, 1989) .

ولقد توصل كولبرج (Kohlberg, 1976) الى تحديث ثلاثة مستويات للنمو الأخلاقي بحيث يتكون كل مستوى من مرحلتين وعلى النحو التالي:

أ- **أولا**، المستوى ما قبل التقليدي (ما قبل العرف والقانون) Preconventional Level يقع ضمن هذا المستوى معظم الأطفال دون سن التاسعة وعدد قليل من المراهقين وقلة من ذوي السلوك المنحرف، والأخلاق هنا تقوم على أساس نتائج الفعل بالنسبة للتعزيز أو العقاب، وتكون طاعة الطفل لقوانين السلطة ناتجة عن الاعتقاد بأن القوة الجسدية للكبار قادرة على إجبارهم على القيام بالسلوك ويحتوي هذا السلوك على مرحلتين:

١- مرحلة العقاب والطاعة The Punishment & Obedience Stage يتمركز الطفل حول ذاته في هذه المرحلة، ويتجنب كسر القواعد، ويطيع السلطة خشية العقاب وتركز هذه المرحلة على الناحية المادية للحدث.

٢- مرحلة الفردية والهدف الوسيلي والتبادل Individualism, Instrumental Purpose & Exchange Stage .

يتبع الطفل القواعد إذا اتفقت مع مصالحه في هذه المرحلة، ويبدأ بالابتعاد عن التمركز حول الذات آخذا مصالح الآخرين بالاعتبار.

ب- ثانيا، المستوى التقليدي (العرف والقانون) Conventional Level .

يقع ضمن هذا المستوى معظم المراهقين والراشدين في أي مجتمع، ويعني العرف والقانون في هذا المستوى أن الفرد يتمسك بقواعد المجتمع وتقاليده لأنها بمثابة العرف

السلوك المتسق مع المعايير الاجتماعية السائدة، بحيث لا يكون شاذا أو غريبا بين الجماعة على أن يكون سلوكا إراديا ونابعا من ذات الفرد وقائما على اعتبار مصالح الآخرين عند تحقيق الحاجات الشخصية (Hurlock 1981) ٠

يختلف تعريف النمو الأخلاقي باختلاف وجهة نظر المدرسة النفسية في تفسيره، إلا أن جميعها تتفق على أن النمو الأخلاقي عبارة عن 'مجموعة من التغيرات التي تطرأ على الحكم الأخلاقي للفرد في أثناء فتر نموه' (حجاج، ١٩٨٤) ٠

هنالك عوامل عدة تؤثر في النمو الأخلاقي منها ما هو بيئي يتعلق بالتنشئة الاجتماعية والمستوى الاقتصادي، ومنها ما هو شخصي ذاتي كالنضج والقدرات والاتجاهات ومدى التكيف الاجتماعي بالإضافة الى عوامل شخصية أخرى كمفهومه عن ذاته وذكائه والقدرة على التفاعل من الاخرين٠

لقد فسرت مدارس علم النفس المختلفة النمو الأخلاقي حسب وجهات نظرها واتجاهاتها، ولقد ركزت الدراسة على الاتجاه المعرفي التطوري بالإضافة الى النظريات الحديثة الأخرى مثل نظرية كولبرج ورست واللتين تعتبران الإطار المرجعي للدراسة٠

يرى جان بياجيه صاحب نظرية الاتجاه المعرفي أن النمو الأخلاقي هو جزء من النمو المعرفي لدى الفرد، ويؤكد على عملية المعرفة الناتجة عن إدراك البيئة والتي تتم نتيجة تفاعل العضوية مع الخبرات السابقة لملاءمة الخبرات الجديدة، فالعضوية لها نزعة ترتيب وتنظيم العمليات في بنى متناسقة ومتكاملة بهدف التكيف مع البيئة وقد أكد بياجيه على عملية التوازن (Equilibration) والتي تشتمل على عمليتين متكاملتين، وهما عملية التمثيل (Assimilation) أي القدرة على دمج ما هو خارجي في النظام المعرفي الموجود، والعملية الأخرى هي المواءمة (Accommodation) وهي النزعة الى تعديل النظام المعرفي الموجود للتمكن من مواجهة العالم الخارجي (Hamachek, 1990) ٠

ويرى لورنس كولبرج بأن نظريات بياجيه المعرفية تعتبر أساسا لنظريته في النمو

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Level of Moral Development Among Juvenile Delinquents and Non Delinquents in Jordan

Shahnaz Nayef Al-Hmoud, Adnan Utum

مستوى النضج الأخلاقي عند الأحداث الجانحين وغير الجانحين في الأردن

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الملخـــــص

هدفت الدراسة الى التعرف على توزيع الأحداث الجانحين وغير الجانحين على مراحل النمو الأخلاقي في الأردن آخذه نظريتي (كولبرج ورست) المعرفية إطارا مرجعيا لها.

تمت دراسة (٢٥٣) حدثاً، منهم (١٣٥) حدثاً سوياً من طلبة المدارس الثانوية الحكومية، و(١٨٨) حدثاً جانحاً من الأحداث المحكومين في مركز "محمد بن القاسم الثقفي" لإصلاح وتأهيل الأحداث، وفي الفترة العمرية (١٣-١٨) عاماً، لكلا الفئتين.

طبق على الجميع مقياس تحديد القضايا (لرست) وبصورته المعربة والمقننه. بينت الدراسة أن الأحداث غير الجانحين يتسمون بنضج أخلاقي أكبر مما يتسم به أمثالهم من الجانحين. وبينت كذلك أن عمر الحدث ليس له تأثير ذو دلالة احصائية على علاقة النمو الأخلاقي الكلية، أو على التفاعل مع مجموعته (جانح / غير جانح).

