Instruction to Authors

The Arab Journal of Psychiatry (AJP) is published by the Arab Federation of Psychiatrists since 1989 in Jordan.

The Journal is biannual published in May and November electronically and as hard copy. Original scientific reports, review articles, and articles describing the clinical practice of Psychiatry will be of interest for publication in AJP. The Articles should not be published before. The articles may be written in English or Arabic and should always be accompanied by an abstract in English and Arabic. All Papers are accepted upon the understanding that the work has been performed in accordance with national and International laws and ethical guidelines. Manuscripts submitted for publication in the Arab Journal of Psychiatry should be sent to:

The Chief Editor.

Papers are submitted in electronic form

- Title, running head (Max: 40 letters), title of the article in English and Arabic, the names of authors should be without their titles and addresses in both languages.
- Abstract in English (max: 200 words). It should follow a structured format (objectives, method, results and conclusion). It should be followed by key words (max. 5).
- Declaration of interest after the key words.
- Names of authors, titles, and full addresses and address for correspondence at the end of the paper.
- Acknowledgment of support and persons who have had major contribution to the study can be included after the references.
- Arabic abstract like the English abstract should follow a structured format. And it follows the references section (last page).
- All Pages should be numbered.

Tables

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

Illustrations

All illustration should be submitted camera-ready; line drawings/diagrams should be approximately twice the size they will appear in print.

Reference List

References should follow the ‘Van Couver style’ only the numbers appear in the text. List them consecutively in the order in which they appear in the text (not alphabetically).

Example of references:


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Editorial Letter

It is my pleasure to offer many excellent papers in Arabic for the current issue of the Arab Journal of Psychiatry (AJP). They are among the best papers I could have and cover a wide range of topics. One observation I would like to convey to young researchers who are trying to write papers is that you truly need to read good papers regularly. Be confident and knowledgeable about your topic. Get to know it well by reading thoroughly about it. Ask your colleagues and your mentors for their guidance and opinions so the chances of your paper being accepted for publication improve.

Please visit the AJP website and register yourself. Once you do, you will be able to read and download all previous issues since November 1989.

I would like to thank Dr Tori Snell who takes care of the final editing and spends so much time and effort in making the journal up to the standard.

I am also thankful to the referees who provide opinions and directions to the authors.

I hope Arab researchers will publish more good papers. The AJP prides itself in fostering and disseminating scientific research for the benefit of readers in the region and more widely.

Dr Walid Sarhan, FRCPsych, IDFAPA
Chief Editor of the Arab Journal of Psychiatry
Amman - Jordan
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Guidelines

Arab Treatment Guidelines for the Management of Major Depressive Disorder


Abstract

Major depressive disorder is currently the second leading cause of disability and is projected to be the leading cause of global burden of disease by 2030. Arab healthcare practitioners face region-specific challenges that the current set of international guidelines do not address. Currently, most Middle Eastern countries are exposed to a multitude of stressors because of conflicts and wars. Consequently, there has been a rise in terrorism and fundamentalism, as well as stress-related mental health problems. A panel of experts from 22 Arab countries met to reach consensus and develop clear practice guidelines on the treatment of major depressive disorder in those countries. The guidelines are based on evaluations of evidence from the Food and Drug Administration (FDA) registration studies and regulatory approvals, as well as large, well-designed, double blind, placebo-controlled studies.

Given the regional specificity of these guidelines (addressing social determinants, religious beliefs, available resources and reaction to treatment modalities), psychiatrist compliance to guidelines might increase and lead to improved patient outcomes. Members of the working group recommend that collaborative projects be developed and initiated regionally to study clinical outcomes of treatment of major depressive disorder in the Middle East.

Key words: Treatment, Guidelines, Major Depressive Disorder, Depression, Arab

Declaration of interest: See below

Introduction

Major depressive disorder (MDD) is currently the second leading cause of disability worldwide and a major contributor to the burden of suicide and ischemic heart disease.1 It is projected to be the leading cause of global burden of disease by 2030. Although national epidemiological studies on the prevalence of MDD showed some differences in Arab countries depending on the region of conflict2-6 the disease prevalence in Arab countries is like the rest of the world, with 5-6% of the population affected in a 12-month period.7

Arab healthcare practitioners face region-specific challenges. The perception and management of mental illness is heavily influenced by the local culture and political situation. Currently, most Arab countries are exposed to a multitude of stressors because of conflicts and wars. Consequently, there has been a rise in terrorism and fundamentalism, as well as stress-related mental health problems.8 Religion also plays an important role in symptom formation, attribution and management of mental health problems. Religious and cultural beliefs are known to have a positive influence on the outcome of psychiatric disorders. At times, however, such beliefs may lead patients and family members to attribute depression to transcendent forces out of their control, such as God’s will, a weak personality or lack of faith. The locus of control in the Arab countries is often external. In addition, a study by Okasha showed that 71% of those attending outpatient counseling in a university hospital had tried traditional and religious therapy before consulting a psychiatrist.9

Availability of resources is also a determinant of clinical care for patients suffering from MDD in the region. Faced with a lack of human resources in the field of mental health, the WHO Regional Office for the Eastern Mediterranean (EMRO) recommended that the most essential antidepressants should be available to every local primary care unit to deal with the disease burden. Treatment cost is also a major challenge. In some
countries medications are an out-of-pocket expense for patients, resulting in poor adherence and compliance with the prescribed treatment.9

This is the first time that treatment guidelines for MDD have been produced for the Arab region. The expert panel expressed concern with the international guidelines’ lack of specificity for the realities of the region. As regional experts write these guidelines, they take into consideration the cultural and religious landscape in which clinical care is provided. This is compounded by the rarity of systematic research that measures treatment outcomes in Arab populations.10 It is the consensus panel’s hope that this will facilitate the adoption of the guidelines by regional psychiatrists and authorities. Finally, the Arab treatment guidelines for MDD are held to a high standard of evidence and should serve as a reference for both junior and senior clinicians, as well as help to frame mental health service policies in the region to support better patient outcome.

Method

Expert panel

A panel of experts met in Dubai on 29 September 2012 to agree and develop clear practice guidelines on the treatment of MDD in the Middle East region. The panel included psychiatrists with expertise in the treatment of MDD. Following the meeting, panel members deliberated before finalizing the current document.

Evidence evaluation

In evaluating the evidence for these guidelines, primary consideration was given to reviews of the available efficacy and safety data in registration studies from the Food and Drug Administration (FDA) and the European Medicines Agency’s (EMA) Committee for Medicinal Products for Human Use (CHMP). In contrast to treatment guidelines by other bodies, meta-analyses were demoted to a lower level of evidence and double-blind placebo-controlled registration studies were promoted to the highest level.

International guidelines for the treatment of MDD were reviewed by the expert panel as a base for the guidelines development discussion included The Canadian Network for Mood and Anxiety Treatments (CANMAT) clinical guidelines for the management of major depressive disorder in adults (2009), The American Psychiatric Association (APA) practice guideline for the treatment of patients with major depressive disorder (2010), and The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for biological treatment of unipolar depressive disorder (2002).11-19 Since the original meeting, panel members have reviewed more recent evidence and treatment options not available earlier, such as the CANMAT 2016 clinical guidelines for the management of major depressive disorder in adults.20

The recommendations in the APA, CANMAT, WFSBP guidelines reviewed by the expert panel were based on meta-analyses and systematic reviews of available evidence. However, the current Middle East guidelines are based primarily on evaluations of evidence from the FDA registration studies and regulatory approvals, as well as large, well-designed, double-blind, placebo-controlled studies, rather than on meta-analyses and systematic reviews. The expert panel chose to use FDA approval documents because they maintain the highest standard and threshold for safety concern.

After critical analysis of the above mentioned guidelines and discussions of the available evidence, the panel arrived at consensus recommendations for the treatment of MDD in the Middle East region.

Levels of evidence and recommendation

After discussing the levels of scientific confidence, the expert panel agreed that levels of evidence and lines of treatment for the regional recommendations would be assigned according to the criteria listed in Tables 1 and 2.

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
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<tbody>
<tr>
<td>1</td>
<td>≥2 RCTs with adequate sample sizes, double-blind, randomized, placebo-controlled</td>
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<tr>
<td>2</td>
<td>≥1 RCT with adequate sample size, double-blind, randomized, placebo-controlled</td>
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<tr>
<td>3</td>
<td>1 meta-analysis with narrow confidence intervals or ≥2 consistent meta-analyses</td>
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<tr>
<td>4</td>
<td>Non-randomized, controlled prospective studies or case control study or cohort study or high-quality retrospective studies or case series or systematic reviews</td>
</tr>
<tr>
<td>5</td>
<td>Expert opinion/consensus</td>
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</table>
Table 2. Lines of treatment based on levels of evidence

<table>
<thead>
<tr>
<th>Line of treatment</th>
<th>Definition</th>
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<tbody>
<tr>
<td>First line</td>
<td>Level 1 and exact wording of indication in FDA approval</td>
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<tr>
<td>Second line</td>
<td>Level 1 or 2 evidence, plus solid clinical support* without FDA approval</td>
</tr>
<tr>
<td>Third line</td>
<td>Level 3 evidence, plus solid clinical support</td>
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<tr>
<td>Fourth line</td>
<td>Level 4 evidence, plus solid clinical support</td>
</tr>
<tr>
<td>Fifth line</td>
<td>Level 5 evidence, plus solid clinical support</td>
</tr>
</tbody>
</table>

*Solid clinical support is defined as the consensus agreement on best practices based on the experience of a group of practicing psychiatrists from various representative communities in the Arab region and approval of the drug for the indication cited in Canada, Europe, or in other major countries.

Levels of evidence for safety were assigned according to FDA product information reports and are shown in Table 11. This source is the most reliable, comprehensive and consistently updated source of pre- and post-marketing product safety data. In the United States, federal law mandates reporting of all safety data in all studies to the FDA. Post-marketing surveillance further strengthens this information. Consequently, the expert panel agreed to base its safety assessments on this source and recommends it as the best guide for clinicians.

Guidelines development

The discussions and consensus statements were recorded during the meeting and written up as a full manuscript draft by a professional medical writer. The panel reviewed, edited and provided comments on the outline and manuscript drafts until a final version was reached, which was approved by all members.

Recommendations for evaluation of major depressive disorder

Therapeutic alliance

The collaborative aspect of the relationship between the psychiatrist/therapist and a patient is highly relevant to the treatment success. The traditional concept of this alliance includes 1) an agreement between psychiatrist/therapist and patient about the goals of treatment, 2) an agreement about the therapy tasks needed to accomplish those goals, and 3) the emotional bond developed between psychiatrist/therapist and patient, which enables the patient to make therapeutic progress. To establish the working alliance, the psychiatrist must be sensitive to the patient’s concerns and perception of psychiatric treatment. Cultural and religious beliefs should be considered. In the Middle East region, for example, beliefs in possession by spirits and in the impact of sorcery or the evil eye may affect the patient’s interpretation of mental symptoms. In this context, the first resort for the families of mental patients might not even be to consult a medical doctor, but rather the traditional and religious healers who acquire a special importance because of their claim of dealing with the ‘mystical’ and the ‘unknown’. The therapeutic alliance should also include considerations for the role of the patient’s family. Middle Eastern countries emphasize social integration more than individual autonomy. This means that the family, not the individual, is the unit of society. Dependence is more natural and infirmity less alien in these cultures. Some cultures value the collectivity of the community rather than the individuality of its member citizens. Decisions are often not taken on an individual, but rather on a familial level.

Psychiatric evaluation

A comprehensive psychiatric evaluation is necessary for the diagnosis of MDD or other psychiatric conditions. The elements of a complete psychiatric evaluation are listed in Table 3.
Table 3. Elements of a psychiatric evaluation

- Establishing a therapeutic alliance
- Identifying information
- Presenting problem(s) and description of current symptoms
- Onset and course of presenting problem(s)
- Past psychiatric history
- Physical examination
- Routine lab tests, including thyroid function test for all hospital admissions for MDD treatment. This should also be considered, but not required, for those who have failed three consecutive courses of standard antidepressant treatments, especially if any clues to medical problems are noted on the medical history and medical review of systems
- Psychiatric medications, past and current
- History of suicide, homicide or violence
- Past medical history (major illnesses, surgeries, hospitalizations, injuries, accidents, physical or sexual abuse, allergies and current review of medical systems)
- Current health practices (current non-psychiatric prescription medications, current non-prescription and over-the-counter medications, consultation with faith/traditional healers, history of or current substance abuse)
- Family psychiatric and medical history
- Social history (home/family, occupational, financial, educational, interests, leisure activities, legal, support systems – availability and quality and agencies etc. involved with patient and family)
- Mental status examination (appearance, review of range of common psychiatric signs and symptoms, sensorium and intellectual abilities). Note especially any past or current psychotic symptoms or symptoms of mania or hypomania
- Family or caregiver input when possible (including interpretation of symptoms)
- Cultural Formulation Interview (CFI) based on DSM-5
- List of diagnoses, list of ICD-9-CM (V codes) or alternatively ICD-10-CM (Z codes) for psychosocial stressors and other conditions that may be a focus of clinical attention, and assess the degree of dysfunction using a disability scale

Adapted from APA 2010

Measurement-based evaluation and care

Careful and systematic assessment of the patient can be facilitated using measurement tools, such as a structured diagnostic interview, depression symptom scales, disability/functional impairment scales, global improvement scales and suicidality tracking scales. Benefits of using such tools in the initial and ongoing evaluation of the patient include monitoring of treatment progress, improved outcomes and accountability. Furthermore, rating scales allow for comparison over time, quality control and an exhaustive review of the patient’s psychopathological symptoms.

The expert panel recognizes that measurement tools are under-utilized in the Middle East region. This is due to a lack of training on the appropriate use of the scales and structured diagnostic interviews, as well as lack of time in the clinician’s practice. Several measurement scales were translated into Arabic (e.g. Montgomery Asberg Depression Rating Scale (MADRS), Hamilton Depression Rating Scale (HAMD), PHQ-9 Depression Scale, Sheehan Disability Scale (SDS)), but only the Mini International Neuropsychiatric Interview (MINI) is available. Consequently, the expert panel recommends that healthcare practitioners in the region work at developing culturally appropriate tools in the future. In addition, the patients themselves, as well as the clinic staff, could be involved in the completion of the measurement tools.

Recommendations for the treatment of major depressive disorder

Treatment modalities

Modalities for the treatment of acute phase major depressive disorder include active management, pharmacotherapy, psychotherapy, a combination of medications and psychotherapy, and other approaches such as electroconvulsive therapy (ECT), also known as (BST) Brain Synchronization Treatment. Treatment selection should be influenced by the patient’s clinical features and preferences for treatment, as well as prior response, the treatment cost and the presence of co-
morbidities. The expert panel agreed on the levels of efficacy of the key treatment modalities used to provide remission in acute phase MDD listed in Table 4.

Table 4. Recommended treatment modalities for acute phase of MDD based on severity

<table>
<thead>
<tr>
<th>Modality</th>
<th>Severity</th>
<th>Moderate</th>
<th>Severe without psychotic features</th>
<th>Severe with psychotic features</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
</tr>
<tr>
<td>Pharmacotherapy alone</td>
<td>Yes (Level 1)</td>
<td>Yes (Level 1)</td>
<td>Yes (Level 1)</td>
<td>Yes (combination of antidepressant and antipsychotic medication) (Level 1)</td>
</tr>
<tr>
<td>Pharmacotherapy + psychotherapy</td>
<td>Useful for patients with psychosocial/interpersonal or social problems, intra-psychic conflict (Level 2)</td>
<td>Useful for patients with psychosocial/interpersonal problems, intra-psychic conflict (Level 2)</td>
<td>Yes (Level 2)</td>
<td>Yes (combination of antidepressant and antipsychotic medication) (Level 2)</td>
</tr>
<tr>
<td>Psychotherapy alone</td>
<td>Yes (Level 3)</td>
<td>Yes (Level 3)</td>
<td>No (Level 4)</td>
<td>No (Level 4)</td>
</tr>
<tr>
<td>BST*</td>
<td>No evidence</td>
<td>No evidence</td>
<td>Yes (Level 1)</td>
<td>Yes (Level 1)</td>
</tr>
<tr>
<td>ECT**</td>
<td>Should not be used</td>
<td>No evidence</td>
<td>Yes (Level 1)</td>
<td></td>
</tr>
<tr>
<td>TMS</td>
<td>No evidence</td>
<td>No evidence</td>
<td>No evidence</td>
<td>No evidence</td>
</tr>
</tbody>
</table>

Adapted from APA 2010

BST - brain synchronization treatment, ECT - electroconvulsive therapy, TMS - transcranial magnetic stimulation

*BST is now the preferred nomenclature for ECT; however, the term ECT remains commonly used for this treatment in many Arab countries. ECT is a misnomer as there should be no convulsion during the treatment. This change in nomenclature should help to reduce the stigma of ECT with patients and families (Okasha A and Okasha T, 2014. A plea to change the misnomer ECT. World Psychiatry 13:327).

**According to the APA guidelines (APA, 2010), BST (ECT) is a treatment option for pregnant patients with moderate to severe depression who are unresponsive to or unsuitable for pharmacotherapy; for pregnant patients with MDD with psychotic features; and for pregnant patients who choose this modality as a matter of preference. Based on review studies and meta-analyses suggesting that the risk of hazardous side effects, although minimal, is not zero, the expert panel recommends that the optimal benefit-to-risk trade-off be determined and documented in each case.

Providing active support, advice on exercise, accurate education on and correcting popular misconceptions about the disorder, encouraging self-management and activation of social support networks (family, friends), and referral for counseling if available are often helpful adjunctive measures. However, they are not intended to replace or substitute for the standard, evidence-based treatments for MDD listed in Table 4.

Depression-focused psychotherapies such as Interpersonal Psychotherapy (IPT) and Cognitive Behavioral Therapy (CBT) should be considered in the treatment plan in combination with medication, especially for those who have had a good response to a particular psychotherapy in the past or who strongly prefer to avoid medication. However, IPT, CBT or psychotherapy should not be mandatory adjuncts to medication for patients who prefer to avoid it.

Pharmacotherapy

The overall goals of treatment of MDD should focus on alleviating functional impairments and improving quality of life in addition to achieving symptom and episode remission.
Selection criteria for antidepressants

Antidepressants are classified as tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs) and other novel antidepressants. Overall efficacy between classes is similar, but safety and tolerability vary across and within classes of antidepressants as well as across individuals.

The selection of an appropriate antidepressant medication should take into consideration the patient’s preference, the nature of the prior response to a medication, the family history of response to a specific antidepressant, the safety and tolerability profile, the patient’s psychiatric and medical comorbidities, potential drug interactions, and cost.

Efficacy of antidepressants

- Serotonin norepinephrine reuptake inhibitors
  The ‘newer’ generation of antidepressants includes venlafaxine, desvenlafaxine, duloxetine, vortioxetine and milnacipran which all demonstrate superior efficacy when compared with placebo.22, 23 Several randomized controlled trials have shown similar efficacy between venlafaxine and duloxetine, and SSRIs.24, 25
- Selective serotonin reuptake inhibitors
  This class includes fluoxetine, sertraline, paroxetine, citalopram, escitalopram, fluvoxamine, and vilazodone. Several studies show no differences in efficacy within this class of antidepressants.23, 26-28 SSRIs are superior to placebo in the treatment of MDD and their efficacy matches that of TCAs.29, 30 Tricyclic antidepressants, these ‘older’ antidepressants, have a well-established efficacy in treating MDD when compared with SSRIs, SNRIs and MAOIs.31 They are effective in treating hospitalized patients with severe to moderate–severe major depressive disorder.32, 33 Based on the efficacy registration studies, the FDA did not approve fluvoxamine for the treatment of MDD.

- Monoamine oxidase inhibitors
  These antidepressants are usually not considered first-line treatment, despite their comparable efficacy to other classes, given their safety issues.34, 35 In fact, MAOIs are now mostly prescribed to patients with MDD who have tried several other medications without adequate response.

- Other antidepressants
  The efficacy of bupropion is comparable to that of the SSRIs, but unlike most other antidepressants it is not effective in addressing any primary anxiety disorder.36 It might, however, be helpful in the treatment of MDD in overweight or obese patients given the minimal weight gain typically experienced.

