



## مجلة شبكة العلوم النفسية العربية

نحو مدرسة عربية للعلوم النفسية

مجلة فطرية محكمة في علم النفس

رئيس التحرير

جمال التركيبي (تونس)

المستشار و نائب الرئيس

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السكرتيرية: أمال القلسي القرقيوي و سفاتلدا كستروفا الطريقة

إصدار مؤسسة العلوم النفسية العربية - تونس

## النّديّة العلميّة ... أمل واعد و سعي د دؤوب

د. جمال التركي - الطب النفسي / تونس

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"في السادس عشر من أبريل عام 1953 قال الرئيس الأمريكي الراحل اينرلهاور ان كل بلدية ينير تصنيها وكل بارجه ينير قد شيها، وكل صاروخ ينير اطلاقه، هو في النهاية مسروق ممن يعاونون الجماعة من دون أن يطعمهم أحد ومن دون أن يدشهم أحد من معاناة البرد. ولعل هذا الشبيه الأمريكي المبك منذ أكثر من نصف قرن يضاعف من صدمتها مما قرؤة حاليا على موقع الإنترنت : [www.costofwar.com](http://www.costofwar.com) من أرقام متغيرة في كل ثانية، تبرز تكلفه الحرب على العراق غير منضمة، ما يكبله العالم في تلك الحرب وإثما ما تدفعه الولايات المتحدّة وحدها. و قد وصل أخيرا إلى 111,778,777,859 دولارا أمريكيا والرقم في تزايد مواصلة بالطرح. وكان يمكن للولايات المتحدّة بدلا من ذلك الإنفاق الهائل على الحرب .. إن تضمن دخول المدارس لـ 15,803,624 طفلا أمريكيا، وتغطية تكليف التأمين الصحي لـ 47,912,160 أمريكيا لمدة عام و توظيف 2,129,125 مدرسا في المدارس الحكومية، وبناء 1,596,845 وحدة سكنية لمواطنيها. فضلا عما كان يمكن أن تحقته تلك الأموال الطائلة لبلدان العالم الثالث المحرومة من الموارد. ولا أحصي هنا أعداد القتلى والمصابين والمعوقين والبنية التحتية التي دمرت والجامعات والمراكز الثقافية التي هُبت .. هذا هو حال العالم...."

أ.د. أحمد عكاشة - مؤسس الجمعية الأمريكية للطب النفسي - ماي 2004

نسهل افتتاحية العدد لهذا المقطف الذي رسم فيه البروغسور أحمد عكاشة الحال الذي أصبح عليه عالمنا اليوم... عالم تشابكت فيه الأوضاع وتعدت خاصة في المنطقة العربية التي شهدت مرضات سنظل لسنوات طوال فغاني انعكاساتها السلبية على مستوى اللياقة النفسية للإنسان العربي. إن جسامته الأحداث وسوقها لن يمس على منطقتنا دون أن تترك بصماتها على مدى عقود من الزمن حيث لم يشهد الإنسان العربي على مدى تاريخه المعاصر مرضات هزت استقراره النفسي وأدت إلى زعزعة جهاز التغير لديه، مثل ما يتعرض له اليوم ومن هنا فإن مسؤولية أخصائيي الصحة النفسية تعد جسيمة فالإنسان العربي لا يكاد ينجو من صدمة حتى تلاحقه أخرى أشد وأعنى... إن وضعا كهذا يتطلب حراسة مستفيضة للحالة النفسية الراهنة والحلول المقترحة مما يمكننا من الصدي للعتايل النفسية للرضات المتتالية، و تجنب الإزمان الذي يعيق التفاعل السوي ويرفع نسبة العطالة النفسية، إن حاجتنا إلى أخصائيي الرعاية النفسية والطب النفسية تعد في غاية الأهمية ولم تكن في يوم ما أكثر ضرورة من اليوم، ولكن قلته هو لا تجعلهم مطالبين بتقدير جهدهم مضاعف للصدي للاضطرابات الآتية والمنظومة.

من محذورات العدد ...

يشاركنا البروغسور عكاشة في مسهل باب الأبحاث والمقالات الأصلية يبحث رسم فيه استراتيجية خدمات تأهيل الرعاية النفسية لعراق ما بعد الحرب، مقدما الجهود الذي قامت به الجمعية العالمية للطب النفسي سواء قبل اندلاع الحرب بالتحذير من انعكاساتها الجسام أو بعد الحرب من خلال الدعوة لأن ينجو الأطباء النفسانيين الصراعات السياسية والعرقية والدينية لصالح مرضاهم والاستعانة بالمنظمات غير الحكومية ومنظمة حقوق الإنسان للمساعدة في تقديم خدمات الصحة النفسية لشعب العراق، مؤكدا حرص الجمعية العالمية للقيام بدور أساسي في هذا المضمار. وبالمناسبة أجعل الدعوة للجمعيات الطبية والعلمية العربية للمساهمة في تقديم خدماتها لضحايا الحرب من الشعب العراقي، إن اهتمام المنظمات الدولية والعالمية لا يعنى المنظمات والجمعيات العربية من مسوق ولما لها تجاه أشقاؤهم. إن من أولويات الرعاية التيام بالدراسات الميدانية والواجبات للاضطرابات النفسية لتخليد نوعية الاضطرابات ونسبة انتشارها ووضع خطط الصدي لها والتقدير الرعاية الصحية في مرحلة لاحقة وفي هذا الإطار نعرض لبحث إيراد السراج وسهير كوتة

حول "اضطرابات الشدة التالية للصدمة النفسية عند الأطفال الفلسطينيين" الذي خلص إلى أن أكثر من 49% من هؤلاء يعانون من هذا الاضطراب. كما نعرض بمناسبة تأسيس موقع "المركز العربي للطب المسند" على شبكة الإنترنت ([www.arabicebm.com](http://www.arabicebm.com)) بحث أديب العسالي حول الطب المسند (الطب المعتمد على البرهان) يسلط الضوء فيه على هذا الفرع من التخصص الطبي الذي يهدف إلى مساعدة الأطباء و مخططي السياسات الصحية لمواكبة مستجدات البحث العلمي الطبي و تسريع نقل المكشفات الطبيعية إلى اللغة العربية، إنني و إذ أشيد لهذا الإجاز العلم عربي أعتز بفضل الزميل العسالي و بجهده المتواصل خلال السنوات الأخيرة لتأسيس هذا العمل الذي يساهم في رفع مستوى خدمات الرعاية الطبية. كما يشاركنا أيضاً كل من الزملاء: جمال نصار (الأردن)، فيصل الزمران (الإمارات)، غيثا الحياط (المغرب) و فريد شكري (المغرب) بالأبحاث التالية: "ظواهر التزامن كمثال على قصور علم النفس اليوتفي"، "العلاج السلوكي"، "أثر وبيولوجيا المعرفة في العالم العربي و الإسلامي"، "الفناء النفسي و الأثر وبيولوجي". و في مركز الحوارات نعرض حوار مع البروفيسور عبد السنار إبراهيم (السعودية) تناول فيه الإبداع من منظور علم النفس و علاقته بالاضطراب النفسي و سبل استكشاف بذور الإبداع و تسميتها و رعايتها، هذا إلى جانب حوار مترجم للزميل سامر جميل رضوان (عمان/سوريا) مع هانس تومي الذي يعد من أبرز علماء النفس الألمان مسلطاً الضوء على مسيرته العلمة و إسهاماته في إثراء علم نفس الشيخوخة. كما يشاركنا في وجهات نظر الزملاء: محمد أحمد النابلسي (لبنان) بقراءة نفسية للنص الاستشراقي خلص فيها إلى قبول كل ما هو إنساني (مشارك بين البشر) في الحضارة المعاصرة مع الإصرار على تعديل كل ما هو خاص بالآخر احتراماً لخصوصيته و استيعاباً لفرادته، ما يساعد المرء على اكتشاف ذاته و تكييفها مع الآخر، و عدنان حب الله (لبنان) في قراءة فلسفية لظاهرة الحجاب في بلد علماني (فرنسا) مفككا دلالاتها و رموزها اللاواعية، و عيسى الرخاوي في "وهو اللاهمل، وهو الأكلب" بتأكيده أن تصارع أوهام الأفراد و جدتها مع بعضها هو الذي يقوم بتأسيس نسيج الثقافة الخاصة بكل جماعة في مرحلة تاريخية، بذاتها هذا النسيج القادر على استيعاب أوهام الأفراد لتصبح واقعا مفركا في حلم قابل للتحقيق في صورة ممتدة. و في مركز القياس النفسي يعرض حسان المالح (السعودية) و فيصل الزمران (الإمارات) اختبار الرهاب الاجتماعي على العرب داعين من خلاله الزملاء مشاركتهم بإجراءه على عينته من المرضى قصد تقييمه للتوصل إلى تأسيس اختبار نفسي لهذا الاضطراب. و في باب مراجعة كتب نعرض لكتاب فاروق المجدوب "طرائق و منهجية البحث في علم النفس" الذي يعد إلهاماً للمكثبة النفسية العربية لافتقارها مراجع هامة عن البحث في علم النفس و الذي يعتبر حدثاً مميزاً في ميدانه. و في مراجعة مجلات تقدم ملخصات العدد 57 من الثقافة النفسية الذي اهتم بمحور الرئيسي بعلم النفس السياسي بإمضاء خفية من الأطباء و الأخصائيين النفسيين العرب. و سعياً وراء متابعة آخر أبحاث العلوم النفسية، تم إحداث باب خاص بمسجدات الطب النفسي نعرض فيه ما خلصت إليه الأبحاث الحديثة العالمية لمواكبة التطور السريع و الملمت الذي تشهد العلوم النفسية، اعتقاداً منا بأهميتها لاستيعاب ما وصل إليه الفكر الإنساني في هذا الفرع من العلوم سعياً لتجاوز خلفا طال أمده أملا في الندية العلمية لاحقاً عندما تنهياً الأسباب الموضوعية لذلك. و في خاتمة العدد، نعرض لبعض من مداخلات الزملاء في منتدى الشبكة حول موضوع المحور الأول "اللغة العربية و العلوم النفسية" آملين إثراء بدعوة الزملاء للمساهمة بأي و الرأي المخالف تطوراً نحو الأفضل. كما نرصد إضافة مركز للتطبيقات نعرض فيه ملتقطات من شهادات أساتذة الطب النفسي حول الشبكة و إصداراتها و هي شهادات نعتز بها و نعتبرها خير حافز لنا لمواصلة التدريب رفقاً لهذا الاختصاص في أوطاننا.

كما نترجم هذا العدد مع نهاية سنة أكاديمية و هي فرصة نعرض فيها لما تم إجازته من النظائر العلمية لهذا الاختصاص على مستوى الوطن العربي حيث كان الحدث البارز تعقد مؤتمر الأطباء النفسيين العرب (بغداد - ديسمبر 2003) في حين انعقد المؤتمر الأول للصحة النفسية بالخليج في ظل ارتباطك التنظيم (الكويت - ديسمبر 2003) ليحظى بالنجاح كل من المؤتمر الأول للمحللين النفسيين الناطقين بالعربية (بيروت - ماي 2004) و المؤتمر الإقليمي الأول لعلم النفس في الشرق الأوسط و شمال أفريقيا (دبي 13-18 ديسمبر 2003) إلها حصيلة هزيلة على مستوى الملتقيات العلمة النفسية و الطب النفسية لمجموعة سكانية يتجاوز عددها 300 مليون نسمة تعكس تزايداً للوضع العلمي العربي و تشدنا عن ديارنا نحن في أشد الحاجة لتجاوزة تحقيقاً لمستقبل أفضل و لن يكون كذلك إلا بالسعي الدؤوب و العمل الجاد المشترك.



## STRATEGIES FOR POST-WAR REHABILITATION OF MENTAL HEALTH SERVICES / FOCUS ON IRAQ

Read at the Presidential Symposium "Reconstructing Postwar Mental Health Services" - APA meeting, May 2004

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*For the purpose of this presentation I was told there is no need for a power point presentation or pictures. We have seen enough pictures during the last few days depicting the atrocities and torture in Iraqi prisons.*

*"Every gun that is made, every warship launched, every rocket fired, signifies in the final sense a theft from those who hunger and are not fed, those who are cold and are not clothed."*

*Those are not the words of an Iraqi or Palestinian politicians denouncing the war and occupation in their respective countries. Those are the words of President Dwight D. Eisenhower, spoken on the 16<sup>th</sup> of April 1953.*

I advise you all to check a site on the internet, the address of which is [www.costofwar.com](http://www.costofwar.com). A running figure to the right top of the page indicates the cost of the Iraqi war not in terms of what the world pays for, but in terms of the US alone pays for. At the time I wrote this presentation the figure was a sobering \$111,778,777,859 and the figure is on the increase, by the second.

Instead, the US could have paid for 15,803,624 children to attend a year of Head Start; it could have medically insured 47,912,160 children for one year; it could have hired 2,129,125 additional public school teachers for one year; it could have provided 2,835,234 students with four-year scholarships at public universities. Instead, it could have built 1,596,845 additional housing units for US citizens. I shall not even start to think what those amounts of money could have saved and provided in the deprived third world countries. I am not also counting the casualties, the dead, the injured, the disabled, the destroyed infrastructure and the looted universities and cultural centers. But this is how the world is run now. Not by health professionals, whose prime concern is saving and improving physical and mental life of people, but by politicians whose prime concern is power and more power, be it political, economic or otherwise.

In April 2003 the WPA released a statement warning the world of the consequences of the war against Iraq. In that statement the EC clearly expressed its deep concern regarding the possibility of a war against the people of Iraq. The humanitarian as well as health consequences of such a war must not be underestimated regarding their devastating effect on the people of the region, international relations and the possibility of a peaceful future for our planet. As psychiatrists we are entrusted with the mental well being of all people of the world with no discrimination on the basis of race, religion, color or gender. The gravity of war in the region, which would have enormous tragic consequences to life, health and security for all involved, locally and across the world, should be considered. We drew on the WHO report issued on the 10<sup>th</sup> of December 2002, i.e. on the international day for Human Rights, estimating the likely humanitarian scenarios following a war against Iraq to include massive destruction of infrastructure, where "Damage to the electricity network will result in collateral reductions in capacity in all sectors, particularly water and sanitation as well as health". The report continued: "Direct and indirect health casualties are estimated at 500,000, vulnerable population is estimated at 5.21 million including most pregnant and lactating women and children. Vulnerable groups in need of rehabilitative programs can be foreseen to include 5,000 persons confined to institutions, comprising orphaned children, the severely handicapped

and children in detention, 21,000 elderly, 150 million unaccompanied minors and 2 million internally displaced refugees, most of whom again will be women, children the elderly and the disabled. War traumas and displacements will be but a few of the life events that are awaiting the country's population of 26.5 million citizens". The provision of mental health care through national institutions will probably have to retreat in front of other services estimated as being more vital.

In 2002, the EC of the World Psychiatric Association urgently called on all its member societies to exercise their best efforts and contacts to prevent war and resolve the conflict in a peaceful manner, under the leadership of the United Nations and its competent structures. We recognized the need to do everything possible to prevent such regional and world wide major psychological and personal trauma.

But nobody listened. The war broke out. One of the tragic traits of our modern times is that once war breaks out, it does not end. In most of the wars there is a party that has launched the war and another that is exercising its right to defense. And yet war is no longer the one-to-one war of the times of the sword; it is no longer the war between armies, between leaders; it is a war of leaders against people, who were never consulted, whose opinion was not taken, and yet who have to suffer the burden of war while the decision makers are taking their decisions in their secure protected and heavily guarded offices. It is those people that are our concern, that are our responsibility.

We tried:

An unprecedented endeavor of the international psychiatric community was held during the inter-country consultation on mental health and rehabilitation of psychiatric services in post conflict and complex emergency countries at EMRO, Cairo Egypt from 28 - to 30 April 2003. The World Psychiatric Association (WPA) collaborated closely in preparation for this meeting with 15 WPA member societies including the two largest societies, the APA and the Royal College, and the two Zonal Representatives from Middle East and North Africa. The objectives of the meeting were to develop a coordinated strategy, methodology and approaches for:

- a rapid assessment and identification of the most immediate needs;
- a comprehensive needs assessment and situation analysis ;
- a plan of action for the remainder of the year 2003;
- planning for the preparation of a strategic program and plan of action for 2004 - 2005;
- the identification of financial implication and fund raising.

The meeting concluded with a number of comprehensive recommendations: Mental health should be given priority in the National Health Plan and be integrated into primary health care

services.

Poverty Reduction Strategy should be tailored to the cultural context.

Needs assessment should take into consideration the needs of the population, infrastructure, facilities and supplies and available human resources.

Human resource development in mental health at different levels is of critical importance.

Empowerment of patients and families of the mentally ill.

Teachers, religious leaders and voluntary agencies should be involved in health education and build on people's initiatives.

We were promised a reconstruction phase and we had planned to use it to ensure that our recommendations were appropriately integrated, despite the constraints of imposed by security concerns and demoralization.

However, this phase never came.

Nongovernmental organizations visiting Iraq try to forge a space for intervention. An Egyptian NGO working on the rehabilitation of victims of Violence visited Iraq and was torn between addressing traumas of the Saddam regime, traumas of the 13 years period of sanctions, and traumas of the occupation. Children are sleepless, enuretic, terrified, lacking all sense of security and left with not answers to basic, legitimate questions of why are those troops still here, why the bombing, why the raids, why the destruction of homes. Adults live between choices of submission and resistance, neither of which spares them the accurate targeting of the missiles. For the Iraqi people, for the Iraqi children, women, men and elderly it is a no win situation.

A recent report launched on the 8<sup>th</sup> of April by the international organization of Occupation Watch states that in Falluja alone, over three hundred Iraqis have been killed and hundreds more injured since attacks began on Sunday, April 4. In Falluja, the hospitals have been surrounded by soldiers forcing doctors to establish field hospitals in private homes. Blood donors are not allowed to enter; consequently, mosques in both Baghdad and Falluja are collecting blood for the injured. Water and electricity have been cut off for the past several days.

You should be familiar with the Arab culture to understand how a state of hopelessness affects their choices, especially when they feel violated. Part of that culture is to avenge defeat, a matter that can cut across generations. Arabs will continue to fight for as long as they feel that their dignity is injured, for as long as they feel violated. They will only stop if the aggressor will publicly acknowledge guilt and assume responsibility for the aggression. Then, and only then are they ready to reconcile. The US army went into Iraq to overthrow Saddam Hussein, allegedly also to search for weapons of mass destruction which were never found. Yet we should not forget: Saddam Hussein was backed by USA and supplied by weapons of mass destruction to fight Iran. Ben Laden himself was on the payroll of the CIA, fighting the Soviet troops in Afghanistan. The US presence in Iraq is an occupation. This is not our claim. This is the name given by the international community to the situation in Iraq. The Arab people cannot live under an occupation. It is too humiliating. They have come to learn that negotiations do not end occupations. Nor does the fighting? Maybe. But the fighting gives them a sense of being, a sense of not giving up. Isn't that the scenario that leads to altruistic phenomena such as suicide bombers.

In Orwellian terms: "You want to live. We want to die". This carries a meaning of helplessness and hopelessness and despair. Ideology and worldview certainly come into play, if only because ideological blinkers have a way of making otherwise intelligent people appear stupid.

But ideology always carries with it the question of how much its proponents actually believe rather than manipulate it as a fundamental instrument of hegemony.

Suicide bombing is an act of absolute despair. It does not only involve the killing of the other. It essentially involves the killing of the self. In both cases it creates a sense of achievement: be it achieving a "victory" against the "enemy" or achieving a state of martyrdom which is rewarded in heaven. This is very serious for a people whose lives are strongly influenced by religion and a belief that those chosen for martyrdom by God are honored.

Let us analyze what happened in countries that breed what is called terrorism. They had political systems usually backed by American policy characterized by dictatorship, atrocities, oppression and corruption. These people are poor. Poverty leads the individual to loose faith in the system, in the leaders, in the world. They turn to faith and religion, fundamentalism and because of their helplessness or hopelessness of any hope in this world, they chose to be martyrs in their conviction, freedom fighters or terrorists.

This is not meant to be a political presentation about Iraq. It is merely providing a background, amidst which we tried to be party of what is happening now in the land which hosted one of the oldest civilizations of history.

We might plan as much as we want and draw the most sane and comprehensive recommendations. But we shall not be able to undertake any of them is the war in Iraq does not stop, if those in charge in Iraq are not made to bear their responsibility regarding the wellbeing, both physical and mental of that people.

A generation that sees nothing but death and blood and disability is hardly a generation capable of reconstructing a nation. A generation tormented by post traumatic stress disorders is a generation drowning in images of the horrible past, rather than one planning for the future.

Unfortunately, we psychiatrists have to deal with disasters initiated by policy makers. Our job is to help the sufferers and the consequences on mental health. On previous occasions, we did not do enough. We did not do enough for Rwanda (one million died) nor for Bosnia or Kosovo, nor for occupied Palestine, Somalia or Sudan. We must find a way to prevent provoking mental ill health regardless of political conflicts. As psychiatrists we should transcend those political, racial, religious conflicts for the welfare of our mental patients. Yet, how can we draw a line of demarcation between the consequences of decisions of policy makers and looking after the victims of their decisions. Very basically how can we have access considering that one needs a permit to help afflicted patients in regions of conflict.

We, as professionals have to tell the world that those desperate situations where you can lose your child to hunger or missiles, where a ceiling over your head is not a matter of fact, where your hours and days are either times of military raids or of expecting those raids.. those are the times for martyrdom, where the only source of a people's value is to offer sacrifices, even if that entails giving life itself.

We have the resources, we have the volunteers who are ready to help rebuild mental health in Iraq. What we do not have is a guarantee of their security.

In June last year the president of the APA and myself wrote to Mr. Bremer concerning the mental health hazards implicit in Iraq and the professional necessity of our intervention. Until this very day we have not received a reply.

The International Community cannot claim that it did not know for we, among other humanitarian and health organizations, warned of the consequences. We are again repeating what we

had previously said.

We need to go into Iraq to identify the needs of the people. We need to have access to patients, to the traumatized, we need to abide by the first provision of the Madrid Declaration, that ours is a medical discipline concerned with the provision of the best treatment for mental disorders, with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health.

The only formula I find is to use NGO, human rights activists and to disentangle ourselves from the ideology of some leaders. Maybe we have to address those leaders, publicly, denouncing their actions, making visible their contribution to the mental ill health of a whole nation. Maybe we should send our own professional messages to the leaders, to the media, to the UN. In short, maybe lobbying is what is needed before we can hope for intervention.

If we want this meeting to be of any use, if we want for our meeting to come across in history as the meeting which

lobbied leaders to take mental health into their consideration we should be more outspoken. In that respect the APA and the Royal College of Psychiatrists are especially in a position to take a lead addressing their respective governments to give priority to the mental health of the people of Iraq. A British and American public opinion that identifies with the traumatized women and children of Iraq is a strong element that can work in the favor of our mission. Needless to say the WPA will be an essential actor in this endeavor.

No matter how much we stress the hazards of the war on the mental health of the people of Iraq, they will never be overstressed. We have to continue trying. We have to be innovative in our trials. Even is that means going beyond our familiar boundaries of psychiatrists.

At best we might make some change. At worst we would spare ourselves the guilt if having been watchers while we could have been agents of prevention.

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- ▶ Guiding and promoting the scientific research in Psychiatry
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- ▶ Making use of the experience of specialists in other branches relating to this specialization
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مجلة شبكة العلوم النفسية العربية: العدد 2 - أبريل - ماي - جوان 2004

## PREVALENCE OF PTSD AMONG PALESTINIAN CHILDREN IN GAZA STRIP

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*This research study aimed to get acquainted with the prevalence of PTSD, and other psychological suffering among Palestinian children living under severe conditions during the last two and half years of the Al-Aqsa Intifada. The sample consists of 944 children whose age ranged between 10-19 years. The group excluded those with previous mental health problems. In this research, trauma scale, PTSD scale, the Child Posttraumatic Stress Index, the Children's PTSD-symptoms, The CPTS-RI and open questions had been used as tools. The results indicated that 32.7% of the children started to develop acute PTSD symptoms that need psychological intervention, while 49.2% of them suffered from moderate level of PTSD symptoms. Also the results showed that the most prevalent types of trauma exposure for children are for those who had witnessed funerals (94.6%), witnessed shooting (83.2%), saw injured or dead who were not relatives (66.9%), and saw family members injured or killed (61.6%).*

**Key words:** PTSD

In September, 2000, a new Palestinian uprising began against the now 36-year old Israeli military occupation. The immediate cause was the visit of then Israeli Knesset Member Ariel Sharon accompanied by over 1000 fully armed Israeli riot police to what Jews call the Temple Mount and Muslims, the Noble Sanctuary ("El-Haram A-Sharif") on which sits Al-Aqsa Mosque. Palestinians' protest of the violation of their holy place resulted in Israeli police shooting several unarmed protesters. This event provided the immediate spark for Palestinian protests throughout the West Bank and Gaza Strip, as well as the name for an uprising that continues at this writing, "The Al-Aqsa Intifada." The more distant cause for this second and more violent Intifada was the evident failure of the Oslo peace process. Instead of a lasting peace between Israelis and Palestinians, Oslo agreement has followed by a 50% increase in Israeli settlement building and land confiscation (KUKA), a decrease in Palestinian freedom of movement and lack of civil liberties (KUKA), and economic de-development including high unemployment.

As the "Al-Aqsa Intifada" continues into its fourth year, the Israeli army frequently shells and destroys the Palestinian homes. Since October 2000 until 31 of January 2004, 3062 homes have been completely and partially demolished and 2524 homes need to be repaired in Gaza Strip (UNRWA, 2004). The army uses a variety of methods to destroy homes, including tank shells, bulldozing, helicopter gunship, and fighter aircraft. As homes have been bombarded and made uninhabitable, many Palestinian families have found themselves living in tents.

When families witness the destruction of their own homes by enemy soldiers, the psychological effects can be serious. Loss of home can be a traumatic experience for not only material loss but for psychological meaning. The home means a shelter and heart of family life. It contains memories of joy and pain as well as attachment to the families' objects. Home is associated with feelings of security and consolation.

As in all modern wars, the victims of the latest Middle Eastern war are mainly civilians. We have an accumulated knowledge about the children's responses to air raids, bombardment, shelling, loss of family members and being target and witnessing killing and destruction. It involves research on acute responses during the II World war (Brander, 1941; Dunsdon, 1941; Freud & Burlingham, 1943), mental

health Middle Eastern children during military attacks (Bryce & Walker, 1986; Baker, 1990; Macksoud & Aber, 1996; Milgram & Milgram, 1976; Ziv & Israeli, 1973; Saigh, 1991), as well as military violence and persecution in Africa (Dawes, 1992; Cliff, 1993) and Europe (Smith, Perrin, Yule, & Rabe-Hasketh, 2001). Children's responses to danger and life-threat include anxiety, somatization and withdrawal symptoms, and especially younger children may regress into the earlier stages of development (Yule, 2002). While almost all children respond with excessive fear, sleeping difficulties and clinging to parents in acute trauma, only a smaller minority develop posttraumatic disorders.

A substantial amount of research is available on the severity of PTSD symptoms and predictive factors among Middle Eastern children, especially of Kuwaiti children during the nine-months of Iraqi occupation (Hadi, & Llabre, 1998; Llabre & Hadi, 1994; Macksoud & Aber, 1996; Nader, & Pynoos, 1993; Pynoos, 1994; Nader & Fairbanks, 1984) and Israeli children during the Iraqi scud missile bombardment (Klingman, 1992; Lavee & Ben-David, 1993; Laor, Wolmer, & Cohen, 2001; Laor, Wolmer, Mayers, Gershon, Weitzman, & Cohen, 1997; Weisenberg, Schwarzwald, Waysman, Solomon, & Klingman, 1993; Rahav & Ronen, 1994; Rosenthal & Levy-Shiff, 1993). The percentages of PTSD diagnosis vary from 22% among Israeli (Laor et al., 1997, 27% among Lebanese (Saigh, 1991) 41% among Palestinian children from Gaza exposed to shelling, (Thabet & Vostanis, 1999) 48% among Cambodian refugee children (Kinzie, Sack, Angell, Manson, & Rath, 1996; Sack, Clarke, & Seeley, 1995), 52% among children from Bosnia-Herzegovina (Smith, Perrin, Yule, Hacam, & Stuvland, 2002), and 78-88% among Iraqi children exposed to bombardment (Dyregrov, Gjestad, & Raundalen, 1993). Longitudinal studies on the PTSD are rare, and they reveal that once the fighting and danger are over, the posttraumatic symptoms decrease considerably (Laor et al., 2001; Punamäki, Qouta, & El Sarraj, 2001). Among Kuwaiti children, the share of severe level of PTSD was 4% after one year of traumatic events, among Iraqi children and among Israeli children 0% after five years (Laor, et al. 2001). Dyregrov et al (2002) followed shelled children at six months, one year and two years, and showed first increase from 84% to 88%, and then decrease to 78% of PTSD. The physical and emotional proximity, severity and nature of the traumatic event prescribe the nature and severity of psychological problems (Macksoud & Aber, 1996; Qouta,



Punamäki, & El-Sarraj, 1996; Punamaki, 1998; Pynoos, 1987; Klingman, 1992). For example, Bryce et al. (1989) found that especially displacement from home increased depression among Lebanese children and women during the 1982 Israeli invasion. Laor et al., (1997; 2001) found among Israeli children that while posttraumatic stress symptoms decreased generally after the Iraqi shelling, the symptoms increased among displaced children.

The present study examines the levels of PTSD among Palestinian children during the current Intifada. We further study how the nature of trauma (personal exposure to and witnessing military violence) correlates with the children vision to their future, and we guess that these traumatic experiences will affect the way, in which the child see his perspectives and solving problems.

### Method

#### - The Sample

The sample consisted of 944 children ranging between 10-19 years, randomly selected from all part of Gaza Strip with Arithmetic mean (15.1±1.5). 49.7% of the sample were boys while 50.3% were girls. Refugee children represented 76.8% of the sample and the rest were citizen's residents. Seven field workers had participated in the field work, which done at schools, with co-operation of the teacher and headmasters,

#### - Measurements

**1. Trauma questionnaire scale:** This was developed for this study by the Gaza Community Mental Health Programme. It consists of 12 traumatic events frequently experienced by Palestinian children during the "Al-Aqsa Intifada" (Box 1). Seven events refer to direct exposure to the traumatic events (e.g., tear gas, shooting, or deprivation of medical help), while five events refer to witnessing military violence, (e.g. witnessing killing and injuring). Reliability by Alpha Cronbach was .82

#### Box 1. Trauma questionnaire scale

The following are a number of questions related to difficult events that you were exposed to. It has nothing to do with a disorder or a normal event.

N°	Item	Yes	No
1	Was your house exposed to shelling		
2	Were you exposed to inhaling tear gas		
3	Were you exposed to burns		
4	Were you shot by live ammunitions		
5	Were you exposed to shot by rubber bullets		
6	Were you shot in the hear to the degree that you lost conscious		
7	Were you derivate of medical care where you need it		

#### Witnessing traumatic events:

The following questions are related to events that you may have witnessed or heard about. Now I would like you to answer them.

N°	Item	Yes	No
1	Witnessing shooting fighting or explosion		
2	Witnessing strangers being injured or killed		
3	Witnessing family members, neighbours, relatives being injured or killed		
4	Witnessing family members being injured or killed		
5	Witnessing shelling and funerals		

Note: the trauma scale is answered by the child not the mother

**2. PTSD Scale (Posttraumatic Stress Disorder Scale)** (DSMIV, American Psychiatric Association, 1994). For the purposes of this study, PTSD refers to chronic and not acute PTSD since the events described by the youths were associated with lifetime trauma exposures. The scale was based the Clinician Administered PTSD published in the Journal of Traumatic Stress. **The Child Posttraumatic Stress Reaction Index (CPTS-RI):** this follows DSMIV criteria, developed by Nader and used to measure PTSD in youths aged 12 and over<sup>(1)</sup> Children's PTSD-*symptoms* were assed by the Child Posttraumatic Stress Disorder Reaction Index (CPTS\_RI).<sup>(2)</sup> The 20-symptom scale is used to assess the degree of a child's reactions to a selected traumatic event, and covers the intrusive re-experiencing of the event, avoiding related memories and numbing feelings and increased hyper-arousal. The older children (13-16) reported themselves and the interviewer estimated together with younger children the occurrence of the symptoms on a five-point scale: (0) none of the time, (1) little of the time, (2) some of the time, (3) much of the time, and (4) most of the time.