دعمت النتائج الدراسات السابقة على النظرية، كذلك أوصت بالاهتمام بالبرامج الإصلاحية للأحداث الجانحين وبمزيد من الدراسات على الموضوع، وبخاصة تطوير أدوات قياس للنمو الأخلاقي محلياً.

خلفية الدراسة

البحث في النمو الأخلاقي يستحوذ على الأهمية باعتبار الأخلاق من العناصر المهمة في شخصية الإنسان وهي ترتبط بثقافة المجتمع من حيث العادات والتقاليد والعرف السائد، وكذلك فهي معايير توجه الأفراد وتقوم انحرافهم.

الأخلاق باعتبارها مصطلحاً لغوياً تفيد معنى المروءة، السجية، والطبع (المنجد ١٩٥٦)، ص ١٩٤ . أما السلوك الأخلاقي فيشير الى

24. Pynoos, R. & Nader, K. prevention of psychiatric morbidity in children after. In S. Goldston: J. Yaeger; C. Heinecke & R. Pynoos (EDS.), prevention of mental health
26. Journal of the American Academy of child Psychiatry.1986,2:306-319.
27. Nader, K.; Pynoos, R.: Fairbanks, L. & Frederick, C. Children in PTSD reaction one year after a sniper attack on their school. American Journal of Psychiatry, 1990, 147:1526-1530.
28. McFarlane, A.C. Post-traumatic phenomena in a longitudinal study of children following a natural disaster. J. A. Acad. Child-Adolesc. Psychiatry. 1987, 26, 764-769.
29. McFarlane, A. G.; Policansky, S.K. & Irwin, C. A longitudinal study of the psychological morbidity in children due to a natural disaster. Psychological Medicine, 1987, 17, 727-738.
30. Dohrenwend, B.P.; Dohrenwend, B.S. et al. Stress in the community: A report to the presidentis commission on the accident at three mile Island. Ann. NY. Acad. Sci. 1981, 365: 159-174.
31. Gleser, G. C.; Green, P.L. & Winget, C.N. Buffalo Creek disturbances in children. Washington, DC: American psychiatric Association Press 1990.
25. Pynoos, R.I., & Eth, S. Witness to violence. The child interview. revisited: Prolonged psychosocial effects of disaster. New York: Simon & Schuster. 1981.
32. Milgram, N.A.; Toubiana, Y. H.; Klingman, A. et al. Situational exposure and personal loss in childrens acute and chronic stress reactions to a school bus disaster. Journal of Traumatic Stress. 1988, 1:339-352.
33. Wilson, J.P. and Krauss, G.E. Predicting post-traumatic stress disorder among Vietnam veterans. In. W. E. Kelly (Ed.) Post-Traumatic Stress Disroder and the war Veteran patient. New York; Brunner/Mazel. 1985, pp 102-147.
34. Yule, W. and Williams, R (1990). Post Traumatic stress reaction in children. Journal of Traumatic stress, 3, 19-295.
35. Yule, W. and Udwin, O. (1991) Screening child survivor for post Traumatic stress disorder. Experience from the Jupiter sinking, British Journal of Clinical Psychology 30(131-138).

طارق فحل الكبيسي: أخصائي الطب النفسي، والطب النفسي والسلوكي في مستشفى الرشيد العسكري
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Iraqi children symposium held by the ANGOS (help) the children in Iraq 28-30 (April) 1994. Baghdad, Iraq.

10. Green, B.L. Assessing levels of psychological impairment following disaster. Journal of Nervous & Mental Disease. 1982, 170, 544-552.
11. Green, B.L.; Lindy, J.D. & Crace, M.C. Posttraumatic disorder: toward DSM-IV. Journal of Nervous & Mental Disease. 1985, 173, 406-411.
12. Green, B.L; Korol. M.; et al. Children and Disaster: age, gender, and parental effect on PTSD symptoms. Journal American Academy of child & Adolesent Psychiatry, 1991, 30.6:945-951.
13. American Psychiatric Association. Diagnostic & statistical Manual of Mental Disorders. 4th Ed. Revision, 1994.
14. Sweang, S.L. Marital and life adjustment and of vietnam combat veterns: A treatment outcome study. Ph.D. thesis, University of Washington, 1987.
15. Young, J.C.A compartive study of post-traumatic stress disorder in vietnam veterans (intrusion, avoidance, PTSD, locus of control). Ph.D. thesis, U.S. Internal University, 1985.
16. Altman, B.A. Generalized external control expectancy in Vietnam veterans with Post-Traumatic Stress Disorder: A new hypothesis Ph.D. thesis, 1988.
17. Solomon, Z.; Mikulincer, M & Avitzur, E. Coping. locus of control, and combat-related post-traumatic stress disorder: A prospective study. Journal of Social Personality & Social Psychology. 1988 (Aug.) vol., 55(2):279-285.
18. Gallers, J.; Foy, D.W.; Donahoe, C.P. & Goldfarb, J. Post-traumatic stess in Vietnam combat veterans: Effects of traumatic violence expoure with military adjustment. Journal of Traumatic Stress. 1988, (Apr.)1(2), 181-182.
19. Gallers, J. Pre and post-combat measures of selected adjustment variables in Vietnam veteram with PTSD, Ph.D. thesis, California School of Professional psychology. 1984.
20. Brinson, T. & Tremoor, V. Alohlism and PTSD among combat vietnam veterans. Alcoholism Treatment Quarterly. 1988 (3-4), 65-82.
21. Bardwell. D. Analysis of Marital cohesion and adaptability of Vetnam veteran families. Washington State Univesity Ph.D. thesis, 1987.
22. Newman, C.J. Children of disaster-Intervention and research aspects. 1986, 25:336-345.
23. Gislason, I. L. & Call, J. Dog bite in infancy. Traumatic and personality development. Journal of the American Academy of Child Psychiatry. 1982,21:203-207.