The noradrenergic/specific serotonergic agent (NaSSA) mirtazapine is comparable to SSRIs in terms of efficacy.37, 38 Trazodone, a serotonin modulator, is an effective antidepressant when compared with placebo,39,40 but is more frequently used in clinical practice for its sedative–hypnotic effect. It is used, but not approved for any insomnia indication. Trazodone can cause postural hypotension in elderly patients.17 Agomelatine has been shown to be superior to placebo in some double-blind placebo-controlled registration trials, but is not approved by the FDA for the treatment of major depressive disorder, because the risk benefit trade off was judged unacceptable.41

Safety of antidepressants

Given the comparable efficacy across the various antidepressant classes and agents, the selection of an antidepressant is generally based on its safety and tolerability. Safety differs across classes and may differ within a class. Polypharmacy is common in patients with MDD because of associated medical and psychiatric comorbidities and limited response to antidepressant monotherapy. Safety within individuals may be based on the potential for drug–drug interactions given most antidepressants’ effect on cytochrome P450 enzymes (Tables 5 and 6, Figure 1).
**Figure 1:** How antidepressants are metabolized

![Diagram of antidepressant metabolism](image)

**Table 5.** Cytochrome P450 enzyme inhibition by antidepressant agents

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>1A2</th>
<th>2A6</th>
<th>2B6</th>
<th>2C8</th>
<th>2C9</th>
<th>2C19</th>
<th>2D6</th>
<th>2E1</th>
<th>3A4</th>
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<td>Bupropion</td>
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<td>Duloxetine</td>
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<td>Escitalopram</td>
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<td>Fluoxetine</td>
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<tr>
<td>Vilazodone</td>
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<tr>
<td>Vortioxetine</td>
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<tr>
<td>Agomelatine</td>
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</tbody>
</table>

Adapted from APA 2010

Note: The antidepressants in the first column inhibit the CYP450 enzymes indicated in columns 2-10. For example, fluoxetine is a major inhibitor of CYP 2D6. By inhibiting 2D6, this will result in an increased blood level of medications metabolized by the 2D6 system including most tricyclic antidepressants and many neuroleptics, causing an increase in side effects and toxicity associated with these latter medications.
### Table 6. Cytochrome P450 enzyme metabolism of antidepressant agents

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>1A2</th>
<th>2B6</th>
<th>2C9</th>
<th>2C19</th>
<th>2D6</th>
<th>3A4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amitriptyline</td>
<td>†</td>
<td>†</td>
<td>††</td>
<td>††</td>
<td>††</td>
<td>†</td>
</tr>
<tr>
<td>Bupropion</td>
<td>†</td>
<td>††</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td>†</td>
</tr>
<tr>
<td>Hydroxybupropion</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td></td>
<td></td>
<td>††</td>
<td>†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desipramine</td>
<td>†</td>
<td></td>
<td></td>
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<td></td>
<td>†</td>
</tr>
<tr>
<td>Desvenlafaxine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Duloxetine</td>
<td></td>
<td>††</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escitalopram</td>
<td>††</td>
<td>†</td>
<td>†</td>
<td>†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>††</td>
<td>†</td>
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<td>†</td>
<td>†</td>
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<tr>
<td>Norfluoxetine</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Imipramine</td>
<td>††</td>
<td>†</td>
<td>††</td>
<td>††</td>
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<td>†</td>
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<tr>
<td>Maprotiline</td>
<td>†</td>
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<td>†</td>
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<tr>
<td>Milnacipran</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>††</td>
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<tr>
<td>Mirtazapine</td>
<td>††</td>
<td>†</td>
<td></td>
<td>††</td>
<td>†</td>
<td>††</td>
</tr>
<tr>
<td>8-Hydroxymirtazapine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mirtazapine-N-oxide</td>
<td></td>
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<td></td>
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<tr>
<td>Nortriptyline</td>
<td>†</td>
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<tr>
<td>Paroxetine</td>
<td></td>
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<tr>
<td>Protriptyline</td>
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<td>††</td>
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<tr>
<td>Selegiline</td>
<td>††</td>
<td>††</td>
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<td></td>
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<tr>
<td>Sertraline</td>
<td></td>
<td></td>
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<tr>
<td>Venlafaxine</td>
<td></td>
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<td></td>
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<tr>
<td>O-Norvenlafaxine</td>
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<td></td>
<td></td>
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<tr>
<td>Vilazodone</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>††</td>
</tr>
<tr>
<td>Vortioxetine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>††</td>
</tr>
<tr>
<td>Agomelatine</td>
<td>†††</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from APA 2010

Note: The antidepressants in the first column are metabolized by the CYP450 enzymes indicated in columns 2-7. For example, medications like fluvoxamine or ciprofloxacin that inhibit the 1A2 system will result in increased blood levels of all meds metabolized by the 1A2 system e.g. agomelatine, mirtazapine and imipramine, causing an increase in side effects and toxicity associated with these medications.

The relative risks and benefits of all medications must be considered when looking at treatment options (Table 7). Based on the FDA and EMA (CHMP) Product Information reports, the expert panel agreed on the safety classification of treatment modalities for MDD listed in Table 8.
Table 7. Potential side effects of antidepressant classes

<table>
<thead>
<tr>
<th>Antidepressant class</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs and SNRIs</td>
<td>Nausea, vomiting, sexual side effects (delayed time to orgasm or ejaculation or orgasmic or ejaculatory blockade), headaches, activation, abnormal bleeding, hypertension, hyponatremia, potential dose-dependent QT interval prolongation (citalopram), increased risk of suicidal ideation and behaviors in children and adolescents and those under 25*.</td>
</tr>
<tr>
<td>TCAs</td>
<td>Cardiovascular: arrhythmia, tachycardia, orthostatic hypotension, QT interval prolongation Anticholinergic: constipation, dry mouth, urinary hesitancy, Increased risk of suicidal ideation and behaviors in adolescents and those under 25*. Hepatotoxicity, blood dyscrasias, delirium.</td>
</tr>
<tr>
<td>MAOIs*</td>
<td>Hypertension (with high-tyramine foods or other vasoactive amines from medications)</td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
<tr>
<td>Bupropion*</td>
<td>Insomnia, activation, dry mouth, seizures</td>
</tr>
<tr>
<td>Mirtazapine*</td>
<td>Weight gain, sedation, dry mouth, agranulocytosis</td>
</tr>
<tr>
<td>Trazodone*</td>
<td>Sedation, priapism, postural hypotension in elderly</td>
</tr>
<tr>
<td>Agomelatine* and **</td>
<td>Hepatotoxicity</td>
</tr>
</tbody>
</table>

MAOI, monoamine oxidase inhibitor; SNRI, serotonin-norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant.

* All antidepressants have suicidality risk as a class warning in the labeling.

** It is important to monitor liver function when treating patients with agomelatine. As per product labeling, agomelatine is contraindicated in patients with liver impairment and in those taking any CYP 1A2 inhibitor (e.g. fluvoxamine and ciprofloxacin). Proceed with caution when prescribing agomelatine to patients with pre-treatment elevated transaminase levels or hepatic injury risk factors, e.g. obesity/overweight/non-alcoholic fatty liver disease, substantial alcohol intake or use of concomitant medicines associated with risk of hepatic injury, diabetes. Prescribers are also reminded that agomelatine is contraindicated in patients with hepatic impairment i.e. cirrhosis or active liver disease.

Table 8. Levels of safety based on FDA Product Information

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minimal safety concern*</td>
<td>SSRIs, SNRIs, bupropion, mirtazapine, trazodone, TMS (the Neuronetics and the Brainsway Ltd devices only), CBT, psychotherapy</td>
</tr>
<tr>
<td>2</td>
<td>Modest safety concern**</td>
<td>TCAs, MAOIs, augmenting atypical neuroleptics</td>
</tr>
<tr>
<td>3</td>
<td>Of serious clinical concern***</td>
<td>BST (ECT), VNS, agomelatine</td>
</tr>
</tbody>
</table>

BST, brain synchronization treatment; CBT, cognitive behavioral therapy; ECT, electroconvulsive therapy; MAOI, monoamine oxidase inhibitor; SNRI, serotonin-norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant; TMS, transcranial magnetic stimulation; VNS, vagus nerve stimulation

*No investigations, no dosing procedures or dietary/drug restrictions recommended by regulatory agencies.

**Good clinical practice suggests that certain investigations be done or dosing procedures or dietary/drug restrictions be followed for some patients under some circumstances, but FDA or EMA regulatory agencies do not routinely recommend or mandate such investigations.

***Mandatory investigations for all patients.

Implementation of pharmacological intervention

Based on the review of efficacy and safety data of the various treatment modalities for MDD, the expert panel developed a treatment algorithm to guide clinicians who treat patients with MDD in the Middle East region, shown
in Table 9. The final assignment for each drug or drug class was based on risk-benefit tradeoffs that emerged from the review of the efficacy and safety data.

### Table 9. Treatment algorithm for major depressive disorder

<table>
<thead>
<tr>
<th>Line of treatment</th>
<th>Treatment modality</th>
</tr>
</thead>
<tbody>
<tr>
<td>First line</td>
<td>SSRIs and SNRIs</td>
</tr>
<tr>
<td>Second line</td>
<td>Bupropion SR or XL, trazodone, mirtazapine</td>
</tr>
<tr>
<td>Third line</td>
<td>TCAs, agomelatine</td>
</tr>
<tr>
<td>Fourth line</td>
<td>MAOIs, tianeptine</td>
</tr>
<tr>
<td>Fifth line</td>
<td>BST (ECT), TMS</td>
</tr>
</tbody>
</table>

BST, brain synchronization treatment; ECT, electroconvulsive therapy; MAOI, monoamine oxidase inhibitor; SNRI, serotonin-norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant; TMS, transcranial magnetic stimulation.

Note: All above medications have serious side effects. Please check the FDA Product Information prior to recommending to your patient. Nefazodone has been withdrawn from most countries and is not indicated for the treatment of MDD.

The consensus group also discussed the importance of basic investigations upon implementation of pharmacotherapy as well as necessary monitoring. They suggest obtaining a basic metabolic panel (including liver function and kidney function tests, glucose level, HbA1c) on all patients before starting any psychiatric medication, particularly in view of the high incidence of diabetes and diabetic renal complications in the Middle East region. This should be encouraged. In the final analysis, the need for such additional testing should be based on medical and family history and any associated physical findings. In addition, liver function tests should be assessed prior to treatment and after dose stabilization and monitored regularly for patients on agomelatine. Blood pressure assessment and monitoring should be performed for patients on SNRIs and MAOIs. For treatment with TCAs, the panel also recommended electrocardiograms (ECGs) at baseline, after initial dose stabilization, and after significant dose changes, with special attention to PR and QTc interval prolongation and arrhythmias. Caution is needed in children, in those over the age of 60 or with cardiovascular disease, and at higher doses. Recommended monitoring for antidepressants and adjuvants are shown in Table 10.

### Table 10. Recommended monitoring of some medications and adjuvants used in the treatment of MDD

<table>
<thead>
<tr>
<th>Agent</th>
<th>Recommended monitoring</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agomelatine*</td>
<td>Liver function tests</td>
<td>1. At baseline initiation&lt;br&gt;2. At 3, 6, 12, 24 weeks after initiation or dosage increase, with further testing when clinically indicated and every 4 months after week 24</td>
</tr>
<tr>
<td>TCAs</td>
<td>ECG</td>
<td>Pre-treatment:&lt;br&gt;o Patients with cardiovascular risk factors&lt;br&gt;o Patients &lt; 18 years or &gt;50 years or&lt;br&gt;&lt;br&gt;ECG monitoring is recommended twice yearly for patients prescribed a higher dose. When the dose is stabilized, a minimum of an annual ECG is recommended in the absence of CVD.</td>
</tr>
<tr>
<td>Lithium</td>
<td>Lithium levels</td>
<td>After each dose change from 900 mg per day and higher and thereafter every 2 months (due to hot and humid weather in the Middle East region, lithium monitoring might be needed more often).</td>
</tr>
<tr>
<td></td>
<td>Serum creatinine, free T4, free T3 and TSH</td>
<td>Every 4 months</td>
</tr>
</tbody>
</table>
Partial and non-response in major depressive disorder

Partial response is defined as less than 50% improvement of baseline level of severity. Partial and non-response should be first addressed by gradually increasing the medication dose and allowing sufficient time for response. The expert panel recommends allowing four to six weeks following the increase to the maximum tolerated dose before switching to another first line agent (SSRIs and SNRIs). The expert committee’s recommended strategy for further lack of adequate response is switching to an antidepressant from another class or augmenting with any of the following adjuvants:

- Aripiprazole or quetiapine XR (Level 1)
- Lithium (Level 2)
- Olanzapine (Level 2)
- T3 (Level 2)
- Risperidone (Level 4)

The panel agreed that switching to another class of antidepressants is not any more effective than switching to an agent within the same class.44

Treatment-resistant major depressive disorder

While there is no consensus definition of treatment-resistant major depressive disorder, the one most commonly used is <20% reduction in depression scores after a trial of at least two different classes of antidepressants at the maximum tolerated dose, for an adequate duration (i.e. eight weeks). Treatment options include augmentation with an agent or modality that is not an antidepressant, combining with another antidepressant or switching to a different agent (Table 11). The expert panel developed an algorithm for the management of pharmacotherapy in the occurrence of partial or non-response, shown in Figure 2.

<table>
<thead>
<tr>
<th>Augment with:</th>
<th>Level of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole* or quetiapine XR* or Neurontics TMS</td>
<td>Level 1</td>
</tr>
<tr>
<td>Lithium or lamotrigine or BST (ECT) or L-methyl folate</td>
<td>Level 2</td>
</tr>
<tr>
<td>None</td>
<td>Level 3</td>
</tr>
<tr>
<td>Mood stabilizer or other antipsychotic or another antidepressant</td>
<td>Level 4</td>
</tr>
<tr>
<td>Psychotherapy (CBT, interpersonal, family-focused)</td>
<td>Level 5</td>
</tr>
</tbody>
</table>

BST, brain synchronization treatment; CBT, cognitive behavioral therapy; ECT, electroconvulsive therapy; TMS, transcranial magnetic stimulation.

*FDA-approved for treatment-resistant depression.
**Arab treatment guidelines for the management of Major Depressive Disorder**

**Figure 2. Medication strategy for major depressive disorder**

Length of pharmacological treatment and recurrence risk for MDD

Pharmacotherapy duration should take into consideration the number of major depressive episodes the patient has experienced. A first MDD episode warrants a minimum of 6 months of pharmacological treatment following clinical and functional remission. This is associated with a 50% recurrence risk within a year of recovery from the index episode. Antidepressants should be continued for three to five years after remission is achieved in the event of a second episode, which carries a 70% recurrence risk within a year of recovery. Finally, the third MDD episode is associated with greater than 90% recurrence risk within a year of recovery and therefore medications should be implemented indefinitely unless there is compelling evidence to justify discontinuation.45, 46

Other treatment modalities

**Psychotherapy**

Cognitive behavioral therapy (CBT) is currently the most studied and efficiently used psychotherapy option. CBT aims to solve problems by identifying and tracking the patient’s dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure focused on the present.47 CBT should only be done by trained therapists and is considered an effective mode of management of MDD.

**Brain synchronization therapy (BST), electroconvulsive therapy (ECT)**

The use of BST (ECT) is more prevalent in certain regions of the world. Several studies showed that maintenance BST (ECT) is beneficial especially in drug-resistant major depressive disorder, intolerance or contraindication to antidepressants.48,49 It can be effective acutely, but is not effective in protecting from long-term relapse.

**Transcranial magnetic stimulation (TMS)**

The use of TMS for the treatment of MDD is still in its early stage. Neuronetics Neuro-Star and Brainsway Ltd

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SSRI, selective serotonin reuptake inhibitor; SNRI, serotonin-norepinephrine reuptake inhibitor; TCA, tricyclic antidepressant; MAOI, monoamine oxidase inhibitor.
are currently the only FDA-approved devices for MDD subjects who are either treatment-resistant (Brainsway Ltd) or have failed to achieve satisfactory improvement from one prior antidepressant medication at or above the minimal effective dose and duration in the current episode (Neuronetics). The results from most studies conducted with devices other than the Neuronetics andBrainsway devices varied in efficacy and could not be clearly established due to the wide variability in the quality of the other TMS devices used. One study showed that a better acute response to TMS could result in less treatment resistance. The user manual for the Neuronetics device warns that effectiveness has not been established in patients with MDD who have failed to achieve satisfactory improvement from zero and from two or more antidepressant medications in the current episode and that, the device has not been studied in patients who have had no prior antidepressant medication.

**Treatment not approved as monotherapy**

The panel of experts agreed that the following treatment modalities should not be used as monotherapy in the treatment of major depressive disorder:

- Benzodiazepines are not antidepressants. They are effective only for anxiety symptoms. They have no specific effect on depressive symptoms or MDD overall. However, they can be helpful for anxiety co-occurring with MDD when used in conjunction with an antidepressant.
- Atypical neuroleptics are a useful augmentation strategy, but should not be used as monotherapy due to the substantial risk of metabolic syndrome and high rates of diabetes in the Middle East region.
- Typical neuroleptics
- Anticonvulsants
- Lithium is not an effective treatment for acute depressive episodes, but it can be used to augment response. It is effective in protecting from future relapses and it has a better anti-suicidal effect than other antidepressants.
- L-methyl folate
- St. John’s Wort*, acupuncture, homeopathy

*The value of St. John’s Wort in the treatment of MDD has been the subject of multiple studies leading to variable outcomes. However, the two largest and most rigorous placebo-controlled, multicenter trials conducted in the United States both found St. John’s Wort ineffective in the treatment of MDD. Furthermore, the potential for drug–drug interactions is a major consideration. Through its effect on CYP 3A4, St. John’s Wort induces metabolism of various drugs such as antiretroviral medications, immunosuppressants (including cyclosporine), antineoplastic agents, anticoagulants (including warfarin), oral contraceptives, and hormone replacement therapy, resulting in a reduction of efficacy with those medications.

**Treatment compliance**

To assess and promote patient compliance, clinicians should inquire about any history of previous non-compliance, family support and cultural or religious attitudes that might affect treatment adherence. Patient and family education is pivotal. It is particularly important to emphasize that antidepressants are not addictive. Patient education regarding time to response, time to remission and necessary duration of treatment with antidepressants plays an important role in setting expectations. Medication side effects should also be addressed as they often drive patient non-compliance. Enlisting the collaboration of family and of the patient’s support network in ensuring compliance with the treatment plan is even more important in Arab than in Western countries.

**Suicidality**

Suicide is difficult to predict and suicidal ideation and behavior should be assessed before starting treatment and then monitored repeatedly throughout the course of treatment for all patients with MDD. The expert panel agreed that any patient at significant suicidal risk should be admitted for treatment based on local laws. In the region, particular consideration should be given to “accidents and accidental overdoses”.

Recent studies report that the risk of treatment emergent suicidal ideation and behaviors on antidepressants is age-dependent. In a study by Stone, the risk of suicidal ideation and suicidal behavior in adults under 25 years of age was higher than placebo and this risk increased as the age decreased. In those between 25 and 65 antidepressants had the same effect as placebo on treatment emergent suicidal ideation and behavior. Only in those aged ≥65 do antidepressants decrease the risk compared to placebo. Recognizing the variety of antidepressants and treatment options currently available for the treatment of MDD, the panel of experts recommends advising patients of all age groups on the risks and benefits of treating their condition with an antidepressant or with other treatments, as well as the risks and benefits of not treating their condition. Major Depressive Disorder significantly increases the risk of suicidal ideation and behavior. This risk is higher if a family member has thought of or attempted suicide. The
patient’s condition, symptoms and personal and family medical history should be taken into consideration when deciding on the appropriate type of treatment.

**Special populations**

**Children and adolescents**

Antidepressants have all consistently failed to separate from placebo in children under the age of 18, except for fluoxetine and escitalopram, which are FDA-approved for the acute and maintenance treatment of major depressive disorder in pediatric patients aged 8 to 18 years (fluoxetine) and 12 to 17 years (escitalopram). This population should be monitored closely given the elevated risk of suicide.

**Elderly**

The presence of chronic illness is a risk factor for major depressive disorder in this patient population. The increased risk for completed suicide associated with males over the age of 65 years mandates that suicide risk assessment be part of the evaluation. Special consideration should be given to drug–drug interactions given the polypharmacy in this population. Treatment should not be initiated with the maximum dose of antidepressant and more time to response should be allowed due to slower drug metabolism in this age group.

**Substance use disorder**

The evidence for the treatment of MDD when it is co-morbid with substance abuse and dependence is limited (Level 5). MDD should be treated as usual with consideration for the substance use disorder. Clinical experience, but not compelling scientific evidence, suggests that proper treatment of the MDD enhances compliance in managing the substance use disorder and in adherence to the long-term abstinence from the abused substance (Level 5).

**Pregnancy and breastfeeding**

There are no controlled trials on the use of antidepressants during pregnancy. Most antidepressants are labeled as Category C. This means that there are animal data suggesting teratogenic effects and no compelling evidence supporting the safety of the medication for the human fetus. The FDA labels paroxetine as pregnancy Category D, which means that studies in pregnant women (controlled or observational) have demonstrated a risk to the human fetus (atrial and ventricular septal defects, persistent pulmonary hypertension of the newborn), but the benefits of therapy may still outweigh the potential risks to the fetus. A recent population-based cohort study from all Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) showed no significant association between the use of SSRI antidepressants during pregnancy and risk of stillbirth, neonatal death or postnatal death. Rates of stillbirth and postnatal death were higher in women who used SSRIs than those who did not, but statistical analyses showed that the increase was more likely to be due to other factors - such as severity of underlying psychiatric illness, smoking and older age - that were more common among SSRI users.

The panel recommends tackling this issue on a case-by-case basis through conducting a simple risk analysis weighing the pros and cons and taking into consideration the cultural background of the family and their personal preferences.

**Value of generics**

Given the large number of generic medications available in the region, the expert panel offers a note of caution and warns that not all generics are equally good. Quality control is not carried out on all generic products in Arab countries. To obtain FDA approval, a generic in the USA must have bioavailability of between 80% and 125% of the approved brand. There are many generics not allowed into the USA for this reason. The panel recommends that people in Arab countries not be exposed to the hazards of flawed generics, as in Canada, Europe and the USA. Due to the variability in bioavailability, patients who are clinically stable on a specific generic should not be switched to a different one; if switched, patients need to be monitored for either an increase in side effects or loss of efficacy.

**Conclusion**

The current report has summarized the consensus agreement of an expert panel for the treatment of MDD in the Middle East region based on evidence-based international guidelines and a review of the relevant literature. It is the opinion of the expert panel that the diagnosis and treatment of MDD should be done systematically using psychiatric measurement tools. The panel encourages the development of regional culturally appropriate depression scales and questionnaires. All classes of antidepressants are equal in terms of efficacy. However, safety and tolerability often differ and determine the selection of antidepressant. Consequently, the expert panel based its treatment recommendations on levels of evidence for efficacy AND safety developed according to the FDA Product Information reports. For drugs not approved by the FDA, the safety data is based on EMA regulatory documents. For all patients, and particularly those with partial or non-response to
pharmacological treatment, it is pivotal to ensure that the adequate dose of antidepressant is used for the appropriate treatment duration. Recurrence risk should be considered when deciding on pharmacological treatment duration. These guidelines provide clinicians with the appropriate evidence-based medication strategy for patients with partial or non-response to pharmacotherapy.

There is strong evidence that improvement in major depressive disorder also comes from non-pharmacological aspects of the intervention; a very important factor is the therapeutic alliance. The relationship between therapeutic alliance and outcome seems remarkably robust across treatment modalities and clinical presentations. What emerges from the evidence is that non-specific factors (client variables, extratherapeutic events, relationship variables and expectancy and placebo effects) account for about 85% of the variance in therapeutic outcomes across the psychotherapy field.