The maximum sum score is 80 and minimum 12, and in our sample the range was 11-68. Averaged sum variables were constructed for intrusive (9 items,  $\alpha = .80$ ), avoidance (7 items,  $\alpha = .77$ ) and hyperarousal (4 items,  $\alpha = .66$ ) symptoms. The CPTS\_RI has been fond reliable and valid in predicting trauma impacts among Arab children in Palestine (Punamäki et al., 2001; Qouta, et al., 2001) and Kuwait (Nader et. al., 1993; Nader, & Pynoos, 1993; Hadi, & Llabre, 1998).

**3. Open questions.** We presented a picture of "Fatima", a 15 year old sitting by herself and looking out into empty space. We asked children to imagine what kinds of problems Fatima might be thinking of and how they, the children, could help solve them. In an effort to avoid suggestibility, the researcher provided the children with no additional information regarding "Fatima."

#### RESULTS:

Research on the "Prevalence of PTSD among Palestinian Child during in Gaza Strip" showed the results of the psychological suffering among Palestinian children living under severe conditions during of Al-Aqsa Intifada in hot and community areas of the Gaza Strip. The most prevalent types of trauma exposure for children in the community areas is for those who had witnessed funerals 94.6%, witnessed shooting 83.2%, witnessed shooting, 66.9 %; saw a friend or a neighbor being injured or killed 61.6% and were tear gassed 36.1%. (see table 1).

**TABLE 1** Prevalence rate of the traumatic experiences among children in the community areas

Direct Personal experience	Frequency	Percentage (%)
Shelling of the home	179	19
Tear-gassed	341	36.1
Severe burns	89	9.4
Shot by live bullets	26	2.8
Shot by plastic bullets	31	3.3
Head injury with loss of consciousness	23	2.4
Deprivation of medical help	73	7.7
<b>Witnessing traumatic events</b>		
Saw shooting, fighting or explosion	785	83.2
Saw stranger being injured or killed	632	66.9
Saw friend or neighbor being injured or killed	584	61.6
Saw family member being injured	239	25.3
Saw funerals	893	94.6

It was found that 32.7% of the children in the community areas suffered from acute level of PTSD while 49.2.1% children suffered from moderate level of PTSD at the same time 15.6% children suffered low level of PTSD and we can say that 2.5% children had no symptoms while in hot areas 54.6% of the children suffered from acute level of PTSD (see table 2). While 34.5% children suffered from moderate level of PTSD at the same time 9.2% children suffered low level of PTSD and we can say that 1.7% children had no symptoms.

**TABLE 2** The severity of PTSD according to the child's gender PTSD score

PTSD score	All (boys and girls)	
	%	N
None or Doubtful (<12)	2.5	24
Mild (12-24)	15.6	147
Moderate(25-39)	49.2	464
Severe (>40)	32.7	309

The study found significant differences between boys and girls. In the acute level of PTSD, 57.9% girls developed such symptoms while the percentage among the boys was 42.1% (see table 3).

**TABLE 3** The severity of PTSD according to the child's gender PTSD score

PTSD score	Girls		Boys	
	%	N	%	N
None or Doubtful (<12)	25	6	75	18
Mild (12-24)	38.8	57	61.2	90
Moderate(25-39)	50.2	233	49.8	231
Severe (>40)	57.9	179	42.1	130

In this research we were eager to explore how children are being coped with their problems, so the researcher presented a picture of "Fatma", 15 years old student, who engage in

thinking, and we asked children how "Fatma" can solve her problems. We found out that 66% of the children would like to concentrate their effort on the school issue, 24.7% would like to be martyrs, 8.7% would like to encourage the peace process, 0.1% would like to involved in national struggle, 0.5% would like to be concentrating on the religion issue.

In addition to the "Fatma" picture it was discovered that some differences between boys and girls. 67.8% of boys would like to be martyrs, while 32.2% of girls go at the same direction.

## DISSCCUSION

This article reports the level of PTSD among Palestinian children currently exposed to war and bombardment, and the role of children trauma perspective to the future outlook. The results revealed a high level of PTSD: more than a half (32.7%) of the children suffered from severe level of PTSD symptoms. The percentage corresponds with the levels of PTSD among the Cambodian (Kinzie, et al., 1996; Sack et al., 1995), and South American (Cervantes, et al., 1989) and Bosnia-Herzegovian (Smith et al., 2002) refugee children fleeing atrocities in their home countries. The level of PTSD was considerably higher than was reported among Lebanese and Israeli children, 22% (Laor et al., 1997), but lower than was reported among Iraqi children, 84% (Dyregrov et al., 1993). There are some context-specific characteristic of the current trauma that may explain the children's high level of PTSD. First, the long duration for the conflict means more than an acute disaster for Palestinians as the children exposed to on going traumatic experiences, and that means the continuation of the stress for long periods, which damage the child psyche, and increased the rate of PTSD.

With regard to the source of trauma for the Palestinian people, many researches indicated that Israeli authorities were held responsible for the majority of direct trauma exposure, an attribution that has face validity since tear gassing, home demolitions and injuries due to bullet wounds have been widely reported by news agencies, Israeli and Palestinian human right organizations and an UNRWA field investigator (PCHR 2001, Palestinian National Authority, State Information Services, 2001). Not surprising under the circumstances, researches found a high level of behavioral problems and neurotic symptoms among the children, who had an average level of 6 PTSD symptoms. Again, this confirms the fact that a safe home fulfills a basic need and makes it possible to establish secure and adaptive human relationships. Tragically, the protective shield that is essential for children's mental health is dramatically destroyed when their families are faced with the shelling and demolition of their homes.

Our knowledge about the effect of violent trauma on children's mental health derives from the experience of both human-made and natural disasters. Studies on the effect of war on civilians come from the experience of the Second World War, contemporary conflicts in the Middle East, South Africa, Ireland and Bosnia, as well as the effect of urban violence targeted at American children. Traumatic experiences and conflicts are the reality of many people throughout the world. All of us have imagines of the civilians victims of contemporary conflicts and what happened for the Palestinian since 1948 uprooting, is a serious of disaster.

As in all modern wars, the victims of the latest Middle East war are mainly civilians. Palestinian uprising and Israeli military

attach to suppress are mainly children. We have an accumulated knowledge about the human being's responses to air raids, bombardment shelling, loss of family member and being target and witnessing killing and destruction. Children's and adult's responses to danger and life-threat include anxiety, somatization and withdrawal symptoms, and especially among younger children regression to the earlier stages of development and clinging to parents. Family's ties are considered one of the most important protectors of the child mental health in war conditions.

Children living in conditions of political violence and war have been described as "growing up too soon", "losing their childhood", and taking political responsibilities ample maturation (Boothby, Upton, & Sultan, 1992). This development is predicting to result in negative psychological consequences (Garbarino, Kostelny, & Dubrow, 1991).

It is tragic fact that Israeli and Palestinian children have become laboratories for the study of the relationship between trauma and violence, conflict, and children's well being during war. Wars and battles have been fought without interruption in the region for fifty years. None of these wars, however, have brought a solution to the conflict between Jews and Arabs.

Palestinian children have not known a day of real peace. Since the war area is small it is difficult to protect children from sights of destruction, the dangers of war and insecurity. Many of these children have taken part in their national struggle. Even if they were not actively fighting on the streets, as so may were they still could not help but experience the national struggle on an emotional level. The atmosphere of insecurity, danger, violence, and hostility that prevailed during the Intifada inevitably left scars on the mental health of the Palestinians children.

Mental health professionals show increasing concern about developmental risks for children who fall victims to political violence and war. Family and parent-child attachment are considered important in providing a protective shield for children's psychological well-being in dangerous conditions (Freud & Burlingham, 1943; Garbarino, Kostelny & Dubrow, 1991).

Researchers assume that experiences related to political violence and war indeed constitute a serious risk for the well-functioning family (Garbarino, Kostelny, 1993). War and political conflict therefore disrupt some of the basic parental functions, such as protecting children and enhancing trust in security and human virtues.

Palestinian families in the Gaza Strip are large, and people show strong affiliation to them. "El Hamula" (the extended family) continues to play an important protective role in modern life too. Traditionally, children submit to the authority of their parents, and older members of the family enjoy special respect. The constant on their security threat and the collective trauma of losing their homeland in 1948 have further increased social cohesion in Palestinian society.

However, the Intifada created a situation that apparently shook traditional parent-child relations and family hierarchy. First, the increased influence of political parties decreased the social role of the extended family. Second, children and youths played a very active role in the national struggle. They were an essential element in the initiation, planning, and organizing of demonstrations against and confrontations with Israeli soldiers (Kuttub, 1988).

Palestinians have expressed serious concern about the future consequences of these shattered parental bonds. Some believe that children who threw stones ("children of the stones") and fought against the occupation army also challenge their parents' authority. Parents face difficulties to protect their children from sights of destruction, violence, and abuse. Many Palestinian children have taken active part in their national struggle. Even if they were not actively fighting on the streets, as so may were, they still could not help but experience of the national struggle on an emotional level interact dynamically inside the child psyche as we see that ( 24.7%) expressed that "Fatma" can be a martyr in order to solve her concerns .

Researchers studied Palestinian children's and adult's vulnerability to trauma and resiliency from the first Intifada through seven years of practicing peace and building national institutes and currently during the three years of Al-Aqsa Intifada (Quota, Punamaki, & El Sarraj, 1995; Punamaki, Quota, & El Sarraj, 1997; Qouta, Punamaki, & El Sarraj, 2003). We found that family could function as a protective shield and secure base despite of the violence predicted children's resiliency. Loving and wise parenting associated with children's creativity and active participation, which then, once peace was there predicted good mental health.

We as a professionals had some questions about future of the Palestinian children and we asked ourselves at that time what kind of teachers, mothers and fathers they will be. We are very afraid to have next lost generation but unfortunately the Palestinian children started their wounds when the Al-Aqsa Intifada broke up the peace treaty and those children inter to the new stage and their psyche goes on. This time the Israeli violence is even more aggressive than during the first Intifada so that why the psychological consequences of traumatic experiences are negative influence of good children development, as those children did not know a day of real peace as their grandparents had been uprooted in 1948 and from that time their suffering had been started. The memory of Palestine is still alive in their mind and they try to keep it alive by telling stories to their sons, daughters and grandchildren about Palestine, about their own country and about their own land. In each home map of Palestine is on the wall to remind about their own country. So because the Palestine is all the time in the concise of the Palestinian children their grow up in high political environment and they grow too soon. Those children lost their right to have normal childhood they gradually stared to be involved in Palestinian-Israeli conflict. It is strange that such young children can carry such responsibility but this is the real characteristics for all area of conflict around the world. The biggest tragedy is that the children whom grow up in such environment can perceive their parents as unable to protect them. Some questions came to their mind; "*if my father is unable to protect me who can protect me?*". So when the chills had witnessed parent's humiliation his trust and his psychology development had been complete destroyed.

Our study has many faults and can be generalized only to the children living in acute danger to life and military destruction. First, our study focused on the epidemiological conclusions, but we need to gain a genuine view of how families survive extreme life endangering situations, also the responses of the parents are essential. Also a more comprehensive setting including family resiliency and vulnerable factors could have been more informative.

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Researchers assume that experiences related to political violence and war indeed constitute a serious risk for the well-functioning family (Garbarino, Kostelny, 1993). War and political conflict therefore disrupt some of the basic parental functions, such as protecting children and enhancing trust in security and human virtues.

Palestinian families in the Gaza Strip are large, and people show strong affiliation to them. "El Hamula" (the extended family) continues to play an important protective role in modern life too. Traditionally, children submit to the authority of their parents, and older members of the family enjoy special respect. The constant on their security threat and the collective trauma of losing their homeland in 1948 have further increased social cohesion in Palestinian society.

However, the Intifada created a situation that apparently shook traditional parent-child relations and family hierarchy. First, the increased influence of political parties decreased the social role of the extended family. Second, children and youths played a very active role in the national struggle. They were an essential element in the initiation, planning, and organizing of demonstrations against and confrontations with Israeli soldiers (Kuttub, 1988).

Palestinians have expressed serious concern about the future consequences of these shattered parental bonds. Some believe that children who threw stones ("children of the stones") and fought against the occupation army also challenge their parents' authority. Parents face difficulties to protect their children from sights of destruction, violence, and abuse. Many Palestinian children have taken active part in their national struggle. Even if they were not actively fighting on the streets, as so may were, they still could not help but experience of the national struggle on an emotional level interact dynamically inside the child psyche as we see that ( 24.7%) expressed that "Fatma" can be a martyr in order to solve her concerns .

Researchers studied Palestinian children's and adult's vulnerability to trauma and resiliency from the first Intifada through seven years of practicing peace and building national institutes and currently during the three years of Al-Aqsa Intifada (Quota, Punamaki, & El Sarraj, 1995; Punamaki, Quota, & El Sarraj, 1997; Qouta, Punamaki, & El Sarraj, 2003). We found that family could function as a protective shield and secure base despite of the violence predicted children's resiliency. Loving and wise parenting associated with children's creativity and active participation, which then, once peace was there predicted good mental health.

We as a professionals had some questions about future of the Palestinian children and we asked ourselves at that time what kind of teachers, mothers and fathers they will be. We are very afraid to have next lost generation but unfortunately the Palestinian children started their wounds when the Al-Aqsa Intifada broke up the peace treaty and those children inter to the new stage and their psyche goes on. This time the Israeli violence is even more aggressive than during the first Intifada so that why the psychological consequences of traumatic experiences are negative influence of good children development, as those children did not know a day of real peace as their grandparents had been uprooted in 1948 and from that time their suffering had been started. The memory of Palestine is still alive in their mind and they try to keep it alive by telling stories to their sons, daughters and grandchildren about Palestine, about their own country and about their own land. In each home map of Palestine is on the wall to remind about their own country. So because the Palestine is all the time in the concise of the Palestinian children their grow up in high political environment and they grow too soon. Those children lost their right to have normal childhood they gradually stared to be involved in Palestinian-Israeli conflict. It is strange that such young children can carry such responsibility but this is the real characteristics for all area of conflict around the world. The biggest tragedy is that the children whom grow up in such environment can perceive their parents as unable to protect them. Some questions came to their mind; "*if my father is unable to protect me who can protect me?*". So when the chills had witnessed parent's humiliation his trust and his psychology development had been complete destroyed.

Our study has many faults and can be generalized only to the children living in acute danger to life and military destruction. First, our study focused on the epidemiological conclusions, but we need to gain a genuine view of how families survive extreme life endangering situations, also the responses of the parents are essential. Also a more comprehensive setting including family resiliency and vulnerable factors could have been more informative.



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يهدف المركز العربي للطب المستند إلى تسريع نقل المكشفات الطبية المنجدة بأسنمر إلى اللغة العربية، وتقديمها إلى أطبائنا بشكل مبسط يسهل الحصول عليه، مع دعوة هؤلاء الأطباء إلى التعرف على مبادئ الطب المستند واعتمادها في الممارسة الطبية اليومية، بهدف تقديم أفضل رعاية طبية ممكنة. هذا من جهة الممارسة السريرية، أما من جهة البحث العلمي فللمركز هدف آخر هو تعريف أطبائنا على المداخلات الطبية التي مازالت بحاجة للتقييم العلمي وتشجيع بعضهم على الأقل على القيام بأبحاث علمية محلية. ولتحقيق هذه الأهداف، يعمل المركز العربي للطب المستند على البحث عن المراجعات المنهجية، وخصوصاً مراجعات كوكران المنهجية، وتلخيصها ونشر الخلاصات المحضرة إلكترونياً بشكل يتيح تحديث هذه الخلاصات بشكل دوري

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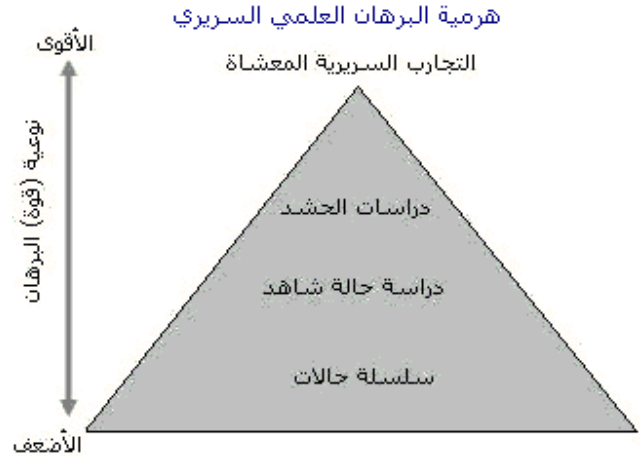
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- إنقاص الخطر النسبي relative risk reduction
- نسبة الأرجحية odds ratio
- إنقاص الخطر المطلق absolute risk reduction
- لعدد الواجب علاجه (number needed to treat (NNT)

risk ratio

$$(0.12 = 15000 \div 1800)$$

$$(.0.2 = 15000 \div 3000)$$

$$(.0.6 = 0.20 \div 0.12)$$

relative risk reduction

$$.40 = 100 \times (0.6 - 1)$$

.40%

odds ratio

$$1 \quad 0.14 = 13200 : 1800 \quad )$$

$$.(1 \quad 0.25 = 12000 : 3000 \quad )$$

$$.(0.56 = 0.25 \div 0.14)$$

absolute risk reduction

(0.12)

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number needed to treat (NNT)

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D	C	غير المستجيبين

EER = A / (A+C) -----	معدل الحدث التجريبي
CER = B / (B+D) -----	معدل الحدث الشاهد
RR = EER / CR -----	الخطر النسبي
OR = (A/C)/(B/D) = AD/BC	نسبة الأرجحية
ARR = CER - EER -----	إنقاص الخطر المطلق
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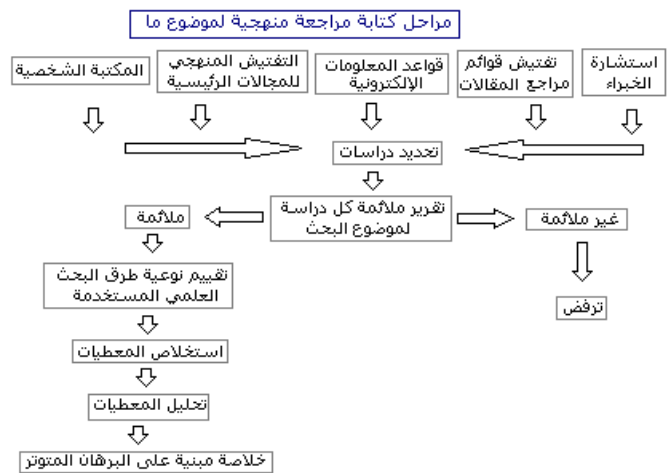
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## Cochrane Systematic

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C. G. Jung Institute

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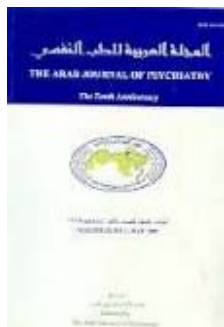
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### المجلة العربية للطب النفسي

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■ ( Behavior analysis ) :

-1 What are the ) ( problem and goals for therapy

■ (Target behavior )

-2 ( How can progress be measured and monitored ) .

■ ( Frequency ) -

■ ( Duration ) / -

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■ ( Latency ) -

■ ( Operationalizing The goals of therapy ( Base-line

■ ( psychometric

■ ( Biofeedback

-3 What ) . ( environmental factors are maintaining the problem

■ (Antecedents

■ (Consequences)

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-4 ( Which intervention methods are likely to be effective

■ Systematic ) ( ) (desensitization

■ (Counterconditioning )

■ (Reciprocal inhibition)

■ (Anxiety hierarchy) -

■ ( Relaxation) -

■ ( Desensitization of the stimulus)

■ ( Relaxation training)

■ (

■ Progressive ) - (relaxation

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■ (Unlearned )

■ ( Adaptive behavior )

■ ( Extinction )

■ ( Extinction )

■ ( Behavior ) :

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(Disarming anger)	-		
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(Problems solving)	-		( 1969 Barrett)
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(Aversion therapy)	-	(Modeling)	-4
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:	-	(Job interview and shyness)	
(Electric shock)	-	(Rehearsal)	
Substances that induce )	-		
(vomiting	-		
(Corporal punishment)	-		
(Social disapproval)	-		
)	-		
	-		
(Positively reinforcing	-	(Assertiveness and social skill training	-5
.....	-	Self )	
(Negative practice)	-1	Sufficient )	(confidence
(Omission therapy)	-2		(self_ esteem
(Shadowing therapy )	-3	( _ )	
(Positive reinforcement)	-4		
(Tokens economy)	-5	.....	
(Biofeedback therapy)	-6		
Multiphasic )	-7		
(behavioral therapy	-	(Role playing)	-
Cognitive behavioral )	-8	(Self control)	-
(therapy	-	(Flooding)	-
(Eclectic psychotherapy)	-9	(Direct advice )	-
Eye movement ) ( 1985)	-10	(Modeling)	-
E.M.D.R (desensitization and reprocessing	-	(Desensitization)	-
	-	(Positive reinforcement )	-
(Oscillations)	-		
PTSD	-		
	-		
	-	(Negative assertiveness)	-
	-	(Negative inquiry)	-

## ANTHROPOLOGIE DU SAVOIR DANS LE MONDE ARABO-MUSULMAN

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*«Tout comme les Iraniens avaient envahi, chargés d'achats effectués en Europe ou aux Etats- Unis, le point de rencontre de leur vol, à Heathrow, Londres, l'aéroport de Téhéran était mutuellement plein de travailleurs émigrés pakistanais qui, eux, avaient fait leurs courses en Iran. Ils ployaient sous les boîtes, les malles, les grandes valises de carton attachées par des ficelles, de grands emballages bruns portant les noms les plus fameux, Aiwa, Akai, Toshiba, National, ces marques du nouveau bazar universel ou les marchandises ne paraissaient plus dépendre d'une culture, d'une volonté ou d'une civilisation particulières mais n'étaient que des produits issus des richesses naturelles du monde.»*

V.S. NAIPAUL: **Crépuscule sur l'Islam** ( Voyage au pays des croyants ) Ed. Albin Michel, Paris, 1981. Edition originale: Among the believers ( An Islamic Journey ) Andre Deutsch Ltd, London.

Cette phrase de Naipaul est d'autant plus intéressante pour ces propos que l'auteur est un Indien né et élevé en Amérique Latine, à Trinidad Y Tobago, et qu'il vit et écrit en Angleterre... Il est indien d'origine comme Salmane Rushdie qui, lui, est musulman à l'origine, mais semble plutôt de religion hindouiste. On aura l'occasion de revenir sur ces écrivains comme émergence de mondes culturels si différents et si semblables.

Si l'on doit réellement exploiter l'article de G.Bibeau: « Cultural psychiatry in a creolizing world: questions for a new research agenda. », il faudra mettre à l'épreuve tous les concepts qu'il avance dans le domaine de l'anthropologie en général et de la psychiatrie culturelle en particulier dans ces autres mondes, sociétés et cultures différentes éloignés à tous points de vue des matrices conceptuelles de l'Europe et du bloc nord américain

### Considérations générales.

En tant que psychiatre exerçant au Maroc et ayant été formée en France à l'ethnopsychiatrie et à l'anthropologie, je n'ai pas pu développer mes connaissances avant de soumettre ces sciences à un certain nombre de questionnements dont la plupart sont encore sans réponses: le plus taraudant est celui du transfert des Sciences et des Techniques de l'Occident vers le monde arabo-musulman, travail présenté à Paris en 1979 et resté sans suite car les recherches en France sont centripètes et rarement centrifuges d'autant plus qu'actuellement il serait normal que ce monde et le reste du tiers-monde commencent à élaborer une pensée intrinsèque sur eux-mêmes alors que leurs penseurs ne produisent réellement qu'une fois « déportés » en Occident.

Je suis persuadée que l'on pourrait arriver dans le tiers-monde (il n'y a malheureusement aucune autre manière de parler de tout le reste du monde qui n'est ni occidental ni ex-communiste) à conceptualiser et à produire intellectuellement ce qui est lui est nécessaire pour son accession à ses potentialités. A mon avis les définitions économique politiques du tiers-monde ont échoué à le définir et à le faire progresser ; ce ne pourra être que l'approche anthropologique qui y parviendra...

Mais qu'en est-il du Monde de l'Islam par opposition au monde musulman, appellation qui l'homogénéise fausement? Le cinquième de l'humanité numériquement est musulman et

les musulmans sont implantés sur les cinq continents de façon non homogène: des pays entiers ici le concept politique de nations- sont totalement musulmans; des musulmans sont ailleurs des minorités avec toutes les spécificités des minorités, parfois dispersés en diasporas éloignées ou encore en « poches » de populations comme en Chine ou en ex-Yougoslavie, parfois en agglomérats fictifs de populations reliées par l'Islam seulement comme c'est le cas des Black Muslims, monde islamique de revendication d'un type nouveau créant un groupe ethnico- religieux qui, auparavant, se définissait par sa seule négritude.

Cette dys-continuité ethnique diversifie à l'infini les problèmes socioculturels et anthropologiques des musulmans créant des dys-continuités dans les concepts mis en place pour aborder l'ensemble des sujets d'étude s'offrant aux anthropologues et aux psychiatres à vocation culturelle. L'outil anthropologique est remarquable surtout eu égard aux caractéristiques actuelles du monde musulman et cela n'est pas une contradiction comme on le démontrera plus tard. En fait cette relecture de l'article de Gilles Bibeau me place dans une donnée anthropologique qui reste intégralement à définir ou à inventer: celle de l'anthropologue dans « l'entre-deux », dans l'interface, recevant cette science d'une culture extérieure à la sienne dans laquelle il travaille et a à l'utiliser. Le problème n'est pas tant de s'en servir comme outil de travail que de le rendre efficace et homogène au milieu d'« importation ». Et là est la difficulté. Cela va nous amener à remonter dans le temps. En effet dans l'« entre-deux » vivaient, il n'y a pas si longtemps, l'Ethnologue, observateur d'un peuple, l'Ethnos, dont il ne faisait pas partie culturellement, linguistiquement, religieusement et historiquement. Ainsi Margaret Mead en Océanie, Georges Devereux chez les Indiens des Plaines aux Etats- Unis ou chez les Sedang Moï de Malaisie, Lévi-Strauss en Amazonie, Pierre Verger au Brésil et au Bénin, Ruth Bénédict en Inde, tous ces spécialistes et bien d'autres illustrent la concomitance du phénomène ethnologique comme relié à celui de la colonisation, domination violente ou symbolique d'un peuple par un autre.

M. Mead a étudié les mœurs sexuelles en Océanie au début de ce siècle car la puissance technologique et intellectuelle de son propre peuple lui permettait de se porter vers d'autres cultures et d'autres civilisations alors qu'une insulaire d'Océanie n'aurait jamais pu faire le voyage et la démarche inverses aux mêmes époques. On ne parlera pas de la femme musulmane aux mêmes moments parce qu'elle était encore en dehors de toute historicité.

C'est pour cela que l'Ethnologie et les sciences dérivées ou annexes paraissent liées à un moment historique de



l'humanité, celui de la colonisation, phénomène unique de l'histoire récente par son ampleur: au début du vingtième siècle l'Europe investissait tout le reste du monde connu de façons différentes seulement dans la nature de l'occupation tandis que le bloc américano-canadien construisait une « puissance » spirituelle et matérielle qui avait fait l'économie de l'investissement effectif hégémonique des territoires de peuples à conquérir. En réalité les choses sont plus complexes encore. En fait l'Europe s'était emparée depuis cinq siècles de l'Amérique « latine », avait essayé de conquérir les Etats-Unis et le Canada en les laissant dans son sillage mais ce sont les populations originaires de l'Europe qui seront les « White » aux prises avec les indigènes de l'Amérique du Nord et puis plus tard avec les « Black » issus du commerce des esclaves. Plus tard l'Europe partait vers l'Asie, l'Afrique et l'Australie où elle reproduit à peu près le même système qu'en Amérique. Il ne faut pas oublier que les Philippines portent le nom d'un roi espagnol dans les temps glorieux ou l'Espagne voguait sur toutes les mers connues... Les musulmans à ces époques avaient été arrêtés dans leurs conquêtes et formaient un espace clos qui serait balayé par les incursions coloniales.

L'anthropologie historique est indispensable pour, un jour, rassembler les êtres humains autour de l'idée des vagues migratoires, des conquêtes, des guerres, des « pacifications », pour qu'advienne un autre type de relations entre les peuples dépassant le racisme, la xénophobie et les conflits idéologiques ou sanglants car, de nos jours encore, les instincts guerriers et de violence n'ont pas disparu comme s'ils faisaient partie intrinsèque de la qualité même d'humain.

C'est ainsi que les peuples ont quand même cherché à évoluer vers d'autres types d'organisation politique après la décolonisation massive des entités sous domination coloniale. C'est la première fois dans l'histoire humaine également que des conquérants acceptent de quitter des territoires soumis par la force dans les périodes contemporaines alors que ce n'était pas le cas, autrefois, à la suite de pressions internationales organisées et du principe d'accélération de l'histoire humaine telle que nous la vivons maintenant. A mon avis et en tant que personne née sous domination coloniale, l'Ethnologie fait partie d'une époque révolue et il semble impossible d'être ethnologue dans sa propre culture alors que l'on peut tout à fait y être sociologue ou anthropologue. L'ethnologie est née en même temps que la colonisation et elle lui était essentielle pour te comprendre et gérer les populations dominées de même que les écoles de langues orientales ou autres; le ressentiment du chercheur vis-à-vis de la colonisation et de ce qu'elle a engagé dans son peuple et sa propre personne est trop récent pour que l'on puisse parler d'égalité réelle dans les relations entre les « mondes scientifiques ». Il y a la parole absente des tiers-mondistes dans le domaine de toutes les recherches scientifiques qui a laissé la place à d'autres formes d'expression comme si la sphère intellectuelle leur étant barrée il ne restait que les passages à l'acte accessibles à d'autres individus non inhibés dans les comportements. C'est le problème de toute la création intellectuelle et scientifique dans le tiers-monde depuis l'autonomisation des peuples anciennement sous domination coloniale.

Cela renvoie à l'assertion de G.Bibeau essentielle à ce niveau de développement: les personnes vivent dans des socio cultures dominées de façon croissante par des experts, des gestionnaires et une nouvelle économie du savoir basée sur un degré élevé d'instruction fonctionnelle ». Cela mérite approfondissement car cette loi est fondamentale tant par

rapport à ce qui précède que par rapport à ce monde de l'islam pris comme objet d'étude:

- 1- est-ce le cas de toutes les socio-cultures existant actuellement?
- 2- le savoir est-il devenu une « denrée universelle »?
- 3- le savoir est-il désigné ici comme liée à l'alphabétisation?
- 4- le savoir s'il suppose des experts, des directeurs, une gestion de sa fonctionnalité, est donc capital pour l'homme actuel.

Ces questions nous amènent à penser que le Savoir est divers et que, intrinsèquement, il est une ramification de tous les savoirs. Il est de surcroît et surtout un pouvoir que seuls quelques-uns détiennent. Ainsi il y aura deux sortes de dominés: tous les analphabètes du monde en nombre très considérable dans le tiers-monde mais également les sous-ou mal- instruits dans le monde avancé qui seront des exclus au même titre que les sous-développés. Ainsi une prémisse de résolution de questionnement est dans l'idée vectrice de Bibeau; Cependant pour nous qui travaillons et observons dans le tiers-monde mais restons ombiliqués par notre savoir justement au monde occidental, les savoirs paraissent multiples mais nous serons obligés de les cliver en deux:

- 1- tous les savoirs qui sont d'ordre scientifique pur, sciences et leurs applications techniques.
- 2- tous les autres savoirs (littérature, arts, traditions et cultures populaires, culture orale) La séparation des savoirs à ce niveau-là n'est pas suffisante car les sciences de l'éducation, les sciences humaines, le cas particulier de la médecine et de la psychiatrie font jouer des mécanismes très sensibles dans les socio-cultures où elles ont été récemment importées. Nous verrons que seules les sciences pures sont importables sans conditions dans le monde de l'islam et que les autres peuvent être irrecevables

L'autre concept-clé, celui de la mondialisation et de ce fait de la créolisation, devrait permettre de penser qu'il y a -ou aura- mondialisation et créolisation du savoir et donc des SAVOIRS.