ABSTRACT

Traumatic events play an important role in precipitating many psychatric disorders such as post-traumatic stress disorder (PTSD). Amiriya Shelter in Baghdad was bombareded during the night of 13.2.1991. As a consequence 403 were dead (52 child, and (261) old women and (90) old man). Only 14 victims survived.

This study aimed to find-out the rate of PTSD among vitim's close relatives and friends, it's relation to closeness of relation, sex and degree of exposure to the event. 300 secondary school students (150 close relatives or friends of the victims) were studied using a specially designed PTSD sclae based on DSM-III-R. Half of the students were females.

The results showed that 37% (59) of the victims had PTSD versus none (among the non-exposed control group). 65% (43) of the students who lost their family members of rclose relatives had PTSD, and only in 19% (16) of those who lost their friends. Among the female group 63% (47) versus only 16% (12) of male group had PTSD.

This concludes that bombardment of Amiriya Shelter as a disaster precipitated PTSD among the traumatized students and raised the need for intensive and long term psychiatric aid, social care and follow-up.

المراجـــع

1. Maida, C.A.; Gordon, N.S. etal. Psycholoica impact of disaster: Victims of the Baldwin Hill Fire. Journal of Traumatic Stress, 1989 (Jan), vol. 2(1), 37-48.
2. Tortorici, P.J. The War in ElSalvador: The child as witness, causality, survivor: a pheno-menological study. Ph.D. thesis University of Southern California. 1988.
3. Cook, C.A. Vietnam veterans: Waking and non-waking cognitive response to life-threatening stressor (nightmares, PTSD, intrusive, thoughts). PH.D. thesis. University of Michigan, 1986.
4.
5. Terr, L.C. Children of Chowchilla: A study of psychic Trauma. Psychoanalytic study of the child. 1979. 34:547-623.
6. Terr, L.C. Chowchilla revisited: The effects of psychic trauma years after a school bus kidnapping. Am. J. Psychiatry. 1983, 140:1543-1550.
7. Terr, L.C.: Childhood traumas: an outline and overview. American Journal of Psychiatry. 1991, 148(1) 10-20.
8. Malmquist, C.P. Children who wittness parental murder: Post-traumatic aspects. J. Am. Acad. Child Adolse. Psychiatry. 1986, 25:320-325.
9. Al-Kubaisy, TF, Al-Qassim, M. and Al-Kubasiy, Z. The effect of war on

ظهور أعراض الـ (ع.ك.ر)، وهذا يتفق مع وجهات نظر "ولسن وكراوس ١٩٨٥"[٣٢] من أن عوامل الشخصية تلعب دوراً هاماً في الاصابة بالاضطراب كما تتفق مع النتائج العامة لدراسة "كرين واخرون Green et. al, 1991" التي وجدت اختلافات في مستويات أعراض الـ (ع.ك.ر) في الاناث المتعرضات للكوارث مقارنة بالصبيان المعترضين للكوارث نفسها. كما أن دراسات دوروند وأخرون Dohrewend, 1981 وكلسر واخرون Glesor, et. al, 1981 وبورك واخرون Burke, et. al, 1986 توصلت الى نتائج مشابهه.

يلاحظ من هذه النتائج أن الاناث أظهرن أعراض (ع.ك.ر) أكثر مقارنة بالبنين، وقد ترجع هذه الفروق بسبب أن ظروف التنشئة الاجتماعية تستهدف أعداد البنين لمواجهة المواقف الصعبة والتي من المتوقع أن يتعرض لها في المستقبل وبالعكس فان التنشئة الاجتماعية للبنات قد لا تضع في اعتبارها اعداد البنات لمواجهة مثل تلك المواقف الصعبة، كما أن الأدوار الاجتماعية التي تسند الى البنين من شأنها أن تنشىء أفراداً لهم القدرة على مواجهة المواقف الصعبة، حيث أن بعض الأفراد قد يكونون ملقحين ضد الشدائد النفسية أما بالتصلب عن طريق اعادة اختبار صدمات قاسية صغيرة كثيرة أو بتدريب خاص مصمم لتهيئة الأفراد لمواجهة مثل هذه الشدائد، وعادة ما تتضمن هذه التدريبات الذكور لتهيئتهم للمواجهة[٣٢] . وقد تكون هناك عوامل اخرى مرتبطة بالجنس في تأثيره على ظهور أعراض الت (ع.ك.ر)، مما يستدعي دراستها وهذا ما سيذكره الباحث في المقترحات.

الاستنتاجات

نستنتج من ذلك أن الأفراد الذين يتعرضون للشدائد النفسية يظهرون أعراض الـ (ع.ك.ر) وهذه الأعراض تختلف بحسب طبيعة التعرض فكلما كان التعرض شديداً كان احتمال ظهور أعراض الـ (ع.ك.ر) أكبر. كما أن متغير الجنس يلعب دوراً هاماً في ظهور أعراض الـ (ع.ك.ض) فقد أظهرت الاناث أعراضاً أكثر مقارنة بالذكور.

لقد أدى حادث ملجأ العامرية الى اصابة الطلاب من أقارب وأصدقاء الضحايا بأعراض الـ PTSD وأدى الى تخلفهم الدراسي والى تأثيرات اجتماعية ونفسية كثيرة.

ان تعرض أطفال العراق الى خبرات صدمية متعددة نتيجة الحرب والحصار قد أدت وستؤدي الى ظهور عقبى الكرب الرضحي ومضاعفاته مما يؤدي الى خبرات مؤلمة مؤدية الى تدني أدائهم في الجوانب الصحية والنفسية والاجتماعية والدراسية مما يستوجب القيام بالاجراءات الوقائية اللازمة لمن لم تظهر عليهم الأعراض لحد الآن كما يستوجب وضع الخطط العلاجية اللازمة وتطبيقها بصورة عاجلة ومتابعتها والعمل على التكاتف لرفع الحصار الاقتصادي والعلمي بصورة عاجلة للتخفيف من معاناة الأطفال في العراق.