The compliance of psychiatrists with practice guidelines is usually poor in the region. This could be due to the lack of culturally tailored recommendations. Given the regional specificity of these guidelines for the treatment of MDD (addressing social determinants, religious beliefs, available resources and reaction to treatment modalities), compliance might increase and lead to improved patient outcomes. Members of the working group acknowledged that these guidelines should be followed as closely as possible and used alongside clinical judgment. It is also recommended that collaborative projects be developed and initiated regionally to study clinical outcomes of treatment of MDD in the Middle East.

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**Editorial**

A Critical Review of the Literature: Safety, Tolerability and Risks Associated with Newer Generation Antidepressant Drugs

Ahmed Okasha

Abstract

Newer generation antidepressant drugs (ADs) are widely used as the first line of treatment for major depressive disorders and are considered to be safer than tricyclic agents. Several side effects are transient and may disappear after a few weeks following treatment initiation, but potentially serious adverse events may persist or ensue later. They encompass gastrointestinal symptoms (nausea, diarrhea, gastric bleeding, dyspepsia), hepatotoxicity, weight gain and metabolic abnormalities, cardiovascular disturbances (heart rate, QT interval prolongation, hypertension, orthostatic hypotension), genitourinary symptoms (urinary retention, incontinence), sexual dysfunction, hyponatremia, osteoporosis and risk of fractures, bleeding, central nervous system disturbances (lowering of seizure threshold, extrapyramidal side effects, cognitive disturbances), sweating, sleep disturbances, affective disturbances (apathy, switches, paradoxical effects), ophthalmic manifestations (glaucoma, cataract) and hyperprolactinemia. At times, such adverse events may persist after drug discontinuation, yielding iatrogenic comorbidity. Other areas of concern involve suicidality, safety in overdose, discontinuation syndromes, risks during pregnancy and breast feeding, as well as risk of malignancies. The rational selection of ADs should consider the potential benefits and risks, likelihood of responsiveness to the treatment option and vulnerability to adverse events.1

Keywords: Antidepressant drugs, SSRI, SNRI, TCA, iatrogenic comorbidity

Declaration of interest: None

**Introduction**

Studies have shown that up to 43% of patients with (Major Depressive Disorder) MDD may discontinue antidepressants due to treatment-emergent adverse effects.2 The introduction of tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors in the 1950s revolutionized the treatment of MDD. Since then, the search for more selective and possibly better tolerated ADs has continued. This movement of rational drug development gave birth to selective serotonin reuptake inhibitors (SSRIs). The ensuing years have witnessed SSRIs becoming the first line drugs for the treatment of MDD among several other indications.3 Following the marketing success of SSRIs, many newer generation antidepressants have gained approval as treatments for MDD, including but not limited to serotonin and noradrenaline reuptake inhibitors (e.g. venlafaxine, desvenlafaxine and duloxetine), bupropion (a noradrenaline and dopamine reuptake inhibitor), mirtazapine (noradrenaline and selective serotonin antagonist) and trazodone (serotonin antagonist and reuptake inhibitor). With the exception of agomelatine (melatonin receptor agonist with 5-HT2C receptor antagonist properties), all other agents primarily act through the modulation of monoaminergic neurotransmission.4,5 Over the past four years, the US FDA has approved three additional antidepressants for the treatment of MDD, namely vilazodone, levomilnacipran and vortioxetine.6

**Cardiovascular**

Among the SSRIs, citalopram may cause a clinically significant increase in the QTc interval and has been associated with cases of torsades de pointes.7 A few case reports have suggested an association whereby the use of fluoxetine and sertraline may lead to QTc prolongation in individuals with preexisting risk factors for QTc prolongation. Paroxetine can be considered the least likely SSRI to cause QTc prolongation.7
Risks associated with newer generation antidepressant drugs

Venlafaxine use has been associated with clinically significant increases in diastolic blood pressure of up to 15 mm Hg from baseline. This risk was lower among individuals receiving doses of less than 200 mg daily.8-9 Duloxetine may also increase blood pressure and levomilnacipran may increase both systolic and diastolic blood pressure, although the magnitude of the effect seems to be small and its clinical significance is yet to be determined.10 It is well established that TCAs may cause orthostatic hypotension due to their well-known antagonistic α1-adrenergic receptor activity.11-12 The main mechanisms associated with SSRI-induced orthostatic hypotension remain unknown. Postural hypotension associated with the use of SSRIs is most commonly observed in elderly populations (Anticholinergic effects).11 Paroxetine seems to be the SSRI most frequently associated with orthostatic hypotension at least partly due to its anticholinergic effects.13 Similarly, fluoxetine use has also been associated with an increased incidence of orthostatic hypotension among the elderly.14 Some studies suggest that venlafaxine may cause orthostatic hypotension in more than 50% of patients aged over 60 years, most likely secondary to its strong noradrenergic action.15

Genitourinary

Urinary retention secondary to the use of SSRIs appears to be a rather rare event and is supported only by case reports.16 In most cases, SSRIs have been implicated only when used in combination with benzodiazepines and/or antipsychotics. These case reports have particularly concerned fluvoxamine, while fewer studies have implicated fluoxetine.16 There have also been a few reports to suggest that venlafaxine can also cause urinary incontinence. Even though the exact underlying mechanism is unknown, the action of venlafaxine on 5-HT4 receptors appears to cause incontinence.17 Likewise, duloxetine appears to be associated with both urinary retention and hesitancy.9

Sexual dysfunction

Loss of libido has been reported to affect 25-75% of patients with MDD, and its prevalence may correlate with the severity of depressive symptoms.18 A significant body of data shows that antidepressants may differentially affect sexual function in multiple aspects, leading to reductions in libido, arousal dysfunction (erection in males and vaginal lubrication in females) and orgasmic dysfunctions.19-20 Several mechanisms may contribute to antidepressant-induced sexual dysfunction, including but not limited to psychosocial factors and comorbid medical diseases, as well as the use of other medications that may affect sexual function.19 The serotonergic action of SSRIs and SNRIs reduces dopaminergic transmission in the mesolimbic area, which in turn is known to regulate orgasm and sexual desire.21 These effects are reduced or absent among individuals taking medications with a predominant effect on dopamine or noradrenaline reuptake (e.g. bupropion). Mirtazapine and agomelatine have been associated with lower risks of sexual side effects.22

Preliminary data suggest that vortioxetine and vilazodone might have some advantage over SSRIs with regards to sexual side effects.23-25 TCA, e.g. Clomipramine, imipramine and amitryptiline, are particularly troublesome, whereas nortriptyline may be less so.26-27 Some antidotes (e.g. bupropion) have been proposed as effective strategies for a subgroup of patients.28 The use of type 5 phosphodiesterase inhibitors (e.g. sildenafil, tadalafil and vardenafil) may also alleviate antidepressant-induced erectile dysfunction.19 Finally, it is worth mentioning that for a small group of patients sexual dysfunction may either persist after treatment discontinuation or be a transitory phenomenon during AD treatment.29

Hyponatremia

SSRIs and venlafaxine appear to be the antidepressants most commonly associated with hyponatremia.30 The incidence could be slightly higher for fluoxetine, citalopram and escitalopram, whereas incidence rates may be lower for paroxetine and sertraline31-32 The risk of hyponatremia is significantly higher in elderly patients and among individuals using diuretics. The discontinuation of the antidepressant, fluid restriction and diuresis are possible measures that can be taken to treat antidepressant-induced hyponatremia.33

Osteoporosis and fractures

Multiple studies and a subsequent meta-analysis have associated depression with an increased risk of fractures and a reduction in bone density among patients.34 This reduction in bone density and a metabolic state which favors bone resorption has been attributed to a complex interplay between the hypothalamic-pituitary-adrenal (HPA) axis and inflammation.35 Patients with depression tend to have increased secretion of cortisol and also display elevation in markers of inflammation, especially, IL-1, IL-6 and TNF-α (which in turn can also increase cortisol secretion).36
Bleeding

SSRIs have been associated with an increased risk of bleeding during surgical procedures. The risk of bleeding appears to be higher with concomitant use of nonsteroidal anti-inflammatory drugs (NSAIDs) including aspirin, preexisting platelet dysfunction, or a concomitant use of heparin.

Central nervous system

All kinds of EPS are seen in patients taking antidepressants, but akathisia appears to be the most common presentation followed by dystonic reactions, parkinsonian movements and tardive dyskinesia. Among antidepressants, SSRIs have the highest number of case reports of EPS. The incidence of EPS appears to be highest among patients taking duloxetine, followed by sertraline, escitalopram, paroxetine, fluoxetine, bupropion and citalopram in decreasing order of incidence. The elderly and individuals who carry the A1 allele of the dopamine D2 receptor (DRD2) gene Taq1A polymorphism were at increased risk of developing EPS with the use of SSRIs.

The widespread use of SSRIs may result in the so-called serotonin syndrome, autonomic hyperactivity and neuromuscular abnormalities, but not all of these manifestations are universally present in patients presenting with this disorder. The concomitant use of SSRIs and monoamine oxidase inhibitors may pose a significant risk, while the serotonin syndrome may occur in up to 16% of individuals who overdose on SSRIs.

Cognitive function

Antidepressants may have a small beneficial effect upon certain cognitive domains (e.g. delayed recall and psychomotor speed). However, the use of antidepressants may also lead to cognitive side effects. In addition, the use of antidepressants was associated with inattentiveness, forgetfulness, word-finding difficulty and mental slowing in depressed individuals reaching partial or full remission.

Cerebrovascular

A meta-analysis of observational studies indicated that the use of SSRIs could be associated with a 40% increased risk of stroke. However, this association was significant only in older age groups. In addition, a recent cohort study conducted in UK primary care settings did not confirm this association.

Sweating

The action of TCAs on muscarinic receptors may lead to excessive sweating in approximately 14% of the patients who take them. Among the newer antidepressants, bupropion and venlafaxine have been more frequently associated with excessive sweating, while fluvoxamine and trazodone may be associated with lower incidence rates. Most studies indicate that approximately 10% of patients on SSRIs may develop excessive sweating, although the incidence may be higher for paroxetine.

Sleep disturbances

Studies have shown that patients suffering from depression have reduced rapid eye movement (REM) latency and a reduction in the non-REM phases in the first sleep cycle. The SSRIs and venlafaxine are associated with increased REM sleep latency and a reduction in the overall time spent in the REM phase while sleeping. These effects on REM sleep are mostly associated with the initial days/weeks of treatment, and may return to baseline levels after eight weeks of treatment. A rebound in REM sleep can be measured upon discontinuation of SSRIs. These effects on REM sleep could be due to an increase in synaptic serotonin levels. Mirtazapine can increase latency to REM sleep. Trazodone and mirtazapine have been associated with improving sleep continuity in patients with MDD. SSRIs and venlafaxine may cause and exacerbate restless leg syndrome. Among the newer antidepressants, mirtazapine followed by paroxetine and sertraline have been associated with the highest incidence of restless leg syndrome.

Affective disturbances

Many patients taking SSRIs have reported experiencing emotional blunting. They often describe their emotions as being ‘damped down’ or ‘toned down’, while some patients refer to a feeling of being in ‘limbo’ and just ‘not caring’ about issues that were significant to them before. Evidence indicates that these adverse affective manifestations may persist even after the symptoms of depression have improved and can occur in patients of all ages. Some authors hypothesize that AD-induced emotional blunting occurs as a result of a downregulation of dopamine neurotransmission in neural circuits that regulate reward processing, secondary to an activation of 5-HT2C receptors in the nucleus accumbens. These changes in emotional processing are not limited to SSRIs, and have also been reported for patients taking mirtazapine, agomelatine and reboxetine. In addition, cases of apathy, lack of motivation and frontal lobe...
Risks associated with newer generation antidepressant drugs

Syndrome have been described in patients taking SSRIs in adults, adolescents and children.58

A meta-analysis indicates that the treatment of juvenile patients for both anxiety and depressive disorders may lead to excessive arousal activation and even hypomania, which calls for a proper clinical monitoring for the emergence of bipolar disorder.59 Furthermore, an activation syndrome in which patients taking antidepressants may experience anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness and impulsivity in the first three months of treatment may ensue.60

Suicidality

Since 2014, the US FDA issued a black box warning regarding the risk of suicidality related to the use of antidepressants in children and adolescents.61 Two recent meta-analyses have not identified a clear increased risk of treatment-emergent suicidality in adult individuals treated with antidepressants in RCTs.62-63 An expert statement issued by the European Psychiatric Association (EPA) mentions that antidepressants decrease suicidality, but there is no consistent evidence to support this statement.64

Safety in overdose

One study reviewed records in the UK and found that among antidepressants the case fatality rate (ratios of deaths to nonfatal overdose) was highest for TCAs (1.6) followed by venlafaxine (0.29) and mirtazapine (0.22), and was lowest for SSRIs (0.06). Among the SSRIs, citalopram was found to be associated with the highest case fatality rates in overdose.65 Another study investigated poison control data in the USA from 2000 to 2004. Likewise, TCAs were associated with the highest mortality rates due to overdose. In addition, among SSRIs, citalopram and fluvoxamine appeared to be related to higher mortality rates in overdose, whereas fluoxetine and sertraline were the safest.66

Discontinuation syndromes (withdrawal syndrome)

An often-underappreciated clinical problem associated with the use of almost all SSRIs and SNRIs is the emergence of withdrawal symptoms of varying degrees of severity upon treatment discontinuation and/or interruption.67-68 These symptoms include flu-like symptoms, tremors, tachycardia, shock-like sensations, paresthesia, myalgia, tinnitus, neuralgia, ataxia, vertigo, sexual dysfunction, sleep disturbances, vivid dreams, nausea vomiting, diarrhea, worsening anxiety and mood instability.68 A recent review suggested that dependence and withdrawal symptoms associated with newer antidepressants were comparable, if not worse, to those experienced with benzodiazepines.68 These reactions have been defined as ‘discontinuation syndromes’, with the aim of avoiding any hint to a potential for dependence that may affect marketing.69 Due to the severity and unpredictability of these manifestations, it has been recently suggested that the term ‘discontinuation syndrome’ should be replaced by ‘withdrawal syndrome’.68 Symptoms typically appear within three to four days of stopping an antidepressant or initiating a medication taper. They may be mild and resolve spontaneously within one to three weeks; in other cases, they may persist for months or even years, leading to what has been defined as ‘persistent postwithdrawal disorder’.70 Withdrawal symptoms are most prominent in agents with shorter half-lives and high potency, such as venlafaxine and paroxetine.68,71 Interestingly, most studies show that although tapering the drug over a period of weeks to months may confer some advantages, it does not eliminate the probability of developing withdrawal symptoms.68 Alternative strategies for the management of antidepressant-related withdrawal syndrome are scarce, and the quality of the evidence is limited.67 A combination of cognitive behavior therapy and well-being therapy has been reported to be successful in a case series for managing persistent postwithdrawal disorders.72

Ophthalmic effects

A subsequent review indicates that the use of different SSRIs may increase intraocular pressure and lead to the emergence of angle-closure glaucoma, which case reports have also indicated may be caused by venlafaxine.73-75 While the use of SSRIs was associated with a substantial independent risk of acute angle-closure glaucoma (OR = 5.80; 95% CI = 1.89-17.9), there was no apparent risk of either primary angle-closure glaucoma or primary open-angle glaucoma in patients with depression on long-term SSRI use.76-77 A nested case-control study found a higher likelihood of cataracts after exposure to newer generation antidepressants, including fluvoxamine (RR = 1.39, 95% CI = 1.07-180), followed by venlafaxine (RR = 1.33, 95% CI = 1.14-1.55) and paroxetine (1.23, 95% CI = 1.05-1.45).78

Hyperprolactinemia

Tuberoinfundibular dopamine pathways primarily regulate prolactin release, but it is also modulated indirectly by serotonin via the activation of 5-HT1C and 5-HT2 receptors.79 Long-standing increases in peripheral prolactin levels are occasionally observed in patients using ADs, including SSRIs; hyperprolactinemia may have deleterious
health consequences (e.g. a decrease in BMD and hypogonadism). Where hyperprolactinemia is confirmed, a switch to mirtazapine may be a good therapeutic choice, although a switch to another SSRI may also stop this abnormality.

Risks during pregnancy and breast feeding

Pregnant women have an increased risk of developing depressive illness by about 10-15%. The risk of depression appears to be highest in the second and third trimester and almost half of these women continue to have symptoms after the end of pregnancy. It is important to treat MDD during pregnancy, as it has been associated with an increased risk of complications during pregnancy, including increased risk of preeclampsia, preterm birth, abnormal bleeding, miscarriages and even fetal death. After controlling confounding factors, SSRIs have not been unequivocally associated with an increased risk of major birth defects. The clinical significance of these data is questionable. SSRIs have been associated with a modest increase in risk of congenital cardiac malformations, with a relative risk of about 1.4, as well as with an increased risk of postpartum hemorrhage. In addition, paroxetine has been associated with an increased risk of congenital cardiac defects and should not be used during pregnancy. A recent meta-analysis indicated that exposure to SSRIs in late pregnancy may confer an increased risk of persistent pulmonary hypertension. However, the absolute risk was small, and thus the clinical significance of this finding seems rather limited. Exposure to SNRIs (e.g. duloxetine and venlafaxine) during pregnancy does not seem to be consistently associated with an increased risk of birth defects, but use of these medications has been associated with an increased risk of postpartum hemorrhage, and venlafaxine in particular has been associated with an increased risk of hypertension during pregnancy.

Similarly, most data suggest that the risk associated with the use of bupropion, mirtazapine and trazodone during pregnancy is low, while some studies have shown equivocal results regarding the potential risk cardiac malformation related to bupropion use. The use of SSRIs and SNRIs during late pregnancy has been associated with withdrawal reactions characterized by irritability, excessive crying, tremor and even seizures. The benefits of treating depression during pregnancy and lactation should be balanced against the risks associated with the treatment itself. Depending on the severity and degree of recurrence of the underlying illness, if the patient is already stabilized on a specific antidepressant, a recent expert panel advises that the patient should be maintained on the same medication, except in the case of paroxetine. Whenever the patient is drug-naïve, sertraline and citalopram appear to be the best therapeutic option.

Risk of malignancies

Preclinical studies have found that antidepressants can increase the growth of fibrosarcomas and melanomas, and may also promote mammary carcinogenesis. However, other animal studies have reported the opposite trend (i.e. antidepressant use has been shown to have protective effects in tumor models). It should be mentioned that the concomitant use of SSRIs, which inhibit the CYP450 2D6 isoenzyme (e.g. paroxetine), and tamoxifen may increase breast cancer-related mortality. In summary, limitations in the overall quality of available evidence do not allow the establishment of causal inferences linking exposure to antidepressants and carcinogenesis.

Conclusions

Patients with multiple major depressive episodes may experience significantly less benefit from long-term AD treatment compared to patients with single episodes. This finding indicates that in patients with chronic recurring MDD, recurrences are difficult to prevent with AD use only. It has been suggested that the use of ADs should be limited to those patients with the more severe and chronic forms of MDD, for the shortest possible period of time. The findings of the current review suggest that long-term treatment with new generation ADs should be avoided if alternative treatments are available. The sequential use of pharmacotherapy in the acute phase of depression and of psychotherapy in its residual stage may allow the tapering and discontinuation of ADs, with significant clinical advantages.

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Short report

Person Centered Psychiatric Medicine

M. Fakhr El-Islam

Abstract

More than any other branch of medicine, psychiatric medicine is keenly focused on the individual. No two cases are exactly alike in psychiatric practice. This not only involves the differential appraisal of mental health for various individuals, but also for the differential delivery of management of their ill health including both pharmacotherapy and psychotherapy. The family also acquires a pivotal position in person-centered psychiatric practice in the Arab world.

In addition, psychiatric research especially in social psychiatry recognized the social person-centered correlates of mental ill health at the levels of psychogenesis and interpersonal consequences. Training in mental health needs also to consider the personal qualities of the trainees and their trainers. In the Arab world, the personal dimension in psychiatry has been observed long before the term “person-centered” was introduced to describe personalized clinical care in medical practice.

Key words: person-centered care, person-centered research, person centered training

Declaration of interest: None

Introduction

Personalized clinical care has been part of holistic medicine since the inception of Hippocratic, Chinese and aryuvedic medicines. The person-centered approach permeates psychiatric practice in its clinical, educational and research domains. The client in all these domains has both ill and positive aspects. The latter are used as a resource to manage the former in the “partnership” among clinicians, patients and families in the form of an alliance in therapy, education and research.

That emotional problems may underlie somatic symptoms is not part of the belief systems of many Arabs. Therefore, patients with somatization believe they have somatic disorder. Person-centered clinical psychiatrists explain the psychophysiological relations involved to patients before offering them psychiatric treatment. The involved person of the patient is brought to the foreground of clinical work. In an Arab community where a woman is socially defined as a child-producer, women who do not get married or are infertile develop a recalcitrant multi-somatic syndrome.

The introduction of a person-centered psychiatric service in the 1970s has elicited the psychogenesis of this culture-bound syndrome in women who reversed the sequence of events by attributing their lack of marriage and childlessness to their physical ill health. None of these women was assured by the multitude of negative physical investigations of their somatic symptoms. The syndrome was introduced to primary care health services and was associated with the introduction of socially accepted multi-roles for women during the 1970s and 1980s. In the 1990s, the culture-bound syndrome eclipsed although the community remained pro-natalist. Women in polygamous marriage were also found to experience a significant excess of somatic symptoms when compared to women in monogamous marriages.

In traditional societies patients and families who attribute illness or suffering to supernatural agents question the
value of Western-type treatment. Person-centered psychiatrists recognize this only too well. Traditional psychic realities which act as stresses, like other life stresses, set into action the same biochemical mechanisms that generate symptoms and impair mental functioning. With this understanding the majority of patients accept Western-type psychiatric management of their illness.\(^{10}\)

Person-centered psychotherapy was initially introduced as client-centered psychotherapy.\(^{11}\) Logotherapy was introduced later as a search for meaning of mental experiences according to patients’ belief systems.\(^{12}\) In both forms of psychological treatment, person-centered psychiatrists study patients’ personal cognitive, affective and spiritual systems to render their distress and suffering meaningful in the patients’ here-and-now. Patients learn how to use their own psychological systems for self-regulation. Person-centered psychiatry fosters partnership for shared understanding and shared decision making in order to deepen understanding and healing through personalized clinical care.\(^{1}\) Moreover, studies of ethnicity and psychopharmacology\(^{13}\) provided more reason for the person-centered approach to treatment using psychotropic medication. Patients who have ethnic differences in the cytochrome P450 enzymes (CYP), e.g. white and Southeast Asians in the USA, metabolize psychoactive drugs in different ways and therefore show differences in therapeutic and unwanted effects attributable to these agents. They have to receive person-centered instructions in pharmacotherapy.