1- Or l'abord que l'on peut qualifier d'anthropologie à vocation humaniste, profondément convaincue de l'égalité des ethnies, des cultures, effaçant le degré d'avancement socio-éco-politique entre les peuples, vocation d'ailleurs nécessaire à une déontologie de la recherche, cet abord donc, paraît scotomiser les attitudes réactionnelles des mondes qui n'ont pas accès à la création idéale, scientifique et intellectuelle propre à émerger sur la SCENE INTERNATIONALE DU SAVOIR. Cette scène est occupée par deux protagonistes: 1- l'occident au fait des sciences et des techniques (et tous les territoires d'héritage occidental « blanc », à savoir l'Afrique du Sud, l'Australie ... )

2- le reste du monde (ex-bloc soviétique, Asie, Afrique et Amérique latine..), disparate et complexe. Si nous prenons comme objet d'étude le monde dans lequel nous sommes immergés, le monde de l'islam et non le monde musulman, terme réducteur, nous nous rendons compte de deux catégories de phénomènes émergents en son sein:

1. une position de revendication d'une singularité spécifique à la Umma (littéralement la « Matrice ») musulmane, singularité très complexe.
2. une contestation de tout ce qui vient de l'occident et de tout ce dont l'occident est vecteur (sciences, techniques mais surtout modes de vie, coutumes,

pensée pure, condition des femmes, créations artistiques, conceptions et attitudes devant l'amour, la vie et la mort ... valeurs philosophiques, esthétiques, eschatologie, métaphysique .... etc.)

Pour ne pas se perdre dans des discours aléatoires et parce que le problème de l'islamisme reste entièrement posé, il faut poser deux catégories de faits:

- 1- le refus de la mondialisation par les musulmans fondamentalistes, courants très puissants qui balaient de fond en comble le monde de l'islam.
- 2- l'impact des nouvelles orientations de recherche sur la psychiatrie culturelle dans la même sphère islamique.

Avant tout il faut préciser que les idées de l'école actuelle d'anthropologie nord-américaine sont empreintes d'un respect total de toutes les cultures, ce qui anéantit enfin les thèses racistes de l'école d'Alger avec A. Porot et celles de Carothers en Afrique Noire qui avaient conclu tous à l'infériorité des races arabes et noires quant au fonctionnement cérébral des « indigènes » qui utilisaient peu ou pas du tout leur cortex cérébral noble et donc les fonctions supérieures cérébrales. Ces allégations scandalisent toujours et très violemment les psychiatres et très rares anthropologues du Maghreb qui n'ont pas dépassé la blessure narcissique qu'ils portent encore en eux, comme si le fait de savoir n'avait pas guéri en eux leur appréhension douloureuse du fait colonial. (Ces thèses refleurissent dans un livre récent paru aux U.S.A. et qui a divisé l'opinion américaine sur l'intelligence moindre des Noirs américains.)

Les psychiatres maghrébins savent « tout »: ce qu'est un cortex cérébral, comment il fonctionne, pourquoi il est absurde qu'Arabes et Noirs soient impuissants à s'en servir... mais ils ne savent pas pourquoi il faut absolument dépasser le problème de leur douleur à évoquer la question. Or cela est absolument nécessaire pour comprendre d'une part pourquoi des scientifiques comme Porot ou Carothers ont conclu à de pareils axiomes et pour réaliser enfin pourquoi la colonisation a eu lieu, pourquoi elle a dû finir et pourquoi il faut avancer avec la matrice socioculturelle quelle a laissée en place en se retirant: c'est une forme de créolisation vécue non pas comme une greffe mais comme un cancer.

Cela étant posé et l'anthropologie pouvant rallier les scientifiques non suspects de racisme ou de désirs hégémoniques sous couvert de la science, reste à résoudre la signification de cette envolée islamique extraordinaire. Peut-on lui appliquer le principe de la mondialisation de tous les systèmes?

En bref. Le monde de l'islam est au premier rang actuel de la contestation de l'ordre non-musulman. Si l'on se réfère aux thèses racistes précitées, on n'aura aucun mal à admettre cette tendance réactionnelle à un passé récent, douloureux et humiliant pour les musulmans avec d'autres vexations historiques comme celle d'avoir été colonisés par d'autres musulmans à l'époque de la Sublime Porte turque...

Si l'on rentre davantage dans la problématique on se rendra compte que des mouvements extrêmement profonds agitent sans arrêt le monde de l'islam depuis plus d'un siècle et qui sont ignorés en occident vu l'hermétisme existant entre occidentaux et (musulmans) orientaux depuis le contentieux gravissime des Croisades en particulier. Ces mouvements et ces courants recherchent un type d'existence, de pensée et de morale authentiquement musulman, non encore réalisé aux yeux des fondamentalistes depuis les premiers temps de l'islam empreints de la pureté des origines et dépravé par le cours de l'histoire du peuple musulman.

Déjà en 1978, Hélène Carrère d'Encausse prévoyait la chute de l'U.R.S.S. à travers un livre fondamental, « L'empire éclaté »: son argumentation s'étayait sur les stades différents des Républiques Soviétiques d'Asie Centrale par rapport à l'état d'avancement « humain » des autres régions du gigantesque empire soviétique. Ouzbékistan, Tadjikistan, Kazakhstan, Kirghizistan, Turkménistan avaient gardé non seulement une empreinte islamique très forte mais de plus tout y était en place pour l'implosion de l'U.R. S.S. et les conditions de l'implosion étaient anthropologiques:

- 1- les caractères religieux avaient résisté à la « soviétisation », c'est-à-dire l'imposition de la laïcité et l'interdiction de tous les cultes religieux.
- 2- la condition des femmes était revenue aux stades antérieurs, dévoilées de force lors de grandes cérémonies de type stalinien, elles se remettaient aux coutumes ancestrales dès qu'une foie du régime le permettait
- 3- la structure familiale patriarcale, agnatique, patrilineaire s'était recomposé (ou n'avait disparu qu'en surface.)
- 4- la fécondité des femmes y était exceptionnelle et le taux de natalité y dépassait toutes les autres régions soviétiques, ce qui, à terme, allait changer les rapports entre les proportions musulmanes et non musulmanes. On voit d'ailleurs par les guerres serbo-croato-bosniaques que l'appartenance religieuse musulmane est restée prévalente dans l'ex-Yougoslavie et la Tchétchénie démontre que son adhésion au bloc ex-communiste était fictive si l'on en croit à la violence déchaînée entre les deux pays.

La cohérence organique du monde de l'islam est telle que la Turquie laïcisée de façon drastique par Mustapha Kémal, dit Ata-Turk, le père des Turcs, au début de ce siècle après l'écroulement de l'empire de la Sublime Porte, la destitution du Sultan, le démantèlement des harems, le renoncement aux caractères arabes pour l'écriture latine, etc. est actuellement en proie à la revendication islamique orthodoxe qui oppose les tendances au sein même de l'islam turc.

Les mêmes phénomènes ont amené la faillite du Chah, le dernier des Pahlavi en Iran, et son départ en exil en janvier 1979 après des tentatives forcées de « modernisation » de son pays. Entre autres revendications violentes contre les idées du Chah il faut relever la répugnance absolue des Iraniens pour leur passé aryen et perse antique que le monarque avait revalorisé dans l'histoire prestigieuse de la Perse.

On retrouve ce scotome historique chez les Arabes aussi (évidemment les perses ne sont pas arabes de même que les turcs ... ) puisqu'ils appellent « El Jahhiliyya », l'ère de la sauvagerie, de l'ignorance, littéralement traduit, toute l'histoire arabe antéislamique. C'est un fait troublant qui n'a jamais été analysé par l'histoire anthropologique. Cela se passe comme si les européens stigmatisaient leur héritage gréco-romain par exemple puisqu'il comprenait un polythéisme très éloigné du monothéisme chrétien. Or la pensée platonicienne ou aristotélicienne est revendiquée comme une fierté par l'occident alors que le monde de l'islam ne se prévaut pas des multitudes de civilisations antéislamiques si l'on parcourt rapidement le monde du Détroit de Gibraltar au Mindanao philippin musulman avec toutes les entités noires d'Afrique et les latitudes asiatiques plus au nord.

C'est ainsi qu'en Chine les musulmans résistent malgré le maoïsme et l'ère communiste à l'intégration dans le reste de la population chinoise comme ce fut le cas en U.R.S.S.

Ces phénomènes de résistances se structurent très fortement autour de l'identité féminine qui reste le canevas réel de la société musulmane tant la typologie des rôles et des statuts féminins est constante depuis quinze siècles. Même dans le monde de l'islam asiatique et noir, une revendication religieuse, politique et sociale d'un islam fort et utile à tous ses membres est très perceptible. Cette analogie est transposable aussi dans cet islam à visage nouveau, celui des Black Muslims nord-américains qui ont récupéré cette religion à des fins révolutionnaires au sein de la société la plus développée du monde.

Toute cette mouvance est devenue encore plus tangible grâce aux progrès techniques occidentaux qui ont permis une communication infiniment plus facile et permanente dans le monde musulman. Le penseur e? politique musulman Mohamed Iqbal a canalisé la force de la Umma du gigantesque empire indien jusqu'à la partition du Pakistan puis au démembrement du Bengla-Desh à partir de ce dernier.

C'est dans le contexte islamique asiatico-indien qu'ont émergé les personnalités de Salumn Rushdie et de Taslima Nasreen. Tous deux musulmans de naissance ils sont l'homme et la femme par qui le scandale arrive. Ils sont surtout des révélateurs de l'état d'esprit du monde actuel de l'islam.

Les déclarations de foi de T.Nasreen sont totalement insupportables pour tout musulman dans le monde car elles violent les règles religieuses et anthropologiques qui constituent le socle même de l'islam depuis les origines et font tomber les tabous qui sont les clés de voûte de tout l'édifice islamique:

- 1- elle s'est départie de la réserve exigée de toute musulmane digne de ce nom.
- 2- elle a osé critiquer le groupe, violation redoutable d'un tabou puisque chez les musulmans, l'individu n'est qu'un élément de la Umma , le groupement humain musulman universel dont la plus pure expression symbolique est le pèlerinage annuel de la Mecque, phénomène unique par son importance et ses significations.
- 3- elle conteste l'ordre sexuel de la société et refus le mariage, attitude abhorrée puisqu'un musulman « ne complète sa religion » que lorsqu'il se marie; elle refuse en plus la maternité, première fonction de la femme musulmane.
- 4- elle ose un crime, le plus radical de tous les crimes qu'un être humain musulman puisse accomplir: être athée, le dire et le vivre.

A ce titre Taslima Nasreen est allée beaucoup plus loin que Salman Rushdie qui s'est rétracté et a voulu ainsi renier son état d'apostasie. Ces digressions nous signalent simplement que l'aile musulmane méditerranéenne et de la Péninsule arabe est beaucoup plus rigoriste et qu'en son sein ces deux écrivains n'auraient jamais pu exister.

Ces considérations au sujet du monde de l'islam ne sont qu'une infinie partie de tout ce qu'il représente et est anthropologiquement mais ces esquisses permettent de comprendre que les notions de mondialisation et de créolisation de Bibeau, les pré-supposés de Hannertz: « ... Cultural interconnections increasingly reach across the world. More than ever, there is a global ecumene. », ceux de Weaver etc., ne sont pas adéquats pour le monde de l'islam. Je m'explique. Si effectivement la terre est devenue un « village », ou une « maison commune », cela ne « marche » pas pm le monde de l'islam on plutôt si: les nouveaux concepts anthropologiques sont les outils qui permettent de comprendre TOUS les phénomènes soumis à l'étude et à l'observation

mais dans un SCHISME MUSULMAN non prévu on non pressenti par les anthropologues qui lui sont extérieurs; en d'autres termes, il y a un refus violent de la mondialisation et de la créolisation dans le monde de l'islam par rapport à TOUT ce qui lui est étranger dans l'essence de la religion islamique qui porte en elle tous les codes sociaux, juridiques, politiques, moraux etc. ... dont cette entité humaine à définition uniquement religieuse a besoin. Plus que cela les intégristes les plus convaincus pensent que toute la science du monde est dans le Texte Suprême, le Coran, avec preuve à l'appui Cependant tous les schémas de réflexion de Bibeau, de Hannerz, de Weaver, de Taylor deviennent valables à l'intérieur du monde de l'islam et pour lui-même grâce à des possibilités qu'il ne possédait pas jusqu'au vingtième siècle, c'est-à-dire les télécommunications, l'aéronautique, les satellites et autoroutes de la communication, l'alphabétisation massive, la médecine moderne, les expériences modernes de gestion et d'organisation ... ! La mondialisation de la médecine moderne, par exemple, a très considérablement changé le visage médical du monde musulman (voir références bibliographiques).

L'hygiène, la vaccination, l'accouchement médicalement assisté, les soins pédiatriques ont réduit la mortalité, la mortalité maternelle, la mortalité infantile et ont agi sur la longévité humaine sans conteste. En 1978, 18000 femmes sont mortes en couches au Pakistan ( Dawn, journal quotidien de Karachi, du 25.12.1978). C'est pourquoi on réunissait la All Pakistan Tibbi Conférence qui devait promouvoir le système Tibbi, mot dont l'origine est la racine arabe TIB signifie médecine, c'est-à-dire la médecine traditionnelle et créer un « Institut national de recherches sur la médecine traditionnelle » et ainsi permettre une couverture de soins totale de toute la population, ce qui laisse supposer deux choses: soit que la couverture moderne était insuffisante, soit qu'une partie de la population n'avait recours qu'à la médecine traditionnelle, faute de moyens ou par choix et par conviction. D'ailleurs l'O.M.S. a tenté dans le monde en voie de développement de « recycler » les matrones, les arracheurs de dents, les sorciers ou exorcistes traditionnels pour « traiter » les malades mentaux, les rebouteux etc. démarche à analyser de façon plus sérieuse quant aux résultats obtenus. Reste à démontrer dans ces énormes groupements humains l'origine réelle de la révolution démographique, hygiénique, sanitaire. Les deux systèmes médecine moderne/ médecine traditionnelle ne se sont pas fusionnés ou harmonisés ou « créolisés ». Ils sont en constante dys-continuité, historique, culturelle, scientifique, socio-économico-politique dans le monde de l'islam. On ne peut nier les apports incalculables de la médecine moderne (ou occidentale?) sur le visage médical du monde musulman. Coexistent actuellement des médecins musulmans « modernes » et traditionnels et dans ceux qui sont modernes une frange veut islamiser la modernité: on ne consulte pas les femmes le vendredi, les gynécologues doivent être des femmes, le jeûne du Ramadan est permis quelque soit la pathologie etc.

Mais avant de revenir sur le problème purement médical ou plutôt de psychiatrie culturelle il faut comprendre l'origine de l'opposition Tradition/Modernité qui est un problème majeur pour le monde musulman. Pour ma part je pense que c'est là le problème essentiel qui travaille cette aire humaine, tout le reste n'étant que des préoccupations annexes. Cette hypothèse est trop vaste pour être résolue par une personne. Mais il faut essayer de comprendre. Cette opposition prend ses racines inconscientes dans la haine nourrie au cours des siècles par deux communautés religieuses qui se sont

réellement affrontées lors des guerres des Croisades et qui, depuis, n'ont pas pu par le fait de l'histoire dépasser ce différé. La modernité vient de l'occident/monde chrétien et à ce titre elle est objet de phobies et de contestations diverses. Le fait est si ancien que la langue française contient une interjection lourde de sens qui provient de la nuit des temps. On dit pour une démarche épuisante ou qui sera suivie d'échec: « c'est la croix et la bannière », signes symboliques sous lesquels se menaient les batailles pendant les Croisades entre chrétiens sous la croix et musulmans sous la bannière... Cette haine a été attisée par des moments très aigus: la chute de l'empire musulman d'Espagne est un bon exemple de moments historiques ou des pans entiers de l'histoire humaine s'écrivent dans des violences et des actes dommageables pour tous.

L'Empire de Grenade, dernier royaume nasride de l'Espagne musulmane s'effondra le 2 Janvier 1492. « La disparition du dernier Etat musulman d'Europe Occidentale non seulement bouleversait l'équilibre politique du monde méditerranéen mais encore mettait en péril le sort des populations minoritaires et la transmission d'un savoir extrêmement riche. » (B. Vincent, cf réf biblio.)

L'observation de l'époque et son étude sont extraordinaires d'enseignements mais elle est trop complexe pour ce propos. Cependant: « En 1501, ordre fut donné de brûler, dans le royaume de Grenade, tous les Corans, tous les livres ayant un lien avec l'islam. SEULS ETAIENT EPARGNES LES LIVRES DE MEDECINE ET DE PFUOSOPHOE... Dix ans plus tard, nouvelle chasse aux ouvrages, sans exception cette fois pour pouvoir les expurger ... Tout fut fait, y compris en recourant à l'inquisition, pour empêcher l'exercice de la médecine par les morisques. Le résultat fut la dégradation d'une science médicale qui, au fil des ans, sombra dans un banal charlatanisme... » (B. Vincent, id.). Ces événements sont au centre de cette démonstration:

- 1- notion de xénophobie
- 2- antagonisme religieux ayant incidence sur d'autres domaines non religieux
- 3- état médical des populations concernées par la xénophobie et les antagonismes religieux et politiques.

Donc les peuples et l'homme conçoivent, consomment et vivent leurs problèmes philosophiques et psychologiques en fonction de leurs époques, de leurs croyances et de leur culture ancestrale. Les musulmans d'Espagne qui avaient été le relais grâce à l'éclat très particulier de la médecine arabe avec la médecine grecque, romaine, indienne et persane disposaient d'une médecine de pointe pour l'époque qui devint inacceptable par les chrétiens pour des raisons politico-religieuses, phénomène vécu actuellement par les musulmans pour des raisons symétriques et inversées malgré le temps passé...et l'époque que nous vivons.

Mais dans le cas envisagé de l'Espagne andalouse à la médecine très brillante (comme dans le reste du monde arabo-musulman de l'époque ou antérieurement avec Avicenne, Averroës, Ibn Omrane, Maïmonide, Al Kindy, Al Khawarizmi.. (cf. « Une psychiatrie moderne pour le Maghreb », notes biblio.), le refus, l'anéantissement des Arabes passait par des autodafés gigantesques qui ont effacé un énorme savoir dans la vague de haine qui refuse l'Autre comme insupportable dans toutes ses dimensions, religieuses, éthiques, scientifiques, culturelles, etc.. Cette démonstration si nouvelle de Bernard Vincent sur la destruction du patrimoine scientifique et humain « mudéjare » est exemplaire de ce qui se pourrait démontrer dans ces propos. Les musulmans ont-ils

la même approche que lui et peuvent-ils démontrer ce qui les affecte de la même manière?

Quoique qu'il en soit, Yvonne Turin (cf. notes biblio.) l'a également démontré en Algérie à travers « les affrontements culturels », refusant toutes les formes de soins et d'instruction pendant la colonisation française qui a duré cent trente ans et n'a pas obtenu l'adhésion à la culture française, loin s'en faut si on considère l'état d'islamisation actuel de ce peuple et sa si importante revendication religieuse; certains s'accordent à dire que c'est parce que l'Algérie a été laminée par la colonisation à un point tel qu'il ne lui est plus possible que d'essayer de se reconstituer un visage arabo-musulman à travers la tourmente qu'elle vit actuellement. Les colonisés refusaient au Maghreb la médecine moderne comme une entité du savoir et de la science aux mains de ceux que l'on refusait de toutes ses forces et désespérément. Et même quand le refus s'atténue ou n'existe plus que dans certaines strates sociales, les attitudes et comportements venus du fond des âges resurgissent comme les coulées de lave des volcans arrivent avec des matériaux du centre de la terre quand se produit un tremblement de terre important. C'est ce à quoi on assiste aujourd'hui dans le monde musulman dans différents domaines et également dans ceux de la médecine avec toutefois une nuance, le rejet est moindre pour la médecine physique que pour la médecine psychique.

Tout se passe comme si les greffons dans une société donnée sont inopérants et ne prennent pas car la culture ancienne nu traditionnelle réagit sans arrêt pour repousser ce qui est nouveau ou étranger. Cela persiste malgré parfois des siècles d'évolution; certains historiens ou philosophes des religions avancent même la théorie d'un recul des sens et des symboles religieux vers un « purisme » ou une orthodoxie qui n'ont même pas été ceux des moments fondateurs, et ce en réaction contre un matérialisme qui envahit toute chose et semble dominer ce siècle en particulier...

C'est ainsi par exemple que le domaine médical et psychiatrique se retrouve constamment sous l'emprise du religieux et cela grâce à deux catégories de faits:

- 1- la médecine est fille de la magie et se nourrissait de religieux puisque la vie, la santé et la maladie et la mort sont au regard des musulmans un don et une décision de Dieu et donc une destinée inéluctable. C'est Dieu qui décide de la mort et toute tentative pour allonger la durée de vie est une velléité humaine. C'est la volonté divine qui crée une maladie ou qui apporte la guérison: pourquoi alors l'être humain devrait-il intervenir dans ces phénomènes? Dans le meilleur des cas, le médecin n'est que le médiateur à qui Dieu a permis de soigner ou de guérir grâce à Sa Volonté Divine. C'est pour cela que les Saints et les guérisseurs sont « aussi » efficaces symboliquement que les médecins ou les psychiatres.

- 2- la médecine et la psychiatrie sont dans leur acceptation occidentale des greffons transférés dans le monde de l'islam. Elles ont tellement à voir avec l'intime, le sexuel, l'horifique, l'angoisse, la notion de mort qu'elles dérangent la structure socioculturelle traditionnelle qui endigue et donne les réponses à toutes les préoccupations concernant l'intime, le sexuel, l'horifique, l'angoisse et la notion de mort dans toutes ses implications, la sienne et celle des autres, la pudeur, le vécu du corps et la sphère instinctivo-affective et intellectuelle. Ainsi une femme musulmane dans certains pays ne peut être soignée par un médecin homme gynécologue obstétricien, même au péril de sa vie; il est inadmissible qu'une femme soit vue à ce degré d'intimité, de viol de la pudeur, dans la sphère



sexuelle sacrée de la femme qui n'appartient qu'à un seul homme (« Honn », le sacré, l'inviolable est par dérivé le met épouse, en arabe ) ...

Si on investit le domaine de la psychiatrie culturelle, la problématique devient telle que, par le REFUS de l'Autre, il y a des réponses culturelles à la maladie psychique qui font faire l'économie de la nécessité de la psychiatrie de type occidental. Il existe en fait des réponses, les attitudes traditionnelles des soins et des explications de la folie et des désordres psychiques, dans une conception magico religieuse qui s'est élaborée au cours des siècles avec tout l'héritage des peuples préislamiques que l'on décèle à travers des rites plus ou moins païens, certains symboles et croyances. La mondialisation de la médecine moderne ne fonctionne pas dans le domaine évoqué: on n'achète pas de la psychiatrie comme on peut acquérir un scanner ou un appareil quelconque d'enregistrement cardiographique ou encéphalographique ou autre. Ce n'est pas un « Sony » que l'on peut rapporter comme les marchandises du bazar mondial dont parlait V.S.Naipaul dans la phrase citée en exergue au début de cet article. Si un appareil équivaut à un autre, toutes les techniques sont mondialisables et créolisables dans leur utilisations locales mais les sciences et le savoir ne le sont pas forcément.

**« La médecine comme tous les autres métiers n'est pas seulement soumise à certaines valeurs idéologiques et morales, elle est utilisée pour les préserver... » / Docteur Naoual Saadaoui.**

Cette femme remarquable (cf. notes biblio.), médecin psychiatre égyptienne, emprisonnée pour délits d'opinion dénonce ce qui est intolérable pour elle dans la société arabe. L'un de ses écrits majeurs analyse la souffrance féminine comme inscrite dans le fonctionnement social même qui ne doit pas varier et fait porter le poids aux femmes qui n'ont aucun autre recours que la maladie psychique pour dire leur douleur intolérable dans le cas où elles sont fragiles ou quand elles contestent le sort qui leur est imparté de toute éternité. N.Saadaoui est féministe, première chose intolérable car le féminisme est une importation occidentale. Elle récuse les mutilations sexuelles féminines, deuxième aberration de la part d'une femme. Elle est un médecin et un psychiatre formée à la science moderne, démarche irrecevable de la part d'une femme en plus: elle ne se contente pas de « bricoler » localement avec son savoir, ce qu'on lui permettrait à la limite de faire. Son essai est en fait une utilisation de la psychiatrie à des fins d'analyse et de description de la condition des femmes. Elle a pris ce droit de parler autour des expériences douloureuses des autres femmes, particulièrement mentalement inaptés et exclues socialement, seize portraits de malades et trois de femmes emprisonnées. Or si la situation des femmes arabes est la plus intolérable au monde objectivement, l'essai de Saadaoui basé sur une enquête sérieuse et approfondie et des interprétations qui, elles, restent à analyser, cet essai, donc est une dérive de sens à partir des outils occidentaux. C'est pour cela que le retour à une cosmogonie musulmane globalisante barre la route à de tels dérapages, insupportables dans leur nouveauté.

Les cultures locales ont des diktats très contraignants à travers lesquels on ne peut passer outre. Les sociétés importatrices de « savoir » n'admettent pas ce qui a trait à l'individu, à la notion de liberté, (philosophique), d'hédonisme, (sexualité), à l'expérience de la gestion publique des peuples, (notion politique de personnes représentant toutes les autres

qui prennent les décisions.)

Les sciences comme la paléontologie, l'évolutionnisme darwinien des espèces, le freudisme, sont irrecevables car elles vont à l'opposé des conceptions et attitudes locales en fait de genèse, d'évolution et de gestion des peuples arabo-musulmans. L'anthropo-paléontologie prévoit que l'homme est une évolution- mutation à partir des branches et des espèces de primates avec des moments très précis dans la progression de l'adresse et de l'intelligence humaines. Cela est antinomique avec la conception religieuse de l'homme qui est divine et sacrée.

Le freudisme est suspect d'athéisme mais de surcroît il favorise l'individualisme qui est, à n'en pas douter, le phénomène-clé de la structuration moderne et post-moderne des sociétés. Cela est en contradiction pure et simple avec la famille arabo-musulmane très nombreuse, grégaire et soudée; la notion de groupes, de clans, de tribus (les Arabes étaient les Bani ..... fils de..., suivi du nom de tribu, de lignage, de père, dans la désinence absolue de l'ordre masculin), régissait le destin même de l'être humain, lui-même un élément diffus d'un tout qui est surinvesti par lui comme essentiel: la Umma ou « matrice » qui devient un sens cosmique lors du pèlerinage annuel à la Mecque ou trois ou quatre "lions de musulmans se dissolvent abandonnant leurs origines, leurs races et leurs schismes pour n'être plus qu'une même et seule aspiration vers le Dieu, unique, en soumission totale (El Islam, l'Islam signifie littéralement: la soumission totale à Dieu)

La psychiatrie culturelle dans le contexte musulman devient alors et du fait de tout ce qui a été précédemment démontré une création encore à faire dans le domaine large du Savoir avec les outils que permettra la religion. Seront admis et utilisés les critères médicaux, génétiques, biologiques et même sémiologiques et psychopharmacothérapeutiques. Seront écartés tous les éclairages anthropologiques, psychanalytiques et sociologiques qui seraient en opposition avec l'orthodoxie musulmane qui régit absolument tout ce qui concerne l'être humain musulman. Il faut avoir expérimenté les théories culturelles de la psychiatrie et leur validité pour prendre la mesure de ce qui constitue l'un des phénomènes les plus imprévus et les plus extraordinaires de la fin du vingtième siècle, à savoir la revendication musulmane d'une science autre que celle qui prévaut dans l'ensemble du monde pour servir les membres de la communauté islamique mondiale.

Ce qui est encore plus difficile à gérer reste l'implication d'un grand nombre de penseurs et de savants musulmans dans les processus modernes avec une pensée de type résolument moderne. Tout se passe comme si il existait des musulmans traditionnels, modernes et ceux qui cherchent entre les deux possibilités. Les savants et les penseurs sont dans le même cas étant entendu que né musulman, un être humain se définit d'abord par sa qualité de musulman qu'il ne perd jamais. Les penseurs musulmans modernes ne peuvent être modernes ou post-modernes que dans le « licite » musulman. Dès que leur pensée sort de cet état de fait, ils sont en état d'apostasie.

Ainsi si l'on prétend que dépassée la superficialité ethnique et culturelle, l'organisation humaine de l'inconscient est universelle, il faudra prouver que rien dans l'universalité de l'inconscient n'est en désaccord avec les préceptes religieux. En d'autres termes, le complexe de l'Oedipe dans les stades de l'évolution psychologique infantile, ne saurait être pris comme un postulat: qu'est-ce que cet enfant surpris de haine pour son parent homologue et séduit par son parent hétérologue? Les parents sont de l'ordre de la sacralité et il

est donc impensable que les fantasmes comme les puissions contreviennent à l'ordre implacable de l'univers cosmogonique islamique.

Ces exemples ne sont qu'un détour pour prouver que le monde musulman entre dans une ère dévolution imprévisible que les penseurs occidentaux auront beaucoup de mal à percer. Ce seront les penseurs musulmans « hybrides » qui auront à résoudre toutes ces inconnues, hybrides dans leurs savoirs, dans l'utilisation de leurs connaissances et dans leurs bipolarités traditionnelles et modernes. Les psychiatres sont dans le même cas ou pire ils sont à l'interconnexion entre le psychisme et le savoir, ce qui en fait l'avant-garde de toute la société islamique. Elle a besoin de ses Freud et de ses Lévi-Straus qui n'apparaissent pas encore comme Ibn Khaldoun en son temps. Il faudrait une étude anthropologique du « Savoir » pour avancer dans toutes ces « Terrae Incognitae ». Je retiens la conclusion de G.Biseau qui va exactement dans le sens de ce questionnement angoissé sur l'avenir du monde de l'Islam: « nous avons abordé une période d'incertitude et d'ambiguïté qui place la psychiatrie culturelle et l'anthropologie médicale comme de possibles sciences subversives... ». On peut l'entendre comme des sciences possiblement subversives, ce qui a été démontré au moins un peu dans les propos précédents. Il faut cependant garder présents à l'esprit

que ce que Biseau appelle « une stratégie cachée désespérée de l'impérialisme occidental qui combat avec de vieilles et nouvelles armes pour maintenir sa souveraineté sur le monde entier.. » peut être reprise à l'extérieur de ce monde occidental pour servir d'autres fins tout aussi subversives. La solution n'est-elle pas justement dans une approche anthropologique de l'être humain enfin universaliste et globalisante?

Il n'y a pas si longtemps le balancement dans la psychiatrie culturelle consistait à rétablir l'équilibre en permanence entre le social et le psychologique pour une compréhension meilleure de toutes les problématiques. Aujourd'hui la réalité des socio cultures permet de considérer le monde en situation d'égalitarisme, ce qui évitera de diviser et de cliver les groupements et les êtres humains pour les comprendre et les aider, comprendre est de l'ordre du savoir, y compris celui de la psychiatrie culturelle, et aider est de l'ordre de traiter, but ultime de tout savoir y compris les sciences du psychisme. Le savoir doit évidemment devenir plus équitable entre toutes les socio cultures du monde. Actuellement le principe des discontinuités anthropologiques interdit cette approche dont on ne pourra faire l'économie à long terme. Le préfixe de « dys » souligne que les sociétés et cultures humaines ne fonctionnent encore ni en synergie ni en harmonie et c' est là toute la complexité du problème et de la psychiatrie culturelle.-

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## ESPACE, ASPECTS PSYCHOLOGIQUE ET ANTHROPOLOGIQUE

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*L'espace enveloppe l'être. C'est l'inclusion dans l'être de l'environnement qui lui appartient et le contient ou avec lequel il se sent entretenir des liens. L'imaginaire de la transformation y est fort présent. En passant d'un espace à un autre, la personne assure la continuité d'un corps vécu qu'il puisait dans sa propre pensée. C'est l'ensemble des représentations psychiques qui entourent un sujet à un moment donné qui fonde la relation au monde. Un monde fait d'espaces de significations et des lieux à habiter, à transformer ou à imaginer.*

L'exploration de l'espace englobe un processus complexe et dynamique faisant intervenir des fonctions cognitives, physiques, psychoaffectives et imaginatives qui entrent continuellement en interaction dans des mouvements d'attachement et de détachement, d'éloignement et de rapprochement, de rejet et de ré appropriation, d'investissement et de désinvestissement. Ce qui crée un autre espace -d'échange- entre le sujet et l'espace. Entre le dedans et le dehors.

L'espace ne peut être vide sinon il devient source de l'angoisse. Angoisse d'un contenant défaillant à accueillir un contenu.