للحادث الـ (ع٠ك٠ر) هو عدم توقع الحادث، حيث أن ضحايا الحادث وأصدقائهم وأقاربهم لم يكونوا يتوقعون تعرضهم للحادث والا لم يحضروا لذلك المكان وكذلك فان الضحايا كانوا يحضرون معهم وسائل الحياة الاعتيادية للملجأ كما أن التاريخ لم يذكر تعرض ملجأ مدني الى الضرب (على حد علم الباحثين)، لذا فان هذه العوامل ساهمت في التأثير الشديد على ضحايا الحادث، ويرتبط بظهور الأعراض لديهم كما تشير أغلب الدراسات٠ وتتفق هذه النتائج مع وجهة نظر (نيدرلاند ١٩٨٢) من أن أغلب الأفراد الذين يتعرضون الى حوادث صدمية تتطور لديهم أعراض الـ (ع٠ك٠ر)٠ كما تتفق هذه النتائج مع نتائج دراسة "كلسر وأخرون ١٩٨١" من أن خطورة الضغوط التي يتعرض لها الأفراد ودرجة الفقدان المختبرة من قبل الضحايا تلعب دورا هاما في الاصابة بالـ (ع٠ك٠ر)[٣٠] ٠ وفي حادث ضرب ملجأ العامرية كانت الضغوط شديدة جداً أما في المجموعة الثانية وبسبب أن التعرض كان أقل شدة مقارنة بالمجموعة الأولى فقد أظهروا اعراضاً أقل وكانت مساهمتها أقل ايضا في الافتراض وهذه النتائج تتفق مع مقترح "هوكنك ١٩٧٠" من الشدة المتطرفة لبعض المواقف تقود الى ظهور الاعراض لكل شخص تقريباً أما من التعرض الأقل تتطرفاً فان عوامل القابلية على الانجراح النفسي تكون تأثيراتها أكبر (Hocking, 1970)٠ ولما كان الباحث قد حذف من عينته الافراد الذين لهم تاريخ مرضي نفسي سابق والذين تعرضوا الى شدائد نفسية غير حادث ضرب ملجأ العامرية، اذن يمكن القول بثقة أن تأثير عوامل على الأفراد داخل الملجأ وخارجه وكما أن الكثير من الأفراد قد فقدوا العديد من أفراد عوائلهم مما شكل ضغطاً شديداً عليهم في فقدانهم عوائلهم وبالتالي شعورهم الشديد بالحزن وعدم الامن وفقدان الاسناد الاجتماعي في مواجهة الضغوط٠

كما أن هذه النتائج تؤيد الموقف الناشيء عن نموذج "ولسن وكراوس ١٩٨٥" من أن فقدان الأقارب وتهديد الحياة وخطورة الضغط في الموقف ترتبط بدرجة كبيرة في معالجة الصدمة وبالتالي ظهور أعراض الـ (ع٠ك٠ر) (Wilson & Krauss, 1985) ونستدل من هذه النتائج أن ظهور الأعراض يعتمد على شدة التعرض لأن المجموعة الاولى (أقرباء وأصدقاء الضحايا) تعرضت بشكل شديد للحادث حيث فقدوا أفراداً من عوائلهم أو أقاربهم وبالتالي أظهروا أعراضاً أكثر من المجموعة الثانية وأكثر اسهاما في الاضطراب اعتماداً على شدة الحدث٠

القابلية على الانجراح النفسي قد حيد وبالتالي فان ظهور الأعراض اعتمد فقط على طبيعة التعرض ولان المجموعة الثانية كانت أقل تعرضاً فان تأثيرها كان أقل أيضاً٠

كما تتفق هذه النتائج مع نتائج دراسات فرتيز ومماركس 1956 Fritz & Marks وجانس 1951 Janis وكوك 1986 Cook وبانيوس واخرون 1987 Pynoos, et. al ومكفرلاين 1988 Mcfarlane وكرين واخرون Green, et. al 1989، من أنه كلما كان التعرض أكبر ارتبط باحتمال ظهور أعراض أكبر٠ ويستدل من هذه النتائج أن متغير الجنس يلعب دور مهم في

جدول (١) يبين النسب المئوية للاصابة لدى الذكور والاناث في العينة المتعرضة والقيمة الزائية

الجنس	العدد	الاصابة		القيمة الزائية	الدلالة
		عدد	٪		
الاناث	٧٥	٤٧	٦٣	٥ر٩٠	٠ر٠١
الذكور	٧٥	١٢	١٦		

٣ ٠ وفيما يتعلق بمتغير التعرف فقد كانت نسبة الاصابة لدى أقارب الضحايا ٦٥٪ (٤٣) مقابل ١٩٪ (١٦) للذين فقدوا أصدقائهم٠ وباستخدام الاختبار الزائي فقد تبين أنن هناك فروقاً دالة احصائياً، حيث بلغت القيمة الزائية (٥ر٧٥) وهي دالة عند مستوى دلالة (٠ر٠١) والجدول التالي يوضح ذلك:

جدول (٢) يبين النسب المئوية للاصابة لدى أقارب الضحايا وأصدقائهم والقيمة الزائية

درجة القربى	العدد	الاصابة		القيمة الزائية	الدلالة
		عدد	٪		
أقارب الضحايا	٦٦	٤٣	٦٥	٥ر٧٥	٠ر٠١
أصدقاء الضحايا	٨٤	١٦	١٩		