Since many patients, needed psychiatric help after conflict between members of young and older generations in the family\(^{14}\) it was hypothesized that conflict precipitated a state of mental ill health. The question to answer through further investigation was whether intergenerational conflict was different in these patients from its analogue in the community. A person-centered community study failed to elicit any correlation between symptoms on the scaled version of a general health questionnaire\(^{15}\) and a scale of measurement of intergenerational conflict in Kuwait.\(^{16}\) It was concluded that withdrawal of family support in families with intergenerational conflict was instrumental in professional help seeking for problems that family support would have solved within the family bounds.

Person-centered psychiatric practice makes use of resources of individual patients and resources of their families in the care, after-care and rehabilitation of the mentally ill.\(^{17}\) All family members seek integration into the family unit irrespective of the individuals’ physical, mental and socioeconomic shortcomings. This accounts for the better outcome of severe mental disorder in collective developing than individualistic developed societies.\(^{18}\) All forms of psychiatric treatment (medicinal, psychological and supportive) empower individual persons to achieve their full potential after understanding the illness experience that underlies the illness behavior.\(^{2,19}\)

In group psychotherapy, person centering is highlighted. The whole group is treated as one person with different feelings and attitudes expressed by different individuals sharing a common dynamic structure or reinforcing a common tension. Each group member receives therapy as a person in a group medium. Various group members offer person-to-person help to each other.\(^{20}\) Therefore, group psychotherapy combines treatment of group with treatment in a group and treatment by a group with pervasive person-centeredness.

The involvement of religion in helping patients is a person-centered approach taken by psychiatrists as well as traditional healers both of whom know about or share patients’ religion. Psychiatrists take a religious history from their patients in order to ascertain the presence of religious slots where religious material could be utilized. However, traditional healers are not person-centered as they consider that religious advice and practice are universally helpful and equally helpful to the mentally ill and the mentally healthy. Religious self-help involves self-regulation using the belief system in the face of stress. e.g. they regard stress as a test where believers show resilience and expect reward in their after-life for patient endurance of stress.\(^{21}\)

Social distance between relatives is smaller in Arabian families and among friends. Social support is a dutiful part of filial piety. In studies of relatives’ expressed emotions towards family members with serious mental disorder\(^{22}\) all relatives would be overinvolved by Western measures if the person-centered approaches were neglected. Moreover, warmth and positive comments were found to mitigate the effects of criticism of patients from relatives who endeavor to prevent social withdrawal of patients by continuous unreciprocated support. Most young people take pride in looking after their elderly and maintain respect for their parents and grandparents as sources of advice and as participants in decision taking on family issues, e.g. arranging marriages, housing or business partnership.

**Person-centered clinical psychiatric training**

The vulnerability of medical students to develop symptoms like their patients’ was recognized by Hippocrates as “morbus medicorum”. This is particularly likely to develop when students deal with mentally ill persons. Trainers recognize the personal needs of trainees. Medical students were instructed in clinical psychiatry by
two methods: one centering on clinical material and the other on students’ subjective feelings and impressions about it. The second method led to ventilation of many students’ anxieties about their possible psychiatric disorder through talking about the patients’ symptoms they identified with. The number of students presenting with fears of being mentally ill was significantly lower in the groups trained by the student-centered method than the groups trained according to the case-taking sheet. 23

Person-centered research in mental health

Psychometric research in mental health yields reliable valid results only if it is appropriate to the persons tested. Translated questionnaires may have to be rephrased in order to convey the same meaning to those who speak a different language from the original language of the questionnaire. Scaled answers may have to be replaced by yes/no answers for persons who are not used to quantify description of feelings as severe, moderate, mild, minimal in everyday life.

Situations tested in projective tests should be common in the environment of the persons tested. Fantasy is not distinguished from memory by many Arab patients. 24 Person-centered psychometry would be the most appropriate approach.

Participants in research can only give “informed” consent if they receive person-centered information that could be comprehended by each person according to his/her cultural and educational background. Written consent forms are not welcome by the majority of persons participating in research. Most IRBs (Institution Review Boards) accept verbal consent in the presence of a witness as good enough evidence of personal consent to participate in research in Arab communities.

Conclusion

In no branch of medicine is a person-centered approach as necessary and appropriate as it is in psychiatry. In the Arab world, clinical psychiatry is not only person-centered, but it is also family-centered. Psychiatric education and psychiatric research can only gain from a person-centered approach. Before the introduction of the term “person-centered” to describe the discipline of medical practice, Arab psychiatrists have had a person-centered psychiatric medicine for several decades.

References


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**Psychiatric audit**

Audit Report of an Inpatient Liaison Psychiatry Service within Baghdad Teaching Hospital

Numan Serhan Ali, Emad Aref Al-Kubaisy, Tori Snell

**Abstract**

**Introduction:** Liaison psychiatry is a sub-specialty of medicine concerned with the management of mental disorder in general medical settings. It deals with conditions where the problem is the co-existence of physical and psychological symptoms regardless of causation. **Aims:** The current audit involved screening all patients referred over a three month period to the Liaison Psychiatry Consultation Service, Baghdad Teaching Hospital. Cases were from all departments of Baghdad Medical City. The purpose was to establish an initial audit cycle for referral pathways, patient demographics, and clinical presentation in order to develop the service. **Methods:** Patients (N=72) were referred to the service between March and June 2016 (N=72). In the current audit, no specific standards were set. A questionnaire was used to record patient information. **Results:** Take up of the service was 9.37%. This was on the basis of there being 2305 hospital beds in use during the audit period. All departments within Baghdad Medical City made at least one referral with the majority being from the Department of Medicine (29.1%) and the Emergency Department (23.6%). The most common presentations were delirium (31.9%) and depression (19.4%). **Conclusions:** Qualitative feedback from resident doctors was that a majority of patients with physical complaints benefitted from having psychiatric input for what appeared to be co-morbid mental health conditions. Future audits should be conducted to examine the initial reason for hospital admission against mental health presentation and patient feedback should be sought.

**Key words:** Audit, liaison psychiatry, Baghdad Teaching Hospital, psychiatric consultation

**Declaration of interest:** None
stays, more procedures performed and incurred more hospital charges.4,13

International recommendations:5

1. 24-hour services are preferable. However, if it is not possible, then it is important to ensure that out of hours services are of the same quality as daytime services. Also, that the links between out-of-hours services and other services are as good as those with the liaison psychiatry team.

2. A very important feature of a liaison psychiatry team is that they spend time listening. It is important to include staff who have the time to listen. This does not have to involve expensive senior staff.

3. The role of liaison psychiatry teams in training other hospital staff is of vital importance and will help reduce stigma as well as improve outcomes for people with mental health problems.

4. Good communication between teams is very important, especially in terms of making sure that everyone has read the same notes and is reporting back to the same set of notes.

5. Services should be delivered seven days a week, and beyond office hours, but this will depend on local conditions.

In a recent systematic review, Chen et al. found that patients who are more likely to be referred to consultation liaison psychiatry tend to be young, have a psychiatric history, live in an urban setting or have functional psychosis.14

A study by Sherda et al. on consultation-liaison psychiatric services in Dubai, UAE over a six months period found that the total number of referrals was sixty and that suicidal behavior was the highest among the reasons for referrals. The most common diagnosis was depression.15

Aims

The current audit aimed to screen all patients referred to a liaison psychiatry inpatient consultation service to the psychiatric unit at Baghdad teaching hospital so as to establish a baseline for socio-demographics, type of referral, and management of referrals, with a view of improving this kind of service.

Participants and methods

Seventy two patients were enrolled into the current audit, whose consultations were sent to the psychiatry unit at Baghdad Teaching Hospital during the period from 15 March to 15 June 2016. A questionnaire was used to record patient information needed for the current study.

The psychiatry unit at Baghdad Teaching Hospital has six consultants and eight SHO/Registrars, the unit offers a 24/7 liaison psychiatry consultation service to all specialties at the Medical City Campus including the causality departments.

The Medical City is the largest medical campus in Iraq. It was established in 1972 and consists of:

1. Baghdad Teaching hospital with a bed capacity of 1000 beds and two emergency rooms (medical and surgical). The psychiatric unit is situated in this hospital.
2. Ghazi Al-Hariri Specialist surgical hospital of 530 beds.
3. Children's Hospital with a 320 beds capacity.
4. Oncology Hospital (30 beds).
5. Burns and plastic surgery hospital (25 beds).
6. GIT surgical hospital (90 beds).
7. Nursing home (250 beds).
8. Cardiac Surgery center (60 beds).

All those hospitals are situated within the Medical City campus, and the total number of beds in the campus included in this audit was (2305) beds.

Results

Results are summarized in Figures 1-4.

Seventy two consultations were made from all departments of Baghdad Medical city during the study period, the referral rate was 9.37% per bed per year.

Consultations originated mostly from the general medical wards comprising 29.1%, followed by the emergency department comprising 23.6%. The hematology wards made the fewest referrals amounting to 1.3% only.

Delirium was the most common presentation (31.9%), followed by depression (19.4%) and suicide attempts (11.1%). Pseudo-seizures and Autism Spectrum Disorder were less common (2% and 1%, respectively).

Approximately one quarter of the consultations were for patients aged 18-29 years (23.6%), followed by those ≥ 60 years (19.4%), then 30-39 years with 13 (18.0%), while there were 11 patients, aged 40-49 years, (15.2%) and eight patients, aged 50-59 years, (11.1%). There were nine patients ranging in ages <18 years.
Eight cases had attempted suicide - six women and two men. Four of the women were below 20 years of age and described having family problems; one had been diagnosed with Major Depressive Disorder and presented with pseudo-seizures. Another woman was a known case of epilepsy. Both men had a diagnosis of chronic schizophrenia.

**Figure 1.** Demonstrated the distribution of sample according to age group

**Figure 2.** Demonstrated the distribution of sample according to diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute psychotic disorder</td>
<td>2</td>
</tr>
<tr>
<td>ADHD</td>
<td>3</td>
</tr>
<tr>
<td>Alcoholic encephalopathy</td>
<td>1</td>
</tr>
<tr>
<td>Autism</td>
<td>1</td>
</tr>
<tr>
<td>Conversion syndrome</td>
<td>2</td>
</tr>
<tr>
<td>Delerium</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>17</td>
</tr>
<tr>
<td>Further Ix</td>
<td>2</td>
</tr>
<tr>
<td>Postpartum blue</td>
<td>1</td>
</tr>
<tr>
<td>Pseudosiezure</td>
<td>1</td>
</tr>
<tr>
<td>Suicide</td>
<td>15</td>
</tr>
</tbody>
</table>
Liaison psychiatry within Baghdad Teaching Hospital

**Discussion**

The current audit was conducted in the largest hospital in Baghdad. The referral rate was 9.37% per bed per year. This is considered to be low, but it was similar to rates reported in other developing countries, for example India.\(^5\),\(^10\) While in developed countries it is much higher, as seen in Guy’s Hospital, London in which it was 37.5% per bed per year (150 inpatient referrals per year for total 400 beds).\(^6\) This might be due to the low index of suspicions and the lack of non-psychiatric staff training, also reported by Prince M, et al. who reported low mental...
health training as one of the causes for low referral rates. Also, referral rates should be calculated regarding number of consultations made rather than number of beds or inpatients.

Average response time in the current study was 21 minutes, and this might be explained on the basis that there was a good number of consultants in the department of psychiatry during the office hours and that resident doctors were available 24h a day and seven days a week, also they were in the same center in which all hospitals could be reached on foot in no more than 15 minutes. In the UK, a report on the second annual survey of liaison psychiatry had shown the response time was in 63.1% less than one hour, while at Guy’s Hospital only 25% were seen within one hour.

The most common presentation in the current audit was delirium (31.9%), but other studies have indicated that the most common was either somatic symptoms or the presence of psychiatric symptoms, while in other studies had psychosis as the commonest cause of referral. This might be because some of the psychiatric presentations could be explained medically and more could not, also Ndetei et al. have suggested that psychosis is too broad to be diagnosed and more measures considered in referred cases for accurate diagnosis.

Consultations from obstetrics/gynecology were very low, with only four out of 72 all with postpartum depression. One study suggested that obstetrics/gynecology patients are much less likely to be referred unless they manifest acute or exaggerated psychotic symptoms.

Referrals due to self-harm were the third most common cause (11.1%). In some developed countries (like England) this remains much higher, frequently cited as the principal reason for referral, but it was lower in some African developing countries and India. This might relate to the stigma associated with suicide in most developing countries.

A study on the pattern of psychiatric referrals in a tertiary care hospital found that out of 400 referrals to the psychiatry unit over a period of one year, the majority were from the medicine department and that substance use disorder was the most common diagnosis followed by depressive disorders.

**Conclusion**

Although there is no proper psychiatric training to resident doctors of other specialties yet the consultations were made properly and those colleagues are more aware of the mental health of their patients.

### Recommendations

1. Adopt a psychiatry referral form to include urgency field, age, gender, medications, physical symptoms, previous psychiatric history, detailed reason for consultation, origin of referral, reason for admission.
2. Storing all the consultations for follow up and more importantly the results and benefits that came out of it.
3. Improve a protocol to recommend a psychiatric opinion to be taken in all cases of alcohol and drug misuse and suicide attempts.

### Limitations

1. The study period was short (three months) and we recommend a longer period of study in the future projects (six months or more) which might give a better idea about CLP at this hospital.
2. We missed a few consults which were made over the phone, mainly from the ER because they were urgent and unfortunately their details were not recorded.

### References

Liaison psychiatry within Baghdad Teaching Hospital


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Abstract

Clinical audit is the process used by health professionals to assess if they are actually doing the right thing in the right way in their clinical practice. A clinical audit might be undertaken to ensure that best practice is being followed and that patient outcomes are the desired ones. The quality of care is measured using accepted standards. The failure to meet these standards means that there is a room to improve an individual, a team, or an organization’s clinical work. The ultimate goal of an audit process is improved clinical practice, leading to better patient outcomes.

Key words: audit, psychiatry, research

Declaration of interest: None

Introduction

It is intuitive for clinicians to critically analyze the quality of their practice in order to assess whether patients are receiving the best quality of care. This is the essence of audit, which may be dated back to as early as 1750 BC when King Hammurabi of Babylon instigated audit for clinicians with regard to outcome. The concept has been developed greatly since then. Most recently, clinical audit has been defined as ‘a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria… Where indicated, changes are implemented…and further monitoring is used to confirm improvement in healthcare delivery.’

Audit and research

Audit should be transparent and non-judgmental rather than confrontational - it is not an opportunity to name, shame, and blame. The aim is to find out how the present provision compares with the desired standard. This information can then be used to plan improvements in the service.

The audit cycle

The term 'audit cycle' is usually used to describe the clinical audit process. A commonly quoted definition states that ‘Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and outcomes’. This cycle is then repeated to determine whether the actions taken have been effective, or whether further improvements are needed. As the process continues, each audit cycle aspires to a higher level of quality; hence the term 'audit spiral'.

Each audit cycle is made up of four steps (Figure 1):

1. Selecting a topic for the audit.
2. Selecting criteria and standards.
3. Conducting the audit.
Selecting a topic for the audit

The first step in the audit cycle is to select a topic for audit. Priority healthcare audit topics are chosen usually because they are associated with high risk or cost, or because they are widely used. Audit topics may also be derived from concerns such as adverse incidents or patient complaints. Patients’ priorities can differ markedly from those of clinicians. Practical approaches have been developed for involving patients in all stages of audit, including design, data collection, and implementing change.5,6

The objective of clinical audit is to measure adherence to healthcare standards that have been shown to produce best outcomes for patients.

Selecting criteria and standards

The second step in the audit cycle is to identify the criteria of the audited topic, and the standards against which current practice will be measured.

Audit criteria are explicit statements defining an outcome to be measured. They should relate to important aspects of care and be derived from the best available evidence, e.g., ‘All patients who take antipsychotic medication should be…’. The standards for achieving the criteria are then defined.

A standard is the level of care to be achieved for any particular criterion, and is usually a target expressed as a percentage.7 It may be a minimum standard or an optimal one, depending on the clinical scenario. ‘A minimum standard describes the lowest acceptable standard of performance. Minimum standards are often used to distinguish between acceptable and unacceptable practice. An ideal standard describes the care that should be possible under ideal conditions. Such a standard by definition cannot usually be attained. An optimum standard lies between the minimum and the ideal. Setting an optimum standard requires judgment, discussion and consensus with other members of the team. Optimum standards represent the standard of care most likely to be achieved under normal conditions of practice.’8

Standards are usually adopted from published evidence-based guidelines or systematic reviews. For instance, the criteria set by recent clinical practice guidelines for the management of schizophrenia and related disorders9 include that psychiatrists should prescribe only one antipsychotic agent at a time. However, antipsychotic polypharmacy is not uncommon in routine clinical practice. A meta-analysis of 147 studies reported that the use of antipsychotic polypharmacy varies considerably, ranging from 6-90%, with a median global prevalence of 19.6%.10 A local audit of the prevalence of antipsychotic polypharmacy may use this median global prevalence as an optimum standard against which local clinical practice may be measured.
Once a standard to measure current performance is agreed, a written plan is devised to include explicit selection criteria and ensure that the collected data are precise and essential for the audit. The plan should define the patients to be included or excluded, the audit criteria, what data to be collected and over what time period, the source of data, and who will collect the data. The data may be available in a computerized information system, or may be collected manually depending on the outcome being measured.

Conducting the audit

The third step in the audit cycle involves measuring the level of performance through collecting data manually and/or from computerized records. Data for an audit are generally collected retrospectively. However, prospective data collection can give immediate feedback on current performance and act as positive reinforcement to improve or maintain practice. Prospective audit usually requires good information technology resources.1

At the end of this step, the collected data is analyzed in order to compare actual performance with the standards that were set for the audit. If the standards were not met, then there is room for improvement.

Making improvements

The fourth step in the audit cycle aims at improving patient care through using the audit results to develop an action plan, specifying what needs to be done, how it will be done, who is going to do it and by when.

The action plan is developed in order to increase compliance with the set standards thus maximizing the benefit of the process to patient outcomes. This is possible, in theory at least, if the set standard was not fully met. However, in practice, if the results were close to 100% further improvement may be difficult to achieve.

Re-auditing

Subsequent audit cycles are planned so that the audit is part of a spiral process of continuous quality improvement. This step is critical to the successful outcome of an audit: it verifies whether the changes implemented have had an effect and determines whether further improvements are needed to achieve the identified standards.

Re-auditing aims at checking whether the practice has improved. If it has improved, re-auditing may aim to measure the service against a new set of standards. Every time an audit cycle is completed, there should be further improvement in patient care.

References


Further reading in Arabic

Clinical audit

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Abstract

Background: Clozapine and olanzapine are highly associated with the risk of metabolic syndrome resulting in lower functional outcomes, poorer quality of life and non-compliance to treatment. Objective: The current study examined the rate of assessment of metabolic syndrome parameters in patients on olanzapine attending Almasarrah Hospital in Muscat. Methods: Patients starting olanzapine between January 2014 and May 2015 were recruited to the study, which is based on the retrospective revision of cases gathered from medical records over a period of 18 months. Patients aged 18 years or above, who were prescribed olanzapine and had five or more hospital visits were included. Demographics included physical health parameters with regards to metabolic syndrome, namely blood pressure, weight, fasting blood sugar level and lipid profile. Results were compared to the ADA-APA monitoring protocol for patients on second generation antipsychotics. Results: N=46 patients met study inclusion criteria. No gender difference was identified. Most (74%) were between 21 and 40 years of age with 50% diagnosed with schizophrenia; 50% did not have a baseline lipid profile and 30% had blood sugar levels checked prior to olanzapine therapy. The majority (97%) had blood pressure and weight measured at baseline and follow-up. Overall, none of the patients matched the full standards of the ADA-APA protocol. Conclusion: Screening for metabolic syndrome among patients prescribed olanzapine in Almasarrah Hospital is behind international standards. This is especially true for lipid profile and fasting blood sugar level parameters. Findings are consistent with similar studies. Further studies should assess factors contributing to suboptimal monitoring of olanzapine-induced metabolic syndrome.

Key words: Metabolic syndrome, atypical antipsychotics, olanzapine, schizophrenia, Oman

Declaration of interest: None

Introduction

Second generation antipsychotics have been consistently linked with an increased risk of metabolic abnormalities. Metabolic syndrome encompasses a cluster of clinical features, including obesity, hypertension, dyslipidemia and impaired fasting glucose levels or overt diabetes mellitus (Expert Panel on Detection, 2001). The presence of these features in patients with schizophrenia increases the incidence of cardiovascular diseases and the mortality rate.

A literature review on this subject revealed a high prevalence of metabolic syndrome among patients with schizophrenia. Alison et al. (1999) found that the rate of metabolic syndrome among patients with schizophrenia was 46% compared with a rate of 27% in the general population. Even before the introduction of antipsychotic medications, metabolic abnormalities have been identified as side effects of schizophrenic illnesses. Several reasons have been put forward to explain the higher incidence of metabolic syndrome among patients with schizophrenia, including poor dietary habits, high rates of smoking and consuming alcohol.

Among all antipsychotic medications, clozapine and olanzapine are the most highly associated with the risk for metabolic syndrome. Hert et al. (2004) estimated that the occurrence of metabolic syndrome in a three-year follow-up of patients treated with olanzapine to be as high as 47%, second only to clozapine (58%). Underlying reasons for this increase in second generation induced metabolic syndrome are still under debate. However, several studies have proposed that an increase in adiposity due to the effects of second generation antipsychotics can lead to a decrease in insulin sensitivity, and thus change plasma glucose and lipid levels.

In addition to its effects on physical health, metabolic syndrome can result in lower functional outcomes, poor quality of life and non-compliance to treatment. Thus, metabolic syndrome and its associated cardiovascular diseases and premature death have become a major clinical
Physical health monitoring for metabolic syndrome in patients prescribed olanzapine in Oman

concern. Moreover, close monitoring of physical health and metabolic abnormalities among psychiatric patients is highly recommended.