Il ne peut y avoir d'inscription dans un espace si celui-ci n'est pas investi comme lieu possible d'accueil et de transformation. La mise en forme de la cognition nécessite à tout instant la possibilité d'une forme contenant dans laquelle la pensée de l'individu puisse être projetée puis ramenée à lui. Il y a toujours une projection d'une profondeur dans l'espace, voir une fusion des deux pour former un tout. La pensée de l'être est projetée sur le support que cet être a choisi de constituer en espace récepteur. L'enfant n'appréhende-t-il pas, imaginairement sa globalité corporelle grâce à la perception de lui-même dans le miroir avant de réaliser son unité perceptive. (Stade de miroir).

La culture n'est pas étrangère à ces processus et parmi ses fonctions celle qui offre à l'individu une conceptualisation de la délimitation entre le dedans et le dehors. « Nous sommes des Imazighen (berbères) et non des apaches. » Espace culturel / Autre espace culturel. Mais à l'intérieur même d'une culture, il existe toute une série de couples conceptuels antagonistes. P. ex. Amazirophones-Arabophones. Plus, chaque culture développe, en son sein, des modèles d'ordre psychique qui lui sont spécifiques. Le statut "ceux du trésor" « Rkenz » était très élaboré chez les Soussis connus par leur esprit d'entreprise qui s'opposait à l'idéal guerrier des Rifains, "ceux de la fierté", n « Râaz » ; de même que le statut que j'appellerais volontier "ceux de l'art" « Rfen », chez les Chleuhs de l'Atlas connu par leurs merveilleuses productions musicales, sans égal.

Les échanges entre l'homme et le monde passent par les médiations du corps propre. Un corps qui se définit comme une puissance qui est en mesure de transformer l'espace réel en un espace imaginaire.

Le thème de l'espace, élaboré dans les rêves, est très riche puisque c'est tout l'espace onirique qui dérive du vécu corporel. Le corps devient dans le rêve tout l'espace environnant ainsi que les perceptions dont il se remplit. L'espace imaginaire du rêve est élaboré symboliquement en fonction du désir qui seul peut faire le tri. Le corps

propre et le monde des choses forment un tout et les caractéristiques spatiales de l'un et de l'autre sont indissolublement liées. « L'espace se ramène à son origine corporelle et le corps à son essence corporelle »

Dans la névrose d'angoisse le corps imprime à l'espace environnant ses propres dimensions. Il s'effectue une expansion démesurée de l'espace corporel qui finit par coïncider avec tout l'espace. Cela se passe comme s'il n'y avait pas de support pour contenir le corps effondré, une sorte de chute, en spirale, dans un trou noir. On retrouve dans toutes les névroses et aussi dans la psychose, à des degrés variables, une symbolique particulière de l'espace avec cette même image de possession par l'espace malgré que l'angoisse se localise « volontiers » à l'un ou l'autre des deux pôles intérieur / extérieur. Dans l'agoraphobie c'est le dehors qui se trouve agressivement investi. Il est identifié à un vide doué d'un pouvoir de destruction par aspiration alors que l'intérieur est sécurisant. Et plus la distance qui sépare l'agoraphobe de son centre de refuge (son point de référence), plus l'angoisse est intense.

Dans la claustrophobie le rapport des forces entre le dedans et le dehors s'inverse. L'angoisse devient liée à l'espace fermé. Le claustrophobe appréhende d'être écrasé ou comprimé entre les parois de l'ascenseur. Piégé dans la cabine lors d'une panne entre deux étages. Plus l'étage prend de l'altitude, plus la crainte est marquée. Etouffé lorsque les portes de l'avion se referment pour le décollage ou se trouver dans le vide si jamais les réacteurs s'arrêtent. Ou tout simplement oppressé lorsque les fenêtres et la porte d'une chambre sont fermées. Cela se passe comme si l'espace se rétrécit, devenait clos et écrase. L'air se comprime, devient rare et étouffe. L'espace, ainsi fermé, rend le mouvement malaisé, ne permettant que le déplacement que pour mieux l'annuler. Le limité devient identique à l'illimité.

Dans la psychose il y a une perte de contact vital avec la réalité. Le psychotique délimite plus ou moins un dedans et tend à refaire une enveloppe. Mais c'est plus un réaménagement des rapports du sujet et du monde extérieur qu'une rupture totale et définitive de l'appréhension des données du réel. L'angoisse provoquée par le dehors éparpillé en fragments projetés réalise une restauration narcissique susceptible d'annuler cette angoisse. Il organise un espace psychique contenant dans lequel se développe son délire personnel. Il fait de cet espace le théâtre des déplacements de ses pensées. Il les apprivoise par les différents mécanismes hallucinatoires selon le type de la psychose. La réalité est ainsi altérée et le psychotique s'aliène dans un espace labyrinthique de fantasmes. Il dénature le monde et le rend plus loin par un contact fusionnel. Le vécu

devient intemporel dans un espace dont l'accès est apparemment inabordable.

**Quel est l'espace thérapeutique que notre société réserve t-elle aux malades mentaux?**

Un vaste espace où se mêlent, dans les pratiques quotidiennes, l'animisme, la magie, la superstition, les phénomènes pseudo religieux... et la médecine. Des **formules magico-religieuses** «des écritures des fqih» «des pratiques d'incantation et d'exorcisme» «des brûlures dans des parties du corps» (Thiqqad)... sont préconisées et censées apporter des remèdes. Car selon un « besoin de croyances » « le malade quand il souffre c'est qu'il est possédé, habité, frappé par des esprits qui révèlent leurs effets maléfiqes, qu'il est agressé par des sentiments négatifs d'un tiers portés sur lui ( mauvais œil, sorcellerie) ou qu'il est soumis tout simplement au destin inéluctable (autre irrationalité). Ces effets se manifestent, par exemple, à travers la crise d'hystérie, la convulsion de l'épileptique, le délire du psychotique, la jaunisse du cirrhotique ou d'un abdomen aigu. Les confréries, les marabouts et les autres ont produit une conception de la maladie et de la folie en rapport avec les phénomènes occultes et superstitieux.

Les saints dont on voit les coupoles blanches partout en Afrique du Nord ont, eux aussi, les fonctions de guérir et de protéger. Leurs réalités mythique et historique dans la plus part des cas sont insaisissables. Certes le culte des saints est un phénomène universel, mais il est particulièrement amazigh (berbère), c'est à dire Nord Africain depuis l'aube des temps. Il n'a fait qu'adopter, successivement, les couleurs des trois religions monothéistes. Sa nature parareligieuse et hérétique est gardée. Mais c'est la fonction sociale du culte qui importe le plus. En général ces sains sont des personnages locaux. Ils ont un territoire délimité. Chaque localité ayant tenu à avoir un patron distingué par une légende qui rivalisait par son contenu merveilleux. Chaque coupole devient un centre, petit ou important, de pèlerinage et de **visite à but thérapeutique ou préventif**. Jadis on se disputait les corps des saints. Il y en a ceux qui ont deux tombes ou parfois plusieurs dans des lieux différents et très éloignés les uns des autres. Parfois on a monté des coupoles sur des sites ayant été, tout simplement, visités par ces prétendus saints. Le Marabout peut désigner à la fois le saint vivant, le saint enterré, sa tombe, et même des objets comme les pierres, les sources, les puits, les grottes, les arbres ou les animaux sacrés. Mais c'est **toujours l'espace qui assure la continuité du sacré**. Un saint musulman a pu succéder à un personnage sacré antérieur, juif, chrétien ou païen. Un même mausolée peut abriter un saint de l'une ou l'autre confession. Un lieu sacré préhistorique, grotte, rocher, mont ou source s'est souvent perpétré à travers les différentes religions qui ont succédé à travers les âges.

Le **but essentiel** d'avoir à ses cotés ces lieux de culte investi de sacré ou de leur rendre visite est le **soulagement de l'angoisse**. Le marabout est un lieu de rencontre. On s'y soigne, on y court à la moindre altération de son état surtout lorsqu'on est femme, on y sacrifie des bêtes... Certains saints sont réputés comme ayant un pouvoir particulier sur telle ou telle affection. L'exemple de **Bouya Omar** est très démonstratif en ce qui concerne le **traitement des maladies mentales**. Avec Bouya Omar on est devant une référence mythique très structurée. Un vrai culte qui s'inscrit dans une ligne de croyances gérées, pour un éventuel soulagement, par des procédés judiciaires curieux instaurés par le maître du lieu pour déposséder le malade de l'esprit provocateur des troubles. Bouya Omar, non loin de Marrakech, est un

rassemblement de quelques bâtiments d'habitations et d'une colonie de tentes, avec au centre le sanctuaire lui-même.

Après avoir appliqué à la lettre des consignes tels que l'arrêt de tabac, la suspension des médicaments, le rejet des talismans, le « possédé » passe au sanctuaire où il doit recevoir un **ensemble de rituels à viser thérapeutique**. Dans ce premier lieu il n'y a ni couleur, ni musique, ni danse. Sur le toit il n'y a qu'une coupole blanchâtre à la chaux. Dans le mur de la façade, qui donne sur la cour où s'organise la hadra, s'ouvre une fenêtre où sont accrochés des cadenas destinés à « nouer l'intention du saint ». Dans le sanctuaire il est reçu par le fqih qui le met entre les mains de Moul Addine. Celui ci l'assoit sur le bord de la fenêtre. Il l'attache avec une chaîne à miracle. En suivant certaines pratiques et rites ésotériques il fait manifester l'esprit. C'est sur cette fenêtre que se réalise le jugement du malade et de l'esprit. Si le malade est très agité ou violent, on lui lie les mains et si nécessaire les pieds afin d'empêcher l'esprit de faire le moindre mouvement et de mettre fin à sa brutalité. On lui fait ensuite accomplir trois fois le tour du tombeau avec la chaîne au cou. Selon l'importance de l'esprit et selon l'agression, on demande un petit sacrifice ( poulet) ou un grand sacrifice ( bouc ou mouton). On lui fait exécuter de nouveau les trois tours du tombeau avec soit le petit sacrifice à la main, soit le grand sacrifice sur les épaules. Si l'animal bêle ou la volaille pousse des cocoricos, c'est que l'esprit est saisi par le tribunal. Les femmes, alors, poussent des cris de joies. Le fqih fait saigner l'animal et marque avec le sang les parties du corps du malade censées être les plus propices pour le logement de l'esprit. Le malade doit attendre trois jours avec les marques tout en subissant plusieurs purificateurs. Les rêves du malade, de sa famille, de ses voisins ou des « chorfas » doivent attirer toute l'attention car ce sont ces rêves qui doivent orienter le malade vers la voix de la guérison. Le rêve constitue l'expression privilégiée de toutes les manifestations du culte. Selon le jugement de Moul Addin, le patient est entraîné dans " rhaddarth" (la transe), prié de rentrer chez lui et d'attendre une autre manifestation onirique, ou orienté carrément vers d'autre thérapeutique s'il estime que sa maladie ne relève pas de la possession.

Le malade ne peut quitter l'espace **Bouya Omar** sans la permission du saint. Il est incarcéré dans un but thérapeutique tant que les tentatives de guérison se sont avérées inefficaces. Le malade, ainsi que sa famille, qui arrivent au sanctuaire ne savent pas, au départ, ce que réserve l'avenir à l'intéressé. Tant que la guérison se fait attendre, la détention s'impose. Les manifestations oniriques et les symptômes psychosomatiques sont les signes caractéristiques de « l'incarcération thérapeutique » qui dépend de l'autorité du saint. Les malades et leurs familles qui se rendent à Bouya Omar sont plus ou moins avertis et donc préparés à subir le poids d'une éventuelle détention. La durée de cette dernière peut aller de quelques jours à plusieurs années. Cependant l'espace entier est imprégné de l'espoir de guérison.

En attendant la délivrance, le malade organise sa vie dans la zaouia selon ses moyens, ses capacités physiques et ses facultés mentales. Quand le malade n'a pas les moyens de subsistance, il peut se donner à de petits travaux de manœuvre au marchand ambulancier de bougies, d'œufs, de Hennie, de chaînes ou de porteur d'eau. Il peut s'occuper d'une cabane (boutique) à titre de salarié ou de gérant. Il peut s'occuper également des nouveaux malades contre un salaire en lui assurant une surveillance et un maintien de rituels. Il y a aussi la possibilité à ce qu'il effectue des travaux rémunérés dans des champs avoisinant qui appartiennent aux « **chorfa** »

Le malade circule librement dans l'espace de la zaouïa. Dans cet espace on trouve aussi de véritables abandonnés qui se livrent à la mendicité et à la clochardisation.

La délivrance, qui peut être provisoire ou définitive, est souvent communiquée au malade par la visite du saint en rêve, par son propre rêve ou celui d'une autre personne.

Pour protéger cette grâce, l'intéressé, en rentrant ou en arrivant chez lui, est soumis à un isolement afin d'éviter tout contact physique susceptible de briser le jugement. La durée de cet isolement, communiqué à la délivrance, est de trois, sept ou quarante jours durant laquelle le patient est soumis à des restrictions draconiennes. Dans les trois jours qui suivent la période de l'isolement, le sujet doit se rendre à **Bouya Omar** pour un **pèlerinage de reconnaissance**. Qui sera suivi, au moins, de pèlerinages annuels pendant les maoussem de Bouya Omar. En cas de délaissement le malade s'expose au châtement ou risque une récurrence de la folie.

Quant à la psychiatrie, médecine spécialisée dans les maladies mentales, s'elle est raisonnablement développée dans les pays avancés, au Maroc elle reste pauvre et reflète notre société. Ce qu'elle offre essentiellement ce sont des consultations surtout dans le secteur privé où la **relation médecin-malade est dominée par une négociation d'ordonnance de médicaments chimiothérapeuthiques**. Les centres spécialisés se réservent les malades agités et agressifs. Par faute de moyens, on ne peut que constater un entassement des malades mentaux dans des hôpitaux isolés, une anarchie des règles de ses institutions, l'insuffisance en nombre et en qualité du personnel soignant. Les sociothérapies, formes d'activités de groupes organisés pour les malades dans un but thérapeutique d'occupation, de réadaptation au travail, de traitement par le travail (ergothérapie), d'activités culturelles, de musicothérapies, d'exercices physiques... sont d'une carence frappante dans nos institutions psychiatriques. -Curieusement et par la nécessité des choses, on a vu qu'à **Bouya Omar** il y a des entreprises similaires dans l'orientation des malades vers la guérison qui fonctionnent-. Mais grâce à la bienveillance de certains médecins, le patient quitte ces espaces d'aliénation, le plus souvent, soulagé de son angoisse mais fort bien imprégné d'une chimiothérapie lourde.

Les autres formes de traitements psychologiques, individuelles (psychanalyse, comportementales, hypnose, de relaxation...) ou collectives (psychothérapies de groupes, familiales...) sont, au Maroc dans un stade embryonnaire.

Partout dans le monde, la **magie et la superstition sont plus répandues qu'on ne pourrait le croire**. L'homme d'aujourd'hui a encore plusieurs moyens de s'y livrer. La « **pensée primitive** » apparaît chez lui que se soit dans sa vie privée ou dans ses fonctions sociales. Elle se juxtapose, dans l'espace psychique, à la **pensée rationnelle**. Il suffit de certaines situations particulières ou déclenchantes d'angoisse pour que l'on assiste à de véritables échanges psychiques qui ne sont que d'éveils de penchants. Un individu a beau être intelligent, intellectuel et adapté à toutes les exigences rationnelles de la vie et en même temps, croit ou pratique les charmes magiques dans des occasions particulières : jeux du hasard, roulettes, loteries, horoscopes, sorcelleries, magnétismes, tarot, talismans, esprits, êtres démoniaques, séances de spiritisme, voyantes, médiums, désenvoûteurs, etc. **La magie n'est pas un état psychique anormal**. Elle fait partie des possibilités d'expérience de tout être humain. Il y a une participation à l'expérience qui doit être comprise non pas au sens d'une signification illusoire, mais comme d'une part prise par tous les membres d'une société culturelle. **La « pensée magique » canalise les anxiétés de l'individu et de la communauté**. C'est une nécessité sociale qui est là où il y a absence d'institutions suffisantes et susceptibles de mieux canaliser les tensions individuelles et de protéger contres les différents troubles. Les sociétés nord africaines, dans l'espace du Tiers Monde, auront tendance à se primatiser et à replier sur les structures traditionnelles. Ce recours n'est pas sans comporter des dangers indéniables.

La raison et les connaissances scientifiques ont bien leur limites dans un espace et dans une époque donnée. **L'espace thérapeutique, avec toutes ses méthodes et ces courants qui se balancent entre le surnaturel et le rationnel, est appelé continuellement à être dépassé lorsque l'on serait avancé et aurait appris à mieux combattre l'ignorance et les craintes qu'on a vis-à-vis de la nature**.

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## حوار مع البروفسور عبد الستار إبراهيم : " سنوات الحصاد في الإبداع وعلم النفس" أجرى الحوار : ماجد غالب كامل

ببريد إلكتروني : [dribrahm@kfupm.edu.sa](mailto:dribrahm@kfupm.edu.sa)

تبقى قضية الإبداع قضية حيوية وهامة لأنها قضية الإنسان الذي يصنع و يكتشف ويضيف . يصنع الحضارة ويضيف لحياتنا بعدا جديدا ويكشف معان أعمق وإجابات مبكّرة لما نخطبنا من مشكلات وأسئلة . ويبقى المبدعون وإنتاجهم الثروة الحقيقية لأي أمة تريد النهوض بنفسها وأبنائها . ويعد علم النفس من العلوم الأساسية التي تناولت ظواهر الإبداع بالبحث والتحليل ، ويعد الدكتور عبد الستار إبراهيم من العلماء المتخصصين المعاصرين في علم النفس في الوطن العربي ، ممن أثروا بدراسة هذا الموضوع سواء من حنت حجم كتاباته ، ومن حيث رؤيته الفريدة والرائدة لظاهرة العلاقة بين الإبداع والمرض النفسي . و سنضيف في هذا الحوار عن الإبداع الأستاذ الدكتور / عبد الستار إبراهيم أستاذ العلوم النفسية واستشاري الصحة النفسية والعلاج النفسي بالمركز الطبي التابع لجامعة الملك فهد للبترول والمعادن ، والذي اهتم بدراسة ظاهرة الإبداع وقضاياها ومفاهيمه منذ وقت مبكّر وكان بعد سفره إلى الولايات المتحدة الأمر بكتابة وإقامته هناك لفترة طويلة ابتعد قليلا عن الاهتمام بموضوع الإبداع ولكنه يعود مجددا ومضيفا حول هذا الموضوع وثلثي معه هذا اللقاء لتلقى الضوء حول الكثير من قضايا الإبداع ومشاكله .

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## حوار مع هانس تومسي

## أجرى الحوار : توماس براتش

ترجمة : أ.د. سامر رضوان - علم النفس - عمان / سوريا

بريد إلكتروني : srudwan@hotmail.com

ولد هانس تومسي Hans Thome في عام 1915 لأب كان يعمل في الجمارك في مدينة فيسكل في باير في ألمانيا، كان أساتذاً لعلم النفس في جامعات إن لانغن و بون. و تصنف دراساته الإمبريقية، ومن بينها التحليل الكيفي والكمي لسنتي آلف سيرة ذاتية مستقصاة، بالثنوع المضموني و قنفا من الحياة الواقعية وأهميتها العملية. حظي هانس تومسي، الذي شغل لبعض الوقت رئيس الجمعية العالمية للنمو السلوكي International Society for behavioral Development، والجمعية العالمية لعلم الشيخوخة International association of Gerontology، بشهرة عالمية وتخصيصية بشكل خاص من خلال دراسة بون الطولية التي بدأت عام 1965 للشيخوخة، التي استمرت حتى ثمانينات القرن العشرين. فإذا كان المرء في السابق يربط بين الشيخوخة والمرض و الفقدان و التقييد، فإنه من خلال هذه الدراسة تمركزت بؤرة الاهتمام على الإنسان المتقدم في السن الفاعل الواعي بالصحة و طول الحياة و القادر على التعلم.

يمثل تومسي أجيالاً عدة من علماء النفس وعلماء الشيخوخة. ومن طلابه الباكريين أومرسولا لير Usula Lehr، التي أصبحت فيما بعد وزيرة الخادبة للشباب والأسرة والمرأة و الصحة، وفرانس فاينرت المديرة اللاحق لمعهد ماكس بلانك لأبحاث علم النفس. ومن بين أكثر من 300 منشور لتومسي هناك كتب مثل الشخصية (1951)، الإنسان في القرام (1960)، الفرد وعالمه (1986)، علم النفس في المجتمع المعاصر (1977)، وعلم النفس في الحياة اليومية (1991: بالاشتراك مع أومرسولا لير)، والطرق البيوغرافية في العلوم الإنسانية (1999: بالتعاون مع غورد بونمان). ويصدر له هذا العام بالتعاون مع أومرسولا لير علم نفس الشيخوخة بطبعة منقحة كلية و جديدة. ولا يرتبط كلا باحثا الشيخوخة في التخصص فحسب وإنما زواجياً كذلك: ففي عام 1998 تزوج كل من هانس تومسي وأومرسولا لير.

يعد هانس تومسي واحداً من جدود علم النفس الألماني. فعالم نفس الدوافع و باحث السيرة الذاتية (Biography) في علم نفس الشيخوخة بلغ في 31 نوز (يوليو) عام 2000، خمس وثمانون سنة. و حول حالة حرفته ما زال العالم غير المرشح دائماً و الدائب النشاط حتى الآن غير مراض - بالمقابل فهو سعيد حول شخصه.

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## قراءة نفسية في الفكر الاستشراقي

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إن كل خلية من خلايا الجسر البشري تحمل في طياتها برناجاً وراثياً معتداً هو بمنزلة التراث البيولوجي - الوراثي للشخص صاحب الخلية. من هنا كان اهتمام الأطباء بمعرفة العوامل الوراثية المؤثرة في صحة مرضاهم. بل بعض الأطباء النفسيين يصرون على تخليد "شجرة العائلة الوراثية" لمرضهم. وفي طليعة هؤلاء العالم المجري ليوبولد سوندي يبنّي نظريته على أساس هذا الخليد. ويوضح لنا مدى جاهل الإنسان لتراثه وجهله له من خلال اختبار يمثّل سؤال واحد هو التالي: "كم تعتقد يبلغ عدد أسلافك خلال 20 جيلاً؟".

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## الحجاب وشرعيته في بلد علماني - فرنسا ( من منظور التويل النفسي )

أ.د. عدنان حبه الله - رئيس المركز العربي للأبحاث النفسية والتحليلية / لبنان

بـريد إلكتروني : [ahabalah@idm.net.lb](mailto:ahabalah@idm.net.lb)

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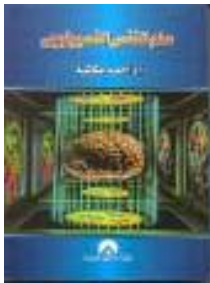
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**علم النفس الفيزيولوجي**  
أ.د. احمد عكاشة - مصر



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**الحرب النفسية على العراق**  
أ.د. محمد أحمد النابلسي - لبنان



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## وهم اللاوهم ... الوهم الأكبر

أ.د. يحيى الرخاوي - أستاذ الطب النفسي / مصر

بريد إلكتروني: [yehia\\_rakhawy@hotmail.com](mailto:yehia_rakhawy@hotmail.com)

كنت مسخرًا في قراءة هذا الكتاب «وهو مترجم بأناقة ودقة بالعنبرين (د. فاطمة نص) ضمن سلسلة إصدارات «سطور». وفي نفس الوقت كنت أقوم بهما ثلاث أربطت بالصدفة. هذا الملف الذي بين أيدينا في هذا العدد.

المهمة الأولى عن «مفهوم أحدث للصحة النفسية» مما دعاني إلى إعادة مواجهة الأوهام التي يربطها المخدوعون من العلماء من ضحايا شركات الدواء عن علم اسم السعادة، والتي تسوقها مراكز أبحاث لترويج البلاة تحت عنوان الصحة، الأمل الذي يستلزم أن تُبَّع مع عقول الأطباء لتكون مهمتهم الأولى هي ملء خزانة تلك الشركات (الثانية بعد شركات السلاح في تسيير السياسة في العالم).

المهمة الثانية فكانت دعوة لتطبيق «المنهج العلمي في الحياة اليومية» حيث أعدت اكتشاف الأوهام المحيطة بتقليد كبير مما يسمى بالمنهج العلمي.

المهمة الثالثة فقد استلزمت مراجعة التاريخ الأحدث بما يسمى «العلم المعرفي» الذي أعلن هر طقنين متالينين اعترفاً تأخيراً في «دين التفكير المنطقي الخطي الرمزي»، وكذلك في: «دين العقل الوصي الظاهر (المرطقة الأولى: التفكير ليس بالموز فحسب. والمرطقة الثانية: المعرفة ليست فقط في الدماغ. تعبير هرطقة ليس من عندي).

هكذا وجلتني محاصراً بعدد من الأوهام الحديثة، أعرف من أيها أبداً. غير أنني فجأة نظرت في أوهامي الشخصية، فأنهت إلى حقي في التمسك بها رغم كل شيء!! ما الحكاية؟ من هنا جاءت فكرة المقال.

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## PASSION FOR vs. PASSION AGAINST

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Since psychiatrists and psychologists are involved primarily with the way humans think, feel, and behave, they are often called upon to explain "strange behavior." Explaining "strange," "abnormal," "extraordinary," or even "bizarre" behavior of a single individual is complex enough; explaining the strange, abnormal, extraordinary, or bizarre behaviors of a whole group involve a much greater complexity. In looking at group behavior, psychiatrists and psychologists find common ground with philosophers, sociologists, political scientists, historians, anthropologists, and many others. We can run away from politics but we can't hide. Even the behavior of a single human being is influenced significantly by it.

There have been periods in history in which there was tribalism, religious fervor and communion, and nationalism. All has their advantages and disadvantages. The advantage was mainly in the form of group security and positive evolutionary impact to improve survival of the "in" group, and thwart dangers from the "out" group. The disadvantages were along the line of pride and prejudice getting married in a fatal matrimony. Pride in the "in" group affiliation was understood as prejudice against as the "out" groups by the narrow minded.

Xenophobia and hatred of outsiders was misunderstood as a necessary outcome for pride in one's own identity. The silent majorities were hijacked by the fanatic minorities who were plagued by insecurity and hatred. We somehow forgot that every fellow human has the right to proud of whom they are and what they are as we are entitled to that right. For a long time Arabs have concerned themselves with-even defined themselves by- what they are against, not by what they are for. The silent majority stood helpless to stem the tide of misdirected passions. The passion for one's identity became a passion against another's identity. The White Man's pride in being white translated by some distorted logic into hatred of non-whites. The Black's passion for being black became passion against non-blacks, and so on. The Moslem's pride in being a Moslem became a passion against non-Moslems, the Jew against gentile, Christian against non-Christian, and so on.

Nationalism and ultra nationalism translated into hatred of others from other nationalities. We have seen through the centuries fellow humans subjugating other humans and nations, usurping resources and practically enslaving other humans.

This seems to be the age of the long list of "Anti's" as many as there are races, ethnicities, religions, nationalities, or even tribes in this world. Even tribal fervor has reached the level of madness and mass murder even in the confines of the same nation such as Hutu against Tutsi and vice versa.

We have created Gods and killed fellow humans under their banner, and we continue to do so. We draw lines on maps,

called them borders of nations then we killed fellow humans to worship those lines on the maps.

It seems that our grandiosity has no bounds. We still insist that we are superior to others. We sometimes quote the scriptures to assert that divine privilege.

We even placed monetary value on the lives of fellow humans: some African child's life not worth more than pennies to save and one other rich man's life cost millions to save. The balance sheet of morality is a disgrace to our humanity.

Long ago we-humans-complicity decided that we are much superior specie to all other fellow species of animals and plants combined. We insisted that it is our divine right to use and abuse every living and non living entity on this planet.

Why not? Did not God itself give us that right?

We pride ourselves on the wisdom of the modern human. We boast about how rational we have become through science and technology. As the world marches into the second millennium, one would hope that a new and more complex identity would emerge which could be described as the "international citizen" identity. This identity is not only forged by the tide of globalization in its economic sense, but through the complexity of cultural influences across national, religious, ethnic, and even language boundaries. The international citizen concerns himself or herself with the affairs of the planet or a region of the planet.

We have failed the planet. We have grabbed our "privilege" and made it into a "God-given" right we have. We conveniently forgot the responsibility attached to that privilege. Looking at planet earth with a powerful telescope what would an extraterrestrial intelligent being think? It sees revenge and counter-revenge; we really came a long way since our cave-man ancestors!!

If all the millions-if not billions-of humans who gave their lives through the ages were resurrected today, what would they think? What are we to tell them as to why they gave the ultimate sacrifice for? Are we to tell them, "The world is a better place because of your sacrifices?" Who is to judge that? Are we lying to them?

Was all that death and mayhem to improve upon the lives of a particular group of humans on this earth worth it? Could it have been avoided? We will never know. Can we prevent it in the future? We'll have to see.

The extraterrestrial intelligent being would ask in bewilderment: "Who is the decision makers on this lonely planet?" "Is there a sign of intelligent life?"

## In defense of words

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1- Some say "Actions speak louder than words," others say "The pen is mightier than the sword." In a world of extremes, dichotomies rule supreme. We often have to remind ourselves that words lead to action and action leads to words. They seem eternally wedded. The teacher tells the first grader: "No hitting, use your words." Words are effective means to express anger and frustration. Mind you, words can hurt as much as hitting, or even more. My Iranian friend-an ER Doctor-teases me all the time by saying playfully: "You Arabs, all you do is talk...talk...talk, and you do nothing." Well, we can do both. It does not have to be the false either/or logic.

2- The power of words can be easily appreciated if one asks one's self the following question: "Other than the Iliad and the Odyssey what do I know of Homer's actions?" "Other than Plato's words what do I know of his actions?" It was not the actions of Mr. Siddhartha Gotama that made him the Buddha; it was his words-still influencing more than 2 billion men and women, if not all humans. The examples are as many as there are books worth reading on this earth. It is no surprise that a thinker's words are often called his "works." It is no coincidence that "word" and "work" differ only in their last letter.

3- The Vedas, the Upanishads, the Mahabharata, the Enuma Elish, Gilgamesh, the Code of Hammurabi, the Iliad and the Odyssey, the Talmud, the Torah, the Bible, the Qur'aan, the Kitab-i-Aqdas, etc. were words; I doubt than many will call them "just words!" The scriptures-despite being "words-" have shaped and continue to shape the minds and behaviors of almost every human being on this planet past, present, and most likely future.

4- The dichotomy of "words" vs. "action" is a false dichotomy (just like most dichotomies). I don't believe that "words" and "action" are opposites. I submit to you that "words" and "action" almost always co-exist. Before we set out to do or achieve something, we, hopefully, will engage in some form of planning. Planning involves ideas yet to be realized-ideas that must be communicated to others if anything is to happen-unless one thinks that he or she will single handedly do everything in person to get something done. Collective effort is impossible without communication. Planning and execution are insoluble. Good execution requires good planning as much as planning without execution becomes useless.

5- Language is mostly words. "Nations" were born out of a common language. The terms "Arab" and "Arabic" are almost always used to refer to someone or something related to the Arabic Language .

6- Words and "just words" have started wars and ended them. This can't be truer than in the Arab world through the ages. A poem in the not so distant past could have triggered tribal feuds and resulted in many lives lost. Another poem would have resulted in many lives saved. The Imam on the podium can inflame youth to kill or can calm emotions to prevent bloodshed, just by using his words.

7- Education is our best defense against the universal enemy of ignorance. Education would be almost impossible

without books full of words.

8- Even if thinkers such as Socrates, Plato, and Aristotle have not lifted a finger, they would have influenced humanity as much as they did and still do .

9- The term "Talk Therapy" is used by many in reference to Psychotherapy, especially Psychoanalysis. Since it is true that psychotherapies involve quite a bit of talking (there are other important aspects not involving talking or words) but mostly it is true that exchanging words is the single most important aspect of psychotherapy. "Talk therapy" is a simple yet descriptive enough term to have some usefulness. The words exchanged are not "just words," they are ideas, concepts, emotions, etc. that hopefully result in behavioral change.

10- Out of all our modes of communication, language may be the most important. Whether spoken or written, language has marked the beginning of history as we know it. Everything about our humanity before language is considered "prehistory." "Written words" started in Mesopotamia, our present day beloved Iraq. Since we designed symbols to refer to "words" we started having access to other people's thoughts and minds through their words. I can feel the presence of a long ago deceased thinker when I am reading his or her "words".