تفسير النتائج

فيما يتعلق بالهدف الثاني فان النتائج تبين وجود فروق دالة في جميع الأعراض بين المجموعة المتعرضة والمجموعة غير المتعرضة وهذا يعني أن الأفراد من طلبة الاعدادية والذين تعرض أفراد عوائلهم أو أقاربهم أو أصدقائهم الى حادث ضرب ملجأ العامرية قد ظهرت عليهم أعراض الـ (ع٠ك٠ر) أكثر مقارنة بغير المتعرضين٠ هذا يدل على أن الأشخاص الذين يتعرضون الى حوادث صدمية من نوع حادث ملجأ العامرية يمكن أن تظهر لديهم أعراض الـ (ع٠ك٠ر) وهذا يتفق مع أغلب الدراسات والأدبيات السابقة والتي ورد ذكرها في هذه الدراسة والتي تشير الى أن التعرض للشدائد النفسية يمكن أن يترك تأثيرات طويلة المدى على الجوانب المختلفة للشخصية الانفعالية والسلوكية والادراكية، حيث أن حادث ضرب ملجأ العامرية وكما ذكرنا سابقاً يعد واحداً من الشدائد النفسية وغير الاعتيادية لان الحادث أدى الى موت أغلب المحتمين بالملجأ وتشوهت جثث أغلب الضحايا بحيث شكلت منظراً مفزعاً ومخيفاً لكل من شاهد الحادث موقعياً أو تلفازياً ومن العوامل التي يمكن أن تلعب دوراً مؤثراً في اصابة الأفراد المتعرضين

طالب وطالبة نصفهم من أقارب وأصدقاء الضحايا والنصف الاخر من غير المتعرضين.

وقد تحقق في هذا المقياس الصدق الظاهري والبنائي والعاملي والتلازمي، أما الثبات فقد اجري بطريقة اعادة الاختبار الفا كرونباخ.

٢- عينة البحث

تم اختيار عينة قصدية من أقارب وأصدقاء الضحايا تتكون من (١٥٠) طالباً وطالبة موزعين بالتساوي بين الجنسين، منهم ٦٦ من أقارب الضحايا، و (٨٤) من أصدقاء الضحايا، و(١٥٠) طالباً وطالبة من غير المتعرضين.

٣- اجراءات البحث

بعد أن تم اعداد المقياس واستمارة المعلومات قام الباحثان بزيارات أولية الى المدارس الاعدادية في منطقة العامرية حيث مكان الحادث وتم تحديد افراد العينة المتعرضة بالتعاون مع ادارات المدارس المعنية. في حين تم تحديد افراد العينة غير المتعرضة بحيث يكافئون العينة المتعرضة في

د- استخراج ثبات المقياس بطريقة اعادة الاختبار.

٣. معادلة "الفا" للاتساق الداخلي لحساب الثبات.

النتائج

١. أظهرت النتائج أن نسبة الاصابة لدى أقارب وأصدقاء الضحايا كانت ٣٧٪ (٥٩) من مجموعهم البالغ (١٥٠) طالباً وطالبة، في حين كانت نسبة الاصابة (صفرا) لدى العينة غير المتعرضة.

المتغيرات المؤثرة على ظهور أعراض الـ (ع.ك.ر).

تم قام الباحثان بعد ذلك بتطبيق المقياس على أفراد العينة وبشكل فردي وكان يتم التناوب في التطبيق بين العينة التجريبية الضابطة لتحاشي حدوث متغيرات دخيلة من الممكن أن تؤثر في نتائج الدراسة.

٤- الوسائل الاحصائية

١. اختبار Z لقياس الفروق بين الجنسين وبين أقارب الضحايا وأصدقائهم في نسبة الاصابة.

٢. معامل ارتباط بيرسون (فيركسون، ١٩٩١) لتحقيق الأغراض التالية:

أ- ايجاد العلاقة بين درجة الفقرة الواحدة والدرجة الكلية للمقياس.

ب- ايجاد العلاقة بين درجة الفقرة الواحدة والدرجة الكلية للمكون الذي تنتمي اليه.

جـ- ايجاد العلاقة بين درجة المكون الواحد والدرجة الكلية للمجال الذي ينتمي اليه المكون.

٢. أما بخصوص متغير الجنس فقد كانت نسبة الاصابة لدى الاناث ٦٣٪ (٤٧) من مجموع الاناث في العينة المتعرضة، أما نسبة الاصابة لدى الذكور فقد بلغت ١٦٪ (١٢)، وباستخدام الاختبار الزائي فقد تبين أن هناك فروقاً دالة احصائية عند مستوى دلالة ٠١ر٠ حيث بلغت القيمة الزائية ٩٠ر٥، والجدول التالي يوضح ذلك.

مبرر اجراء الدراسة

في الليلة الثالثة عشر من شباط عام ١٩٩١ قصفت قوات التحالف ملجأ العامرية بالطائرات. معيدة الى الاذهان هيروشيما وناجازاكي. كان هذا الملجأ مأهولا بالمدنيين من الرجال والنساء والأطفال في تلك الليلة ونتج عن هذا القصف استشهاد ٤٠٣ من المواطنين بينهم (٥٢) طفلا و (٢٦١) امرأة و (٩٠) من الرجال، أكثرهم كبار في السن ونجا (١٤) شخص فقط.

لقد كانت ليلة العامرية فجيعة بشرية ولم ينج من الناس المحتمين داخل الملجأ الا نفر قليل كتب الله لهم النجاة ليكونوا شهود عيان على هذه المأساة المروعة. أما الاخرون من نساء وشيوخ وأطفال فقد احترقوا في الداخل بالنار والابخرة والبارود والدخان.