Almasarrah Hospital is the biggest mental health center in the Sultanate of Oman. It receives referrals from all around the country and provides in-patient, as well as outpatient, services. Olanzapine is widely used as a first line treatment for various indications, such as schizophrenia and bipolar disorder. There is a paucity of studies investigating the effects of olanzapine on physical health among patients with mental health disorders in Oman. The current study aims to assess the rate of screening for metabolic syndrome among patients who have been prescribed olanzapine.

Methods

Study design and sampling

The current study involves a cross-sectional design based on retrospective data collected via case series from a medical records database from January 2014 to May 2015. All records of newly registered patients, both inpatients and outpatients, visiting Almasarrah Hospital, a tertiary care hospital in Oman, were reviewed for recruitment to the current study.

Patients who were aged 18 years or above, who were placed on olanzapine and had five or more documented hospital visits were included. In order to obtain a clearer view on the rate of patient monitoring, a minimum of five visits to the hospital were selected for inclusion. Patients with insufficient data (excluding metabolic syndrome parameters) were excluded. A data collection sheet was designed to record the patients’ age, gender and the given diagnosis during their final visit. In addition, the data collection sheet included a checklist for the physical health parameters of metabolic syndrome, namely blood pressure, weight, fasting blood sugar levels and lipid profile. These parameters were chosen based on the definition of the Expert Panel on Detection (2001) for metabolic syndrome\(^2\). The present study also took into account the recommendations in the existing guidelines for monitoring patients who are on second-generation antipsychotic-induced metabolic syndrome, such as the ADA-APA guideline.\(^1^4\) this guideline recommends a baseline monitoring of the patient’s weight, blood pressure, lipid profile and fasting glucose level prior to commencing the patient on second-generation antipsychotics. Their weight should be monitored after four weeks for a period of three months, and then annually. The ADA-APA guidelines also recommend the monitoring of blood pressure, fasting glucose levels and lipid profile after three months following the start of treatment and then annually.

Medical records of patients fulfilling the inclusion criteria were reviewed to trace the frequency that the metabolic syndrome parameters were monitored. The rate of monitoring blood pressure, weight, lipid profile and fasting glucose levels at baseline and subsequent visits were analyzed using the patients’ medical records.

Data analysis

The Statistical Package for the Social Sciences (SPSS) version 20 (IBM Corp., Armonk, NY, USA) was used to analyze the results. For descriptive purposes, categorized variables were described as percentages with confidence intervals. Continuous variables were presented as means with standard deviations or medians with an inter-quartile range.

Ethical approval

Ethical approval for the study was obtained from the hospital administration of Almasarrah Hospital.

Results

A total of 381 visits among 46 patients were included in this cross-sectional retrospective study after eliminating 883 visits due to the inclusion criteria.

The mean patients’ age and the average number of visits during the study period is illustrated in Table 1. The patients’ characteristics are provided in Table 2.

Table 1. Mean participant age and average number of visits

<table>
<thead>
<tr>
<th></th>
<th>Mean (± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant age (in years)</td>
<td>33.4 (± 13)</td>
</tr>
<tr>
<td>Number of visits</td>
<td>7.4 (± 2.4)</td>
</tr>
</tbody>
</table>

SD = standard deviation
The gender among the sample was evenly distributed, with 50% being men. With regard to age distribution, 74% of the patients fell within the 21 to 40 year old age range, followed by 20% of the sample being above the age of 40 years with 6% who were 20 years or younger. In terms of number of visits, 45.7% of the sample had six to eight, 32.6% had more than eight visits and 21.7% had five visits.

The majority of the patients who were included in the present study were diagnosed with schizophrenia (50%), followed by bipolar disorder (19%). The rest of the sample had different diagnoses, such as depression with psychotic features, schizoaffective disorders, and intellectual disability among others.

In respect to lipid monitoring, results found that 54.3% of the patients had no lipid monitoring during their visits, while the rest of the patients had their lipid profile monitored one to two times (30.4%) and three to four times (15.2%). Fasting plasma glucose testing was not carried out in 92.2% of the visits, and only in 8.6% of the visits was fasting glucose checked, though on an irregular basis.

The non-invasive interventional parameters, blood pressure and weight measurements, were noted to be highly monitored, both noted in about 91% of visits. Blood pressure monitoring was noted to occur variably, with around 37% of patients having their blood pressure checked five times or more, 30.4% checked one to two times and 23.9% checked three to four times, over their visits. Blood pressure was not monitored in 8.7% of the patients. Weight monitoring was noted to occur with variable frequencies in this study, ranging from one to four times (26.1%) to five times and more (39.1%). Table 3 summarizes the results of the blood pressure, weight, fasting plasma glucose levels and lipid profile monitoring.

| Table 3. The overall frequency of monitoring parameters of metabolic syndrome for all participants |
|----------------------------------|-----------------|-----------------|-----------------|
|                                  | Not done | one to two times | three or more times |
| Lipid profile                   | 54.3%    | 30.4%           | 15.2%           |
| Blood pressure                  | 8.7%     | 30.4%           | 60.9%           |
| Weight                          | 8.7%     | 26.1%           | 65.2%           |
| Fasting plasma glucose          | 69.6%    | 30.4%           | 0%              |

In comparison to the APA-ADA protocol for monitoring patients on second generation antipsychotics, none of the patients in the current study matched all of the requirements. Only 52% of the patients had a baseline lipid profile and only one patient had repeated lipid profile taken after three months and one year. Fasting blood sugar levels were checked in 21% of the patients at baseline. As previously, only one patient had repeated blood fasting sugar level testing after three months and one year.

Baseline weight and blood pressure measurements were documented in 89% and 69% of the patients, respectively.
Patients’ weight was taken after four weeks for 60% of the patients, after eight weeks for 48% of the patients and after three months for 41% of the patients. Blood pressure was monitored after three months in 45% of patients and only five patients had an annual blood pressure measurement in their records.

Among the whole cohort, 10.8% discontinued olanzapine before they had been taking it for one year. Side effects such as weight gain and excessive sedation were the main contributing factors for this discontinuation.

**Discussion**

The current study is the first to examine the rate of assessment of metabolic syndrome parameters among patients who were commenced on olanzapine in Oman. The findings from this study demonstrated that the rate of assessing blood pressure and weight as screening measures for metabolic syndrome were undertaken at a frequency that matched international standards. The reasons for this are likely due to the routine practice among nursing staff to measure blood pressure and weight prior to the patients seeing the doctor and due to the ease of taking these measurements.

Lack of cooperation, agitation or a busy nursing staff might explain the small percentage of missed blood pressure and weight measurements.

On the other hand, interventional parameters such as lipid profile and blood glucose level monitoring lags behind international standards. In Almasarrah Hospital, doctors are expected to collect blood from their patients. Therefore, busy clinics and a lack of doctors’ clinical awareness to check for these measures could attribute to the low frequency of monitoring fasting glucose levels and lipid profile. In addition, some patients may refuse to have their blood collected.

The results from this study are parallel to those of similar studies investigating the frequency of assessment of metabolic syndrome parameters. A UK audit screening for the metabolic side effects of antipsychotics among 1966 patients under the care of 48 multidisciplinary assertive outreach clinical teams (AOTs) found that the rate of blood pressure screening was 26%, obesity was noted in 17% of patients, blood glucose or HbA1c in 28% of patients, and plasma lipid in 22%. All four measures were only documented in 11% of the patients. Notably, the frequency of screening patients prescribed second generation antipsychotics was even lower in the centers included in the AOTs study as compared to the current study in Almasarrah Hospital, particularly with regards to weight and blood pressure measurements.

There are a series of obstacles to routine screening practices in AOTs, including uncertainty as to whether physical health screening is the responsibility of the psychiatric team or primary care providers, as reported by about a third of the participating teams in the UK audit. Less than half of the teams were confident enough to interpret abnormal screening results. In addition, limited access to basic equipment, such as tape measures and weighing scales was a relatively common problem.

An Australian study conducted in 2009 assessed the rate of metabolic syndrome screening among patients who were prescribed antipsychotic drugs in Australia concluded that routine screening was inadequate due to some practical barriers, such as busy clinicians, lack of basic measurement tools and a lack of local monitoring protocols.

Screening for metabolic syndrome among patients prescribed olanzapine in Almasarrah Hospital currently lags behind international standards. This is especially true for the lipid profile and fasting blood sugar parameters. Nevertheless, the results from the current study are comparable to similar studies carried out in the field. Further studies are required to assess the factors contributing to the suboptimal monitoring of olanzapine-related metabolic syndrome in Almasarrah Hospital. The present study reflects the need to improve the clinical practices of regular monitoring for metabolic syndrome parameters. Increasing awareness among health workers about the side effects of antipsychotic medications, developing local protocols with easy follow-up algorithms, building special blood collection rooms with blood collectors may result in an improved monitoring frequency rate.

Finally, the current study has highlighted an important aspect of metabolic syndrome in Oman. The prevalence rate of metabolic syndrome in Oman in a community based study was found to be 23%, compared to 37% in Saudi Arabia and 21% in the USA. In most developing countries, the annual rate of metabolic syndrome is substantially high. There are several factors, which could explain this high rate of metabolic syndrome in developing countries, such as demographic and epidemiologic transitions, rapid urbanization and changes in nutritional patterns. Though it is a controversial subject, a thrifty genotype, which increases survival during famines, can increase the tendency to develop metabolic syndrome during abundant food availability.

Concerning olanzapine-induced metabolic syndrome, Ellingrod et al. (2005) demonstrated that patients with a T allele of the 5HT2C receptors -759 C/T polymorphism may have a lower incidence of weight gain from olanzapine...
over a 6 week period of treatment compared to those with the C allele.21

Therefore, screening for metabolic syndrome and implementing effective interventions to lower the risk of metabolic syndrome in patients taking olanzapine is of paramount importance in order to prevent the risk of cardiovascular disease and decrease mortality rates.

Limitations

Larger sample sizes and longer study duration may yield more results that are generalizable. In addition, the current study did not include self-reported blood pressure or weight for the patients on olanzapine. It is not uncommon for patients to check their weight and blood pressure in local health centers and to attend clinic with the measurement report. This is applicable to the fasting glucose level and lipid profile too.

Conclusion

Screening for metabolic syndrome among patients who have been prescribed olanzapine in Almasarrah Hospital lags behind the international standards. This is especially true for lipid profile and fasting blood sugar-testing parameters. Findings in the current study are consistent with similar studies conducted in other mental health centers. Further studies are required to assess the factors contributing to suboptimal monitoring of olanzapine-related metabolic syndrome.

Acknowledgment

The authors would like to thank the department of information technology at Almasarrah Hospital for their generous and active corporation in collecting the data for the present study.

References


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Prevalence of Depression in a Sample of Hypertensive Outpatients in Mosul

Adnan Yassin Mohammed

Abstract

Hypertension is a common chronic cardiovascular disease that affects all ethnic groups throughout the world. It leads to chronic disability and excess mortality. Depression is common sequelae of hypertension and contributes significantly to poor health in hypertensive patients. **Objective:** The current study assessed the prevalence of major depression in patients with hypertension. The effect of sociodemographic and hypertension related factors on its development were also assessed. **Method:** Hypertensive patients were selected randomly from a medical outpatient unit in Mosul. Patients were diagnosed by a specialist physician, denied any past history of psychological illnesses or psychiatric consultations prior to having hypertension. N=300 (n=140 men, n=160 women) received the International Ne Questionnaire -version 5.0.0- (major depression module) by direct interview. Antihypertensive drugs used by the patients were also taken in consideration. Severity of the depression was assessed by Beck depression inventory. **Results:** Current prevalence of major depression in hypertensive patients was 27.3%. Statistically significant difference was found between employed and unemployed, the income of the patient, age groups (>40 years was found to be risky) and marital status groups (being widow, divorced or single risky). While being employed was a protective factor against the development of major depression in some patients. **Conclusions:** Current prevalence of major depression in hypertensive patients was 27.3%, which is higher than other studies (5-26.5%). Also, it was found that having the grade II hypertension, being a widow, divorced or single, or age >40 years old are risk factors to develop major depression in hypertensive patients, while being employed was a protective factor.

Key word: Depression, hypertension, employed, widow, single, age

Declaration of interest: None

Introduction

**Systemic hypertension**

Systemic hypertension is diagnosed when an individual’s blood pressure is found to be higher than what is considered normal for age and gender. Past studies have viewed it as a predominantly psychophysiological condition. The association between the physical and psychiatric disorder is evident in many cases, where the emotional impact of illness is sufficiently profound to precipitate psychiatric disorder. Several factors influence this development, including the patient's personality, social circumstances, the type of treatment required and the nature of the physical illness. Diagnosis of hypertension in adults is decided when the average of two or more diastolic BP measurements on at least two subsequent visits is 90 mm Hg or more or when the average multiple systolic BP readings on two or more subsequent visits is consistently greater than 140 mm Hg.

**Depressive disorder**

Depressive disorders are common, with a prevalence of 5-10% in primary care settings. These currently rank as a fourth cause of disability worldwide, but projected to rank second by the year 2020. The prevalence of depressive symptoms may be as high as 30% in the general population with women being twice as likely to be affected as men.

**Relationship between depression and hypertension**

Depression and hypertension are frequently occurring disorders although their association could be a chance coincidence. Many patients with recurrent depression or chronic depression (dysthymia) may develop hypertensive disease as part of their distress.

The prevalence of depression among people with hypertension is variously reported to range from 30% to
Prevalence of depression in a sample of hypertensive outpatients in Mosul city

37% in many studies using differing methods of case finding and differing operational definitions of depression and hypertension.6 This is appreciably higher than the 2% to 9% prevalence, both in DSM-III affective disorders reported for several general populations,7,8 and depression among normotensives.9,10 The association between hypertension and depression can be understood from three positions: 1) a common physiological factor underlies both disorders;11 2) depression results from side effects of some antihypertensive medications, e.g., impotence or drowsiness;17,25,26 Depression is secondary to experiencing a chronic illness and hypertension is one of them.6,12 Depression results from treatment that lowers the blood pressure such that it causes cerebral insufficiency in the elderly;13 and, 3) the association is coincidental.14 A number of studies have examined the association between hypertension and depression. While most have found support for the existence of an association,15 there are also a number of negative reports.16 Several review papers have concluded that the findings remain inconsistent.13,15,16 Undetected psychiatric morbidity among PHC patients commonly leads to unnecessary investigation, medication and possibly hospitalization, as well as the continued suffering of the patient. This will inevitably lead to impaired family, occupational and social functioning.17,18 Bridges and Goldberg demonstrated that psychiatric illness occurs in a quarter to a third of all new episodes of illness seen in primary care settings. Most of these illnesses occur either in conjunction with a known physical disease or as a “somatized” presentation of a psychiatric disorder.19

Method

Design

The present study is a descriptive observational cross sectional study. It was conducted in the medical outpatient department of Ibn Sina Teaching Hospital in Mosul from 1 Jan to 5 June 2014. A total of 300 attendees in the medical outpatient clinic (n=140 men, n=160 women) were randomly selected by choosing every fifth patient. Inclusion criteria were 1) diagnosis by a specialized physician, 2) no past history of psychological illnesses or psychiatric consultations prior to having hypertension. Patient interviews were completed in a confidential space. After completing the interview, the researcher returned to the examining room and identified subsequent participants via the randomization procedure.

Drugs used by the patients

Participants reported using a range of medications, including:

- Atenolol,
- captopril,amlodipine,valsartan,candesartan,metoprolol,nifedipine,aprisoline and deltiazem.

Ethics

Ethical approval was obtained from a senior panel at the Ibn Sina Teaching Hospital, which included the chairman of the hospital’s medical unit. All participants provided their verbal consent prior to interview.

Statistical analysis

Results were subjected to statistical analysis using Chi-square test, OR, 95% CI and p value. The computerized statistical program used was STATISTICA version 5.

Measures

All participants were interviewed on their own after providing socio-demographic information and data relating to their experience of hypertension. The Mini International Neuropsychiatric Interview was used (MINI). Arabic Version 5.0.0 (Module A) concerned in the diagnosis of major depressive episodes currently in respect. The MINI is a brief structured interview that assesses the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies comparing the MINI to the SCID-P for DSM-III-R and the CIDI showed that it has acceptably high validation and reliability scores.20 Response options were either ‘Yes’ or ‘No’. Clinical judgment by the rater should be used when coding the responses.20 Diagnosis of major depression is established if all of the followings are met:21

- ‘Yes’ response for either A1 or A2 questions or both.
- ‘Yes’ response for three or more questions of A3 group (or 4 if either A1 or A2 question is answered ‘No’).
- Severity of the patient who is depressed would be assessed via the Beck Depression Inventory (BDI) on four levels of severity (Likert scale).
- Severity of hypertension is assessed as either Grade I when systolic BP 140-159mmHG or diastolic BP is 90-99HG, Grade II when systolic BP more than or equal to 160HG or diastolic BP is more than or equal to 100mmHG.22

Inclusion criteria

Inclusion criteria were patients of either genders ranging in age from 20 to 70 years with a confirmed diagnosis of
hypertension clinically and without history of depression prior to hypertension.

**Discussion and conclusions**

The current study found that prevalence of major depression in hypertensive patients was 27.3%, which is higher than prevalence of depression in the general population (4-6%). The prevalence of depressive symptoms may be as high as 30% in the general population with women being twice as likely to be affected as men. In a previous study, greater psychiatric morbidity was associated with chronic illnesses. Also it is more than that in hypertensive patients in studies done elsewhere (5-26.5%) and this may be due to the difficult situation in Mosul. However, the figure is approximate to a study done by Dr. Reem AlBedawy in A.R.E, which was 26.5%.

Analyzing the effect of gender showed no statistical significant difference between prevalence of major depression in men (39%) and women (61%) with hypertension in accordance with a study conducted in Hong Kong that found depression, as measured using the HADS-D, correlated with increasing age and hypertension severity, respectively, but not with gender. Analyzing the effect of ethnicity showed no statistically significant difference between ethnic groups. This is in contrast to an earlier study, which found that the risk factors in black participants were significantly higher than those of the white cohort. Analysis of the effect of age showed differences between a group of 40-59 year olds and a group of 60-70 year olds were statistically significant as a risk factor as compared to the younger age group.

Analysis of the effect of marital status showed that being a widow, divorced or single had a very highly statistically significant difference as compared to the married group as a strong association in development of major depression in hypertensive patients. The relationship between the development of major depression in hypertensive patients and association with financial satisfaction has shown statistically significant difference. Study had shown that having a low income is a risk factor for development of depression in hypertensive patients. The relationship between the development of major depression in hypertensive patients and association with employment has shown statistically significant difference (p-value 0.029). Another study found that being unemployed is a risk factor for development of depression in hypertensive patients when compared to those who were retired, employed in government or private sector. The relationship between the development of major depression in hypertensive patients and the effect of duration of illness has shown a statistically significant difference. Those whose duration of illness was less than one year due to the psychological impact of the illness on them and those whose illness was more than five years due to added complications seemed to be at greater risk of developing depression than those whose illness was between one to five years only.