My very own ideas are not truly mine, they are the amalgamation of all the words I have read and heard, the words of deceased masters and the words of living family, friends, my patients, my teachers, co-workers, and even the stranger that I had a few minutes 'conversation with without ever knowing his or her name.

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## الرهاب الاجتماعي عند العرب

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أ.د. فيصل الزراه - علم النفس / الإمارات : برید إلكتروني : [drzarad@adnph.com](mailto:drzarad@adnph.com)

### و آخرون

يعتبر الرهاب الاجتماعي (الخوف الاجتماعي المرضي أو القلق الاجتماعي المرضي) اضطراباً نفسياً واسع الانتشار (1، 8). وتصل نسبة انتشاره إلى 7-14 بالمائة في المجتمعات الغربية، وغيرها (1، 8، 13). وهو اضطراب مزمن (5) ومعطل (1، 13) ولكنه قابل للعلاج (4). وهو يظهر عند الإناث والذكور بنسبة 2 إلى 1 (13) ويظهر عادة في سن الطفولة أو المراهقة (13) وهو يترافق مع اضطرابات القلق الأخرى ومع الاكتئاب (13) كما يمكن أن ينشأ سوء استعمال الكحول والمواد الإدمانية في بعض الأشخاص الذين يعانون من معالجة أعراض خوفهم بالكحول أو المواد الإدمانية (15). ويضمن اضطراب الرهاب الاجتماعي قلقاً شديداً وارتباكاً في المواقف الاجتماعية. ويعاني المصابون به خوفاً شديداً مزمناً من أن ينظر الآخرون إليهم وأن يبتلعوا عليهم أحكاماً وتقييمات سلبية. وأيضاً يخافون من أن تسبب أعمالهم وتصرفاتهم إحراجاً لهم أو خزيًا. ويمكن لهذا الخوف أن يكون شديداً لدرجة أنه يتدخل في الأداء المهني أو الدراسي أو النشاطات الاعتيادية الأخرى للمصاب به. وعلى الرغم من أن كثيراً من المصابين بالرهاب الاجتماعي يشعرون بأن خوفهم المرافق لاجتماعهم بالآخرين هو خوف مبالغ فيه وغير منطقي، فهم لا يستطيعون التغلب على هذا الخوف، وغالباً ما يفتقرون لأيام أو أسابيع قبل حدوث الموقف المخيف. ويمكن للرهاب الاجتماعي أن يكون محدوداً بنوع واحد من المواقف مثل الخوف الشديد من الحديث أمام الآخرين أو تناول الطعام أو الشرب أو الكتابة أمام الآخرين. وفي الحالات الشديدة يكون الخوف مزمناً حيث يعاني المريض من أعراض الخوف والقلق في كل الأوقات التي يكون فيها مع الآخرين. ويمكن للرهاب الاجتماعي أن يكون معطلاً وأن يمنع المصاب به من الذهاب إلى العمل أو المدرسة لعدد من الأيام. وكثير ممن يعانون من الرهاب الاجتماعي يتضون وقتاً صعباً في ابتداء الصداقات أو المحافظة عليها. وغالباً ما يرافق القلق والنورس النفسي أعراض القلق الجسمية مثل احمرار الوجه والغرق الزائد والرجفة والغثان وصعوبة الكلام... ومن يعاني من هذه الأعراض الجسمية فإنه سوف يشعر بالإحراج الشديد منها وهو يشعر أن كل العيون تتركز عليه وتنتظر إليه. وربما يصبح فيما بعد في الحالات الشديدة خائفاً من أن يجتمع مع أشخاص آخرين غير أسرته..

يمكننا القول بشكل عام أن هذا الاضطراب المزمن يعطل الفرد وطاقاته في مجال السلوك الاجتماعي فهو يجعله منسحباً متعزلاً خائفاً لا يشارك الآخرين ولا يستطيع التعبير عن نفسه كما أن أداءه المهني أو الدراسي أقل من طاقاته وقدراته. ويضاف إلى ذلك أن المعاناة الشخصية كبيرة والمصاب به يتألم من خوفه وقلقه ونقصه وهو يصاب بالاكتئاب وأنواع من القلق والسلوك الإدماني... وغير ذلك. وترتبط أسبابه بعوامل وراثية وعائلية وعوامل تربوية وسلوكية ونفسية واجتماعية (11، 5) وله علاجات دوائية فعالة وعلاجات نفسية مفيدة مثل العلاج السلوكي والمعرفي وتنمية المهارات (6). وتدلل بعض الدراسات في العالم العربي إضافة للملاحظات العيادية أن هذا الاضطراب واسع الانتشار في مجتمعاتنا العربية.. وتصل نسبة المصابين به من مرضى العيادات النفسية إلى حوالي 13% من عموم المرضى (12، 17). والحاجة كبيرة في مجتمعاتنا إلى إجراء الدراسات العلمية حول هذا الاضطراب للتعرف على انتشاره وملائمه وارتباطاته بعوامل تربوية واجتماعية وعيادية متنوعة.. ويبدو أن إجراء دراسة عبر شبكة المعلوماتية (الانترنت) شيق وجديد.. حيث يمكن الوصول إلى شراخ واسعة من الجمهور العربي في أماكن مختلفة ومباعدة وإجراء الدراسة بسهولة نسبية.. ومن ثم الحصول على معلومات مفيدة يمكن تحليلها ومناقشتها واستخلاص النتائج العملية منها.. مما يمكن له أن يفني همنا لهذا الاضطراب وما يرتبط به من مشكلات متنوعة وبالتالي المساهمة في وضع الحلول المناسبة معها.. وأوها نشر الوعي النفسي ورفع مستواه مما يزيد في تحديد الحالات والتعرف عليها وبالتالي علاجها (14)، وأيضاً زيادة الاهتمام بالخدمات النفسية على مختلف أنواعها ودعمها لتلبية الحاجات المتزايدة للجمهور من النواحي العلاجية والثقيفية والوقائية، وغير ذلك.

اعتمدنا في إعداد الاستبيان الخاص بهذه الدراسة على عدد من المراجع الحديثة (3، 7، 10، 16، 9، 3) وعلى خبرتنا العيادية. ويضمن الاستبيان عدداً من المقاييس العالمية التي تجيب عليها المتحوص، وقد أضفنا عدداً من النقاط التي تتناسب مع بيئتنا العربية (17)، إضافة لعدد من الأسئلة التي ترتبط بتحديد الشخيص وأسئلة تتعلق باستعمال شبكة المعلوماتية، وغيرها..

تسراً مشاركة الجميع في هذه الدراسة وبأمل تعاون الأخصائيين والأطباء النفسيين في مختلف البلدان العربية بإجراء الاستبيان على عينته من مرضى الرهاب الاجتماعي (المزيد الإسترشاد الاتصال بالذكور حسان المالم).

ملاحظة: يمكن المشاركة في هذا الاستبيان كل من كان بين 15-54 سنة.

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**نموذج الإجابة على الاستبيان**

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Dates to Remember	DESCRIPTION	How to Contact Us
July 1, 2004	Deadline for submission of proposals Symposia, Workshops and Courses	<b>Important Addresses</b> Please address all correspondence concerning the congress to: ☆ XIII World Congress of Psychiatry Scientific and Technical Secretariat <b>TILESA OPC, S.L.</b> c. Londres, 17 - 28028 Madrid (Spain) Tel.: +34 913 612 600 Fax: +34 913 559 208 e-mail: <a href="mailto:secretariat@wpa-cairo2005.com">secretariat@wpa-cairo2005.com</a> ☆ Travel Agent <b>EMECO Travel</b> Accommodation, Tourist Services e-mail: <a href="mailto:accommodation@wpa-cairo2005.com">accommodation@wpa-cairo2005.com</a> For the latest information, please visit our web site: <a href="http://www.wpa-cairo2005.com">http://www.wpa-cairo2005.com</a>
November 1, 2004	Deadline for submission of Abstracts for Lectures, Papers and Posters	
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## المركز العربي للأبحاث و التحليل النفسي

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بريد إلكتروني: ahabalah@idm.net.lb

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## 1<sup>ER</sup> CONGRES DES PSYCHANALYSTES DE LANGUE ARABE ANAFS DANS LA TRADITION ARABE ET LA PSYCHANALYSE

LIBAN - BEYROUTH 20-23 MAI 2004

## المؤتمر الأول للمحللين النفسانيين الناطقين بالعربية النفس في التقاليد العربية و علاقتها بالتحليل النفسي

لبنان - بيروت 20-23 ماي 2004

### Argument du Congrès

L'université Saint Joseph de Beyrouth ( faculté des lettres et sciences humaines) et le Centre Arabe des Recherches Psychanalytiques et Psychopathologiques ont le plaisir de vous inviter à participer au Congrès ayant pour thème le problème de l'âme ( An-nafs) chez les arabes et son rapport avec les concepts psychanalytiques et qui constituera un lieu et un temps de rencontre de la culture arabe avec le champ de la psychanalyse.

Cette manifestation scientifique sera l'occasion pour chacun de nous de poser des questions relatives soit à la pratique soit à la méthode psychanalytique en tant que pensée appelée à trouver sa place dans la culture arabe. De fait, la psychanalyse a commencé à exister progressivement dans les pays arabes, même si, jusqu'à présent, la majorité des psychanalystes arabes est toujours installée en Occident, notamment à Paris. Le discours psychanalytique s'avère déterminant dans trois champs :

1) Le champ thérapeutique : en dépit des progrès de la science moderne, notamment les neurosciences, et de la recrudescence des thérapies médicamenteuses qui en résulte, l'expérience montre avec évidence les limites de telles orientations. Celles-ci sont parfaitement inefficaces pour le traitement des causes de la souffrance psychique et de la compréhension de ses aspects psycho-dynamiques. Si la médecine prétend, par exemple, soigner la dépression, ce n'est qu'en agissant sur tel relais synaptique dans un parcours neuronique. Elle reste incapable de répondre à la question suivante : comment un signifiant précis a-t-il pu être à l'origine d'un état dépressif ? Le système nerveux central possède certes des aires cérébrales dont l'activité peut être modifiée à l'aide de drogues, mais cela ne révèle rien des éléments de réponse au sujet de l'origine des troubles psychopathologiques ; d'ailleurs les effets secondaires des médicaments entraînent souvent un phénomène de dépendance qui enchaîne - parfois de façon chronique - le patient et tend à amenuiser ses capacités mentales et sa créativité.

Plusieurs méthodes psychothérapeutiques ont fait leur apparition ces derniers temps sur le « marché psy » et sont devenues un objet d'offre et de consommation pratiqué par une foule d'amateurs et de profiteurs de tout genre. Et malgré une technicité apparente qui peut les rendre séduisantes, ces psychothérapies agissent essentiellement par le biais qui aliène la volonté du sujet et sa liberté .

Depuis sa découverte par Freud, la psychothérapie analytique a pu, au contraire, acquérir ses lettres de noblesse, en s'appuyant sur la révélation du refoulé, lequel est l'équivalent d'une vérité subjective et d'un savoir, qui s'ignore et que recèle toute crise psychique. L'expérience analytique nous montre que seule la mise en lumière d'une vérité refoulée - véritable source de la souffrance psychique - peut avoir une vertu thérapeutique.

2) Le champ épistémologique : avec Jacques Lacan, la psychanalyse a été introduite plus délibérément dans le champ du langage et a entrepris de questionner d'autres disciplines intellectuelles telles que la philosophie, l'anthropologie, la littérature, les arts, les mathématiques, etc. En effet, tout est signifiant, et rien n'existe en dehors de la langue. Notre langue arabe est riche en métaphores, métonymies, litotes, symboles et diverses représentations. A ce titre, elle se trouve parfaitement en conformité avec les particularités de la méthode psychanalytique.

Ce congrès sera l'occasion d'insister sur ce point, à travers l'expérience de chacun.

3) Le champ social : loin de se limiter à son champ stricto sensu, la psychanalyse est vouée, grâce à sa méthode, à élargir le champ de pensée et à permettre de problématiser les questions dont la mise en suspens - sinon le rejet - est responsable de la stagnation en matière de liberté d'expression et de démocratie dans nos sociétés. Il est clair que le fardeau de l'héritage traditionaliste, que la pensée moderne n'a pas réussi à modifier, est la cause principale de la crise intellectuelle dans laquelle les sociétés arabes se débattent actuellement.

L'ensemble de ces constats fait du discours analytique une nécessité, non seulement sur le plan thérapeutique, mais surtout au niveau de la libération de la pensée arabe à laquelle il donne l'opportunité d'une renaissance comparable à celle qui, en Occident, reçut l'appellation de Siècle des Lumières. Il nous paraît fondamental que les participants confrontent intensément leurs points de vue et partagent rigoureusement leurs expériences sur ce dernier point.

Les organisateurs ont choisi le thème de la psyché ( An-nafs) pour ce premier Congrès international des psychanalystes de langue arabe, parce que ce sujet est au centre des préoccupations de tous ceux qui se réclament de la science d'An-nafs ou des thérapeutes d'An-nafs et qu'il est temps de le définir, d'en préciser le contenu et d'en faire véritablement un sujet de la science. Depuis l'âge d'or de la civilisation arabe, penseurs et philosophes n'ont cessé, à partir d'Al Kindi, AL Farabi, Avicenne, Averroès, Ibn Arabi, Sadreddine Chirazi etc... de s'interroger sur l'essence de ce concept, et sur la définition qu'on peut lui attribuer. La majorité de ces philosophes s'est référée aux travaux de Platon et d'Aristote, sans parvenir à dissiper le malentendu et l'obscurantisme qui les entourent. Le Congrès veut ouvrir ce champs à la réflexion et à la recherche, en se référant aux concepts psychanalytiques, appuyés sur l'expérience Freudienne et Lacanienne.

Ce Congrès servira, par ailleurs, à promouvoir l'idée d'une association ou d'une société destinée à regrouper les psychanalystes arabes. Nous souhaitons donc que cette première rencontre en annonce d'autres, afin que les psychanalystes puissent échanger - via le Centre Arabe des

Recherches Psychanalytiques et Psychopathologiques et ses alliés- leurs réflexions cliniques et théoriques en prenant appui sur la langue et la culture arabes en ce qu'elles possèdent de plus singulier.

Université Saint Joseph de Beyrouth

Le centre arabe des recherches Faculté des Lettres et des sciences humaines Psychanalytiques et psychopathologiques

Responsables :

Mounir CHAMOUN  
Adnan HOUBBALLAH  
Moustapha SAFOUAN

### Le Programme /

	2004	20	
<b>Jeudi 20 Mai 2004</b>			
18h 00-18h 30 <b>Séance inaugurale</b>			: 30 18 - 18
- Mot d'accueil : Georges CORM			:
- Mot de L'USJ : Mounir CHAMOUN			:
- Mot du Centre arabe : Adnan HOUBBALLAH			:
18h30- 20h00 <b>Première table ronde</b>			:
Modérateur- discutant : Adel AKL			: 20 - 30 18
- La question de l'âme dans la tradition Chrétienne (en français) : Père Samir KHALIL s.j			:
- La psyché dans la perspective de L'ISLAM et dans la perspective philosophique (en arabe): Sayed Hassan EL AMINE			: (فرنسية) -
			: (عربية) -
<b>Vendredi 21 mai 2004</b>			
8h00-9h00 : <b>Accueil des participants</b>	2004	21	: 9 - 8
9h00-10h30 <b>Deuxième table ronde</b>			: 30 10 - 9
Modérateur- discutant : Moustafa SAFOUAN			:
- Propos sur la psyché dans la tradition arabe Entre la vision du passé et la créativité de L'avenir (en arabe) : Hussein ABDEL KADER			: (عربية) -
- Le concept de l'âme et son rapport au corps Dans la culture arabe (en arabe) : Majdi ABDEL HAFEZ			:
10h30-11h00 <b>Pause</b>			: 11 - 30 10
11h00-12h30 <b>Troisième table ronde</b>			: 30 12 - 11
Modérateur- discutant : Mounir CHAMOUN			:
- Par pitié, ne me parlez pas d'âme! (en français): François WAHL			: (فرنسية) -
- Les portes musulmanes du rêve (en français): Jean Michel HIRT			: (فرنسية) -
12h30-14h30 <b>Déjeuner</b>			: 30 14 - 30 12
14h30- 16h00 <b>Quatrième table Ronde</b>			: 16 - 30 14
Modérateur- discutant : Maha HAMMAD			:
- Le psychanalyste médiateur des âmes (en français) : Jalil BENNANI			: (فرنسية) -
- Problématique du concept de la personne et du sujet dans l'Orient arabe (en arabe) : Ahmed FAYEK			: (عربية) -
16h00- 16h30 <b>Pause</b>			:
16h30- 18h00 <b>Cinquième table ronde</b>			: 30 16 - 16
Modérateur- Discutant : Nadine KHAIRALLAH CHAKAR			: 18 - 30 16
- J'ai perdu mon âme (en français) : Marie HAZAN			:
- De l'âme en exil (en français) : Marie JAWich			: (فرنسية) -
			: (فرنسية) -
<b>Samedi 22 mai 2004</b>			
9h00- 10h30 <b>Sixième table ronde</b>	2004	22	: 30 10 - 9
Modérateur- discutant : Houda KACHROUD et Christian HOFFMAN			:
- L'âme Chez Avicenne le poète ; l'âme chez Avicenne Le philosophe (en arabe) : Khaled EL ALEJ			: (عربية) -
- La signification des liens associatifs entre les jeunes Autour du sujet et des autres (en arabe): Racha EL DIDI			:
10h30- 11h00 : <b>Pause</b>			: (عربية) -
			: 11 - 30 10 -

11h00- 12h30 <b>Septième table ronde</b>	: 30 12 - 11
Modérateur- discutant : Charles MELMAN	: /
- La réduction du sujet à son symptôme (en français) : Chawki AZOURI	: (فرنسية) -
- Le pas de la psychanalyse entre les sciences de l'âme et Les neurosciences (en français) : Elie DOUMIT	: (فرنسية) -
12h30- 14h00 : <b>Déjeuner</b>	: 14 - 30 12
14h30- 16h00 : <b>Huitième table ronde</b>	: 16 - 30 14
Modérateur- discutant : Karim GEBAILY	: /
- An-nafs et le miroir (en arabe) : Farid MERINI	: (عربية) -
- Peut-on ne pas croire à son inconscient ? (en français) : Nazir HAMAD	: (فرنسية) -
16h00- 16h30 : <b>Pause</b>	: 30 16 - 16
16h30- 18h00 : <b>Neuvième table ronde</b>	: 18 - 30 16
Modérateur- discutant et conférencier : Adnan HOUBBALLAH La division du sujet	: /
- Vous avez dit psychanalyste ? (en français) : Mohammed Fouad BENCHOUKROUN	: (فرنسية) -
- La question du sujet chez Freud et chez Lacan (en français) : Charles MELMAN	: (فرنسية) -
<b>Synthèse Finale</b> : Moustafa SAFOUAN	: -

### Dimanche 23 mai 2004

2004 23

9h00-11h00 : <b>Dixième table ronde</b>	: 11 - 9
Psychanalyse et démocratie	
<b>Intervenants – discutants :</b>	: /
- Mounir CHAMOUN	-
- Georges CORM	-
- Grégoire HADDAD	-
- Adnan HOUBBALLAH	-
- Charles MELMAN	-
- Moustafa SAFOUAN	-
Cette table ronde se retiendra à la suite de l'exposé bref de Abdallah ASKAR : La Psychanalyse de la réalité sociale arabe et la crise de la démocratie (en français)	: (فرنسية) .

### Contact

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E.mail : secrétariat du congrès : .....  
Membre du comité d'organisation :  
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23<sup>EME</sup> CONGRÈS FRANCO MAGHRÉBIN DE PSYCHIATRIESchizophrenie Et Psychoses Infantiles :  
Orientations Actuelles Et Aspects Culturels

MONASTIR (TUNISIE) 7 ET 8 OCTOBRE 2004

Association Franco-Maghrébine de Psychiatrie  
Société Tunisienne de Psychiatrie Hospitalo-Universitaire  
en collaboration avec : Société Tunisienne de Psychiatrie  
Association Tunisienne des Psychiatres d'Exercice Privé

Je suis très heureux de l'honneur que l'Association Franco-Maghrébine de psychiatrie me fait en me chargeant d'organiser cette édition du Congrès Franco-Maghrébin en Tunisie, pays d'accueil et d'hospitalité, et c'est un grand plaisir de vous inviter à Monastir où l'occasion sera certainement offerte pour joindre l'utile à l'agréable en conciliant tes fructueux échanges scientifiques aux plaisirs de la découverte d'une terre de rencontres dotée d'atouts naturels enchanteurs.

Monastir est cette coquette ville balnéaire du Centre-est tunisien, anciennement appelée Ruspina, cette ville est réputée pour la beauté de ses sites naturels et archéologiques ainsi que pour son infrastructure touristique moderne, qui font d'elle un des pôles d'attraction du visiteur en Tunisie.

Le choix du thème du Congrès «schizophrénie et psychoses infantiles, orientations actuelles et aspects culturels» veut souligner l'intérêt d'une réflexion sur l'état de nos connaissances de cette maladie mentale par excellence rencontrée dans toutes les cultures et dont l'incidence épidémiologique élevée justifie la poursuite des recherches la concernant tenant compte des progrès biologiques et thérapeutiques et de l'évolution sociale.

Dans la pléiade des thèmes qui seront débattus notre pari est double : satisfaire d'abord une palette aussi large que possible des pôles d'intérêt des participants et faire cohabiter ensuite les discours scientifiques pointus avec les enjeux de la pratique quotidienne.

Le congrès comportera des conférences plénières, deux symposia, des ateliers et des sessions de communications orales et affichées offrant l'opportunité aux psychiatres, pédopsychiatres et autres participants d'échanger leurs expériences.

Je formule le souhait que ce congrès nous aide à partager connaissances, difficultés et espoirs et j'espère que vous repartirez en emportant un doux souvenir de Monastir et également du Sud Tunisien et de l'île de Djerba dont la visite est prévue en post congrès.

Vive l'amitié Franco-Maghrébine et à bientôt en Tunisie.

Pr. Lotfi GAHA - TUNISIE

□ Comité d'organisation

Président du Congrès : Lotfi GAHA

Présidents d'honneur: Jean DALERY (France), Saida DOUKI (Tunisie), Farid KACHA (Algérie), Driss MOUSSAOUI (Maroc).

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الفصام وذوات الأطفال :

التوجهات الحالية والمظاهر الثقافية

المنستير (تونس) 7-8 أكتوبر 2004 - نزل كريات بلاص

الجمعية الفرنسية المغاربية للطب النفسي  
الجمعية التونسية للأطباء النفسانيين الاستشفائيين و الجامعيين  
بالمشاركة مع : الجمعية التونسية للطب النفسي  
الجمعية التونسية للأطباء النفسانيين بالممارسة الحرة

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### Thèmes Scientifiques

- 1- Epidémiologie de la schizophrénie et des psychoses infantiles. -1
- 2- Psychoses infantiles - problèmes nosographiques. -2
- 3- Actualités dans l'étiopathogénie de la schizophrénie. -3
- 4- Vulnérabilité à la schizophrénie et aux psychoses infantiles -4
- 5- Exploration neuro cognitive -5
- 6- Génétique des psychoses infantiles et de la schizophrénie -6
- 7- Culture et expression clinique des psychoses -7
- 8- Schizophrénie et troubles des conduites -8
- 9- Schizophrénie et dépression -9
- 10- Société, famille, stigmatisation et psychoses -10
- 11- Schizophrénie : expression du passage d'une culture collective à une culture individuelle ? -11
- 12- Schizophrénie et qualité de vie -12
- 13- Evolution à long terme et concept de guérison dans la schizophrénie -13
- 14- Des neuroleptiques aux anti psychotiques -14
- 15- Aspects culturels de la prise en charge des psychoses -15
- 16- Prescription des anti psychotiques atypiques -16
- 17- Du traitement du 1<sup>er</sup> épisode psychotique à la prévention des rechutes -17
- 18- Particularités de la prise en charge ambulatoire des patients schizophrènes -18
- 19- Observance des traitements dans la schizophrénie -19
- 20- Prévention de la schizophrénie -20

### Ateliers de travail

**Atelier 1:** La prise en charge des enfants autistes, quelle est la part de la chimiothérapie, de la psychothérapie et de la rééducation ?

**Atelier 2:** Schizophrénie et troubles bipolaires : cousins germains ou parents lointains ?

**Atelier 3 :** Les conduites addictives dans la schizophrénie

**Atelier 4 :** Prise en charge psychosociale de la schizophrénie

**Atelier 5 :** Les neuroleptiques classiques ont-ils encore une place dans le traitement de la schizophrénie ?

### Ateliers

#### Atelier 1: La prise en charge des enfants autistes, quelle est la part de la chimiothérapie, de la psychothérapie et de la rééducation ?

Les approches thérapeutiques de l'autisme sont fort nombreuses, fondées ou non sur des bases empiriques prouvant leur efficacité.

Un consensus semble acquis quant à la nécessité d'une intervention précoce, d'une approche multidisciplinaire, de l'importance d'une forte implication de la famille et du maintien d'un cadre éducatif favorisant les apprentissages. Mais par delà ces lignes directrices, la prise en charge varie de pays en pays, voire de région en région, créant une inégalité face au système de soins, s'ajoutant à celle inhérente aux moyens matériels et humains.

Ainsi, la chimiothérapie semble de moins en moins limitée à une visée symptomatique pour réduire les troubles du comportement les plus gênants. Des pistes physiopathologiques orientent vers un dysfonctionnement sérotoninergique avec des effets thérapeutiques obtenus avec les ISRS et la fenfluramine, ainsi que vers certaines carences comme en témoigneraient l'efficacité des traitements supplétifs en vitamines ou en sécrétine.

Le noyau dur de la prise en charge, centré sur un abord éducatif et psychothérapeutique, demeure fortement dépendant des modèles théoriques de compréhension du trouble, d'où de grandes disparités des pratiques. Elles vont des méthodes comportementales, très répandues en Amérique du Nord, aux techniques d'apprentissage de la communication sociale issues de la théorie de l'esprit, en passant par les approches d'inspiration analytique, fortement ancrées en France et au Maghreb, se réalisant dans un cadre duel, familial et surtout institutionnel (hôpital de jour, centre spécialisé). L'approche corporelle est souvent au centre de la thérapie avec de multiples techniques psychomotrices entre rééducation et psychothérapie. L'indication d'une rééducation du langage est fréquente, mais là aussi selon des méthodes différentes.

L'atelier offrira aux participants l'occasion de confronter leurs expériences selon les orientations et les contraintes de chacun et permettra aussi aux thérapeutes maghrébins, souvent en position de pionniers, de discuter des meilleures options à prendre compte tenu de leur contexte socio-économique

#### Atelier 2 : Schizophrénie et troubles bipolaires : cousins germains ou parents lointains ?

La schizophrénie et les troubles bipolaires semblent partager un certain nombre de caractéristiques communes : des symptômes tels que le délire, les hallucinations et la dépression peuvent survenir dans les deux affections. Des anomalies structurales au niveau de l'hippocampe (SNC) peuvent être constatées chez des patients présentant l'une ou l'autre de ces pathologies. De même, une susceptibilité génétique commune a été mise en évidence par des études familiales. Cependant, la schizophrénie et les troubles bipolaires répondent différemment aux traitements psychotropes. De plus, ils ne présentent pas le même profil évolutif au long cours.

Cet atelier se propose d'élucider si la schizophrénie et les troubles bipolaires sont

- Soit deux entités distinctes
- Soit des expressions cliniques différentes d'un même processus étiopathogénique.
- ou les extrêmes d'un même continuum, dans lequel les troubles schizo-affectifs occupent une position intermédiaire.

En définitive, cette thématique suscite une riche discussion, à la quelle vous êtes conviés en participant à cet atelier.

**Atelier 3 : Les conduites addictives dans la schizophrénie**

Les conduites addictives dans la schizophrénie sont fréquentes et font référence à un ensemble de conduites spécifiques qui vont du tabagisme à la consommation de drogues illicites. Cette comorbidité a fait l'objet d'innombrables travaux au cours des dernières décennies et constitue un terrain de recherche fertile et prometteur pour l'amélioration de la prise en charge des malades schizophrènes.

Cet atelier se propose d'aborder un certain nombre de questions soulevées par les travaux consacrés à ce sujet:

- Quelle est l'influence de la consommation de toxiques sur le déclenchement et le cours évolutif de la maladie?
- L'addiction à un toxique et la psychose représentent-elles des comorbidités distinctes ou existe-t-il des facteurs de risques neurobiologiques communs?
- Quel lien existe-t-il entre les anomalies neurobiologiques en relation avec l'addiction et celles en relation avec la psychose ?
- Les effets secondaires des médicaments sont-ils susceptibles d'induire une appétence pour certains toxiques?
- Existe-t-il des stratégies de prise en charge des conduites addictives spécifiques à la schizophrénie?

Toutes ces questions, malgré une littérature abondante ne sont pas encore résolues et ne manqueront pas de susciter un débat intéressant pour les participants

**Atelier 4 : Prise en charge psychosociale de la schizophrénie**

La prise en charge psychosociale prend une place de plus en plus importante dans la stratégie thérapeutique de la schizophrénie. Elle vise le maintien du patient schizophrène dans la communauté en lui offrant un système de soutien extra-hospitalier qui dépend de plusieurs facteurs socio-culturels et économiques et de la politique sanitaire du pays. Dans les pays du Maghreb, cette prise en charge est tenue à se développer. Elle est partagée entre, d'une part, le modèle occidental qui s'appuie sur des structures de soins hospitalières et intermédiaires développées et d'autre part, le modèle traditionnel basé sur le soutien familial et communautaire.

Les mutations socioculturelles du Maghreb évoluent rapidement vers l'occidentalisation et poissent les intervenants en santé mentale à adopter les deux modèles de prise en charge psychosociale des schizophrènes, mais aussi à développer un système de soins adapté à leur réalité culturelle, sociale et économique.

Cet atelier se propose de discuter ces différents aspects au vu des expériences occidentales et Maghrébines en matière de prise en charge psychosociale des patients

**Atelier 5 : Les neuroleptiques classiques ont-ils encore une place dans le traitement de la schizophrénie ?**

Découverts en 1952, les neuroleptiques avaient constitué le point de départ de la psycho-pharmacologie moderne, transformé radicalement les conditions d'exercice de la psychiatrie et s'étaient imposés comme traitement de choix, à court et à long terme, des troubles schizophréniques.

Cependant, malgré l'avènement de plusieurs familles chimiques de neuroleptiques

- la résistance au traitement concernait 20 à 30% des patients
- les symptômes «négatif», ou déficitaires étaient peu améliorés par le traitement et la multitude des effets indésirables participait à la stigmatisation des malades, diminuait l'observance thérapeutique et altérait la qualité de

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vie des patients.

L'évolution des connaissances et les progrès de la recherche ont permis de développer de nouvelles molécules plus efficaces et mieux tolérées avec la découverte des antagonistes DZ et 5-HT2 .

L'avènement de ces nouveaux antipsychotiques a permis d'aspirer à une capacité fonctionnelle supérieure du patient ainsi qu'à une diminution des effets nocifs de la maladie et des traitements.

Cet optimisme thérapeutique repose sur les multiples avantages de ces molécules : une incidence moindre d'effets extra-pyramidaux, une efficacité supérieure sur les symptômes négatifs, une réduction des symptômes dépressifs, et une amélioration des fonctions cognitives.

Aussi, différentes conférences de consensus recommandent l'emploi des nouveaux anti-psychotiques en première intention dans le cadre des troubles schizophréniques.

Cet atelier fera le point sur les consensus actuels dans le traitement chimiothérapeutique des schizophrénies, et discutera les pratiques de prescription en fonction de l'évolution des idées et des connaissances, des habitudes culturelles locales et des réalités économiques nationales.

Contact

Les résumés pour des communications orales ou affichées doivent parvenir avant la date du 31 juillet 2004 à l'adresse suivante : Pr. L. GAHA, Service de Psychiatrie, Hôpital Universitaire Fattouma Bourguiba, 5000 MONASTIR, TUNISIE.

Tél : 00216 73 461 965 - Fax : 00216 73 460 678
Email : gaha.lotfi@ms.tn

Pour tout autre renseignement, contacter Mme -Mongia Fendri, Agence Haouala Travel, Tbaka. Skanes, 5000 Monastir.