ان الحادث لم يكن من حوادث الحرب التقليدية، وانما كان حادثا مروعاً وفاجعة، اذ كيف يمكن أن نتخيل تجمعا بشرياً هائلاً يلوذ بأحد الملاجئ المحكمة، فيسقط عليهم جحيم من النيران فلا يجدون مفراً. كما أن الحادث يمكن أن يعد واحداً من الأحداث التي تقع خارج مدى الخبرة الانسانية الاعتيادية، ذلك لان أي شخص طبيعي لا يمكن أن يدرك حادث ضرب ملجأ مليء بالناس، دون أن يكون ذلك مروعاً وشديد الوقع عليه.

أسئلة البحث

يهدف البحث الحالي الى الاجابة على الأسئلة التالية:-

١. ما نسبة الاصابة بعقبى الكرب الرضحي لدى العينة المتعرضة مقارنة بغير المتعرضة؟
٢. ما نسبة الاصابة لدى الذكور مقارنة بالاناث لدى العينة المتعرضة؟
٣. ما نسبة الاصابة لدى أقارب الضحايا مقارنة بأصدقائهم؟
٢. تجنب الاحداث التي تمثل وجها من أوجه الحدث الصدمي أو يشبهه Avoidance of the emotionally charged stimuli.
٣. أعراض مزمنة لاثارة متزايدة مقترنة بالحدث Hightened arousal stimuli related to traumatic events.

وقد تم عرض المقياس على لجنة من الخبراء يتكون من أطباء نفسانيين ومختصين في علم النفس للحكم على مدى صلاحيتها للقياس. ولغرض التأكد احصائياً من صدق المقياس وثباته في قياس الاضطراب فقد تم تطبيقه على عينة من (٣٠٠)

منهجية البحث

تمثلت منهجية البحث في أربع محاور:-

١- ادارة البحث

تم اعداد مقياس لقياس عقبى الكرب الرضحي اعتماداً على تصنيف الجمعية الطبية النفسية الامريكية DSM III-R لعام ١٩٨٧ . وقد تألف المقياس من عدد من الفقرات تتوزع على ثلاث مكونات:-

١. اعادة اختبار الحدث الصدمي Rexperiencing the traumatic events.

الجديدة[٢٢] . وتشير دراسة "كلزون وكول ١٩٨٢" ان الاصابة بالـ (ع.ك.ر) لها تأثير محتمل على عملية التطور الطبيعي للطفل، لان وجود هذه الأعراض قد يؤثر على ادراك الطفل وشخصيته واحساسه بالامن Sence of Safety وتقدير الذات[٢٣] . كما ينخفض ضبط الحوافز لدى الأطفال Control Reduce Impulse أو تزيد الاعاقة Inhibition والجانبية للخطر Attraction وضعف الاحساس بالخوف[٢٣،٢٤،٥] وان نمو الطفل ربما يتأثر بشكل مهم[٢٥،٢٦] . كما أن الـ (ع.ك.ر) يمكن أن ينتج تغيرات في الشخصية تتضمن اضطراب الوظائف التطورية الاجتماعية والادراكية والانفعالية بسبب ضعف التفاعل الشخصي مع الاخرين[٢٤] .

وفي مجال تأثير التعرض للشدائد على التحصيل الدراسي، تشير دراسة "ماكفرلاين ١٩٨٧" وهي دراسة طولية بحثت التأثيرات النفسية للكوارث وفق دراسة مدى انتشار أعراض عقبى الكرب الرضحي (ع.ك.ر) لدى ضحايا ملجأ العامرية من طلبة الاعدادية، مهمة لعدة أسباب أهمها:-

١. أن التعرض للشدائد النفسية Traumatic Stress يمكن أن ينتج أعراض (ع.ك.ر) وهذه الأعراض تتطلب المعالجة السريعة والمتابعة المستمرة. كما أنه حتى عند عدم ظهور أعراض دالة لدى العينة فان هذا لا يعني تماما أن هذه الأعراض غير موجودة، فقد تكون تلك الأعراض كامنة ويمكن أن تظهر في أي وقت بسبب أو بغيره وهذا واحد من العوامل الخطرة في الاضطراب.

ثلاث فترات زمنية بعد الحادث (بعد شهرين وبعد ثمانية وبعد ٢٦ شهرا)، الى أن هناك ضعف في التحصيل الدراسي، ويرتبط بدلالة بشدة الاضطراب[٢٧،٢٨]

تشير بعض الدراسات الى أن المراهقين المتعرضين للصدمات اظهروا مخاوف خاصة بالصدمة وأعراض كآبة وقلق وحب القتال ومؤشرات اضطرابات انفعالية متداخلة أكثر مقارنة بالاطفال الذين بعمر أقل من المراهقة[٢٩،٣٠،٣١]

كما أن التعرض للشدائد النفسية بمثل هذا العمر يمكن أن يترك تأثيرات سلبية على الشخصية في المستقبل حيث تشير دراسة (تر ١٩٩١) الى أن الصدمة النفسية في الطفولة تظهر لتكون عاملا سببيا رئيسيا في تطور عدد من الاضطرابات الخطيرة في الطفولة والكبر[٧] . وعليه يتبين ان

٢. ان التعرض للشدائد النفسية في مرحلة الطفولة يمكن أن يترك تأثيرات نفسية طويلة المدى على المتعرضين، كما أن المراهقين يظهرون أعراضاً اكثر للاضطراب مقارنة بمن هم أقل عمراً منهم.
٣. ان المراهقين يمثلون شريحة عمرية واسعة من المجتمع كما أن لهم عمراً انتاجياً أطول مقارنة بغيرهم من كبار السن.
٤. ان ضحايا ملجأ العامرية يمثلون عينة لكل أولئك الذين تعرضوا الى حوادث مماثلة هددت حياتهم بالخطر.

"جرين ١٩٨٢" أن نوع الكارثة يمكن أن يكون متغيراً مهما في انتشار أمراض ما بعد الصدمة[١٠] .