The clinical relevance of this theme is clear, since depressive symptomatology is associated with poor BP control in hypertensive patients and with the development of complications of hypertension. Analysis of the effect of severity of the illness showed that, having the more severe form of hypertension (Grade II) had a very highly statistically significant difference (<0.025) as compared to the (Grade I) is a risk factor for the development of major depression in hypertensive patients. This supports a study that found depression reflects more severe hypertension. Analyzing the effect of the level of education showed no statistically significant difference between all levels of educations studied in this research, although those with primary education appeared risky group than others on OR. This might be due to sharing the same stressful life events. Connecting the severity of the depression with the severity of hypertension showed that the most significant relationship was between mild and moderate depression and Grade I hypertension with p-value being 0.001, which is highly significant. Severe depression and severe hypertension were not correlated, which supports a study that found no correlation between elevated scores on the Zung SDS and elevated BP. Data were reanalyzed in terms of subscales of the Zung SDS, especially the Depressed Mood Index, and again there was no significant association between depression and hypertension severity.
Table 1. Distribution according to gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Cases</th>
<th>Non-Cases</th>
<th>OR</th>
<th>95% Confidence Interval</th>
<th>$\chi^2$</th>
<th>$p$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>32</td>
<td>39%</td>
<td>108</td>
<td>49.5%</td>
<td>0.65(*)</td>
<td>(1.092,0.387)</td>
</tr>
<tr>
<td>Female</td>
<td>50</td>
<td>61%</td>
<td>110</td>
<td>50.5%</td>
<td>1.53(**)</td>
<td>(0.917,2.554)</td>
</tr>
</tbody>
</table>

(*) Protective  
(**) Risk  
No statistical difference is seen between genders

Table 2. Distribution according to age

<table>
<thead>
<tr>
<th>Age</th>
<th>Cases</th>
<th>Non-Cases</th>
<th>OR</th>
<th>95% Confidence Interval</th>
<th>$\chi^2$</th>
<th>$p$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 - 39</td>
<td>15</td>
<td>18.3%</td>
<td>73</td>
<td>33.5%</td>
<td>0.54(*)</td>
<td>(0.810,0.239)</td>
</tr>
<tr>
<td>40 - 59</td>
<td>50</td>
<td>61%</td>
<td>113</td>
<td>51.8%</td>
<td>1.4(**)</td>
<td>(1.099,1.798)</td>
</tr>
<tr>
<td>60 - 70</td>
<td>17</td>
<td>20.7%</td>
<td>32</td>
<td>14.7%</td>
<td>1.5(**)</td>
<td>(1.109,2.028)</td>
</tr>
</tbody>
</table>

* Significant at the 0.05 level  
(*) Protective  
(**) Risk  
Increasing age is highly associated with depression

Table 3. Distribution according to marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Cases</th>
<th>Non-Cases</th>
<th>OR</th>
<th>95% Confidence Interval</th>
<th>$\chi^2$</th>
<th>$p$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>12.2%</td>
<td>16</td>
<td>7.3%</td>
<td>1.75(**)</td>
<td>(1.373,2.231)</td>
</tr>
<tr>
<td>Married</td>
<td>47</td>
<td>57.3%</td>
<td>178</td>
<td>81.7%</td>
<td>0.30(*)</td>
<td>(0.506,0.178)</td>
</tr>
<tr>
<td>Widow</td>
<td>15</td>
<td>18.3%</td>
<td>13</td>
<td>5.9%</td>
<td>3.5(**)</td>
<td>(2.032,6.029)</td>
</tr>
<tr>
<td>Divorced</td>
<td>10</td>
<td>12.2%</td>
<td>11</td>
<td>5.1%</td>
<td>2.6(**)</td>
<td>(1.717,3.937)</td>
</tr>
</tbody>
</table>

** Significant at the 0.01 level  
(*) Protective  
(**) Risk  
Marital status is less likely associated with depression than widow, divorced and single
Table 4. Distribution according to employment

<table>
<thead>
<tr>
<th>Employment</th>
<th>Cases</th>
<th>Non-Cases</th>
<th>OR</th>
<th>95% Confidence Interval</th>
<th>( \chi^2 )</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>53</td>
<td>64.6</td>
<td>99</td>
<td>45.4</td>
<td>2.1**(**)</td>
<td>(1.295,3.406)</td>
</tr>
<tr>
<td>Retired</td>
<td>4</td>
<td>4.9</td>
<td>13</td>
<td>5.9</td>
<td>0.8(*)</td>
<td>(0.925,0.692)</td>
</tr>
<tr>
<td>Privates sector</td>
<td>12</td>
<td>14.6</td>
<td>47</td>
<td>21.6</td>
<td>0.6(*)</td>
<td>(0.837,0.430)</td>
</tr>
<tr>
<td>Gov. employed</td>
<td>13</td>
<td>15.9</td>
<td>59</td>
<td>27.1</td>
<td>0.5(*)</td>
<td>(0.786,0.318)</td>
</tr>
</tbody>
</table>

* Significant at the 0.05 level
**(*)Protective
(**)Risk
Being unemployed is highly associated with depression

Table 5. Distribution according to duration of hypertension

<table>
<thead>
<tr>
<th>Hypertension related factors</th>
<th>Cases</th>
<th>Non-Cases</th>
<th>OR</th>
<th>95% Confidence Interval</th>
<th>( \chi^2 )</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; one year</td>
<td>20</td>
<td>24.4</td>
<td>26</td>
<td>11.9</td>
<td>2.3**(**)</td>
<td>(1.572,3.365)</td>
</tr>
<tr>
<td>(1-5) year</td>
<td>30</td>
<td>36.6</td>
<td>139</td>
<td>63.8</td>
<td>0.30(*)</td>
<td>(0.520,0.173)</td>
</tr>
<tr>
<td>≥ 5 year</td>
<td>32</td>
<td>39.0</td>
<td>53</td>
<td>24.3</td>
<td>1.9(*)</td>
<td>(1.417,2.548)</td>
</tr>
</tbody>
</table>

** Significant at the 0.01 level
(*)Protective
(**)Risk
Duration of hypertension less than one year and more than five years is highly associated with depression

Table 6. Distribution according to severity of hypertension and severity of depression

<table>
<thead>
<tr>
<th>Severity of depression</th>
<th>Severity of Hypertension</th>
<th>n=82</th>
<th>95% Confidence Interval</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grade I (140-90) (mmHg)</td>
<td>Grade II ≥ 160 mmHg</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>no.</td>
<td>%</td>
<td>no.</td>
<td>%</td>
</tr>
<tr>
<td>Mild</td>
<td>38</td>
<td>16.8</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Moderate</td>
<td>10</td>
<td>4.4</td>
<td>18</td>
<td>28</td>
</tr>
<tr>
<td>Severe</td>
<td>6</td>
<td>2.7</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

* Significant at the 0.01 level.(Z-Two proportion test)
Most association is seen between mild and moderate depression with Grade I hypertension
Conclusions

The current study identified the following:

1. The prevalence of major depression in hypertensive patients attending the medical outpatients unit at Ibn Sinā Teaching Hospital was 27.3% and this is more than the prevalence of depression in general population (4-6%). However, it is somewhat equal to studies done elsewhere (5-26.5%).
2. Age groups (>40 yr.) have a higher association to develop major depression in hypertensive patients.
3. Being single, widow or divorced are having high association for developing major depression in hypertensive patients.
4. Having a severe form of hypertension is associated with developing major depression in hypertensive patients.
5. Being employed is a protective factor against the development of major depression in hypertensive patients.
6. Depression was found to be more prevalent in those whose illness were less than one year and those more five years.
7. A strong association was found between the mild and moderate form of depression with Grade I hypertension.
8. The most significant relationship was between mild depressions and Grade I hypertension.

Limitations

1. For estimation of socioeconomic status level, a rough estimation approach of the author is conducted rather than relying on a specific standardized tool.
2. The tools used in the study have not been standardized on Iraqi individuals; the use of their original scoring system was one of the limitations in the current study.

References

Trauma in Palestine

The Trauma of Humiliation in the Occupied Palestinian Territory
Samah Jabr and Elizabeth Berger

Abstract
Humiliation has been described as the pervasive and fundamental experience of the Palestinian people under occupation, underlying the varied military, social, economic, and human rights violations that have been imposed over generations. We review the current social science research literature regarding humiliation in Palestine. We then present clinical vignettes from psychiatric practice in the occupied territory and our observations of the Palestinian community, material which illustrates various aspects of humiliation in this context. We argue that a multidisciplinary conceptualization of humiliation is necessary to account for its phenomena as an individual and collective trauma; sociopolitical, experiential, and psychoanalytic models must be integrated to understand the dynamics of humiliation and how these dynamics drive the experience for both victim and perpetrator. Based on an integrated model, we describe several clinical tools for therapists to use that may be helpful interventions in the treatment of victims of humiliation in Palestine.

Key words: Palestine, trauma, humiliation, human rights, mental health

Declaration of interest: None

Part One: The Context

Traumatic violence has formed the core of the Palestinian experience since the Nakba or catastrophe of 1948, when eight hundred thousand Palestinians were expelled from their villages to permit the establishment of Israel as a Jewish state. These refugees and their descendants reside today as over five million displaced persons within the Occupied Palestinian Territory, composed of the West Bank, Gaza, and East Jerusalem. Citizens nowhere, these Palestinians survive in stateless insecurity with all elements of life - their economy, judicial system, education, healthcare, human movement, water, roadways, and natural resources - entirely under the external control of the occupying power. These conditions impose losses and injuries upon every Palestinian.

Traumatic incursions continue to harm the Palestinian community through wars and bombings, shootings, house demolitions and dispossession, destruction of agricultural land, checkpoints and closures, fragmentation of neighborhoods, extrajudicial assassinations, states of siege, and particularly through mass detention - it is estimated that over one third of all Palestinian men have been detained in Israeli prisons, often without charges brought against them and sometimes for decades. Here men, women, and children are very often mistreated to a degree constituting torture; over a period of six months in 2014, for example, there were over six hundred children arrested in Jerusalem alone - of which nearly 40% reported sexual abuse. Members of the Palestinian leadership such as academics and human rights activists have been especially targeted. Israeli policy has thus led to a downward spiral of increasing poverty and social disintegration.

Material losses are accompanied by harassment of the Palestinian public by Israeli forces in their inevitable daily contact, reinforced by a global propaganda campaign justifying its abuses through a debased image of Palestinian identity as dangerously irrational and dishonest. A mixture of both weakness and violence, this is the classic portrait of the colonized Oriental as viewed through the eyes of Western power. In this way, the cultural heritage of the Palestinian people suffers a further degradation.
Part Two: A Literature of Injury

Social science has developed a robust literature of Palestine studies exploring the themes of assault and resilience. Early measurements reported high rates of stress-related disorders such as post-traumatic stress, depression, and anxiety induced by the hazards of life under occupation, but these results were later challenged as forcing the Palestinian experience onto a Procrustean bed of medical diagnostic categories.8

Bringing the social context into focus, researchers at the Gaza Community Mental Health Program under the Psychiatrist Dr Eyad El Sarraj observed an association between improved levels of resilience among adolescents and their level of personal engagement in local political action.9 Likewise examining the larger context, the public health researcher Dr Rita Giacoman at Birzeit University identified humiliation as an especially salient element of injury in Palestine, predicting negative health outcomes regardless of exposure to other traumatic events; importantly, her work emphasizes a relational perspective, viewing humiliation as the instrument of disconnection within human relationships necessary for psychological well-being.10

These findings were broadened by Dr Brian Barber’s recent paper demonstrating that over a 25-year period, persistent humiliation in Palestine was associated with widespread poor outcomes in not only physical health but economic, political, and psychological functioning. He concludes that persistent humiliation is “a neglected form of political violence that is best represented as a direct…, acute…, macro…, and high-grade… stresstor whose particular injury is due to the violation of individual and collective identity, rights, justice and dignity.”11

Research focused on humiliation in Palestine acknowledges a broader literature regarding the construct of humiliation and its consequences.11 Relevant domains of inquiry are varied and far-reaching, including group phenomena such as war and the discrimination faced by minorities as well as intimate contexts such as the abuse of children by their parents.12-17

Part Three: A view from the office (details have been altered to protect confidentiality)

One night a patient, Mr A, was walking home when Israeli soldiers stopped him, demanded his papers, pushed him against a wall, kicked him, and stripped him of his clothing. The soldiers then coerced Mr A to divulge the names of his mother, his wife, and his sisters and insulted these women with obscenities, which they forced him to repeat. Eventually Mr A was reduced to tears, at which the soldiers burst out laughing.

Another man, Mr B, was employed as a vehicle driver for a medical organization. He had dropped off a group of health workers, when he was approached by Israeli soldiers demanding his papers. He produced the papers and explained that he was awaiting the medical team to return. One of the soldiers began to shout, “You’re here to treat dogs! Come treat my sick dog!” Mr B replied, “I don’t treat anyone. I just drive the car.” In response, the soldier stuck him in the face.

In 2006, the Israeli army attacked the prison in the Palestinian town of Jericho and forced both the prisoners and the correction officers to undress. The soldiers took photos of the prisoners and the officers, which were widely reproduced in the media.18 The internet, by the way, has provided a broad platform for public exposure - as practiced for example by an Israeli woman ex-soldier who took selfies with elderly blindfolded Palestinian men and displayed these trophies on Facebook.19

The abuse of Palestinians in detention is a domain in which humiliation appears to play a particularly central role. Ms C, an activist tortured by the Israelis, described among her experiences being hung suspended from shackles, causing permanent damage to both hands. But the aspect of her interrogation which was the most difficult for her to reveal involved the Israeli interrogator stroking her thighs and making sexual suggestions, experiences associated with an extreme degree of revulsion and shame.

Mr D, an adolescent of 14, was asleep in his bed when Israeli soldiers burst into his home and detained him for several months. Although previously an excellent student, he dropped out of school following his release and withdrew from his friends. He reported beatings and other mistreatment leaving physical evidence of scarring on his body. He was taken to a mental health clinician and described being repeatedly interrogated by the Israeli forces, who laughed at him while making obscene references to his female relatives. He stated that one male interrogator took him blindfolded to the toilet area and...
shouted, “I am going to fuck you right now!” At this point in the interview, Mr D was unable to continue speaking and ended the clinical interview. As a result, further clarification of what had occurred in detention was not possible. He has refused all treatment.

**Part Four: An Anatomy of Humiliation**

Listening to trauma is not easy, and listening to the trauma of humiliation may be even more painful than reports of physical violence. A professional response involving moral outrage as well as intellectual analysis complicates the issue of our responsibilities. Moreover, the analysis of the humiliation of the Palestinian people is made difficult by the fact that our theory-building lacks adequate integration of social identity, collective history, and political action with an understanding of individual psychology.

On a clinical level, we observe the legacy of humiliation in Palestine working damage through multiple channels and in a variety of guises. Prominent among these is a withdrawal from intimacy within family and social relationships, a loss of the capacity for trust, growth, and joy. How can a man who has been publicly humiliated resume his role as a protective husband and father? We see the consequences of humiliation likewise behind many presentations of anxiety and depression in Palestine, although the patient may not at first see an immediate connection between them. Humiliation is deeply pathogenic because it provokes intense feelings of shame and impotent rage, and a powerful resistance to their re-emergence in conscious memory and narrative.

There are those in Palestine who may identify with the perpetrators, discrediting the experiences of fellow victims and reinforcing the victim’s isolation. The experience thus becomes inaccessible to reworking through a counter-narrative in which the humiliated is recast as a protagonist, further denying an opportunity to reconnect the victim to a network of supportive relationships.

Then too, humiliation can lead to conscious experiences of intense anger which may be misdirected. Individual and group activation of displaced rage can lead to a vicious cycle of revenge aimed at targets close to home - within the family, tribe, or political party. Humiliation stimulates community polarization, weakening the fabric of society.

The impulse for revenge may drive impulsive acts of retribution or identification with violent extremist groups, fulfilling the cycle of destruction by appearing to provide justification for further policies of humiliation.

A theory of the psychological trauma of humiliation must account for damage inflicted at many levels, involving harm to deep psychic structures, as well as the individual’s subsequent capacity for participation in interpersonal roles which ultimately depend upon the integrity of these psychic structures.

Humiliation can be conceptualized from a psychoanalytic perspective as a traumatic reconfiguration of self and object images, in which the effect of shame plays a cardinal role. The goal of humiliation - to annihilate through shame - reflects the downward flow of agency from the powerful to the powerless, reinforcing the discrepancy between them. One might say that the humiliator assumes the omnipotent capacities of a primitive destructive bad object; the humiliated then experiences a catastrophic loss of self-regard associated with helplessness and fear at the hands of this archaic and dangerous introject. The humiliator boasts of his total control over the humiliated, including control over the contents of his body and his mind. The archetypal acting out of this power dynamic in rape symbolizes the humiliator’s claim that he possesses the entirety of the humiliated from the inside out. Through a sadistic perversion of sexual intimacy, the humiliator experiences what Klein termed “the manic triad” of contempt, triumph, and control - defenses against envy, depression, and anxiety.

But the victim contains the depression and anxiety that the perpetrator has denied and projected onto him. Since self-esteem is related to the effectiveness of the ego to defend itself, there is a corresponding loss of self-esteem when this defense fails. Shame confirms the humiliated as complicit in his own violation in the identification with the aggressor that is characteristic of submissive acquiescence. The humiliated and the humiliator can at last agree - that the humiliated deserves nothing but contempt. With the loss of human dignity, there is nothing left to envy. The acquiescence, the point in which the humiliated “breaks,” is a kind of climax in which the degradation is complete, eradicating through the victor’s omnipotence the reality of the victim’s status as a human being. Despite the fact that women in Palestine are often said to be especially victimized, we believe that it is men and particularly younger men who are most likely to be humiliated and are most vulnerable to its devastation.
It is not our assertion that soldiers performing humiliation rituals themselves suffer from sadistic perversion or manic phenomena - or even that they are especially wicked people. Rather, we view the abuse of a captive civilian population by an occupying military force as the inevitable result of political hate propaganda and regressive group dynamics. Unlike the sexual abuser of children or the domestic batterer, the political humiliator appears to be an ordinary personality in a special social context that legitimizes enactment of primitive destructive impulses which are otherwise taboo. As agents of a politicized humiliation ritual, the humiliator is only temporarily insane - the entire experience takes place in a split-off psychic space. We are encouraged by movements within Israel that seek to recapture these split-off domains through protesting the mistreatment of Palestinians, such as the organization Breaking the Silence that permits ex-soldiers to explore their guilt and shame in regard to what they have seen and what they have done. 22

Part Five: Recovery and Restitution

Therapeutic approaches to Palestinian individuals who have suffered humiliation by Israeli forces include conventional psychiatric interventions such as medication for target symptoms of depression, anxiety, and PTSD as well as psychotherapy. These techniques may need modification in view of special challenges posed by humiliation. It appears, for example, that while Cognitive Behavior Therapy (CBT) techniques are effective in reducing PTSD symptoms of hyperarousal, the shame generated by humiliation appears relatively resistant to CBT. 23 We focus here on some of these challenging aspects and suggest principles for management that could be examined in future research; it is beyond the scope of the current paper to propose how future research should be conducted, but we would expect that a full exploration of these issues would require both qualitative and quantitative clinical studies.

1. Not everyone is a patient. One adolescent brought to a psychiatrist by his family following detention refused to cooperate at all with the interview, exclaiming “I’m not crazy!” A discussion group made up of similar youngsters led by an older man who has himself experienced the humiliations of detention may be more appropriate. Groups such as the Prisoner’s Club in Palestine offer self-help based on this model. 24

2. The construction of a trauma narrative undergoes a process of many revisions. Initially, a therapist can offer a holding environment for the patient’s viewpoint, which is difficult enough to articulate because of the dysregulating effects of shame and rage. Later, proposing cognitive shifts can open the possibility of reframing the narrative: for example, what initially seemed as the patient’s shameful acquiescence might be re-conceptualized as the path of wisdom in precluding even further violence, given his available choices.

3. A powerful tool in reframing humiliation through counter-narrative is to ask, “What motivated the perpetrator in the act of humiliation?” Inquiry about the perpetrator’s frame of mind can stimulate empathic insight into the infantile needs behind the humiliation ritual. Mr A, the man stripped of his clothes and forced to repeat obscenities about his wife, was initially unable to look his wife in the eye following this experience. It was helpful to him to speculate that the soldiers were perhaps themselves anxious about their own masculine dignity and that they viewed him in contrast as somehow more adequate as a man - thus needing to humiliate him so that he would no longer be an object of their painful envy. Utilizing the interpersonal perspective in this way may be a useful intervention specific to addressing the shame of humiliation.

4. Humiliation attacks identity, especially in its expression through social roles. Sensitive exploration of sources of connection may help the patient re-situate himself in roles from which he has been alienated. Couples counseling and family-oriented treatment may help as well as re-involvement in cultural and community groups and political action.

5. There can be no genuine validation of the Palestinian historical narrative without the restoration of justice to the Palestinian people, and no containment of fantasies of revenge without a mature moral and cultural transformation within Israel and the occupied territory. Working towards the goal of equitable liberation is an ethical mandate but it is also the sole therapeutic modality for each and all of its participants. Only an end to politicized humiliation can open the door to reconciliation on an international as well as a personal level - in which it is possible for injury to be counted, acknowledged, and worked through. 25
Acknowledgment

A version of the current paper was presented at a panel at the conference, “Listening to Trauma” held in Washington D.C. during October 2016.

References


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Prevalence of Psychiatric Disorders among Saudi Adolescent Girls in a Riyadh City High School

Yousra Alatiq, Meshael Alshalan, Omar Almodayfer

Abstract

Objective: Studies have shown that mental health problems at an early age can lead to greater impairment in adult life. Epidemiological evidence on the prevalence and incidence of mental health disorders is fundamental for planning mental health services. However, such data are lacking in Saudi Arabia. Method: This two-stage epidemiological study used the Strengths and Difficulties Questionnaire (SDQ) to screen all eligible participants for the presence of a possible psychiatric disorder. A structured psychiatric interview (MINI-Kid) was administered to a subsample to confirm the presence or absence of psychiatric disorders. Results: A total of 4745 participants were screened in the first stage, and 692 participants underwent follow-up interviews. Results revealed the most common disorders were agoraphobia, with a prevalence of 30.6%; major depression, with a prevalence of 30.0%; and separation anxiety, with a prevalence of 27.1%. Although many factors were expected to predict the diagnosis of a psychiatric disorder, having a private teacher was the only significant factor (OR=1.87, p=.013). Conclusion: Agoraphobia, major depression and separation anxiety are the most common psychiatric disorders among Saudi adolescent girls. The only factor that predicted a psychiatric disorder was having a private teacher.

Keywords: Psychiatric disorders, prevalence, adolescent girls, Saudi Arabia

Declaration of interest: None

Introduction

The study of adolescent mental health disorders is increasingly important, as these disorders involve significant impairments in general functioning, marked deterioration among different domains of quality of life and increased health care utilization. There is substantial agreement among epidemiologists that mental health problems at an early age can lead to greater impairment in adult life. A 2003 World Health Organisation report noted that the ‘Lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens, and reduces the capacity of societies to be safe and productive’. Epidemiological evidence on the prevalence and incidence of mental health disorders is fundamental for planning mental health services. While psychopathology in children and adolescents is not uncommon (the mean prevalence estimate is between 15.0% and 17.5%), many conditions are commonly unrecognised. A Western study found that only 27% of children with a psychiatric disorder had been in contact with a health care specialist. In an Arab community sample, 1 in 7 children had a psychiatric disorder that involved significant functional impairment, but none of them had received professional health care. Epidemiology studies of child and adolescent mental health problems shape the rational planning of service delivery, improve early detection and allow professionals to develop prevention programmes for this vulnerable group.

In the past decade, large-scale child and adolescent psychiatric epidemiology studies have become increasingly common in developed countries, especially in the United States and the United Kingdom. In comparison, such studies are much less common in the Arab world and the Gulf countries, with the exception of a limited number of studies from the United Arab Emirates. Using data from studies in other countries allows for estimates of mental health problems in general. However, the planning of local health service delivery should be based on results from local communities;
Psychiatric disorders in adolescent girls in Riyadh City

therefore, research into mental health problems in Saudi Arabia is warranted.

The current study is a school-based study from Saudi Arabia that examines the prevalence rates of mental health problems in Saudi adolescent girls attending high school in Riyadh City. This is a much needed study that is believed to be an important step toward expanding epidemiological research that can have important clinical implications.

Method

The current study involved a two-stage epidemiological method that investigated the rates of psychiatric disorders in a school-based sample of adolescent girls in Saudi Arabia. Saudi education is delivered to girls and boys separately. The current study was conducted with students on an all girls’ campus and thus required women researchers. Initially, a study with boys was designed to be conducted in parallel, but due to funding difficulties, only the study with girls was completed.

The first stage involved use of a self-report questionnaire, the Strengths and Difficulties Questionnaire (SDQ), to screen eligible participants for the presence of a possible psychiatric disorder. Participants with higher scores than the cut-off on the screening measures were identified as the high-risk (screen-positive) sample. Participants who scored below the cut-off scores were identified as the low-risk (screen-negative) sample. To confirm the presence of a psychiatric disorder among a subsample of both groups, both the high- and low-risk participants were invited to participate in a detailed diagnostic structured interview.