Tél/Fax : 00216 73 502 103 - GSM : 00216 22 876 830
Email : mongia.fendri@poste.net

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## طرائق و منهجية البحث في علم النفس

شركة المطبوعات للتوزيع و النشر - الطبعة الأولى 2003

د. فاروق مجذوب - علم النفس - لبنان

بـريد الـكتروني : [FMAJZOUB@cyberia.net.lb](mailto:FMAJZOUB@cyberia.net.lb)

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" إذا كان هناك من شيء لا نستطيع غفرانه للرئيس السابق صدام حسين فهو أنه حولنا طوال سنوات حكمه إلى شعب من المنافقين، لكل واحد فينا ألف وجه و وجه و ليس من السهل أن يميز المرء بسهولة الحقيقي من المزيف " ( )

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## GENERALIZED ANXIETY DISORDER (GAD)

### ▪ POOLED ANALYSIS OF VENLAFAXINE XR EFFICACY ON SOMATIC AND PSYCHIC SYMPTOMS OF ANXIETY IN PATIENTS WITH GENERALIZED ANXIETY DISORDER.

*Authors* : Meoni P, Hackett D, Lader M. - Wyeth Research, Paris, France.

*Source* : *Depress Anxiety*. 2004;19(2):127-32.

*Summary* : We evaluated the relative efficacy of venlafaxine XR on the psychic versus somatic symptoms of anxiety in patients with generalized anxiety disorder as determined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Data were pooled and analyzed from 1,841 patients with generalized anxiety disorder who participated in five short-term (8-week) double-blind, multicenter, placebo-controlled studies, two of which had long-term (6-month) extensions. Somatic and psychic anxieties were studied using the Hamilton rating scale for anxiety (HAM-A) factor scores. We examined response rates (> or =50% improvement over baseline severity score) in the overall population and in patients with mainly somatic symptomatology at baseline (somatizers). Venlafaxine XR significantly reduced factor scores for both psychic and somatic HAM-A factors compared with placebo, from the first and second weeks of treatment, respectively. Patients treated with venlafaxine XR had significantly higher rates of response than patients receiving placebo on the psychic (58% vs. 38%,  $P < .001$  at week 8; 66% vs. 35% at week 24,  $P < .001$ ) and somatic (56% vs. 43%,  $P < .001$  at week 8; 67% vs. 47% at week 24,  $P < .001$ ) factors of the HAM-A. There was a Treatment x Factor interaction ( $P < .027$ ) in response rates: Patients treated with venlafaxine showed similar somatic and psychic anxiety response rates, whereas placebo-treated patients showed higher somatic compared with psychic response rates. Somatizers showed similar rates of response to the total population for the somatic factor of the HAM-A in either treatment group. Patients with generalized anxiety disorder treated with venlafaxine XR showed similar absolute rates of response on somatic and psychic symptoms, but relative to patients treated with placebo, more improvement in psychic than somatic symptoms.

## POSTTRAUMATIC STRESS DISORDER (PTSD)

### ▪ PREVALENCE OF PTSD AMONG PALESTINIAN CHILDREN IN GAZA STRIP

*Authors* : Samir Qouta, PhD - Eyad El Sarraj, MD

*Source* : *Arabpsynet Journal*; 2004 Apr.May.June;2:8-14.

*Summary* : This research study aimed to get acquainted with the prevalence of PTSD, and other psychological suffering among Palestinian children living under severe conditions during the last two and half years of the Al-Aqsa Intifada. The sample consists of 944 children whom age ranged between 10-19 years. The group excluded those with previous mental health problems. In this research, trauma scale, PTSD scale, the Child Posttraumatic Stress Index, the Children's PTSD-symptoms, The CPTS-RI and open questions had been used as tools. The results indicated that 32.7% of the children started to develop acute PTSD symptoms that need psychological intervention, while 49.2% of them suffered from moderate level of PTSD symptoms. Also the results showed that the most prevalent types of trauma exposure for children

are for those who had witnessed funerals (94.6%), witnessed shooting (83.2%), saw injured or dead who were not relatives (66.9%), and saw family members injured or killed (61.6%).

### ▪ CURRENT CONCEPTS IN PHARMACOTHERAPY FOR POSTTRAUMATIC STRESS DISORDER

*Authors* : Schoenfeld FB, Marmar CR, Neylan TC.

*Source* : *Psychiatr Serv*. 2004 May;55(5):519-31.

*Summary* : This article describes current approaches to the pharmacologic treatment of posttraumatic stress disorder (PTSD) and reviews the classes of pharmacologic agents used in the treatment of PTSD. Pharmacotherapy for PTSD that is comorbid with other psychiatric disorders is highlighted. **METHODS**: The primary-source literature was reviewed by using a MEDLINE search. Secondary-source review articles and chapters were also used. Results from studies of the psychophysiology of PTSD are outlined in the review to help inform treatment choices. The review gives more consideration to controlled studies than to open clinical trials. Recommendations for treatment are evidence based. **RESULTS AND DISCUSSION**: A growing body of evidence demonstrates the efficacy of pharmacologic treatment for PTSD. The effectiveness of the selective serotonin reuptake inhibitors sertraline and paroxetine in large-scale, well-designed, placebo-controlled trials resulted in their being the first medications to receive approval from the U.S. Food and Drug Administration for the treatment of PTSD. Observation of psychophysiological alterations associated with PTSD has led to the study of adrenergic-inhibiting agents and mood stabilizers as therapeutic agents. Controlled clinical trials with these classes of medication are needed to determine their efficacy for treating PTSD. Finally, the choice of medication for treating PTSD is often determined by the prominence of specific PTSD symptoms and the pattern of comorbid psychiatric conditions.

### ▪ SLEEP IN LIFETIME POSTTRAUMATIC STRESS DISORDER : A COMMUNITY - BASED POLYSOMNOGRAPHIC STUDY

*Authors* : Breslau N, Roth T, Burduvali E, Kapke A, Schultz L, Roehrs T. - Department of Epidemiology, College of Human Medicine, Michigan State University, East Lansing 48824, USA. [breslau@epi.msu.edu](mailto:breslau@epi.msu.edu)

*Source* : *Arch Gen Psychiatry*. 2004 May;61(5):508-16

*Summary* : On standard measures of sleep disturbance, no differences were detected between subjects with PTSD and control subjects, regardless of history of trauma or major depression in the controls. Persons with PTSD had higher rates of brief arousals from rapid eye movement (REM) sleep. Shifts to lighter sleep and wake were specific to REM and were significantly different between REM and non-REM sleep ( $F(1,278) = 5.92$ ;  $P = .02$ ). **CONCLUSIONS**: We found no objective evidence for clinically relevant sleep disturbances in PTSD. An increased number of brief arousals from REM sleep was detected in subjects with PTSD. Sleep complaints in PTSD might represent amplified perceptions of brief arousals from REM sleep.

## PANIC DISORDER (PD)

▪ **PERSONALITY DISORDER & SOCIAL ANXIETY PREDICT DELAYED RESPONSE IN DRUG AND BEHAVIORAL TREATMENT OF PANIC DISORDER**

**Authors :** Berger P, Sachs G, Amering M, Holzinger A, Bankier B, Katschnig H. Department of Psychiatry, Division of Social Psychiatry, University of Vienna, Austria. [peter.berger@akh-wien.ac.at](mailto:peter.berger@akh-wien.ac.at)

**Source :** J Affect Disord. 2004 May;80(1):75-8

**Summary :** The aim of this study was to analyze the impact of pretreatment characteristics and personality disorders on the onset of response in the treatment of panic disorder. **METHODS:** The data of 73 out-patients with panic disorder who had completed at least 6 weeks of a randomized trial of 24 weeks of either paroxetine only or paroxetine combined with cognitive group-therapy were analyzed in a Cox proportional hazards model. **RESULTS:** The likelihood of having responded to treatment (defined by a CGI rating of improvement) was more than twice as high for patients without a personality disorder or social phobia than for Patients with a personality disorder or social phobia. **CONCLUSIONS:** We suggest that patients with these characteristics do benefit from prolonged treatment, and they may profit from an additional treatment focused on social anxiety.

▪ **SERTRALINE VERSUS PAROXETINE IN THE TREATMENT OF PANIC DISORDER: AN ACUTE, DOUBLE-BLIND NONINFERIORITY COMPARISON.**

**Authors :** Bandelow B, Behnke K, Lenoir S, Hendriks GJ, Alkin T, Goebel C, Clary CM. - Department of Psychiatry & Psychotherapy, University of Gottingen, von-Siebold-Strasse 5, D-37505 Gottingen, Germany. [bbandel@gwdg.de](mailto:bbandel@gwdg.de)

**Source :** J Clin Psychiatry. 2004 Mar; 65(3) :405-13

**Summary:** Several classes of medications have demonstrated efficacy in panic disorder, but direct comparison of 2 proven treatments is still uncommon. The purpose of this study was to compare sertraline and paroxetine in the acute treatment of panic disorder. **METHOD:** Adult outpatients with panic disorder with or without agoraphobia (DSM-IV and ICD-10 criteria) were randomly assigned in double-blind fashion to 12 weeks of treatment with flexible doses of sertraline (titrated up to 50-150 mg/day; N = 112) or paroxetine (titrated up to 40-60 mg/day; N = 113). Patients were then tapered off medication over 3 weeks. The primary analysis was a noninferiority analysis of Panic and Agoraphobia Scale (PAS) scores. Secondary measures included panic attack frequency and the Clinical Global Impressions-Improvement scale (CGI-I) (with responders defined as those with a CGI-I score < or = 2). Data were collected from January 2000 to June 2001. **RESULTS:** Sertraline and paroxetine were associated with equivalent levels of improvement on the PAS total score, as well as on all secondary outcome measures. Eighty-two percent of patients taking sertraline versus 78% of those taking paroxetine were CGI-I responders at endpoint. Numerically more patients on paroxetine treatment compared with sertraline treatment discontinued due to adverse events (18% vs. 12%; NS), and a significantly higher proportion of paroxetine patients showed > or = 7% weight gain (7% vs. < 1%; p < .05). During the taper period, the proportion of panic-free patients increased by 4% with sertraline but decreased by 11% with paroxetine (p < .05). **CONCLUSION:** Sertraline and paroxetine had equivalent efficacy in panic disorder, but sertraline was significantly better tolerated and was associated with significantly less clinical worsening during taper than paroxetine.

## ANXIETY DISORDERS

▪ **PREGNANCY COMPLICATIONS ASSOCIATED WITH CHILDHOOD ANXIETY DISORDERS.**

**Authors :** Hirshfeld-Becker DR, Biederman J, Faraone SV, Robin JA, Friedman D, Rosenthal JM, Rosenbaum JF. Pediatric Psychopharmacology Program, Massachusetts General Hospital, Cambridge, Massachusetts.

**Source :** Depress Anxiety. 2004;19(3):152-62

**Summary :** To determine whether perinatal complications predict childhood anxiety disorders independently of parental psychopathology, we systematically assessed pregnancy and delivery complications and psychopathology in a sample of children (mean age=6.8 years) at high risk for anxiety disorders whose parents had panic disorder with (n=138) or without (n=26) major depression, and in contrast groups of offspring of parents with major depression alone (n=47), or no mood or anxiety disorders (n=95; total N=306). Psychopathology in the children was assessed by structured diagnostic interviews (K-SADS), and pregnancy and delivery complications were assessed using the developmental history module of the DICA-P. Number of pregnancy complications predicted multiple childhood anxiety disorders independently of parental diagnosis (odds ratio=1.6 [1.4-2.0]). This effect was accounted for by heavy bleeding requiring bed-rest, hypertension, illness requiring medical attention, and serious family problems. Associations remained significant when lifetime child mood and disruptive behavior disorders were covaried. Results suggest that prenatal stressors may increase a child's risk for anxiety disorders beyond the risk conferred by parental psychopathology alone.

▪ **VENLAFAXINE IN THE TREATMENT OF ANXIETY DISORDERS**

**Authors :** M Katzman

**Source :** Expert Review of Neurotherapeutics - Drug Profile 4(3),371-381 (2004)

**Summary :** Venlafaxine extended-release (Effexor®XR, Wyeth-Ayerst Co.) is a novel, dual acting serotonin-norepinephrine reuptake inhibitor antidepressant, which inhibits the synaptic reuptake of both serotonin and norepinephrine. Controlled trials have demonstrated the efficacy and safety of venlafaxine in the treatment of anxiety disorders including social anxiety disorder, generalized anxiety disorder, post-traumatic stress disorder, panic disorder and obsessive-compulsive disorder. Generally well-tolerated with side effects that usually abate with continued treatment, venlafaxine is an important alternative to the selective serotonin reuptake inhibitors for patients with anxiety disorders

▪ **STANDARD VERSUS EXTENDED COGNITIVE BEHAVIOR THERAPY FOR SOCIAL ANXIETY DISORDER : A RANDOMIZED-CONTROLLED TRIAL**

**Authors :** James D. Herbert a1 c1, Alyssa A. Rheingold a2, Brandon A. Gaudiano a3 and Valerie H. Myers a4 / a1 Drexel University, USA / a2 Medical University of South Carolina, USA / a3 Brown University School of Medicine, USA / a4 Pennington Biomedical Research Center, USA

**Source :** Behavioural & Cognitive Psychotherapy (2004), 32: 131-147 Cambridge University Press

**Summary :** Although cognitive behavior therapy (CBT) has been shown to be generally effective in the treatment of social anxiety disorder (SAD), not all individuals respond totreatment,

and among those who do respond the degree of improvement is sometimes far from optimal. Little research has examined the impact of variations in the format of treatment delivery in this area. Participants were randomly assigned to either a standard, 12-session CBT program for generalized SAD in which treatment was delivered in successive weekly sessions (standard treatment) or a similar program in which the 12 sessions were delivered over 18 weeks (extended treatment). Intent-to-treat analyses revealed that the standard treatment program resulted in superior outcome in terms of self-rated symptom and impairment levels, categorical ratings of responder status, and lower dropout rates. Analyses of treatment completers only revealed comparable gains between the two conditions by post-treatment. However, the standard treatment condition revealed a more rapid improvement in magnitude initially. These findings suggest no benefit from extending the course of CBT treatment over a greater length of time, and suggest that such extension may in fact substantially increase the likelihood of premature termination.

**Key Words:** Social Anxiety Disorder; social phobia; cognitive behavior therapy; cognitive restructuring; exposure therapy; extended treatment.

**Correspondence:** c1 Reprint requests to James D. Herbert, Department of Psychology, Drexel University, 245 N. 15th Street, Philadelphia, PA 19102-1192, USA. E-mail : [james.herbert@drexel.edu](mailto:james.herbert@drexel.edu)

## Bipolar Disorders (BD)

### STATE OF THE ART IN THE MANAGEMENT OF BIPOLAR DISORDER

**Authors :** Ahmed Okasha

**Source :** The Arab Journal of Psychiatry – 2004 May;15(1):1-7

**Summary :** In this paper there is a revision of the classification and prevalence of mood disorders, with the emphasis on the higher rates of prevalence of Bipolar Disorders in recent studies. The clinical phenomenology is updated with some discussion of the misunderstood classification and inconsistent diagnosis and treatment worldwide. The managements in psychiatry generally and in Bipolar disorder in particular has been discussed. The pharmacotherapy of Bipolar Disorder is reviewed. Lithium, Novel antipsychotics and the management of acute mania or mixed episodes as well as acute depression and rapid cycling also maintenance treatment is clarified, without forgetting the importance of psychosocial intervention. The conclusion calls for more research in the field

### A REVIEW OF ACUTE TREATMENTS FOR BIPOLAR DEPRESSION.

**Authors :** Silverstone PH, Silverstone T. Departments of Psychiatry & Neuroscience, University of Alberta, Edmonton, Alberta, Canada; Department of Psychiatry, University of London, London, UK; Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada.

**Source :** Int Clin Psychopharmacol. 2004 May; 19(3): 113-24.

**Summary :** Bipolar patients generally spend much more time in the depressed phase of their illness than the manic phase, and there are many more bipolar type II and bipolar spectrum disorder patients than there are bipolar type I. Additionally, there is a significant risk of suicide in bipolar patients when depressed. The treatment of the depressed phase of bipolar disorder is therefore a matter of some priority. Here, we review current evidence supporting the use of five groups of

treatments: anti-depressants; lithium; anti-convulsants (valproate, and carbamazepine, lamotrigine, gabapentin); anti-psychotics; and other treatments (electroconvulsive therapy, benzodiazepines, sleep-deprivation, and dopamine agonists). From this review, it is apparent that the literature regarding the treatment of bipolar depression is significantly limited in several key areas. Nonetheless, from the evidence currently available, the treatments with the best evidence for efficacy are selective serotonin reuptake inhibitors (SSRIs) and lamotrigine. There is also some evidence in favour of bupropion and moclobemide. Although lithium and olanzapine monotherapies can also be beneficial, they appear less efficacious than antidepressants. One of the major concerns about treatment with antidepressants has been the risk of precipitating a switch into mania. However, recent studies suggest that, if a mood stabilizer and antidepressant are given concurrently, then the risk of switching is minimized. There is also recent evidence for an independent antidepressant action for at least one atypical antipsychotic. Therefore, the conclusion from this review, in contrast to previous suggestions, is that a combination of an atypical antipsychotic and either an SSRI or lamotrigine may provide a useful first-line treatment for depressed bipolar disorder patients. Further research is clearly required to examine this approach and compare it with other possible treatment options.

### PSYCHOTIC SYMPTOMS IN PEDIATRIC BIPOLAR DISORDER

**Authors :** Pavuluri MN, Herbener ES, Sweeney JA. Center for Cognitive Medicine, University of Illinois at Chicago, USA. [mpavuluri@psych.uic.edu](mailto:mpavuluri@psych.uic.edu)

**Source :** J Affect Disord. 2004 May;80(1):19-28

**Summary :** There is under-recognition or misdiagnosis of pediatric bipolar disorder with psychotic features. It is of major public health importance to recognize psychosis in bipolar disorder. **METHOD:** Original research on phenomenological description of psychosis and external validators including family history, longitudinal course and treatment effects are systematically reviewed. Age differences, sampling, and interview methods of the studies on pediatric bipolar disorder that reported psychotic features are compared. Critical differentiating features between pediatric bipolar disorder and pediatric schizophrenia are summarized given the presence of overlapping psychotic features. **RESULTS:** Prevalence of psychotic features in pediatric bipolar disorder ranged from 16 to 87.5% based on age and methodological differences. The most common psychotic features are mood congruent delusions, mainly grandiose delusions. Psychotic features appear in the context of affective symptoms in pediatric bipolar disorder as opposed to schizophrenia where psychotic symptoms are independent of them. Family history of affective psychosis aggregated in probands with bipolar disorder. **Limitations:** There is discrepancy in clinical appraisal of what constitutes psychosis and pediatric bipolar disorder, apart from the differences in methodology and nature of the samples. **CONCLUSION:** Clinicians must be vigilant in identifying psychosis in pediatric bipolar disorder, especially when there is a positive family history of psychosis

### MELANCHOLIC OUTPATIENT DEPRESSION IN BIPOLAR-II VS. UNIPOLAR

**Authors :** Benazzi F. E. Hecker Outpatient Psychiatry Center, Ravenna, Italy. [f.benazzi@fo.nettuno.it](mailto:f.benazzi@fo.nettuno.it)

**Source :** Prog Neuropsychopharmacol Biol Psychiatry. 2004



May;28(3):481-5

**Summary :** DSM-IV melancholic major depressive episode (MDE) in bipolar II disorder (BP-II) is understudied. Study aim was to compare melancholic MDE in BP-II vs. unipolar major depressive disorder (MDD) on diagnostic validators and clinical features. **METHODS:** Consecutive 39 BP-II and 34 unipolar MDD outpatients in a private practice were interviewed (off psychopharmacotherapy) with the Structured Clinical Interview for DSM-IV, as modified by Benazzi and Akiskal [J. Affect. Disord. 73 (2003) 1], when presenting for treatment of MDE. DSM-IV criteria of melancholic features specifier were followed. Variables studied were index age, gender, age at onset of the first MDE, number of MDE recurrences, severity (measured by GAF, index MDE psychotic features, index MDE symptoms lasting more than 2 years, Axis I comorbidity), index MDE and melancholic symptoms, bipolar family history. Diagnostic validators were onset, family history, course of illness, and clinical picture. **RESULTS:** BP-II melancholic MDE, vs. MDD melancholic MDE, had significantly lower age at onset and more bipolar family history. Psychomotor agitation was significantly more common in BP-II melancholic MDE, but was present only in 43.5%. Psychomotor retardation was more common in MDD melancholic MDE at a trend level, but was present only in 20.5%. **CONCLUSIONS:** Psychomotor agitation was more common in BP-II melancholic MDE vs. unipolar MDD, while previous studies on bipolar I (BP-I) had usually found more retardation. The difference could be related to BP-I and BP-II being at least partly distinct disorders. The relatively low frequency of psychomotor change does not seem to support the view that this is the core feature of melancholia. Differences on diagnostic validators (most importantly family history) further support the distinction of melancholic MDE between BP-II and MDD, and support DSM-IV classification.

#### ▪ DEFINING AND IDENTIFYING EARLY ONSET BIPOLAR SPECTRUM DISORDER.

**Authors :** Quinn CA, Fristad MA.

**Source :** Curr Psychiatry Rep. 2004 Apr; 6(2) :101-7

**Summary :** Early onset bipolar spectrum disorder (EOBPSD) is difficult to diagnose because of symptom overlap with other disorders and nearly ubiquitous comorbidity. A thorough assessment of EOBPSD should include the following : 1) a timeline of the child's development, from birth to present, showing the episodic nature of EOBPSD ; 2) a structured clinical interview determining comorbidity and differential diagnosis ; 3) a family history genogram to ascertain familial loading and environmental stressors, which informs case conceptualization ; 4) depression and mania rating scales to assess symptom severity and track treatment outcome ; 5) global rating scales to obtain cross-informant data and inform broad-based treatments ; and 6) a current mood log to document baseline functioning and track treatment outcome. Examples of a timeline, family history genogram, and current mood log are presented. This comprehensive approach to assessing EOBPSD, a severe and possibly lifelong disorder, is strongly advocated. No scale, instrument, or technique alone is adequate to diagnose EOBPSD.

#### ▪ PSYCHOLOGICAL TREATMENT FOR BIPOLAR DISORDERS A REVIEW OF RANDOMISED CONTROLLED TRIALS.

**Authors :** Gutierrez MJ, Scott J. - Psychological Treatments Research, Institute of Psychiatry, Denmark Hill, 96, London,

SE5 8AF, UK.

**Source :** Eur Arch Psychiatry Clin Neurosci. 2004 Apr; 254(2): 92-8.

**Summary :** The increased acceptance of stress-vulnerability models of severe mental disorders and of brief evidence-based psychological treatments in their treatment has finally led to increased interest in the role of psychotherapies in bipolar disorders. This paper reviews the results from randomised controlled trials of psychological therapies as an adjunct to standard medications. The evidence suggests that the addition of a psychological therapy may significantly reduce symptoms, enhance social adjustment and functioning, and reduce relapses and hospitalisations in patients with bipolar disorder. However, the methodological problems in the published randomised controlled trials and the heterogeneity in the outcomes achieved (some therapies reduce manic but not depressive relapses, others have the opposite effect) suggests that further studies are required to fully establish the place of these approaches in day to day practice.

## MAJOR DEPRESSIVE DISORDER (MDD)

▪ مشاركة البنزوديازيبينات مع مضادات الاكتئاب في علاج الاكتئاب الكبير

Furukawa TA, Streiner DL, Young LT :

The Cochrane Library, Issue 3, 2001. Oxford :

[www.arabicebm.com](http://www.arabicebm.com) :

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 (1.66                      1.15 :% 95                      1.38

▪ **QUANTITATIVE  
 ELECTROENCEPHALOGRAPHY (qEEG) TO  
 DISCRIMINATE PRIMARY DEGENERATIVE  
 DEMENTIA FROM MAJOR DEPRESSIVE  
 DISORDER**

**Authors :** DESLANDES, Andréa, VEIGA, Heloisa, CAGY, Mauricio et al.

**Source :** Arq. Neuro-Psiquiatr., Mar. 2004, vol.62, no.1, p.44-50. ISSN 0004-282X

**Summary :** Electroencephalography (EEG) can be a valuable technique to assess electrophysiological changes related to dementia. In patients suspected of having dementia, the EEG is often quite informative. The sensitivity of the EEG to detect correlates of psychiatric disorders has been enhanced by means of quantitative methods of analysis (quantitative EEG). Quantitative features are extracted from, at least, 2 minutes of artifact-free, eyes closed, resting EEG, log-transformed to obtain Gaussianity, age-regressed, and Z-transformed relative to population norms (Neurometrics database). Using a subset of quantitative EEG (qEEG) features, forward stepwise discriminant analyses are used to construct classifier functions. Along this vein, the main objective of this experiment is to distinguish profiles of qEEG, which differentiate depressive from demented patients (n = 125). The results showed that demented patients present deviations above the control group in variables associated to slow rhythms: Normed Monopolar Relative Power Theta for Cz and Normed Bipolar Relative Power Theta for Head. On the other hand, the deviation below the control group occurs with the variable associated to alpha rhythm: Normed Monopolar Relative Power Alpha for P3, in dementia. Using this method, the present investigation demonstrated high discriminant accuracy in separating Primary Degenerative Dementia from Major Depressive Disorder (Depression).

**Keywords:** qEEG; neurometrics; Alzheimer's disease; depression.

## DYSTHYMIE DISORDER (DD)

▪ **CITALOPRAM IN THE TREATMENT OF  
 DYSTHYMIE DISORDER**

**Authors :** Hellerstein DJ, Batchelder S, Miozzo R, Kreditor D, Hyler S, Gangure D, Clark J. - New York State Psychiatric

Arabpsynet Journal : N° 2-April - May - JUNE 2004

Institute, New York; Department of Psychiatry, St Luke's-Roosevelt Hospital Center, New York; University of Massachusetts Memorial Hospital, Amherst, Massachusetts; Beth Israel Medical Center, New York, USA.

**Source :** Int Clin Psychopharmacol. 2004 May;19(3):143-148.

**Summary :** This study aimed to provide preliminary data on the tolerability and effectiveness of citalopram for patients with dysthymic disorder. Twenty-one adult subjects meeting DSM-IV criteria for dysthymic disorder were enrolled in this 12-week open-label study, of whom 15 had pure dysthymia (e.g. no major depression in the past 2 years). Citalopram was initiated at 20 mg/day, and increased to a maximum of 60 mg/day. Response was defined as 50% or greater drop in score on the Hamilton Depression Rating Scale (HDRS) and a Clinical Global Impressions-I score of 1 ('very much improved') or 2 ('much improved'). Of these 15 pure dysthymic disorder subjects, all completed the trial, and 11 (73.3%) were treatment responders. All paired sample t-tests were highly significant, demonstrating significant average improvement on all measures of symptomatology and functioning. Scores on the 24-item HDRS decreased from 22.3+/-4.3 at baseline to 9.1+/-7.8 at week 12 [t(14)=6.1, P<0.001]. In addition, improvement was noted in self-reported measures of temperament and social functioning. The average final dose of citalopram was 39 mg/day. Side-effects were reported by nine of 15 subjects (60%), most frequently gastrointestinal symptoms (n=5), dry mouth (n=5) and sexual side-effects (n=3). These findings suggest the effectiveness and tolerability of citalopram in treating dysthymic disorder. Double-blind prospective studies are needed comparing citalopram both to placebo and to other medications, assessing both initial and sustained response to treatment.

## Mood Stabilizers (MS)

▪ **كاربامازيبين في الفصام والفصام الوجداني**

Leucht S, McGrath J, White P, Kissling W :  
 Cochrane Review 2, 2003. Oxford: Update Soft :  
[www.arabicebm.com](http://www.arabicebm.com) :

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### ■ الليثيوم في المعالجة الوقائية لاضطرابات المزاج

Burgess S, Geddes J, Hawton K, Townsend E, Jamison K, Goodwin G  
Cochrane Review : 2, 2003. Oxford : Update Soft  
[www.arabicebm.com](http://www.arabicebm.com)

### ■ CLOZAPINE : A MOOD STABILIZER IN CHRONIC RESISTANT BIPOLAR AFFECTIVE DISORDER

*Authors* : Abdulrazzak ALHAMAD / Associate Professor and Consultant - Department of Psychiatry Medical College King Saud University - [alhamad@ksu.edu.sa](mailto:alhamad@ksu.edu.sa)

*Source* : Arab Journal of Psychiatry November 2003 (14;2)

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

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

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

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

*Key words* : Clozapine, chronic resistant bipolar affective, Saudi Arabia.

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### ■ DEPRESSION MOOD STABILIZATION: NOVEL CONCEPTS AND CLINICAL MANAGEMENT

*Authors* : Joseph R. Calabrese, MD

*Summary* : A role for lamotrigine as a depression mood stabilizer is now recognized internationally. According to the World Federation of Societies of Biological Psychiatry (WFSBP) 2002 guidelines, the first line of treatment for bipolar depression should usually be a combination of a mood stabilizer (lithium or lamotrigine) and an antidepressant (bupropion or a selective serotonin reuptake inhibitor [SSRI]). [1] Furthermore, lamotrigine may be recommended for maintenance in rapid cycling.[2]

The 2002 revision of the American Psychiatric Association guidelines recommends lamotrigine as an alternative to lithium for first-line treatment of acute bipolar depression; as an alternative to lithium or valproate for initial treatment of rapid cycling; and as a possible alternative to lithium or valproate for BPD maintenance therapy.[3] (Note: lamotrigine is currently US Food and Drug Administration [FDA] approved only for maintenance therapy of bipolar I disorder [BP I]).[4]

The depression study included both bipolar and unipolar patients who were hospitalized with acute depression, stabilized, and then randomized to receive lithium, imipramine, or placebo for 2 years. Among the 31 bipolar patients who received either lithium or placebo, lithium was significantly more effective in preventing new mood episodes. During months 5 to 24, depression occurred in 12% of the lithium group and 55% of the placebo group. Mania occurred in 12% of the lithium group and 33% of the placebo group. Thus, lithium prevented both manic and depressive episodes.[9]

More recently, the prophylactic efficacy of lamotrigine, compared with lithium and placebo, was evaluated in 2, 18-month, randomized, double-blind trials, prospectively designed for pooled analysis. In one trial (GW606/2006), 175 patients with recent manic episodes were randomized; in the other (GW605/2003), 463 patients with recent depressive episodes were randomized. In each trial individually, as well as in the pooled analysis, lithium primarily delayed relapse into depression.[5,7] Thus, lithium and lamotrigine appear to complement each other, suggesting that they might be used together prophylactically in patients at risk for both types of mood episodes.

#### ▪ MOOD STABILIZERS : A PROPOSED RECLASSIFICATION

*Authors :* Erik Herman, MD

*Source :* Current Medical Research and Opinion

*Summary :* Slide 1. Lamotrigine: A Depression Mood Stabilizer

Most mood stabilizers were initially investigated for use in mania, and have not been well studied in bipolar depression. Until recently, there was no systematic effort to develop mood stabilizers for the depressed phase of bipolar disorder (BPD). Thus, there has been a lack of well-evaluated treatment options for bipolar depression, which has been especially problematic for patients with rapid cycling.[1]

Slide 2. Reconceptualizing Bipolar Disorder

To highlight this unmet need, a reconceptualization of BPD has been proposed, in which euthymia is defined as the baseline. Mania, hypomania, and mixed states are "above baseline," while depression and subsyndromal depression are "below baseline." [1]

Slide 3. 'Class A' Mood Stabilizers

Based on this conceptualization, 2 classes of mood stabilizers can be defined. Class A consists of agents that stabilize mood from above baseline - in other words, agents that have antimanic properties without inducing or worsening depression.

Slide 4. 'Class B' Mood Stabilizers

Class B consists of agents that stabilize mood from below baseline - in other words, agents that have antidepressant properties without inducing mania or cycle acceleration.[1]

Conventional mood stabilizers - lithium and the anticonvulsants, carbamazepine (off-label use) and valproate or divalproex -- are primarily antimanic agents, but do appear to have some antidepressant activity.[2] Of these agents,

lithium probably comes closest to meeting the definition of both a Class A and a Class B mood stabilizer.[1] However, in acute treatment of bipolar depression, response to lithium is often delayed or incomplete.[1,3] In lithium prophylaxis, depressive breakthrough is usually more of a problem than manic breakthrough,[4] and several placebo-controlled trials have failed to show significant efficacy in preventing depressive relapses.[5-8] Lithium appears to be most effective in classical BPD, and less effective in atypical variants, such as rapid cycling.[1]

On the other hand, the anticonvulsant lamotrigine may be considered the prototype of a Class B mood stabilizer.[5] In clinical trials it has been shown to benefit acute bipolar depression without inducing mania or cycle acceleration; it also prevents depressive relapse. Lamotrigine was approved in 2003 by the US Food and Drug Administration (FDA) for long-term maintenance treatment of BPD.