وتؤكد دراسة "جرين واخرون ١٩٨٥" أنه على الرغم من أن درجة المرض النفسي تكافيء عادة مقدار الكارثة، فان المشاكل النفسية بعد الكوارث الطبيعية تعتبر عموماً أقل خطورة ودواماً مقارنة بتلك المشاكل التي تعقب الكوارث التي هي من صنع الانسان[١١] .

كما استنتج عدد من الباحثين ان التعرض الى العنف فيه احتمال اكثر لاظهار الاضطراب في الاطفال مقارنة بالانواع الاخرى من الاحداث الصدمية كالكوارث الطبيعية[١٢] .

نستنتج من ذلك ان التعرض الى احداث صدمية (Traumatic Event) وخصوصاً تلك التي من صنع الانسان كحوادث السيارات الكبيرة وسقوط ودراسة "يونج ١٩٨٥" تشير الى أن الأفراد الذين يعانون من (ع٠ك٠ر) شديد أظهروا عجزاً في حياتهم أكبر من أولئك الذين يعانون من (ع٠ك٠ر) متوسط الشدة[١٥] . كما تشير دراسات "يونك ١٩٨٥ والتمان ١٩٨٨ وسلمون وآخرون ١٩٨٨" الى أن المصابين بالـ (ع٠ك٠ر) يكونون من ذوي مركز السيطرة الخارجي والذي يمكن على ضوئه تفسير عجز المريض من التخلص من المخاوف والهواجس المرضية والشكوى غير السوية حيث أن الأفراد من ذوي مركز السيطرة الخارجي يعتقدون اعتقاداً جازماً بأنهم فقدوا القدرة على ضبط أو السيطرة على أي حدث في حياتهم وبالتالي يشعرون بالعجز[١٥،١٦،١٧] .

الطائرات والحروب وغيرها يمكن أن تنتج ما يسمى عقبى الكرب الرضحي (ع٠ك٠ر)٠

وتؤكد الجمعية الطبية النفسية الامريكية في DSM IV أن أعراض هذا الاضطراب قد تكون كامنة ويمكن أن تظهر في أي وقت بسبب أو بغيره[١٣] .

وهنا تشير الدراسات الى تأثيرات عديدة للاصابة بالـ (ع٠ك٠ر) على الفرد والمجتمع، فدراسة "سونيك ١٩٨٧" تشير الى أن الاضطراب يقلل قدرة الفرد على تحقيق أهداف حياته في العمل والعائلة والتطور الشخصي، كما أن الاضطراب مكلف اقتصادياً للفرد والمجتمع[١٤]، وذلك بسبب تعطل أو ضعف قدرة الفرد على العمل، كما أن اصابة الأفراد بالـ (ع٠ك٠ر) تستدعي وجود مراكز علاجية لخدمتهم وهذه من شأنها أن تكلف المجتمع جهداً ووقتاً ومالاً٠

كما تشير دراسات "كلرز ١٩٨٤ وبرنسون وترينر ١٩٨٨ وكلرز واخرون ١٩٨٨" الى أن الذين يعانون من الـ (ع٠ك٠ر) يكثرون من تناول الأدوية والكحول والمخدرات[١٨،١٩،٢٠] .

كما أن دراسات "باردوول ١٩٨٧ وكلرز ١٩٨٤ تشير الى أن الأفراد الذين يعانون من الـ (ع٠ك٠ر) يعانون أيضاً من اضطرابات في علاقاتهم الزوجية فهم أقل تكيفاً وأقل رضا عن زيجاتهم٠ وربما يرجع ذلك الى أن الأفراد الذين يعانون من الاضطرابات يمتلكون مدى محدداً من العاطفة، كما أنهم ينزعجون من الاختلاط بالاخرين وبسبب ذلك فان علاقاتهم الزوجية تضطرب نتيجة لذلك[٢١] .

أما "تيومان ١٩٨٦" فيشير الى ان التعرض للاحداث يضعف قابلية الاطفال على مواجهة الضغوط

وتخلص الدراسة الى أن قصف ملجأ العامرية قد أدى الى اصابة الطلبة من الضحايا باضطرابات نفسية وهم بحاجة الى الرعاية النفسية والسلوكية ويحتاجون الى دراسات متابعة ودراسات ضابطة لاختبار أنواع العلاج المناسبة.

مقدمة الدراسة

يعتبر عقبى الكرب الرضحي (Post-Trumatic Stress Disorder) من الاضطرابات النفسية التي قد يعاني منها الكبار والصغار حيث صنفت هذا الاضطراب في كل من دليل الجمعية الطبية الامريكية (DSM IV 1994) وكذلك في التصنيف العالمي للاضطرابات النفسية ICD 10 وتظهر هذه الأعراض كنتيجة للتعرض للأحداث الصدمية (Traumatic events). حيث يرافق هذا الاضطراب أعراض مختلفة نذكر منها اضطرابات النوم ومشاهدة الكوابيس، شعور بعدم الأمان، اضطراب استعادة الموقف للذاكرة Flash back، سلوكات تجنبية، ضعف القدرة على التكيف مع المحيط والمجتمع ضعف في الوظائف العامة من ضمنها القدرات العقلية مما يؤثر على التحصيل الدراسي والقدرة على التركيز عند الأطفال.

وتشير كثير من الدراسات الى أن التعرض للأحداث الصدمية Traumatic Events يمكن أن يؤدي الى اضطرابات نفسية وجسمية لدى المتعرضين حيث تشير دراسة ميدا وآخرون ١٩٨٩ التي اجريت على عينة بحجم (٢٥) فرداً بأعمار مختلفة من ضحايا حريق في احدى ضواحي لوس انجلوس، الذي ادى الى تدمير (٥٠) منزلاً واضطراب حياة السكان بشكل خطير نتيجة الحريق، حيث أظهر المفحوصين مشاكل انفعالية وجسمية نفسية وصحية نتيجة الحادث كما أن النتائج تقترح أن التعرض للحادث يرتبط بدلالة بعدد من اعراض عقبى الكرب الرضحي (ع.ك.ر)[١].