Sample

The study sample included Saudi girls attending high schools in Riyadh City. Based on the statistics provided by the Ministry of Education, the original sample population included approximately 87,000 students from 177 schools (private and public) distributed over eight geographical areas. To ensure a representative sample, participating schools were randomly selected from 16 categories (eight geographical areas x two public vs. private); this random selection was proportionate to the size of each category area. The number of schools selected was proportionate to the total number of schools in each category. The total number of schools included in the study was 48, and all Saudi students attending these schools in grades 10 through 12 were considered eligible for participation.

We included only Saudi students in the study sample for two reasons. First, the majority of students in the public schools are Saudis. Including other nationalities would have added a small subgroup that would have been difficult to analyse or compare to the total sample. Second, including non-Saudis would require paying attention to other factors that may affect mental health, such as reasons for moving away from the country of origin, adjustment to living in Saudi Arabia and the availability of a social support system. All these factors warrant a separate study design and focus beyond the scope of the present study.

Procedures

Ethical approval was obtained from King Abdullah International Medical Research Center and from the Ministry of Education. The research team was comprised of trained psychologists who visited the selected schools, introduced themselves and described the study rationale and procedures to the head teacher to facilitate recruitment. The study was conducted in the 2012/2013 academic year.

Stage one

All high school students in these schools were informed about the study and asked to participate by providing demographic data and completing the screening measure (SDQ) in a group setting. Students who did not wish to participate were asked to return the forms without completing them. In addition, each student was given a folder for their parents that included the same screening measure (SDQ-parent form) and consent for their daughter to be included in the study.

Stage two

Only students who completed the screening measures and whose parents granted permission for them to participate in the study were eligible for this stage. The sample consisted of students who were identified as high risk based on the screening questionnaire and an equal number of low-risk students. Both groups were randomly selected.
The demographic questionnaire

The demographic questionnaire was a structured questionnaire that covered age, years of education, number of family members, family status and socioeconomic status.

Possible predicting variables

Based on the literature of psychiatric disorders, a list of possible social and educational variables was assessed as possible predicting factors. These included a loss of one parent, a chronic medical illness, an experience of a traumatic accident, and a history of physical or sexual abuse. Educational risk factors included: being absent from school, failing a school year, and having a private teacher. With a multiple choice question, we also assessed perceived stress based on participants’ reports of stability in the family, the quality of their parents’ marital relationship and the current level of stress in the family. Finally, we assessed participants’ use of time, including how much time they spent watching TV, browsing the internet and using social media, as a possible risk factor. The list of variables is included in Table 1.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief, friendly and nonintrusive self-reported questionnaire that covers common areas of emotional and behavioral difficulties. The questionnaire consists of 25 items that are divided into five scales: conduct, hyperactivity, emotional problems, peer problems and prosocial scales. It has been proven to be a valid and reliable screening measure for mental health difficulties in young people. The Arabic version has also displayed good psychometric properties and is available in both parent and teacher versions. In this study, we used the self-report (S-14-17) and parent-report versions (P 11-17).

The MINI International Neuropsychiatric Interview for children and adolescents (MINI-Kid)

The MINI-Kid is an abbreviated structured psychiatric interview that takes approximately 15-20 minutes to administer. The MINI-Kid uses decision-tree logic to identify all of the symptoms that are listed for major Axis I diagnostic categories and for suicidality. The MINI has been validated against other structured interviews, including the English version of the Structured Clinical Interview (SCID-P) and the English and Arabic versions of the Composite International Diagnostic Interview (CIDI). There is no validation on the Saudi sample; therefore, we are using only the Arabic version validated on an Egyptian sample. The MINI-Kid-Parent interview was used to interview parents about the symptoms of their children.

Teacher involvement

In the initial design for this study, the primary teacher for each class was asked to complete the SDQ teacher form about the students. During the pilot for the current study, teachers consistently refused to complete the questionnaire, as they were not fully aware of the students’ emotional aspects as indicated in the SDQ. Therefore, we substituted the SDQ with one question: ‘Do you think the student has an emotional or behavioral problem?’ with the possible answers of (Yes/No/I do not know). The question was followed by the following open question: ‘If yes, please specify your main concern.’ Again, almost all teachers in the pilot study reported ‘I don’t know’ as an answer, making their input not useful for the study. Therefore, the teacher screening measure was removed from the current study.

Results

Demographic characteristics of the screened and interviewed samples

At stage one, the total number of students who were screened was (N=4745). At stage two, the total number of students who were interviewed was (N=692). The demographic data are presented in Table 1 as the mean and standard deviation for continuous variables or as the proportion and percentage for categorical variables. A comprehensive analysis comparing the two groups (screened vs. interviewed) revealed no significant differences between the subsamples from the second stage and the overall sample form stage one. There were also no significant differences between the students who agreed to take part in the second stage and those who did not.
Table 1. Demographic and psychosocial characteristics of sample*

<table>
<thead>
<tr>
<th>Sample Characteristics</th>
<th>Screened (N=4745)</th>
<th>Interviewed (N=692)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: Mean (SD)</td>
<td>16.9 (.02)</td>
<td>16.9 (.05)</td>
<td>0.031</td>
</tr>
<tr>
<td>Marital status (single)</td>
<td>3951 (98.7)</td>
<td>650 (99.0)</td>
<td>1.000</td>
</tr>
<tr>
<td>Number of family member M(SD)</td>
<td>8.60 (0.06)</td>
<td>8.66 (0.14)</td>
<td>0.214</td>
</tr>
<tr>
<td>Father has more than one wife</td>
<td>637 (17.9)</td>
<td>106 (16.67)</td>
<td>.394</td>
</tr>
<tr>
<td>Mother is not Saudi</td>
<td>668 (19.27)</td>
<td>122 (20.78)</td>
<td>.089</td>
</tr>
<tr>
<td>Mother is working</td>
<td>782 (20.49)</td>
<td>126 (20.19)</td>
<td>0.511</td>
</tr>
<tr>
<td>Property independency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent home</td>
<td>1265 (32.70)</td>
<td>198 (31.03)</td>
<td>0.550</td>
</tr>
<tr>
<td>Shared with extended family</td>
<td>2485 (64.23)</td>
<td>418 (65.52)</td>
<td></td>
</tr>
<tr>
<td>Shared with other wives</td>
<td>119 (3.08)</td>
<td>22 (3.45)</td>
<td></td>
</tr>
<tr>
<td>Socioeconomic status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 4000</td>
<td>476 (15.4)</td>
<td>77 (14.31)</td>
<td>0.089</td>
</tr>
<tr>
<td>4000 - 7000</td>
<td>549 (17.8)</td>
<td>106 (19.7)</td>
<td></td>
</tr>
<tr>
<td>7000 -10000</td>
<td>469 (15.23)</td>
<td>68 (12.64)</td>
<td></td>
</tr>
<tr>
<td>10000-13000</td>
<td>442 (14.35)</td>
<td>71 (13.20)</td>
<td></td>
</tr>
<tr>
<td>&gt; 13000- 16000</td>
<td>373 (12.11)</td>
<td>62 (11.52)</td>
<td></td>
</tr>
<tr>
<td>Has a home maid</td>
<td>1562 (38.88)</td>
<td>265 (40.46)</td>
<td>0.368</td>
</tr>
<tr>
<td>Has a driver</td>
<td>921 (23.43)</td>
<td>154 (23.99)</td>
<td>0.496</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have failed a class before</td>
<td>481 (12.30)</td>
<td>77 (12.18)</td>
<td>0.127</td>
</tr>
<tr>
<td>Frequent absence from school (&gt; 1/week)</td>
<td>281 (7.71)</td>
<td>45 (7.36)</td>
<td>0.158</td>
</tr>
<tr>
<td>Have ever had private teachers</td>
<td>1475 (38.95)</td>
<td>253 (40.54)</td>
<td>0.116</td>
</tr>
<tr>
<td>Use of time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent on watching TV (&gt;3hr)</td>
<td>576 (17.6)</td>
<td>96 (17.5)</td>
<td>0.938</td>
</tr>
<tr>
<td>Time spent on the internet (&gt;3hr)</td>
<td>1149 (36.98)</td>
<td>202 (39.22)</td>
<td>0.452</td>
</tr>
<tr>
<td>Time spent on social network (&gt;3hr)</td>
<td>953 (33.45)</td>
<td>169 (36.11)</td>
<td>0.649</td>
</tr>
<tr>
<td>Time spent with friends (&lt;1hr)</td>
<td>558 (19.6)</td>
<td>100 (21.01)</td>
<td>0.219</td>
</tr>
<tr>
<td>Known risk factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost father</td>
<td>222 (5.6)</td>
<td>31 (4.78)</td>
<td>0.663</td>
</tr>
<tr>
<td>Lost mother</td>
<td>80 (2.04)</td>
<td>9 (1.39)</td>
<td>.616</td>
</tr>
<tr>
<td>Has a chronic medical condition</td>
<td>977 (24.57)</td>
<td>178 (27.18)</td>
<td>0.153</td>
</tr>
<tr>
<td>History of head injury</td>
<td>169 (3.56)</td>
<td>30 (4.44)</td>
<td>1.000</td>
</tr>
<tr>
<td>Witnessed traumatic accident</td>
<td>624 (13.15)</td>
<td>111 (16.42)</td>
<td>0.055</td>
</tr>
<tr>
<td>History of physical abuse</td>
<td>123 (2.59)</td>
<td>27 (3.99)</td>
<td>0.159</td>
</tr>
<tr>
<td>History of sexual harassment/abuse</td>
<td>95 (2.00)</td>
<td>25 (3.70)</td>
<td>0.566</td>
</tr>
<tr>
<td>Had a visit to psychiatrist last year</td>
<td>94 (2.80)</td>
<td>20 (3.59)</td>
<td>0.755</td>
</tr>
<tr>
<td>Family psychiatric illness (yes)</td>
<td>104 (2.88)</td>
<td>18 (3.04)</td>
<td>0.496</td>
</tr>
<tr>
<td>Family is stable (no)</td>
<td>260 (6.61)</td>
<td>47 (7.26)</td>
<td>0.395</td>
</tr>
<tr>
<td>Parental marital compatibility (bad)</td>
<td>203 (5.39)</td>
<td>53 (8.38)</td>
<td>0.424</td>
</tr>
<tr>
<td>Perceived stress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family stressor (yes)</td>
<td>1020 (26.38)</td>
<td>192 (30.38)</td>
<td>0.250</td>
</tr>
</tbody>
</table>

*Data are given as percentage unless otherwise indicated.
Prevalence of psychiatric disorders

Table 2 displays the prevalence estimates and 95% CIs for DSM-IV diagnoses in the sample from stage two (N=692). (DSM-IV was used because it is the one applied in the Arabic version of the MINI-Kid.) Agoraphobia was the most common disorder with a prevalence of 30.6%. This was followed by major depressive episodes with a prevalence of 30.0%, followed by separation anxiety with a prevalence of 27.1%. The fourth in the list was oppositional defiant disorder with a prevalence of 23.9%.

Hypomania, specific phobias, obsessive compulsive disorder, generalized anxiety disorder, social phobia and mania were each rated between 18% and 12%. Panic and posttraumatic stress disorders were 8-9% each. This was followed by conduct disorder with a rate of 5.7% and dysthymia with 4.4%. There was an approximate 3% rate for bulimia and ADHD-combined. Psychotic disorder was rated at approximately 2.1%. Finally, adjustment, anorexia, and substance dependency were below 1%.

Table 2. Prevalence of major psychiatric disorder*

<table>
<thead>
<tr>
<th>Major Psychiatric Disorder</th>
<th>Prevalence n (%)</th>
<th>95% Confident Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agoraphobia</td>
<td>211 (30.58)</td>
<td>0.271 - 0.341</td>
</tr>
<tr>
<td>Major Depressive Episode</td>
<td>207 (29.96)</td>
<td>0.265 - 0.335</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>187 (27.10)</td>
<td>0.238 - 0.305</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>165 (23.91)</td>
<td>0.207 - 0.272</td>
</tr>
<tr>
<td>Hypomania</td>
<td>125 (18.22)</td>
<td>0.154 - 0.213</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>99 (14.35)</td>
<td>0.118 - 0.171</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>95 (13.77)</td>
<td>0.112 - 0.165</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>94 (13.64)</td>
<td>0.111 - 0.164</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>90 (13.02)</td>
<td>0.106 - 0.157</td>
</tr>
<tr>
<td>Mania</td>
<td>84 (12.17)</td>
<td>0.098 - 0.148</td>
</tr>
<tr>
<td>Panic</td>
<td>61 (8.85)</td>
<td>0.068 – 0.112</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>57 (8.28)</td>
<td>0.063 – 0.106</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>39 (5.66)</td>
<td>0.040 – 0.076</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>30 (4.37)</td>
<td>0.029 – 0.061</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>23 (3.34)</td>
<td>0.021 – 0.049</td>
</tr>
<tr>
<td>ADHD - Combined</td>
<td>21 (3.05)</td>
<td>0.019 – 0.046</td>
</tr>
<tr>
<td>ADHD - Inattentive</td>
<td>19 (2.75)</td>
<td>0.06 – 0.042</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>15 (2.17)</td>
<td>0.012 – 0.035</td>
</tr>
<tr>
<td>ADHD - Hyperactivity-Impulsivity</td>
<td>11 (1.59)</td>
<td>0.008 – 0.028</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>5 (0.72)</td>
<td>0.002 – 0.016</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>4 (0.58)</td>
<td>0.001 – 0.014</td>
</tr>
<tr>
<td>Substance Dependency/Abuse</td>
<td>1 (0.14)</td>
<td>0.000 – 0.008</td>
</tr>
<tr>
<td>Alcohol Dependency/Abuse</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Results from the Interview Phase (N=692)
Psychiatric disorders in adolescent girls in Riyadh City

**Sensitivity and specificity of the SDQ in predicting psychiatric disorder**

The SDQ screening measure was reported by two informers, which included the students and the parents (primarily the mother) during stage one. The predictive power of the SDQ in determining psychiatric disorders as identified by the interview in stage two were assessed by the sensitivity and specificity as follows: students SDQ vs. MINI results, parents SDQ vs. MINI results. These results are presented in Table 3.

The results showed a poor sensitivity for the SDQ of the two informers (18.5 for students and 11.0 for parents as screening tools. However, the specificity was much stronger (96.0 for students and 98.2 for parents). This suggests that the SDQ was not a good screening measure for identifying true positive cases, but it is highly specific in excluding true negative cases.

<table>
<thead>
<tr>
<th>SDQ</th>
<th>Value</th>
<th>95% Confident Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDQ Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>32 (11.00)</td>
<td>0.076 – 0.151</td>
</tr>
<tr>
<td>Specificity</td>
<td>108 (98.18)</td>
<td>0.935 – 0.997</td>
</tr>
<tr>
<td>SDQ Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>89 (18.50)</td>
<td>0.151 – 0.222</td>
</tr>
<tr>
<td>Specificity</td>
<td>168 (96.00)</td>
<td>0.919 – 0.983</td>
</tr>
</tbody>
</table>

**Predictors of psychiatric disorders**

Most of the independent variables included in the current study were not a statistically significant predictor of psychiatric disorders among our sample (See Table 4). However, the only variable with a p value of 0.013 was ‘Ever had a private teacher’ (OR 1.868).

<table>
<thead>
<tr>
<th>Variables</th>
<th>OR</th>
<th>95 % Confident Interval</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have ever had private teachers</td>
<td>1.868</td>
<td>1.137 – 3.070</td>
<td>0.013*</td>
</tr>
<tr>
<td>Have failed a class before</td>
<td>2.228</td>
<td>0.811 – 6.122</td>
<td>0.120</td>
</tr>
<tr>
<td>Family stressor (yes)</td>
<td>1.526</td>
<td>0.851 – 2.738</td>
<td>0.156</td>
</tr>
<tr>
<td>Parental marital compatibility (bad)</td>
<td>0.573</td>
<td>0.197 – 1.671</td>
<td>0.308</td>
</tr>
</tbody>
</table>

**Discussion**

This was a two-stage epidemiology study examining the prevalence rate of psychiatric disorders among Saudi adolescent girls attending high school in Riyadh City. The first stage was the screening phase, which used the self-reported SDQ measure in a group setting and the SDQ-parent form for the parents. The second stage was the interview stage and was conducted by trained psychologists using the MINI structured interview.

**Prevalence of psychiatric disorder**
Agoraphobia, depression and separation anxiety were among the most common psychiatric disorders in the current sample with rates of 30.6%, 30%, and 27%, respectively. This is in line with other international studies that found anxiety disorder to be the most common condition with a prevalence rate of 31% among a representative sample of adolescents in the US. Another study measured the lifetime prevalence of psychiatric disorders among adolescents and found a rate of 33%. Moreover, a rate of 31% was found at follow-up among girls who were between the ages of 9 to 16 years.

In comparison with an Arab study, Alyahri and Goodman found anxiety disorder to be the most common diagnosis, which is in line with the current finding, but with a rate of 9.3%. Our rates were much higher than those reported in the study, which reflects differences in the informers and methodology. Our study was based on the diagnosis and adolescent self-report, whereas in the previous study, the parents were the primary source of information. It has been reported that the parents are better informers of behavioral problems, whereas adolescents are better informers of their emotional difficulties.

In a comparison of the present results with findings from Saudi Arabia, we again found similar patterns. In a study using a self-report measure with 545 adolescent girls in a secondary school in Abha City, anxiety disorder was found to be the most common condition in approximately 16% of the sample. Another study using the self-reported Beck Depression Inventory with secondary school boys and girls in Taif city found a rate of 22% for depressive symptoms. Another study using the self-reported Depression, Anxiety and Stress Scale with 1723 high school boys indicated that approximately 59.4% had reported at least one disorder, with depression being the most common condition.

Although anxiety disorder has shown a similar rate in international studies, as reported above, other disorders, such as eating disorders, are considered to have a stronger cultural influence, and therefore, might not be globally similar. In our study, we found a rate of only 3.3% for bulimia and less than 1% for anorexia. In comparison to an international study of 934 adolescent girls, a rate of 17% was found for any eating disorder.

Regarding the rate of hypomania and mania, which is higher than expected, it is important to remember that this is a study of adolescents girls who are asked to self-report specific mood symptoms (such as “feeling full of energy, grouchy or annoyed”). It is possible, therefore, that mood fluctuation, which is a major characteristic of this age group, could result in the over-reporting of such symptoms. One way of overcoming this potential bias is to include more informants in the study design, such as parents or teachers, which is a major limitation of the present study to be discussed later.

It is important to note that a comparison with an epidemiological study is not easily performed due to a large variation among study methodologies, designs and sample selections. Therefore, it is crucial that these results be interpreted with caution in reference to its methodological process.

**Predictor factors**

Previous studies and surveys have found psychiatric disorders to be associated with specific factors, such as family socioeconomic status and the parents’ education level and occupations. Our study found only one educational factor that predicted the presence of a psychiatric disorder, which was ‘having a private teacher’.

Previous international studies have noted that lower educational achievement was strongly related to poor mental health. Another study found that anxiety disorder significantly increased the risk of premature withdrawal from school.

Although we have not assessed academic performance, we only ask whether private teaching is a possible proximal indication of school difficulties. Therefore, the result might reflect the fact that school performance and difficulties in school that require extra help (such as private teaching) might be an indication of psychological difficulties in adolescents. However, it is possible that the use of private teachers for supervised studies is not necessary an indication of difficulties. Therefore, the question remains for future research to confirm and to add onto these findings. We encourage future research into look into this possible link.

**Teacher involvement**

It is unfortunate that the present study was unable to include input from teachers via the same screening measure (SDQ teacher version). However, almost all of the teachers initially included in the pilot study declined to complete the screening measure stating that they did not feel fully aware of their students’ psychological wellbeing. This gap of knowledge raises concern about the lack of early identification of a student’s psychological difficulties, which might go unnoticed by the school. It was reported by Ford et al. in a large epidemiology study that some disorders, such as ADHD, may be missed if information from the teacher is not sought out. This is also important in light of the current findings, which indicate that having a private teacher might predict a psychiatric disorder.
**Limitations**

The limitations of the current study need to be addressed. First, the results were based on information obtained from one informant group – the adolescents. Other sources of information, such as information from the mother or father should also be explored. Second, not being able to assess the teacher input is a major limitation to this study and those with a similar design. Researchers should therefore think carefully when designing a similar study. It might be advisable to use a follow-up study design in which teachers are asked to evaluate their students over a longer period of time. Finally, our study did not identify social predictors of psychiatric disorders, which is likely attributable to having only one informer for each subject. Psychiatric disorders are complex conditions in which no single cause can fully explain the variation observed among patients; therefore, one informer is not enough to explain this complex dynamic with social factors. Having acknowledged these limitations, the current findings have important clinical implications for adolescent mental health research and service planning. This is especially important because information on this topic is very limited in Saudi Arabia.

**Conclusion**

The current study was a two-stage epidemiological survey that examined the prevalence of mental health problems in Saudi adolescent girls attending high school in Riyadh City. The most common psychiatric disorders were agoraphobia and depression with prevalence of 30.6% and 30%, respectively. The differences in methodology affect the comparability with other studies; the use of a school-based sample and reliance on information from the adolescent only may have contributed to a relatively higher rate compared with other Arab studies. Having a private teacher was the only predictor of a psychiatric illness in the sample.

**Acknowledgement**

We would like to thank all participants for giving their time to participate in the study. Also we thank the research assistants who collected the data.

**References**


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الذهان في الدليل الأمريكي التشخيصي والإحصائي الخاص للأضطرابات النفسية

تغيرات في تشخيص اضطرابات طيف الفصام:

1. تشخيص الفصام المزاجي يتطلب 6 أشهر من الأعراض المرضية، ولكن الأعراض الفصامية مستمرة لمدة أسبوعين على الأقل دون أي أعراض مزاجية. وهذا يساعد على التفريق بين الفصام المزاجي وآخرين. ولا يكتفي وجود أعراض مزاجية للدليل المشخص الفصام المزاجي، بل يجب أن تكون الأعراض المزاجية لمدة طويلة، أي أن تشخيص الفصام المزاجي يعتمد على مقطع طول زمني في الأعراض وليس مقطعًا عرضاً.