Other anticonvulsants, including gabapentin, topiramate, and levetiracetam, have been used off-label in BPD. Gabapentin has anxiolytic properties, and may be a useful adjunct, particularly in patients with comorbid anxiety;[9] however, controlled data do not support its use as monotherapy for either mania or depression.[10] Controlled data for topiramate are scarce. One randomized study failed to show an acute antimanic effect (as monotherapy); another randomized study suggested an acute antidepressant effect (as an adjunct to mood stabilizer therapy).[11] However, topiramate has also been observed to induce depression in some epilepsy patients.[7] Levetiracetam (added on to previous treatment) has shown promise in stabilizing both mania and depression in case reports of refractory rapid cycling.[12] but there have been no controlled trials with this agent.

Antidepressants, though widely used to treat bipolar depression, do not meet the criteria for Class B mood stabilizers because they can potentially induce switching into mania and cycle acceleration. Tricyclic antidepressants appear to carry the highest risk,[13] while newer agents, such as selective serotonin reuptake inhibitors (SSRIs) and bupropion, have been associated with low rates of switching in most (but not all) reports.[2,13,14] However, treatment-emergent mania has been reported with all major antidepressant classes.[13] *An estimated 20% to 40% of bipolar patients may be at risk,[13] especially those with rapid cycling.[4,7,14] Naturalistic observations suggest that concurrent use of mood stabilizers may reduce the risk by as much as 50%.[15] Antidepressants are not recommended as monotherapy for bipolar depression.[16]*

#### ▪ LAMOTRIGINE IS HELPFUL IN PREVENTING DEPRESSIVE RELAPSES IN BIPOLAR DISORDER

*Authors :* Laurie Barclay, MD -Reviewed by Gary D. Vogin, MD

*Source :* ICBP 2004: Abstract 5. February 9-13, 2004.

*Summary :* Feb. 18, 2004 — Lamotrigine (LTG) is better than placebo or lithium for preventing depressive relapses in bipolar disorder, according to a presentation at the International Congress of Biological Psychiatry held in Sydney, Australia, from Feb. 9-13.

"The results of this study suggest that [LTG] is the only medication that has better efficacy in preventing depressive relapse," lead author Lakshmi N. Yatham, MBBS, FRCP, MRCPsych, told Medscape. Dr. Yatham is a professor of psychiatry and Michael Smith Foundation Senior Scholar at



the University of British Columbia in Vancouver, Canada. "This has important clinical implications, as all medications currently used for prophylaxis of bipolar disorder have better efficacy in preventing mania than depression."

Lithium, which is commonly used to treat bipolar mania, is also thought to have antidepressant activity. Based on the results of two clinical trials in bipolar I disorder that enrolled 463 currently or recently depressed patients and 175 currently or recently manic patients, the investigators compared the effects of 18 months of prophylactic treatment with placebo (PBO), lithium (Li), and LTG.

Compared with placebo, LTG treatment resulted in fewer recently manic patients who required intervention for depression (LTG 14%, Li 22%, PBO 30%;  $P = .034$  for LTG vs. PBO); reported depressive adverse events (LTG 0, Li 4%, PBO 3%); met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), criteria for depression (LTG 10%, Li 17%, PBO 28%;  $P = .024$  for LTG vs. PBO), or had Hamilton Depression Rating Scale (HAMD) scores greater than 20 (LTG 3%, Li 11%, PBO 19%;  $P = .011$  for LTG vs. PBO).

In recently depressed patients, the treatment groups did not differ significantly in the incidence of depressive symptoms. Intervention for depression was required in 39% of the PBO group, 34% of the LTG group, and 38% of the Li group. The corresponding proportions for reported depressive adverse events were 2%, 4%, and 3%; for DSM-IV depression, the proportions were 36%, 31%, and 36%; and for HAMD scores greater than 20 were 26%, 22%, and 18%, respectively.

The authors suggest that because LTG can protect against depressive symptoms in currently or recently manic patients, administration of LTG should be considered during or shortly after stabilization of mania, before depressive symptoms occur.

"Clinicians can combine lamotrigine with lithium or atypical antipsychotics for achieving optimal control of both depression and mania," Dr. Yatham said.

#### ■ LAMOTRIGINE IN MOOD DISORDERS

**Authors :** Ben Green

**Source :** Current Medical Research and Opinion

**Summary :** Lamotrigine is an anticonvulsant drug with good efficacy and safety in the treatment of epilepsy. There is now substantial evidence that lamotrigine is also useful in treating resistant depression, rapid cycling bipolar affective disorder, depressive episodes in bipolar affective disorder and in the maintenance phase or prophylaxis of bipolar affective disorder. There are possible roles in managing mood changes in borderline personality disorder, reducing chronic pain and treating schizoaffective disorder.

The general range of doses found effective in affective disorders is from 50 to 300 mg daily. Clinical use seems to involve a titration of dose upwards over several weeks until the desired effect is obtained.

However, further definitive double-blind, randomised controlled trials against gold standard treatments are required.

Lamotrigine has a preferable side-effect profile compared to standard agents for bipolar affective disorder such as lithium or carbamazepine. Further research is certainly warranted and, given its tolerability, could point to lamotrigine as the treatment of choice for some affective disorders.

## EATING DISORDERS (ED)

#### ■ BARCELONA BIPOLAR EATING DISORDER SCALE (BEDS) : A SELF-ADMINISTERED SCALE FOR EATING DISTURBANCES IN BIPOLAR PATIENTS.

**Authors :** Torrent C, Vieta E, Crespo J, Gonzalez-Pinto A, Del Valle J, Olivares J, Rodriguez A, De Arce C, Sanchez-Planell L, Colom F; Programa de Trastornos Bipolares. Hospital Clinic-IDIBAPS. Barcelona.

**Source :** Actas Esp Psiquiatr. 2004 May;32(3):127-131

**Summary :** The presence of eating disorders in bipolar population is not rare, with rates over 10 %, according to the few available epidemiologic studies, however the literature on this issue is still scarce. An even higher percentage of bipolar individuals suffer from serious problems related to eating behavior without fulfilling criteria for DSM-IV eating disorder. **Methods.** The Bipolar Eating Disorders Scale (BEDS) was designed on the basis of the existing eating scales, adjusted to the characteristics of bipolar disorders from the complaints of our sample of patients (n=350). Subsequently, a group of experts made the selection of the most representative and independent items in order to obtain a short, 10-item scale, aimed at assessing the intensity and frequency of eating dysfunctions in the bipolar population and not at diagnosis. We administered the scale to a healthy control group (n=55) to evaluate feasibility and to determine the cut-off score. **Results.** The BEDS is a 10-item simple, self-administered scale. Average time of completing this scale is about 1.13 min (1 min, 21 seconds) +-26 seconds. Median score was 6 and the mean score was 6.6 with a standard deviation of 3.7, this being the reason why the cut-off point was found to be around 13 points. Patients receiving scores over 13 may require an individualized intervention to evaluate which were the main difficulties and to propose treatment. **Conclusions.** The BEDS allows for a rapid and effective evaluation of both the intensity and the frequency of eating dysfunctions in bipolar patients in order to perform an adequate intervention for the specific needs of each one of the patients.

#### ■ TREATMENT OF BULIMIA NERVOSA IN A PRIMARY CARE SETTING

**Authors :** Walsh BT, Fairburn CG, Mickley D, Sysko R, Parides MK. - Department of Psychiatry, College of Physicians and Surgeons of Columbia University, New York, NY 10032, USA. [btw1@columbia.edu](mailto:btw1@columbia.edu)

**Source :** Am J Psychiatry. 2004 Mar;161(3):556-61.

**Summary :** The authors' goal was to determine whether treatments known to be effective for bulimia nervosa in specialized treatment centers can be used successfully in primary health care settings. They examined the benefits of two treatments for bulimia: 1) fluoxetine, an antidepressant medication, and 2) guided self-help, an adaptation of cognitive behavior therapy. **METHOD:** Ninety-one female patients in two primary care settings were randomly assigned to receive fluoxetine alone, placebo alone, fluoxetine plus guided self-help, or placebo and guided self-help. **RESULTS:** The majority of the patients did not complete the treatment trial; many patients found the treatment program too demanding, but others indicated it was not sufficiently intensive. Patients assigned to fluoxetine attended more physician visits, exhibited a greater reduction in binge eating and vomiting, and had a greater improvement in psychological symptoms than those assigned to placebo. There was no evidence of benefit from guided self-help. **CONCLUSIONS:** The treatment of patients with bulimia nervosa in a primary care setting is

hampered by a high dropout rate. Guided self-help, a psychological treatment based on cognitive behavior therapy, appears ineffective, but treatment with fluoxetine is associated with better retention and substantial symptomatic improvement.

▪ **EATING DISORDERS IN MID-CHILDHOOD**

*Authors* : Irene Chatoor, MD, and Jaclyn Surlis, BA

*Source* : Primary Psychiatry. 2004;11(4):34-39

*Summary* : Most literature on the subject of eating and feeding disorders has focused primarily on feeding difficulties in infants and young children and on eating disorders in adolescents and young adults. This article examines eating disorders in mid-childhood, specifically during the preadolescent elementary school age, an area that has undergone relatively little scrutiny. Specific symptoms and diagnostic criteria for infantile anorexia, sensory food aversions (both starting during infancy or early childhood), and posttraumatic eating disorder are described, and the presentation of anorexia nervosa and bulimia nervosa in children is discussed. The specific treatment for each of these five eating disorders is outlined and the need for family therapy for children with eating disorders is emphasized.

▪ **ANOREXIA NERVOSA AND GENDER IDENTITY DISORDER IN BIOLOGIC MALES: A REPORT OF TWO CASES.**

*Authors* : Winston AP, Acharya S, Chaudhuri S, Fellowes L. Eating Disorders Unit, Woodleigh Beeches Centre, Warwick Hospital, Warwick, United Kingdom

*Source* : Int J Eat Disord. 2004 Jul;36(1):109-13.

*Summary* : Gender identity disorder is a rare disorder of uncertain etiology. The emphasis on body shape in this disorder suggests that there may be an association with anorexia nervosa. **METHOD**: We report two cases of anorexia nervosa and gender identity disorder in biologic males who presented to an eating disorders service. **RESULTS**: One was treated successfully as an outpatient and subsequently underwent gender reassignment surgery. The other patient required admission and prolonged psychotherapy. **DISCUSSION**: Differences between the two cases are discussed. Issues of gender identity should be considered in the assessment of male patients presenting with anorexia nervosa. Copyright 2004 by Wiley Periodicals, Inc. Int J Eat Disord 36: 109-113, 2004.

**Schizophrenia**

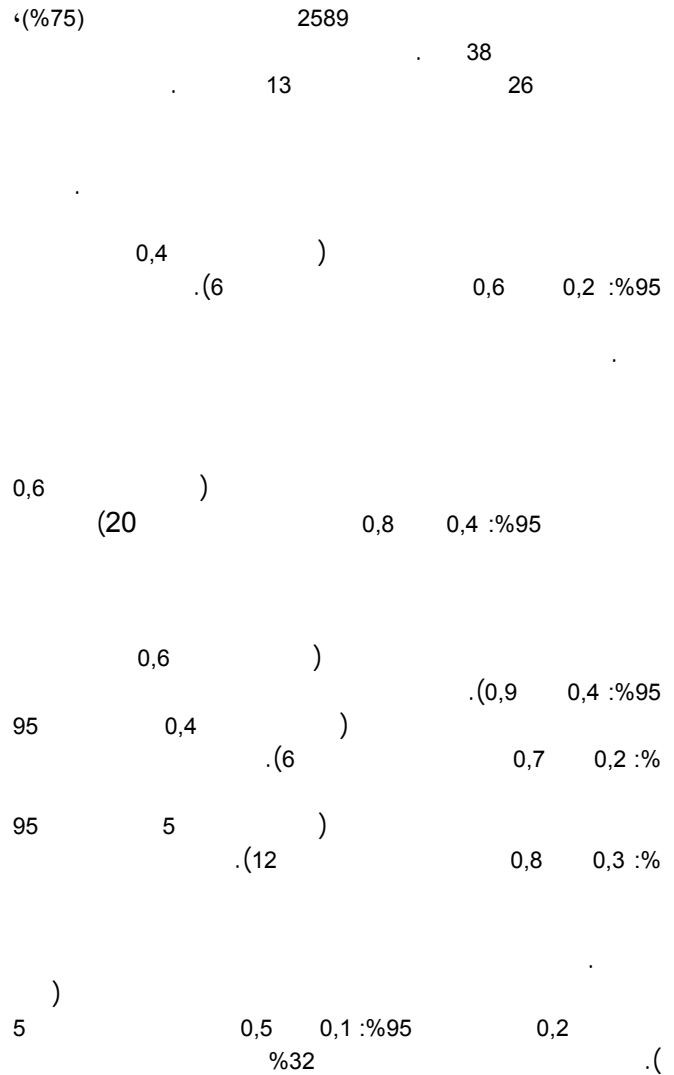
▪ **كلوزابين في علاج الطعام مقارنة بمضادات الذهان النمذجية**

Wahlbeck K, Cheine M, Essali MA :

Cochrane Review 2, 2003. Oxford: Update Soft :

[www.arabicebm.com](http://www.arabicebm.com) :

%33-25



#### ■ ADVERSE EFFECTS OF RISPERIDONE AND HALOPERIDOL TREATMENT IN SCHIZOPHRENIA.

**Authors :** Yen YC, Lung FW, Chong MY. - Department of Psychiatry, Military Kaohsiung General Hospital, 2 Chung Cheng 1st Road, Kaohsiung, 802, Taiwan.

**Source :** Prog Neuropsychopharmacol Biol Psychiatry. 2004 Mar;28(2):285-90.

**Summary :** Side effects of pharmacological treatment in schizophrenia continue to be a major issue in spite of the development of new antipsychotics. The aim of this study is to explore the adverse effects of conventional and atypical antipsychotic drugs and their associated factors. **METHODS:** Over 3 months, 41 patients with schizophrenia were randomized to treatment with risperidone 1-12 mg (n=21) or haloperidol 2-20 mg (n=20) daily. Efficacy was assessed by improvement of psychotic symptoms, measured on the Positive and Negative Syndrome Scale (PANSS). The safety and tolerability were assessed with the Extrapyramidal Symptom Rating Scale, the UKU Side-Effect Rating Scale and clinical laboratory assessments. **RESULTS:** Each treatment reduced psychotic symptoms. PANSS total scores, positive scores, and general psychopathology scores declined as trial went on without significant differences between the two groups. While PANSS negative scores improved better in the risperidone group than in the haloperidol group. The tolerability of antipsychotics was statistical significantly better in the risperidone than in the haloperidol-treated patients. The most frequent adverse effects for both groups were tremor and rigidity. Antipsychotics, their doses, and hyperprolactinemia predict short-term extrapyramidal side effects. Serum prolactin levels could predict parkinsonism and dyskinesia severity.

However, dyskinesia was best predicted by the doses of neuroleptics. The predictive factor of dystonia was the antipsychotic drug itself. After adjusting drug doses and concomitant medications, side effects could be markedly improved. **CONCLUSIONS:** This study suggested that risperidone was superior to haloperidol in improving negative symptoms and better tolerated during the 12 weeks' treatment of schizophrenia. Serum prolactin levels could predict the severity of parkinsonism and dyskinesia.

#### ■ GENERAL AND SPECIFIC COGNITIVE DEFICITS IN SCHIZOPHRENIA

**Authors :** Dickinson D, Iannone VN, Wilk CM, Gold JM. Veterans Affairs Capitol Health Care Network, Mental Illness Research, Education, and Clinical Center, 10 North Greene Street, Suite 6A, Baltimore, MD 21201, USA.

**Source :** Biol Psychiatry. 2004 Apr 15;55(8):826-33

**Summary :** It is controversial whether the cognitive deficit in schizophrenia is better characterized as generalized or as reflecting relatively independent deficits in different cognitive domains. The issue has implications for assessment practice, intervention design, and the exploration of schizophrenia

genetics. **METHODS:** We used a specialized structural equation modeling approach, single common factor analysis, to explore the relative importance of generalized versus independent cognitive deficits in schizophrenia. Eighteen subtest scores from the Wechsler Adult Intelligence Scale-III and the Wechsler Memory Scale-III were included in the analysis. We analyzed these data for 97 schizophrenia or schizoaffective disorder outpatients and 87 healthy control subjects. **RESULTS:** Approximately two thirds of the overall effect of a schizophrenia diagnosis on cognitive performance was mediated through a single common factor. The Wechsler subtest scores showed almost uniformly strong relationships with this factor. The independent associations of group status with the subtest scores were smaller in magnitude and only selectively significant. **CONCLUSIONS:** The relatively greater magnitude of illness effects mediated through the common factor in this analysis, compared with the specific, independent effects, suggests that a generalized cognitive deficit is a core feature of schizophrenia.

#### ■ SULPIRIDE TREATMENT OF COTARD'S SYNDROME IN SCHIZOPHRENIA

**Authors :** Shiraishi H, Ito M, Hayashi H, Otani K. Department of Psychiatry, Yonezawa City Hospital, Yonezawa 992-8502, Japan

**Source :** Prog Neuropsychopharmacol Biol Psychiatry. 2004 May;28(3):607-9

**Summary :** A 33-year-old male suffering from schizophrenia developed the typical symptoms of Cotard's syndrome, i.e., various delusions of negation and severe depressive symptoms. Atypical symptoms such as delusions of persecution and control related to body parts were also observed. These symptoms gradually improved by the treatment with sulpiride 300 mg/day. In the course of improvement of Cotard's syndrome, the patient developed Capgras syndrome. This report suggests that sulpiride is effective for Cotard's syndrome in schizophrenia. It also suggests that the symptoms of Cotard's syndrome are modified according to basic disorders, and this syndrome has a close connection with Capgras syndrome.

### PREMENSTRUAL Dysphoric Disorder (PMDD)

#### ■ PREMENSTRUAL DISORDERS: ADVANCES IN TREATMENT DISCLOSURES

**Authors :** Shaila Misri, MD, FRCPC

**Source :** The 1st World Congress on Women's Mental Health, Berlin, Germany - March 2001.

**Summary :** 2% to 9% of women are affected by severe mood and physical symptoms during the luteal phase of their menstrual cycles; these women suffer from PMDD.

The DSM-IV outlines the criteria for PMDD as a specific clinical syndrome.

Major depression and PMDD are interrelated: women with depression are more likely to suffer from PMDD, and women with a history of PMDD are at higher risk of developing an episode of depression.

A dysfunction of the serotonin transporter gene may play a role in PMDD.

The efficacy of the SRI antidepressants for the treatment of PMDD has been established. Newer medications such as venlafaxine are currently under investigation.

Medication has a rapid onset of action in PMDD sufferers,



usually within the first month of treatment and often within the first few days; it targets both physical and mood symptoms.

Longer-term treatment (9 menstrual cycles) with SRI antidepressants seems to reduce the risk of symptom recurrence. Women treated with an SRI medication for 3 cycles or less often relapse after discontinuation within 1 cycle.

Quality of life is severely diminished in women who suffer from moderate PMS and PMDD. Treatment with an SRI antidepressant results in significant improvement in quality of life, and this is expressed through increased functioning in the work, leisure, and family/marital domains.

#### ▪ LUTEAL PHASE ADMINISTRATION OF AGENTS FOR THE TREATMENT OF PREMENSTRUAL DYSPHORIC DISORDER.

**Authors :** Freeman EW. - Departments of Obstetrics / Gynecology & Psychiatry, University of Pennsylvania, Philadelphia, Pennsylvania, USA.

**Source :** CNS Drugs. 2004;18(7):453-68.

**Summary :** This review focuses on current information about luteal phase administration (i.e. typically for the last 2 weeks of the menstrual cycle) of pharmacological agents for the treatment of premenstrual dysphoric disorder (PMDD). Compared with continuous administration, a luteal phase administration regimen reduces the exposure to medication and lowers the costs of treatment. Based on evidence from randomised clinical trials, SSRIs are the first-line treatment for PMDD at this time. Of these agents, sertraline, fluoxetine and paroxetine (as an extended-release formulation) are approved by the US FDA for luteal phase, as well as continuous, administration. Clinical trials of these agents and citalopram have demonstrated that symptom reduction is similar with both administration regimens. When used to treat PMDD, SSRI doses are consistent with those used for major depressive disorder. The medications are well tolerated; discontinuation symptoms with this intermittent administration regimen have not been reported. Other medications that have been examined in clinical trials for PMDD or severe premenstrual syndrome (PMS) using luteal phase administration include buspirone, alprazolam, tryptophan and progesterone. Buspirone and alprazolam show only modest efficacy in PMS (in some but not all studies), but there may be a lower incidence of sexual adverse effects with these medications than with SSRIs. Symptom reduction with tryptophan was significantly greater than with placebo, but the availability of this medication is strictly limited because of safety concerns. Progesterone has consistently failed to show efficacy for severe PMS/PMDD in large, randomised, placebo-controlled trials.

#### ▪ EVALUATION AND MANAGEMENT OF PREMENSTRUAL SYNDROME AND PREMENSTRUAL DYSPHORIC DISORDER

**Authors :** Edyta J. Frackiewicz and Thomas M. Shiovitz

**Source :** Journal of the American Pharmaceutical Association

**Summary :** To review premenstrual disorders, their varied symptoms, possible etiology, and treatment options. Data Sources: Published articles identified through MEDLINE (1966-2001) using the search terms premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) and the additional terms treatment and etiology.

Additional references were identified from the bibliographies of the retrieved articles.

Data Synthesis: PMS refers to a group of menstrually related disorders that are estimated to affect up to 40% of women of childbearing age. The varied symptoms of PMS include mood swings, tension, anger, irritability, headache, bloating, and increased appetite with food cravings. PMS symptoms occur during the luteal phase of the menstrual cycle and remit with the onset of menstruation or shortly afterward. Approximately 5% of women with PMS suffer from PMDD, a more disabling and severe form of PMS in which mood symptoms predominate. Because no tests can confirm PMS or PMDD, the diagnosis should be made on the basis of a patient-completed daily symptom calendar and the exclusion of other medical disorders. The causes of PMS and PMDD are uncertain, but are likely associated with aberrant responses to normal hormonal fluctuations during the menstrual cycle. For most women, symptoms can be relieved or reduced through lifestyle interventions, such as dietary changes and exercise, and drug therapy with hormonal or psychotropic agents. For PMDD, selective serotonin reuptake inhibitors have recently emerged as first-line therapy. Certain dietary supplements, including calcium, also may be an option for some women.

**Conclusion:** PMS and PMDD are complex but highly treatable disorders. Pharmacists can improve the recognition and management of these common conditions by providing patient education on premenstrual symptoms and counseling women on lifestyle interventions and pharmacotherapy to relieve their discomfort.

## POSTPARTUM DEPRESSION (PPD)

### ▪ مفادات الاكتئاب في اكتئاب بعد الولادة

.Hoffbrand S, Howard L, Crawley H :

Cochrane Review : 2, 2003. Oxford: Update Soft. :

[www.arabicebm.com](http://www.arabicebm.com) :

### ▪ TREATMENT OF POSTPARTUM DEPRESSION

*Authors* : Barbara L. Parry, MD

*Source* : Primary Psychiatry. 2004;11(3):48-51

*Summary* : Postpartum mood disorders are often underrecognized and undertreated. They can present as maternity blues or baby blues, a major depressive episode with features of melancholia, or postpartum psychoses. Untreated postpartum depression in the mother is particularly distressing, as it can impair the neurocognitive development of the child. However, a range of therapeutic modalities are available that have reasonable safety and efficacy in breastfeeding women. New nonpharmacologic treatment strategies include sleep and light therapies that potentially offer benefit within days and do not have the potential adverse effects that are of concern with some pharmacologic interventions.

### ▪ INTERPERSONAL PSYCHOTHERAPY FOR ANTENATAL & POSTPARTUM DEPRESSION

*Authors* : Lisa S. Segre, PhD, Scott Stuart, MD, and Michael W. O'Hara, PhD

*Source* : Primary Psychiatry. 2004;11(3):52-56,66

*Summary* : Despite its prevalence, postpartum depression is frequently not detected. Primary care physicians (PCPs) are often a woman's only contact with healthcare professionals. These professionals have a vital role in the screening and treatment of depressed women; therefore it is necessary that PCPs be aware of assessment issues and effective treatments. This article describes the use of interpersonal psychotherapy (IPT), a timelimited and empirically validated treatment for perinatal depression, in terms of the relevant clinical issues for pregnant or postpartum women. During the assessment phase, the symptoms of depression must be disentangled from the normal physical states of pregnancy and the postpartum, and an accurate diagnosis must be made. During the initial and intermediate phases of treatment, interpersonal problems that are common to the perinatal period are addressed. Given the risk for future depressive episodes, provisions for future treatment must be established prior to the conclusion of therapy. With these adaptations, IPT can be modified for effective use with perinatal women. As a result, PCPs may gain an increased understanding of both an effective treatment and the salient interpersonal issues for these women.

### ▪ CHALLENGES IN IDENTIFYING AND DIAGNOSING POSTPARTUM DISORDERS

*Authors* : Leslie Born, MSc, PhD, Dawn Zinga, PhD, and Meir Steiner, MD, PhD, FRCPC

*Source* : Primary Psychiatry. 2004;11(3):29-36

*Summary* : - Perinatal mental illness is underdiagnosed and may have serious consequences for both the mother and the infant. Early screening and identification are crucial.

- Risk factors for postpartum mental illness include depressed or anxious mood during pregnancy, personal or family history of psychiatric disorder (especially in first-degree relatives and including alcoholism), unplanned pregnancy, perinatal sleep deprivation, and major psychosocial stressors

- Women suffering from perinatal mood disturbances are more likely to seek help from their primary care physicians or obstetricians rather than mental health professionals. Screening new mothers should be implemented by these healthcare providers using a few simple questions during regular

In spite of greater awareness that childbirth can be accompanied by severe emotional disorders, problems with timely identification of perinatal mental illness persist.

Controversy as to whether puerperal illnesses are discrete nosological entities or instead episodes of mood, anxiety, or psychotic disorders that occur coincidentally in the puerperium or are precipitated by it, has endured for over 30 years. Recent research suggests that significant adverse mood reactions may be induced by major, albeit normal, changes in estrogen and progesterone levels in women with a biologic vulnerability to depression. Despite the fact that the etiology of perinatal mental illness is unknown, early recognition of the risk factors and the signs and symptoms of a postpartum disorder is crucial. Women who are at risk for or who may be suffering from a postpartum mood disorder can and should be identified by being asked a few simple questions during routine pregnancy or postpartum primary care, gynecologic, or pediatric visits.

Rapid identification and treatment can in many cases prevent a major episode.

### ▪ CAN POSTPARTUM DEPRESSION BE PREDICTED?

*Authors* : Michael W. O'Hara, PhD, & Laura L. Gorman, PhD

*Source* : Primary Psychiatry. 2004;11(3):42-47

*Summary* : Postpartum depression (PPD) is a mental health problem that carries substantial risk for women, children, and families. Depression may emerge during pregnancy and carry over into the postpartum period or develop soon after delivery and even many months later. Numerous studies have been undertaken to determine the etiology of PPD and to identify risk factors during pregnancy that may predict its occurrence. Risk factors measured during pregnancy that show the strongest relation to PPD include current and past depression and anxiety disorder, negative stressful life events, marital discord, and poor social support. Many of these risk factors have been incorporated into scales and are used to screen women during pregnancy and to select high-risk women for prevention trials. In general, these instruments do identify a group of women with substantial increased risk for PPD over the base rate and can serve as a basis for a conversation between a woman and her healthcare provider. Despite their positive attributes, these instruments tend to over identify women at risk and at the same time miss many women who go on to experience a PPD.

### ▪ IDENTIFYING DEPRESSION IN THE FIRST POSTPARTUM YEAR : GUIDELINES FOR OFFICE-BASED SCREENING AND REFERRAL

*Authors* : Peindl KS, Wisner KL, Hanusa BH. Department of Psychiatry and Human Behavior, Jefferson College of Medicine, Thomas Jefferson University, Philadelphia, PA 19107, USA. kathleen.peindl@mail.tju.edu

*Source* : J Affect Disord. 2004 May;80(1):37-44

*Summary* : Some 10-15% of women experience postpartum-onset major depression (PPMD). The objective of this study was to determine if the Edinburgh Postnatal Depression Scale (EPDS) is an effective screen for major depression (MD)

prospectively. The outcome of the study was identification of a recurrence of major depression in the first year postpartum by a clinical interview and the EPDS. We had the unique opportunity to examine the relationship between EPDS scores and PPMD. **METHODS:** Participants were pregnant women who had experienced an episode of previous PPMD but were well during their index pregnancy. This study was part of a double-blind, randomized clinical trial in which new mothers received nortriptyline or placebo within 24 h following delivery for prevention of PPMD. Recurrence of depression was established according to Research Diagnostic Criteria. Participants completed the EPDS weekly through 20 weeks postpartum and into a 1-year follow-up phase. **RESULTS:** Out of 50 women, 13 experienced recurrence of MD in the first 20 weeks postpartum with a total of 20 out of 50 recurring in the first year. The EPDS score of >9 at week 4 postpartum identified 60% of women who nurtured in the first 20 weeks and 80% who recurred in the first postpartum year. **Limitations:** The study population included only women who had a previous episode of postpartum depression. The generalizability to all women is limited. **CONCLUSIONS:** The EPDS is an effective depression screen for women who had a previous episode of PPMD. Clinical guidelines are provided for use of the EPDS to identify MD in the first postpartum year in primary care settings.

## WOMEN DEPRESSION

### ▪ PREMATURITY AT BIRTH & ADOLESCENT DEPRESSIVE DISORDER

**Authors :** Patton GC, Coffey C, Carlin JB, Olsson CA, Morley R. - Murdoch Children's Research Institute. Department of Paediatrics, University of Melbourne, Australia.

**Source :** Br J Psychiatry. 2004 May;184(5):446-7.

**Summary :** Association between prematurity/low birthweight and adolescent depressive disorder studied using a case-control design within a prospective cohort study of 2032 adolescents. Odds for depressive disorder were 11-fold (95% CI 2-62) higher for the premature/low-birthweight participants after regression adjustment for major confounding factors. For premature/low-birthweight females, cumulative rates of depressive disorder over 30 months were 15.2% (95% CI 11.1-20.5) v. 1.8% (95% CI 1.6-2.1) in those with normal deliveries. Physiological adaptations in utero before full term may be implicated causally in some cases of depression in adolescence.

### ▪ SPECIAL ISSUES IN THE MANAGEMENT OF DEPRESSION IN WOMEN.

**Authors :** MacQueen G, Chokka P.

**Source :** McMaster University, Hamilton, Ontario. [macqueng@mcmaster.ca](mailto:macqueng@mcmaster.ca)

**Summary :** Depression is more prevalent in women than in men, which may be related to biological, hormonal, and psychosocial factors. Four depressive conditions are specific to women: premenstrual dysphoric disorder (PMDD), depression in pregnancy, postpartum depression, and depression related to perimenopause or menopause. Antidepressant therapy with selective serotonin reuptake inhibitors and venlafaxine has demonstrated efficacy in PMDD. Both continuous and intermittent dosing regimens were effective at usual but not at low dosages. Despite reluctance of some women to take medication for depression

during pregnancy and breastfeeding, substantial evidence suggests that antidepressants are safe and efficacious during these periods, while untreated depression has negative consequences for both mother and child. In peri- or postmenopausal women with depression, estrogen may enhance the effects of antidepressant medications, although a pooled analysis of data in women aged 50 years or over treated with venlafaxine found that remission rates were similar in those who were taking estrogen and those who were not. The management of women with depression can be done safely and effectively using antidepressants and alternative interventions throughout the life cycle.