كما تؤكد دراسة "تورتوريسي١٩٨٨" الى أن الصدمة المتطرفة الشدة تنتج تأثيرات دائمة البقاء على الأطفال وتنتج تغيرات اساسية في كيفية نظرتهم لانفسهم وللاخرين والانسانية ككل[٢]، أما دراسة "كوك ١٩٨٦" فتفترض أن الناس الذين يتعرضون لضغوط مهددة للحياة يميلون للاستجابة لكوابيس وأفكار تسلطية، وتقترح نتائج هذه الدراسة أن التعرض للعنف ربما يرتبط بالاضطراب الشخصي والاجتماعي الذي يوجد في حياة الضحايا[٣] كما أن "انثوني ١٩٨٦" لاحظ أن الافراد بعد الكارثة يشعرون بنقص واضح بالامن وقابلية على الانجراح اكبر[٤]. كما وتشير عدد من الدراسات الى أن الاطفال الذين تعرضوا للعنف المرتبط بالحرب والاطفال الذين تعرضوا لحادثة اختطاف باص مدرسي[٥،٦،٧]، والاطفال الذين شاهدوا قتل اباتهم[٨] قد ضنفوا كمختبرين لل (ع.ك.ر).

وتشير دراسة "الكبيسي واخرون ١٩٩٢" والتي تمثل خبرات أطفال عراقيين عن الحرب أن الحرب تركت تأثيرات واضحة على الأطفال منها، الخوف من الظلام والخوف من حلول الليل، وكوابيس تتعلق بمحتوى الحرب، واستجابة الفزة[٩] وتفترض دراسة

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Post-Traumatic Stress Disorder Among Amirya Shelter Disaster Student Victims

Tareq Al-Khubaisy, Saed Al-Atrany

عقبى الكرب الرضحي لدى طلبة الاعدادية من ضحايا ملجأ العامرية

طارق الكبيسي، سعد العطراني

الملخـــــص

يلعب التعرض للاحداث الصدمية Traumatic Events دورا كبـيرا في احـداث عقبى الكـرب الرضحـي (PTSD) لدى المتعرضين لتلك الأحداث.

لقد قصف ملجأ العامرية في بغداد ليلة الثالث عشر من شباط عام ١٩٩١، ونتج عن هذا القصف استشهاد (٤٠٣) من المواطنين بينهم(٥٢) طفلاً و (٢٦١) امرأة و (٩٠) من الرجال أكـثرهم كبـار في السـن. ونجـا فقط (١٤) شخصاً.

وقد هدفت الدراسة الى التعرف على نسبة الاصابة بعقبى الكرب الرضحي لـدى المتعرضـين مـن الطـلاب من أقرباء الضحايا وأصدقائهم ونسبتها تبعاً لدرجة القربى والجنس.

استخدم مقياس عقبى الكرب الرضحي الذي أعد خصيصاً لهذا التعرض بالاعتماد علـى المراجعـة الثالثـة المنقحة للمساعد التشخيصي والعلاجي (DSM-III-R) وكـان حجـم العينـة (٣٠٠) مـن طـلاب الثانويـة (منهم ١٥٠ من أقرباء أو أصدقاء الضحايا) ومقسومة بالتساوي بين الجنسين.

لقد أظهرت النتائج أن نسبة الاصابة لدى الضحايا كانت (٣٧٪) ٥٩ مقابل (٠٪) للعينـة غـير المتعرضـة لاي حادث صدمي، أما بالنسبة لمتغير درجة القربى فقد كانت نسبة الاصابة لدى الذين فقدوا أفرادا من عوائلهم أو أقربائهم (٦٥٪) ٤٣ مقابل (١٩٪) ١٦ للذين فقدوا اصدقائهم. أمـا بالنسـبة لمتغـير الجنـس فقد كانت نسبة الاصابة لدى الاناث (٦٣٪) ٤٧ من عينة الانـاث في حـين كـانت نسـبة الاصابـة لـدى الذكور (١٦٪) ١٢ من عينة الذكور.

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المحتويات

المجلة العربية للطب النفسي (١٩٩٧)، العدد (١)، المجلد (٨)

معلومات هامة للناشرين

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

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

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

الصفحة الثالثة: تحتوي على أسماء المشاركين وعناوينهم وعناوين المراسلة.

يمكن أن تخصص صفحة للشكر للأفراد والمؤسسات التي دعمت البحث.

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

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

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

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

١. اسماعيل، عزت (١٩٨٤)، جنوح الاحداث، وكالة المطبوعات: الكويت.

٢. الشيخ، سليمان الخضري (١٩٨٢) دراسة في التفكير الخلقي لدى المراهقين والراشدين، الكتاب السنوي في علم النفس.

٣. الخطيب، جمال والحديدي، منى والسرطاوي، عبد العزيز (١٩٩٢). ارشاد أسر الأطفال ذوي الحاجات الخاصة. دار حنين، عمان، الأردن.

٦١٦،٨٠٥
مجل المجلة العربيـة للطب النفسي / اتحاد الأطباء النفسيين العرب. ـ عمان، ع١، تشرين ثاني، ١٩٨٩
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تصدر عن

إتحاد الأطباء النفسانيين العرب

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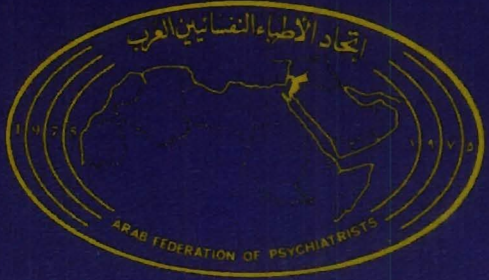

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