2. في الاضطراب الذهن، يمكن أن يكون الهدن غريبًا وجريءًا أو المتصرف بشكل جمود أو أشفًا. الهدن يتكون ضمن الاضطرابات الذهنية الأخرى، وليس ضمن الاضطرابات الذهنية الأخرى.

3. إضافة تشخيص الفصامي لدقة الاضطرابات: الانتكاب - اضطراب المزاج الثاني الشبيه - الاضطرابات الذهنية - حالة طبية.

4. ويطلب تحليل جمودي وجود ثلاثة أعراض من التبت عن عرضًا موجوًا، لما بعد ذهني موجوًا عن خمسة أعراض، وفي حالات التحليل المطري عرض واحد فقط.

5. اقتراح للثاني من الدراسة: تطور الذهن المخطط، من البشريات وللذهن المخطط.

Psychotic Syndrome

وهو الأضطراب يعاني من الفصام، وهذا يعاني من صفات محددة، وهي: أعراض ذهنية خفيفة، أو أوها، أو اضطراب التفكير، أو الأعراض الباطنية، مع أعراض السلوكية والصederlandية، مع ملاحظة وظهور في الأداء الوظيف.

شائع وانتشار حوالي 1.8% من السكان، حيث يعاني المصابون به من تجارب أحداث، أو أفكار فيتنامية، أو صورة، وهو أكثر شيوعًا عند الذكور، وحوالي 30% من هؤلاء الذين يعانون من أعراض ذهنية.

تعتبر: اضطراب عشري، وحيدًا وغير واضح، يعتمد في إدارة الاضطراب الذهني، صغر الأم، ولكنها أخف أعراضًا، وربما تكتن ألمه في التدخل العلاجي، والمنقرضة.

المراجع:


ووفقًا في الدليل الرابع كان يذكر وجود عرض واحد إذا كان من أعراض المزاجية الأولي لتشخيص (هذيات المهربة وصدى الأفكار، أو أفكار، أو أفكار الأخرى) مع ح胍ًا في الأعراض المزاجية الأولى لتشخيص (هذيات المهربة، أو أفكار، أو أفكار الأخرى) مع ح胍ًا في الأعراض المزاجية الأولى لتشخيص (هذيات المهربة، أو أفكار، أو أفكار الأخرى).

أيnyaً يتعين على التفريق بين تشخيص الفصام والتشخيصات الأخرى، مثل التشخيصات الأولي لتشخيص الفصام. وفي حالات معقدة، يمكن أن تظهر في حالات اضطراب المزاج المختلفة، كما في الأكتيب أو الهوس، طبعًا إلا إذا استمر التهدن مع نعومة ونعمًا، مما يعنى أن يساهم في تشخيص.

وأيضاً يجب أن تكون أعراض الذهنيات من الأعراض الإيجابية الثلاثة الأولى. وهذا يساعد على التفريق بين التشخيصات المزاجية، وبين التشخيصات المزاجية، وبين التشخيصات المزاجية، وبين التشخيصات المزاجية، وبين التشخيصات المزاجية، وبين التشخيصات المزاجية.

وبما ت.JPG

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الذهان في الدليل الأمريكي التشخيصي والإحصائي الخامس للأضطرابات النفسية
حسن المالح
Psychoses in DSM-5
Hassan Almaleh

الذهان هو مصطلح حديثاً، وقد أطلقه الطبيب النفسي بلويرز في ألمانيا عام 1911، وقد قدص به عدة اضطرابات نفسية ذهانية

وقد ساهمت الحرب العالمية الثانية بتطورات هامة في ميدان الطب النفسي حيث ظهر التنسيق العالمي للأمراض بطبعه السادس ومن ثم للمرة الأولى تشخيص عدة أمراض نفسية منها القسم 6، عام 1949.

كما ظهر في الولايات المتحدة الأمريكية الدليل التشخيصي والإحصائي الأول للأمراض النفسية عام 1952، وكان يضم 106 من الاضطرابات النفسية لكل منها أوضاعها ومعايير تشخيصها المحددة. وظهر فيها مصطلح الفصام الارتكاسي ويعني الفصام الناتج عن ضغوط وأزمات معينة.

وقد ظهرت خلال السنوات التالية إلى الوقت الحالي عدة تعديلات على تشخيص الأمراض النفسية.

الدليل الأمريكي التشخيصي والإحصائي الخامس للأضطرابات النفسية

وفي عام 2013، ظهر الدليل التشخيصي والإحصائي الخامس، وفيه أكثر من 350 شخص (ملاحظة: تم استخدام الأرقام العربية في تسمية الدليل الخامس 5 بدلاً عن الأرقام الرومانية v لأنها أكثر سهولة في برامج الكمبيوتر.)

اضطرابات طيف الفصام وغيرها من الاضطرابات الذهانية في
Schizophrenia spectrum and other psychotic disorders

يضم الدليل التشخيصي والإحصائي الخامس للأضطرابات النفسية ستة اضطرابات تحت عنوان اضطرابات طيف الفصام وغيرها من الاضطرابات الذهانية وهي على الشكل التالي:

1. Schizophrenia: القسم

2. Delusional Disorder: الأضطراب

3. Schizoaffective Disorder: القسم المزاجي

4. Schizotypal personality disorder: الشخصية ذات النمط الفصامي

5. Brief psychotic disorder: الذهان قصير الأمد

6. Hallucinations: هولاوس

التغيرات في تشخيص الفصام في الدليل الخامس:

1. وجود عرضين من الأعراض الذهانية التالية:
   - Delusions (أوهام)
   - Hallucinations (هولاوس)
Abstract

The 20th Century was characterized by significant advances in science and information which were greatly supported through improved methods of communication. In light of IT technology and the internet age, psychological science began to be seen differently.

The ever-evolving field of communication continues to bring with it the promise of change because of the speed at which information can be delivered. Thus inarguably, the widespread dissemination of information enhances the value of science.
المعلقون في العلوم النفسية

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الموسع الإنجليزي (إنجليزي - فرنسي - عربي)

الموضوع "الموسع" في علوم وطب النفس (الإصدار الإنجليزي (44142 مصطلحا).

الموسع الفرنسي (فرنسي-إنجليزي – عربي)

الموضوع "الموسع" في علوم وطب النفس (الإصدار الفرنسي (66346 مصطلحا).

دليل المؤتمرات النفسية العربية والعالمية

· مجموع المؤتمرات: 335 م
· المعدل السنوي: 26/س
· التوزيع السنوي:
  - 2011: 37 م/ 2012: 39 م/ 2013: 33 م
· ماجستير & ملتقات تكوينية من 2007 إلى 2017: 15 م

معالج ومعوسات في علم وطب النفس

المعجم التفاعلي في علم وطب النفس - على الموقع الرسمي للشبكة

تعرض المعجم التفاعلي في علم وطب النفس حيث يمكن المتصفح

• نسخة مختصرة من المعجم الورقي في العلوم النفسية، موجهة بالأساس إلى
  كل مهتم بالثقافة النفسية ويشمل تخصص الطب النفسي وعلوم النفس،
  الذين يتضمنون أولى خطواتهم وهم يجدون هذا الحقل من العلوم.

• العربية-إنجليزي، (32163 مصطلحا)
• العربية–فرنسي، (44142 مصطلحا)
• العربية-إنجليزي، (66346 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسية- عربي) (32163 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسية- عربي) (44142 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسية- عربي) (66346 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (32163 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (44142 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (66346 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (32163 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (44142 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (66346 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (32163 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (44142 مصطلحا)

المعجم الإنجليزي (إنجليزي-فرنسا- عربي) (66346 مصطلحا)

المعجم العربي (عربي-إنجليزي – فرنسي)

الموضوع "الموسع" في علوم وطب النفس (الإصدار العربي (36646 مصطلحا).

الموسع العربي (عربي-إنجليزي – فرنسي)

الموضوع "الموسع" في علوم وطب النفس (الإصدار العربي (36646 مصطلحا).

الموسع الإنجليزي (إنجليزي- فرنسي – عربي)

الموضوع "الموسع" في علوم وطب النفس (الإصدار الإنجليزي (44142 مصطلحا).

الموسع الفرنسي (فرنسي-إنجليزي – عربي)

الموضوع "الموسع" في علوم وطب النفس (الإصدار الفرنسي (66346 مصطلحا).

دليل المعجم "الوجيز" في علم وطب النفس. إعداد جمال التركي

الوجيز العربي (عربي-إنجليزي – فرنسي)

المعجم "الوجيز" في علم وطب النفس ـ الإصدار العربي (32163 مصطلحا).

الوجيز الإنجليزي (إنجليزي- فرنسي – عربي)

المعجم "الوجيز" في علم وطب النفس ـ الإصدار الإنجليزي (44142 مصطلحا).

الوجيز الفرنسي (فرنسي-إنجليزي – عربي)

المعجم "الوجيز" في علم وطب النفس ـ الإصدار الفرنسي (66346 مصطلحا).

المعجم الشامل لمصطلحات علوم النفس والطب

الذي جاء في ثلاثة اصدارات ثلاث:

· إصدار عربي (عربي-إنجليزي - فرنسي): محتوي على أكثر من 36 ألف مصطلح نفسيًا عربياً.
· إصدار "الكليا" (إنجليزي- فرنسي – عربي): محتوي على أكثر من 44 ألف مصطلح نفسيًا انكليزيًا.
· إصدار فرنسي (فرنسي-إنجليزي – عربي): محتوي على أكثر من 32 ألف مصطلح نفسيًا فرنسيًا.
 Salaam 2016 آية الاستنذان والمشهد الأصلي
- أحمد البطيني.
سلسلة إصدارات: "الكتاب الأبيض" (وفق الصحة النفسية في الوطن العربي)
- الإصدار الأول 2012 مطبخ النفس في اليمن - مع عبد الباري القصالي.
- الإصدار الثاني 2013 الصحة النفسية في دولة فلسطين.
- الإصدار الثالث 2015 واقع العلوم النفسية في الجزائر.
- د. زيري بن مبارك.

دليل السلسلة المكتبية "الكتاب الأبيض" 
من العدد (تشرين الثاني 2013) إلى العدد 3 (ربيع عام 2016)
سلسلة: الإنسان والتطور - يحيى الرخاي (النشرة اليومية حسب المحاور)
الإصدارات السابقة
- الإصدار الأول 2010 (دراسة في علم السيكوپولوجيا).
- الإصدار الثاني 2011 (ملف الإنسان - الجزء 1).
- الإصدار الثالث 2011 (ملف المعارف النفسية - الجزء الأول).
- الإصدار الرابع 2012 (ملف العلاج النفسي - الجزء 2).
- الإصدار الخامس 2012 (وفق تجربة الإنسان).
- الإصدار السادس 2012 (وفق تجربة الانتقادات).
- الإصدار السابع 2013 (وفق تجربة الإنسان).
- الإصدار الثامن 2014 (وفق تجربة الإنسان).
- الإصدار التاسع 2015 (وفق تجربة الإنسان).
- الإصدار العاشر 2015 (وفق تجربة الإنسان).
- الإصدار الحادي عشر 2015 (وفق تجربة الإنسان).
- الإصدار الثاني عشر 2016 (وفق تجربة الإنسان).
- السلسلة المكتبية: "ممارسات" (أسئلة من ميناء مختلف)
- "الإنسان والتطور - يحيى الرخاي (النشرة اليومية حسب المحاور)
- السلسلة المكتبية: "ممارسات" (أسئلة من ميناء مختلف)
- ميبا صيحة.
- الإصدار 11: سكنة الأمان، محمد كمال الشريف.
- الإصدار 12: علاقة التربة محمد السعيد عبد الجواد.
- أهواج. 
- الإصدار 13: سلسلة التواصل والاعتقاد ما بين اللغويين وتفاهم.
- الفناد سي. مرسيل شعبان حس. 
- الإصدار 14: أعلام العرب في عالم النفس. د. عبد الرحمن.
- إبراهيم.
- د. محمد شريف.
- د. رضوان.
- د. محمد شريف.
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سلام...
لا يمكنني قراءة النص العربي.
瓶子 (صوف - خريف 2013) | مجلة: المجلة الطبية (مصر) / الجمعية العالمية للصحة النفسية / إناث (إيطاليا) / الجريدة (ال🌙) / الجمعية العالمية للطب النفسي

العدد 18-19(مطبوع - خريف 2013) | المجلة: مجلة النفسية (مصر)

العدد 11-12(مطبوع - خريف 2012) | المجلة: مجلة النفسية (مصر)

العدد 10-11(مطبوع - خريف 2012) | المجلة: مجلة النفسية (مصر)

العدد 9-8(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 8-7(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 7-6(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 6-5(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 5-4(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 4-3(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 3-2(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 2-1(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)

العدد 1-0(مطبوع - خريف 2011) | المجلة: مجلة النفسية (مصر)
المجلات والدوريات النفسانية:

• مجلة ودوريات بكلمات نصوصها:
  - الجنسية العربية للطب النفسي (الاتحاد الأطباء النفسيين العرب - الأردان): بدايةً من العدد 2 من المجلد 21.
  - الجنسية العربية للطب النفسي (الجمعية العالمية للطب النفسي - سويسرا): بدايةً من العدد الأول.
  - الجنسية العربية للطب النفسي (الجمعية السعودية للطب النفسي).

• في شمال شرق مراكز ودوريات العالم النفساني:
  - نشرة الإدمان (مصر) / الصحة النفسية (اليمن) / الصحة النفسية العربية (الإمارات).

• أعمال وأبحاث ودوريات علم النفس:
  - تأسست قاعدة بيانات الأبحاث النفسانية والعقلانية العربية.

• تكمل جمعيات العلم النفسية العربية... من نجوم سلسلة عامة.
The Arab Network of the Psychological Sciences: Seventeen Years of Arab Cooperation and Achievement

Jamal Turky


The Arab Network of the Psychological Sciences: Seventeen Years of Arab Cooperation and Achievement

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ABSTRACT

The new historians of Zionism, both Israeli and Arab, have lifted the narrative of this controversial subject to new levels of scholarship and trust. At the same time, the concepts and insights of individual and family centered psychoanalysis have been applied to this complex social and political phenomenon. Under an integrated paradigm, the self or reflective individual is redefined essentially as linked to its history and environment. Such a model facilitates the analysis and explanations of the evolving movement of Zionism from its origins in the last decades of the 19th Century in Europe to its manifestations in Israel in the present time. Parting from the fear and latent anxiety experienced by individual Jews and collectively by the Jewish persecution and suffering in Eastern Europe in the last one hundred years, most prominently by the Holocaust under the regime of Nazi Germany, the psychological defenses against this anxiety most commonly listed have been paranoia, denial and the divided self. They have been common components and are manifest in the classic and neo Zionist narratives. Paranoia is not meant in a clinical sense, but as a discursive political ploy, which is also noted in other social and political instances in the United States’ history. The paper concludes with the hope that truth in history, like in any personal or national narrative, will become the basis for justice in the resolution of the Israel and Palestine conflict.

Author

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The Case of Israel: Abandoning the Public Committee Against Torture in Israel


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فِي فرانس ستانجل القائد النمساوي في معسكرات سوير، وترجع إليه الأدلة الملموسة في 1942 وليرى ما كان من سوء حال، وعلى رأس هذا المعكر. وقضايا الذين ليسوا بالطبع في أمريكا اللاتينية في ظل الكتالوجات العسكرية في الجماعات في كل هذه القضايا كأنه قام بالتعديل بعد يوم من العمل الجاد بعد إلى أنه لم يكن هناك شرطية أو شروط أخرى أو العادات أو المشكلات أو الأفكار أو الكتب يمكن أن يكون له أي تأثير أو دور في الحالة أو في الحالة. 

وعلي ذلك، فإن التغييرات في الجماعات والثقافات لها تأثير كبير على القضايا الاجتماعية والسياسية. 

وأخيراً يمكن التعليق على كتابات وآراء علماء النفس النازحين والمخرجين البذل الصهيونيين، أن العلم يعدد مقتنيته الاجتماعية الحقيقية والأخلاقية الاسم الناجم من خلاله النصائح الاجتماعية والاجتماعية. عند بعض النصائح مثل تأثيرات الت sıkıntıات التي تحدث في شجاعة أو مرونة، وعند بعض الكتالوجات حول مراحل تجربة المجتمعات الإسرائيلية في خضم القرن الماضي من خلال تجربة ودفقي وسفر في رايزمان. وتشير هذه الظاهرة، فاز ليبراليات مع مجتمعات لا، أو المدارس أو المجتمعات أو غيرها من مجتمعات لا أو مجتمعات. 

وال🛋疗程 تقدمت في الجملة الملاحظة، فإنها تقدمت في خضم القرن الماضي من خلال تجربة ودفقي وسفر في رايزمان. وتشير هذه الظاهرة، فاز ليبراليات مع مجتمعات لا، أو المدارس أو المجتمعات أو غيرها من مجتمعات لا أو مجتمعات. 

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لا يمكنني قراءة النص العربي بشكل طبيعي.
أن ندرك أنه عندما نستخدم أسلوب فلنسبت تفاعلي، فإننا نرى أن التحليل النفسي قد يكون له تأثيرات إيجابية والمخاطر التي تواجهه. ونعلم أن النظام السياسي والاجتماعي لا يزال يستمر في التأثير على الحياة الشخصية في المجتمع.

**منهج التحليل النفسي**

إن النموذج النفسي والهيكل الاجتماعي يمكن أن يؤدي إلى تأثيرات إيجابية، ولكن ذلك يعتمد على كيفية التحليل النفسي. ونعلم أن النموذج النفسي هو منهج نظري يساعد في فهم الأزمات الاجتماعية والسياسية.

**ضالة الشك – البارانويارو**

قد عرف البرانواريو بأنه مناهضة معارضة لوجود الخلايا. ونتيجة لذلك، فإنه يشير إلى أن المجتمعات البشرية تفتقد للإنسانية. ونعلم أن هذه الأفكار قد تكون تجاهًا لأفكار أخرى، ولكنها تشير إلى أن المجتمعات البشرية تفتقد للإنسانية.

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التحليل النفسي للصهيونية في سياق التاريخ والظروف

فيديريكو أندي

الترجمة العربية: أحمد عكاشة، عيد يوسف

Psychoanalysis of Zionism in the Context of History and Circumstances

Federico Allodi, Ahmed Okasha, Adel Youssef

لمصطلح

إن المؤرخين الجدد للصهيونية، الإسرائيليين والعرب على حد سواء، قد قاموا برفع درجة سردهم هذا الموضوع المثير للجدل إلى مستويات جديدة من التخصص والثقة. وفي الوقت نفسه تم تطبيق مفهوم تحول التحليل النفسي المتمركز حول الفرد والأسرة على هذه الظاهرة الاجتماعية والسياسية المحورية. كما تم إعادة تعريف "الذات" أو "الفرد المفكك" بواسطة موجات فكاكين بشكل وثيق باختصار والصلة المحيطة به. إن هذا الموجز يمثل تحليل ورش الحركة الصهيونية الناشئة من بداياتها في العقود الأخيرة، وبجهود وذوق معركة في أوروبا، وتماماً في القرن الهروفي والنقاش المكتف التاريخ والقلق الكائن في نفس الفرد الهروفي والACING في المجالات الأخرى، وخاصة كمسيرة الهدوء تحت حكم ألمانيا النازية، فإن الفعاليات النفسية التي تم تكرارها ضدها حالياً (الصالة الإطاحة) والإعاقة واللغة المنقولة، وظهرت هذه الدفقات كمكعوب مشتركة في الكتب التقليدية والصهيونية الحديثة. إن الصالة الإطاهة لا تزال معنى الألكسيسي يكمن حالة سياسية سيطرية لوحة في موقع إعلامي وسياقية أخر في تاريخ الولايات المتحدة الأمريكية. إن ذلك المقال يضع في اعتبارنا أن الحقيقة في التاريخ، بلما في أي سرد أو قومي، تصبح أساس العدل في الاحتلال الصهيوني والطبي.

توجد العديد من الكتب الشهيرة والمتخصصة في الصهيونية، إلا أننا ننظر أولاً للعلاقة العادل للاختيار، فلكل من الكتاب جاف وأورك دائرية تكراراً. وازداد، وفي أوروباgowالإسلامة، ونفسيات قصد اعداد "أدخل الحيوان" الذي يُعرف بالـ"الذات" في الصحافة اليوم، رئيس الهولوكوست و تمثل النواة من الحركة الصهيونية في الأوروبا، ومنذ أن ظهرت هذه الكتب كمكعوب مشتركة في الكتب التقليدية والصهيونية الحديثة. إن الصالة الإطاهة لا تزال معنى الألكسيسي يكمن حالة سياسية سيطرية لوحة في موقع إعلامي وسياقية أخر في تاريخ الولايات المتحدة الأمريكية. إن ذلك المقال يضع في اعتبارنا أن الحقيقة في التاريخ، بلما في أي سرد أو قومي، تصبح أساس العدل في الاحتلال الصهيوني والطبي.

إن بارون وروز وزوخارف قد أطلقوا تعبير "العلاقة العادل للاختيار"، وأوجوهها إلى القلق المكبوت ومساعدتان النظامية التي تغيرها في المجلة الصهيونية في أوروبا، ومنذ ذلك الحين، انتشر النهج في التحليل النفسي، إذ لم يعد يتردد في اختصاره، وأخيراً روزمارون الطيف الصهيوني من أصل اليهود الصابرين، وتحقيقه في النهج التحليلي ومؤسسة جمعية أطفاء من أجل حقوق الإنسان الإسرائيلية، والنظرية النفسية من مراحل الإطاحة، ومساءة الصهيونية، و致 sanitizers الشهيرة، ومساءة الصهيونية، واتخاذها في الأصل قد جمعت دراسات الأدوار والأعمال، وخلاصاً من لاساونغ استخدمت في تطبيق الإسリアي الفلسطيني ضمن حركات أسراء الأسئلة في الأسر، وروايات تعود إلى الأقران المعاصرة. إن ذلك المقال يضع في اعتبارنا أن الحقيقة في التاريخ، بلما في أي سرد أو قومي، تصبح أساس العدل في الاحتلال الصهيوني والطبي.

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