### ▪ NEONATE CHARACTERISTICS AFTER MATERNAL USE OF ANTIDEPRESSANTS IN LATE PREGNANCY.

**Authors :** Kallen B. Tornblad Institute, University of Lund, Lund, Sweden. [embryol@embryol.lu.se](mailto:embryol@embryol.lu.se)

**Source :** Arch Pediatr Adolesc Med. 2004 Apr ;158(4) :312-6.

**Summary :** Exposure to antidepressants during the third trimester of pregnancy has been associated with an increased risk for adverse birth outcomes, including preterm birth, respiratory distress, and hypoglycemia. **OBJECTIVE :** To investigate neonatal outcomes in 997 infants (987 mothers) after maternal use of antidepressants based on prospectively recorded information in antenatal care documents. **RESULTS :** An increased risk for preterm birth (odds ratio [OR], 1.96) and low birth weight (OR, 1.98) was verified, but the gestational week-specific birth weight was increased notably after exposure to tricyclic antidepressants. An increased risk for a low Apgar score (OR, 2.33), respiratory distress (OR, 2.21), neonatal convulsions (OR, 1.90), and hypoglycemia (OR, 1.62) was found, the latter especially after exposure to tricyclic drugs, but no significant effect on the frequency of neonatal jaundice was seen (OR, 1.13). Most effects seemed not to be selective serotonin reuptake inhibitor drug specific, and outcomes after exposure to paroxetine hydrochloride were not worse than after exposure to other selective serotonin reuptake inhibitors. **CONCLUSIONS :** Neonatal effects after maternal use of antidepressant drugs during late pregnancy were seen. Selective serotonin reuptake inhibitors may be the drugs of choice during pregnancy.

### ▪ A PILOT STUDY OF BRIEF INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION AMONG WOMEN

**Authors :** Swartz HA, Frank E, Shear MK, Thase ME, Fleming MA, Scott J. Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania 15213, USA. [swartzha@msx.upmc.edu](mailto:swartzha@msx.upmc.edu)

**Source :** Psychiatr Serv. 2004 Apr ;55(4) :448-50.

**Summary :** A matched-case-control study compared eight-week outcomes between a group of 16 depressed women who received brief (eight-session) interpersonal psychotherapy and a group of 16 who received a selective serotonin reuptake inhibitor (sertraline). Women who met DSM-IV criteria for major depression and who had a score above 15 on the Hamilton Rating Scale for Depression were treated openly with brief interpersonal psychotherapy and were matched on key variables with women being treated with sertraline. Linear mixed-effects regression models were used to compare groups on measures of symptoms and functioning during eight weeks of treatment. Both groups improved significantly over

time, with large effect sizes. However, contrary to expectations, the women who received psychotherapy improved more quickly than those who received sertraline.

## MENOPAUSAL DEPRESSION (MD)

### ▪ CHALLENGE OF MENOPAUSAL DEPRESSION

*Authors* : By Roberta Friedman

*Source* : PRI-MED WEST

*Summary* : ANAHEIM, CA -- May 14, 2004 -- Depression commonly accompanies menopause and in fact is more common in the perimenopausal years. Treatment is challenging given the new take on hormonal treatments following the early halt to the Women's Health Initiative study.

In a presentation here May 13th at the Annual Pri-Med West Conference and Exhibition, Karen J. Carlson, MD, assistant professor of medicine and deputy director of the Center of Excellence in Women's Health, Harvard Medical School, and director, Women's Health Associates, Massachusetts General Hospital, Boston, Massachusetts, said that women who are at risk for depression in their menopausal years are those who have been depressed before, who have hot flashes, and who are in disrupted marriage or employment situations.

Doctors are left fairly empty handed when trying to help women with approved, evidence-based therapy for menopausal depression that relies on hormones. For instance, said Dr. Carlson, a trial of transdermal estrogen gave good results compared to placebo, even independent of whether or not any hot flashes were present. Yet unopposed estrogen, she said, is "not viable in the long term, and we don't know the effect of adding progesterone."

Analysis of quality of life findings in the WHI study showed no differences, but this was for the older women of the study population, who were a mean age of 64 years, Dr. Carlson said. "People use this [finding] to say we should never give women who develop depression, perimenopausally, hormone replacement," Dr. Carlson said.

She added that women who are not having hot flashes should try selective serotonin reuptake inhibitors (SSRIs), and that if they are having lots of hot flashes, they should consider low dose hormones or SSRIs.

## WOMEN MENTAL HEALTH (WMH)

### ▪ برامج التدريب على الأهمية لدعم الصحة النفسية للأمة

Barlow J, Coren E :

Cochrane Review : 2, 2003. Oxford: Update Soft. :

[www.arabicebm.com](http://www.arabicebm.com) :

### ▪ RELATIONSHIP OF SEXUAL ASSAULT HISTORY TO SOMATIC SYMPTOMS AND HEALTH ANXIETY IN WOMEN

*Authors* : Stein MB, Lang AJ, Laffaye C, Satz LE, Lenox RJ, Dresselhaus TR. - Veterans Affairs San Diego Healthcare System and the University of California San Diego, La Jolla, CA, USA.

*Source* : Gen Hosp Psychiatry. 2004 May-Jun;26(3):178-83

*Summary* : Prior reports have pointed to a link between traumatic experiences and health consequences in women. The objective of this study was to determine whether there is an association between sexual assault history and measures of somatic symptoms and illness attitudes in a sample of female Veterans Affairs primary care patients, a group in whom high rates of sexual trauma have been reported. We conducted a cross-sectional study of a representative sample of 219 women in a Veteran's Affairs primary care outpatient clinic. Sexual assault history, somatic symptoms and health



anxiety were assessed by self-report questionnaire. Multivariate analyses were used to examine relationships between sexual assault exposure and these outcomes. Ninety-seven women (43.9%) reported experience(s) of sexual assault (i.e., rape, attempted rape or being made to perform any type of sexual act through force or threat of harm). Sexual assault was associated with a significant increase in somatization scores, physical complaints across multiple symptom domains and health anxiety. Sexual assault was also a significant statistical predictor of having multiple sick days in the prior 6 months and of being a high utilizer of primary care visits in the prior 6 months. These data confirm a strong association between sexual trauma exposure and somatic symptoms, illness attitudes and healthcare utilization in women. Causal mechanisms cannot be inferred from these data. Studies in other cohorts are warranted.

#### ■ CLINICAL UTILIZATION OF ATYPICAL ANTIPSYCHOTICS IN PREGNANCY AND LACTATION (JULY/AUGUST).

**Authors :** Gentile S. ASL Salerno 1, Head of Mental Health Center District n. 4 Piazza Galdi, 84013 Cava de' Tirreni (SA), Italy, fax 39 089 4455440, [salvatore\\_gentile@libero.it](mailto:salvatore_gentile@libero.it)

**Source :** Ann Pharmacother. 2004 May 18

**Summary :** To analyze the available literature regarding the safety of atypical antipsychotics in pregnancy and lactation in order to recommend evidence-based strategies for pharmacologic management of psychosis in these conditions. **DATA SOURCES :** We summarized the results from articles identified via MEDLINE/PubMed/TOXNET (1993-January 31, 2004), using the key terms pregnancy, lactation, breast-feeding, human milk, psychotropic drugs, atypical antipsychotics, olanzapine, quetiapine, risperidone, clozapine, ziprasidone, and aripiprazole. **STUDY SELECTION AND DATA EXTRACTION :** Retrospective studies, clinical observations, and case reports regarding the 6 atypical antipsychotics mentioned above were selected and analyzed. Extensive manual review of pertinent journals and textbooks was also performed. **DATA SYNTHESIS :** Reviewed studies show that olanzapine and clozapine apparently do not increase the teratogenic risk if administered to pregnant women, while evidence on quetiapine, risperidone, aripiprazole, and ziprasidone is still limited. In contrast, available information is not able to exclude unwanted serious effects associated with the use of all atypical antipsychotics on mother-infant dyads. Furthermore, more than a few studies suggest increased hyperglycemic risk for pregnant women related to atypical antipsychotic therapy during gestation. Finally, published evidence about the effects on long-term infant neurodevelopment of drug exposure through both placenta and breast milk is represented only by sporadic case reports. **CONCLUSIONS :** It is well known that potential consequences of an untreated psychotic episode may be severe and may lead to the mother attempting suicide and/or infanticide. For these reasons, clinicians need to help mothers weigh both fetal and neonatal risks of exposure to drugs against the potential risk they and their infant may incur if the psychiatric illness is not treated. On the other hand, atypical antipsychotics in pregnancy and breast-feeding do not show evident advantages in safety when compared with typical neuroleptic agents. Therefore, we suggest that the most relevant parameters for selecting the best clinical option for pregnant and breast-feeding women with schizophrenia and related disorders remain strongly related to 3 main points : (1)

cautious evaluation of the risk/benefit ratio of fetal and neonatal drug exposure, (2) degree of severity of maternal psychiatric illness, and (3) careful preliminary choice of drugs characterized by a balanced safety/efficacy profile.

## Biological Psychiatry

#### ■ THE ROLE OF PSYCHIATRIC GENETICS IN PEDIATRIC PSYCHOPHARMACOLOGY

**Authors :** Kutaibe Chaleby

**Source :** The Arab Journal of Psychiatry – 2004 May;15(1) : 17-25

**Summary :** Psychiatric genetics is relevant to psychopharmacology in many respects. First it is undebatable current state of knowledge that, genes make youths susceptible to psychiatric disorders. This has been shown for Attention Deficit/Hyperactivity Disorder, Depression, Autism, Tourette's Syndrome, Mood Disorders in general, Anxiety, Bipolar Disorder, Learning Disabilities and Conduct Disorder. In fact, it is fairly certain that the D4 Dopamine receptor gene is a susceptibility gene for Attention Deficit/Hyperactivity Disorder. For Learning Disabilities, there is a consistent finding on Chromosome 6, that a gene that is as of yet unknown is involved in Learning Disabilities. Breakthroughs are being made in Autism, Bipolar Disorders. This is amazing when we consider that 20 to 30 years ago psychiatric disorders were considered to be reactions to environmental events. We have really moved very far beyond that in psychiatric genetics. While genes control many brains systems, these mediate therapeutic response, drug metabolism and side effects. So, the question for the future is « To what degree can psychiatric genetic studies help clarify these points ? » Finally, there is a possibility that genetic studies may also set the foundation for primary prevention. The genetic variance would predict drug response, molecular genetic diagnosis, can gene improve psychiatric diagnoses, and then primary prevention.

#### ■ DEPRESSION IN AGING MEN : THE ROLE OF TESTOSTERONE.

**Authors :** Carnahan RM, Perry P.J. - Clinical & Administrative Pharmacy, College of Pharmacy, University of Iowa, Iowa City, Iowa, USA.

**Source :** Drugs Aging. 2004; 21(6): 361-76.

**Summary :** Age-related decline in testosterone levels is associated with a number of mild, nonspecific symptoms, including depressive symptoms. The relationship between depressive symptoms and testosterone levels is confounded by numerous factors, including medical illness, obesity, smoking, alcohol use, diet and stress, and is thus complex. Studies have not consistently supported an integral role of reduced testosterone levels in major depressive disorder, although levels may often be reduced in men with treatment-refractory depression and older men with dysthymia. Low testosterone levels may also increase the risk of incident depression in older males, although this may depend upon androgen receptor genetic polymorphisms. Testosterone replacement has demonstrated short-term tolerability and efficacy in augmenting antidepressants to alleviate treatment-refractory depression in adult males. Case studies support the potential need for maintenance therapy to maintain response. In a placebo-controlled trial, testosterone monotherapy was not effective in treating major depressive disorder in men with

hypogonadism. However, in an open-label, noncomparative study, testosterone monotherapy appeared effective in treating late-onset but not early-onset major depressive disorder in older males. Testosterone therapy is not without potential for adverse effects, the most worrisome of which is the worsening of pre-existing prostate carcinoma. Oral, short- and long-acting parenteral, and transdermal patch and gel formulations are available. Testosterone has demonstrated usefulness in the treatment of a number of depressed populations, but further studies are needed to fully elucidate its role in the treatment of depressive syndromes in the aging male.

#### ▪ THE BIOLOGY AND PATHOPHYSIOLOGY OF PERIPARTUM PSYCHIATRIC DISORDERS

**Authors :** Vivette Glover, MA, PhD, DSc, & Martin Kammerer, MD

**Source :** Primary Psychiatry. 2004;11(3):37-41

**Summary :** Cortisol, progesterone, and estrogen increase to high levels by the end of pregnancy and show a sharp reduction on parturition. These hormones are known to have large psychoactive effects, and it is likely that some women with affective disorders over the peripartum period are especially sensitive to these changes. In a subgroup of women, postpartum depression has been associated with the presence of thyroid autoantibodies during pregnancy. It is important to differentiate the different types of mood disorders that occur over this time in order to understand their biological bases. Parturition can trigger the "blues," which is a mild lability of mood associated with crying; the "highs," which is a mild hypomania; or postpartum psychosis. A family history of manic depression is a strong risk factor for postpartum psychosis; there is also evidence for genetic vulnerability to a puerperal trigger. Both severe blues and highs are risk factors for later depression. Symptoms of anxiety and depression are as common during pregnancy as during postpartum. Some episodes of depression and/or anxiety start during pregnancy and resolve postpartum; others are triggered for the first time by parturition. These are likely to have different biological bases, possibly related to the functioning of hypothalamic-pituitary-adrenal axis of the individual.

## RESTLESS LEGS SYNDROME (RLS)

#### ▪ RESTLESS LEGS SYNDROME

**Authors :** Lesage S, Earley CJ.

**Source :** Curr Treat Options Neurol. 2004 May;6(3):209-219.

**Summary :** In the past 10 years, restless legs syndrome (RLS) has gained recognition as a common sleep disorder. There are several therapeutic options in treating patients with RLS. RLS causes significant sleep disturbance and negatively impacts on patient quality of life. Pharmacologic treatment can result in improved sleep and quality of life issues. RLS patients should be evaluated for iron deficiency anemia; iron replacement in deficient patients may lead to a resolution of symptoms or may reduce the severity of their symptoms. For patients with daily symptoms, the initial therapy is dopamine agonists. Low doses given in the evening or 2 hours before bed provide adequate relief of symptoms for many RLS patients. Augmentation can be seen with all dopamine agents, but is most prevalent with levodopa. Levodopa therapy is best used for milder intermittent symptoms or in aggravating situations, such as long car rides. Opiates and antiepileptics remain a beneficial therapy for RLS and are useful in patients

who experience pain as part of their RLS. Newer anticonvulsants may provide additional treatment options, but they have yet to undergo clinical trials. Intravenous iron also may provide relief of RLS symptoms; however, dosing and safety issues have not been fully evaluated in a RLS population.

#### ▪ TOPIRAMATE USE AS TREATMENT IN RESTLESS LEGS SYNDROME

**Authors :** Perez A; Servicio de Psiquiatria. Complejo Hospitalario Xeral-Cies. Vigo (Pontevedra)

**Source :** Actas Esp Psiquiatr. 2004 May-Jun;32(3):132-7

**Summary :** Restless legs syndrome is an underdiagnosed disorder of unknown etiology, that generates severe sleep and life quality disturbances. In its therapeutic approach, drugs with very different action mechanisms and variable results have been used. Methods. Nineteen outpatients diagnosed of restless legs syndrome were studied observationally. A semistructured interview was carried out and physical variables (weight, arterial pressure and heart rate), sensitive and motor symptoms, effective dose of topiramate, side effects and fulfillment of the treatment at 30, 60 and 90 days were studied. Results. The patients studied, with an average age of 62.052 +/- 6.22 years, showed improvement in sensitive and motor symptoms, as well as non-significant reductions in cardiovascular parameters. The mean effective dose of topiramate was established at 42.1 +/- 18.7 mg. A significant reduction in weight stands out among the side effects. Conclusions. Topiramate is profiled as an effective treatment in restless legs syndrome, with good tolerability and minimal side effects. Actas Esp Psiquiatr 2004;32(3):132-137

## SLEEP DISORDERS (SD )

#### ▪ SLEEP, SLEEP APNEA, AND EPILEPSY.

**Authors :** Bazil CW. The Neurological Institute, Columbia University, 710 West 168 Street, New York, NY 10032, USA. [cwb11@columbia.edu](mailto:cwb11@columbia.edu)

**Source :** Curr Treat Options Neurol. 2004 Jul;6(4):339-345.

**Summary :** Sleep disorders occur commonly in patients with epilepsy, and can be responsible for symptoms of daytime somnolence and also can contribute to the intractability of epilepsy. The most important aspect of treating sleep disorders, especially sleep apnea, is the recognition of the problem. In a busy clinical practice, symptoms of sleep disorders are frequently overlooked or mistaken. Whenever sleep disruption or excessive daytime somnolence is potentially problematic, the patient should be referred to a sleep specialist and, if indicated, diagnostic testing performed (usually polysomnography with or without multiple sleep latency tests). The author also recommends that all patients receive basic counseling about sleep hygiene, because its principles are often helpful to patients in general. Even in the absence of a sleep disorder, the choice of an anticonvulsant can be partly tailored to the sleep needs of the patient, with alerting drugs (lamotrigine and felbamate) dosed early in the day and relatively sedating agents (phenobarbital and phenytoin) dosed later or at bedtime.

## ALZHEIMER DISEASES (AD)

#### ▪ DONEPEZIL FOR ALZHEIMER'S DISEASE

### IN CLINICAL PRACTICE - THE DONALD STUDY. A MULTICENTER 24 - WEEK CLINICAL TRIAL IN GERMANY

**Authors :** Froelich L, Gertz HJ, Heun R, Heuser I, Jendroska K, Kornhuber J, Kurz A, Mueller-Thomsen T, Ries F, Waechter C, Metz M, Goebel C. - Division of Geriatric Psychiatry, Central Institute for Mental Health Mannheim, University of Heidelberg, Germany.

**Source :** Dement Geriatr Cogn Disord. 2004 Apr 6;18(1):37-43. Epub 2004 Apr 06.

**Summary :** This multicenter open-label clinical trial was designed to investigate the safety and efficacy of donepezil, a selective acetylcholinesterase inhibitor, in the treatment of Alzheimer's disease (AD) in routine clinical practice in Germany. A total of 237 patients with mild-to-moderate AD were treated with donepezil for 24 weeks, 186 completed the study according to the protocol. In the completer group, mean MMSE score for efficacy showed an improvement from baseline of +1.6 points at week 12 (95% CI +1.1 to +2.1) and of +1.1 points at week 24 (95% CI +0.5 to +1.7). In more than 80% of the patients, global tolerability was rated to be very good or good. There were only insignificant effects on ECG parameters. This study confirms the results obtained in previous double-blind trials, which showed that donepezil is effective and well tolerated in patients with mild-to-moderately severe AD. Copyright 2004 S. Karger AG, Basel.

### ▪ EFFECTS OF CHOLINERGIC DRUGS AND COGNITIVE TRAINING ON DEMENTIA.

**Authors :** Requena C, Lopez Ibor MI, Maestu F, Campo P, Lopez Ibor JJ, Ortiz T. - Universidad de Leon (Area de Psicología), Leon, Madrid, Spain.

**Source :** Dement Geriatr Cogn Disord. 2004 Apr 6;18(1):50-54. Epub 2004 Apr 06.

**Summary :** A study was performed on patients with Alzheimer's disease (AD) in order to evaluate the efficacy of a combined treatment (donepezil plus cognitive training) in both cognitive processes and affective states. Eighty-six subjects, 25 men and 61 women, with an average age of 75.58 years, were studied. Almost all the subjects had a basic educational level. Donepezil was administered at a dose of 10 mg daily along with cognitive treatment involving images of everyday life and reminiscent music; the sessions took place on Monday to Friday and lasted three quarters of an hour. The study lasted 12 months. Subjects underwent test-retest with the following tests: Mini-Mental State Examination (MMSE), the cognitive subscale of the Alzheimer's Disease Assessment Scale (ADAS-cog); the Geriatric Depression Scale (GDS) and the overall deterioration scale (FAST). The results showed that subjects receiving the combined treatment had a better response than those who did not receive any cognitive training. These subjects' MMSE score decreased by 3.24 on average. The affective symptomatology of those receiving only drug treatment improved whereas the cognitive processes did not.

## GERIATRIC PSYCHIATRY

### ▪ SPECIAL ISSUES IN THE MANAGEMENT OF DEPRESSION IN OLDER PATIENTS

**Authors :** Rabheru K. - Department of Psychiatry, University of Western Ontario, London. [Kiran.Rabheru@sjhc.london.on.ca](mailto:Kiran.Rabheru@sjhc.london.on.ca)

**Source :** Can J Psychiatry. 2004 Mar;49(3 Suppl 1):41S-50S.

**Summary :** Major depressive disorder is frequently undiagnosed and untreated in older patients. Grief, pain, sleep issues, concurrent medications, altered physiology, and the presence of comorbid medical and psychiatric conditions can complicate the management of depression in older patients. Remission should be the goal of therapy in treating depression in the elderly, just as it is in younger patients, to maximize the impact of treatment on quality of life. Managing depression in older patients can be done effectively with the antidepressant therapies currently available, including selective serotonin reuptake inhibitors (SSRIs), venlafaxine, and mirtazapine. Comorbid medical conditions, which are common among older patients, can have a significant impact on depression and vice versa. Antidepressant therapy with SSRIs has demonstrated efficacy and tolerability in patients at high risk for cardiovascular events and stroke and in those with vascular dementia or Alzheimer's disease. Care should be taken to choose antidepressants with no or minimal effects on glucose levels in patients with diabetes. In addition, venlafaxine has demonstrated beneficial effects on the relief of the pain of diabetic neuropathy. Venlafaxine, mirtazapine, and the SSRIs have demonstrated efficacy and tolerability in older patients, while tricyclic antidepressants have also demonstrated efficacy; however, tolerability can be a problem. Depression is not a natural part of the aging process, as some still believe. The review of current data indicates that the goal of management can and should be full remission. Further, the use of newer agents is safe and effective in this population, as long as one considers the pharmacokinetics and pharmacodynamic properties and inherent biological differences in the elderly population when selecting appropriate therapy.

### ▪ COGNITION & LATE-LIFE DEPRESSION

**Authors :** Christopher F. Murphy, PhD, and George S. Alexopoulos, MD

**Source :** Primary Psychiatry. 2004;11(5):54-58

**Summary :** It is not uncommon for older patients to present with symptoms of both depression and cognitive impairment. Proper diagnoses in such cases are complicated by overlapping symptoms, heterogeneity of syndromes, and impaired self-report. What follows is a discussion of the literature on the clinical and etiological association of late-life depressive syndromes, cognitive dysfunction, and dementia. Assessment and treatment strategies are discussed with the recommendation that when presented with a depressed elderly patient with cognitive impairment, the clinician should evaluate both the psychiatric symptoms and signs and the cognitive impairment. Careful tracking of both depressive and cognitive features and well-targeted, long-term pharmacotherapy and psychosocial interventions can help reduce the burden on these compromised patients

### ▪ ASSESSMENT AND MANAGEMENT OF DEPRESSION IN OLDER ADULTS

**Authors :** Linda H. Harpole, MD, MPH, and John W. Williams Jr, MD, MHSc

**Source :** Primary Psychiatry. 2004;11(5):31-36

**Summary :** Approximately 5% to 10% of older patients who visit a primary care provider suffer from clinically significant depression. Making the diagnosis in the older population can be challenging, as the cardinal symptom of depression, depressed mood, is less prominent than symptoms such as



loss of interest and enjoyment in life, anergia, sleepless-ness, and loss of appetite. Significant barriers to successful treatment exist in this population, including patient resistance to accepting the diagnosis and its perceived stigma, the inappropriate attribution of depressive symptoms to natural aging, and the primary care physician's lack of time and resources to provide adequate treatment. Primary care physicians should make special efforts to screen for depression in their older patients, and once identified, provide education and close follow-up, with the goal of achieving remission from depressive symptoms. Collaborative care models, incorporating patient education, case management, and liaison mental health care, which were developed to overcome some of the barriers to successful treatment of depression in older adults, have proven to be successful. Elements of these models can be incorporated into current practice with the goal of improving the quality of depression care in older adults.

## Psycho-oncology

### ▪ PSYCHIATRIC DISORDERS IN ONCOLOGY : RECENT THERAPEUTIC ADVANCES AND NEW CONCEPTUAL FRAMEWORKS.

**Authors :** Ronson A - Institut Jules Bordet Supportive Care Clinic, Brussels Belgium.

**Source :** Curr Opin Oncol. 2004 Jul;16(4):318-323.

**Summary :** PURPOSE OF REVIEW: Major advances achieved in anticancer treatment have resulted in significant increases in cancer patients' survival periods. At the same time, growing awareness of the psychologic impact of the diagnosis and treatment of cancer on quality of life has created the need for deeper insights into the adjustment process, its disorders, and effective strategies for the treatment of psychiatric morbidity. The wider availability of brain imaging techniques and other neurobiologic tools is creating major opportunities for a scientific understanding of psychodynamic processes. RECENT FINDINGS: Several elements indicate a stress-system activation in response to cancer. The existence of traumatic stress-like syndromes has received increasing support. Structural brain imagery has revealed volumetric alterations of the amygdala, a major participant in emotional and fear responses. Hypotheses about functional modifications at the hypothalamic-pituitary-adrenal axis level may have significant implications for the identification, treatment, and even prevention of psychopathology. Finally, longitudinal studies assessing psychologic adjustment confirm the need for psychosocial and pharmacologic interventions. SUMMARY: Our understanding of the cancer experience at the emotional and cognitive levels remains insufficient, leading to weakly positive results of psychosocial intervention models. The use of antidepressant medication has received substantial empiric and scientific support, but a risk of antidepressant-induced carcinogenesis has not been excluded, which should keep clinicians from overprescribing attitudes. Finally, improving the quality of doctor-patient communication and the psychologic impact of carrying a genetic marker of cancer risk should be the focus of further attention.

## ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

### ▪ THE USE OF ANTIDEPRESSANTS TO TREAT ATTENTION DEFICIT HYPERACTIVITY DISORDER IN ADULTS

**Authors :** Pierre Blier University of Ottawa, Canada - Ian D. Maidment , Pharmacy Department, Kent and Canterbury Hospital

**Source :** Published in Association with : British Association for Psychopharmacology - Editors David J Nutt University of Bristol, UK Journal of Psychopharmacology - Volume 17 Issue 03 - Publication Date: 09/2003

**Summary :** There is increasing evidence that children continue to experience attention deficit hyperactivity disorder (ADHD) symptoms into adult life. The two main treatments for ADHD are antidepressants and stimulants. Here, the effectiveness data relating to the use of antidepressants in adults with ADHD are reviewed. Four controlled and six open studies were identified. Although, there is only limited data currently available, antidepressants may offer an effective therapy for adult ADHD. Controlled trials have studied desipramine, atomoxetine and bupropion, with most evidence supporting the efficacy of desipramine. The initial data indicate that atomoxetine is less effective than desipramine. The efficacy of bupropion is unclear. Initial published open data suggest a response rate of 50-78% with venlafaxine. Controlled studies are required to confirm this efficacy. Most of the present data are short-term, therefore long-term effectiveness data are required.

## TARDIVE DYSKINESIA

### ▪ TARDIVE DYSTONIA INDUCED BY ATYPICAL NEUROLEPTICS : A CASE REPORT WITH OLANZAPINE

**Authors :** Charfi F, Cohen D, Houeto JL, Soubrie C, Mazet P. - Departement de Psychiatrie de l'Enfant et de l'Adolescent, Paris, France.

**Source :** J Child Adolesc Psychopharmacol. 2004 Spring; 14(1):149-52.

**Summary :** We report the case of a 17-year-old-boy with schizophrenia who developed tardive dystonia after 9 months of treatment with olanzapine. This case and the relevant literature show that when neuroleptic treatment is indicated, switching to another atypical neuroleptic might be helpful for both tardive dystonia and schizophrenia. In such a case, clozapine appears to be the first-line therapeutic option.

### ▪ LOWER RISK FOR TARDIVE DYSKINESIA ASSOCIATED WITH SECOND-GENERATION ANTIPSYCHOTICS : A SYSTEMATIC REVIEW OF 1-YEAR STUDIES.

**Authors :** Correll CU, Leucht S, Kane JM. - Department of Psychiatry Research, Zucker Hillside Hospital, North Shore-Long Island Jewish Health System, Schneider Children's Hospital, Glen Oaks, NY 11004, USA. [ccorrell@lij.edu](mailto:ccorrell@lij.edu)

**Source :** Am J Psychiatry. 2004 Mar;161(3):414-25.

**Summary :** Based on lower rates of acute extrapyramidal side effects associated with second-generation antipsychotics, compared to first-generation antipsychotics, and based on preliminary data, second-generation antipsychotics are expected to cause less tardive dyskinesia than first-generation antipsychotics. This hypothesis was examined in a systematic

review of studies involving open or controlled treatment with any second-generation antipsychotic. **METHOD:** Studies of treatment with second-generation antipsychotics lasting > or =1 year and reporting on new cases of tardive dyskinesia or dyskinesia were systematically reviewed. **RESULTS:** In 11 studies, 2,769 patients received treatment with risperidone (five studies, N=1,235), olanzapine (two studies, N=610), quetiapine (two studies, N=386), amisulpride (one study, N=331), or ziprasidone (one study, N=207) for a weighted mean and median duration of 263 and 306 days, respectively. Study designs were double blind and randomized (N=3); open-label extensions of double-blind, randomized trials (N=4); and open label (N=4). Of the four trials that had a comparator (all involving adults with schizophrenia spectrum disorders), three used haloperidol (N=408) and one used placebo (N=71). Studied populations included children (N=77), adults (N=1,419), adults and elderly persons (N=794), and exclusively patients age 54 years or older (N=479). The weighted mean annual incidence of tardive dyskinesia for second-generation antipsychotics was 0% in the children, 0.8% (range=0.0%-1.5%) in the adults, 6.8% in the mixed adult and elderly population, and 5.3% (range=0.0%-13.4%) in the patients age 54 years and older, compared to 5.4% (range=4.1%-7.4%) in adults treated with haloperidol. **CONCLUSIONS:** Results from 11 long-term studies support the idea that second-generation antipsychotics have a reduced risk for tardive dyskinesia, compared to first-generation antipsychotics, although the doses of haloperidol used in the comparator studies were relatively high. More carefully designed studies, ideally lasting beyond 1 year and comparing the effects of different second-generation antipsychotics in patients who have never taken first-generation antipsychotics, are needed to estimate the true risk. It would not appear premature for clinicians to consider these findings in making long-term treatment decisions.

## CHRONIC TENSION-TYPE HEADACHE (CTHA)

### ■ MIRTAZAPINE IS EFFECTIVE IN THE PROPHYLACTIC TREATMENT OF CHRONIC TENSION-TYPE HEADACHE

**Authors :** Bendtsen L, Jensen R. Danish Headache Center, University of Copenhagen, and Department of Neurology, Glostrup University Hospital, Copenhagen, Denmark. [bendtsen@dadlnet.dk](mailto:bendtsen@dadlnet.dk)

**Source :** Neurology. 2004 May 25;62(10):1706-11

**Summary :** The tricyclic antidepressant amitriptyline is the only drug with prophylactic efficacy for chronic tension-type headache. However, amitriptyline is only moderately effective, with headache reduction of approximately 30%, and treatment is often hampered by side effects. Mirtazapine is a relatively new so-called noradrenergic and specific serotonergic antidepressant, which is more specific and therefore generally better tolerated. **OBJECTIVE:** To evaluate the efficacy of mirtazapine. **METHODS:** Twenty-four nondepressed patients with chronic tension-type headache were included in a randomized, double-blind, placebo-controlled, crossover trial. All patients had tried numerous other treatments. Mirtazapine 15 to 30 mg/day or placebo was each given for 8 weeks separated by a 2-week wash-out period. **RESULTS:** Twenty-two patients completed the study. The primary efficacy variable, area-under-the-headache curve (AUC; duration x intensity), was lower during treatment with mirtazapine (843)

than during treatment with placebo (1,275) ( $p = 0.01$ ). Mirtazapine also reduced the secondary efficacy variables headache frequency ( $p = 0.005$ ), headache duration ( $p = 0.03$ ), and headache intensity ( $p = 0.03$ ) and was well tolerated. **CONCLUSIONS:** Mirtazapine reduced AUC by 34% more than placebo in difficult-to-treat patients. This finding is clinically relevant and may stimulate the development of prophylactic treatments with increased efficacy and fewer side effects for tension-type headache and other types of chronic pain.

## NEUROLEPTIC MALIGNANT SYNDROME (NMS)

### ■ NEUROLEPTIC MALIGNANT SYNDROME

**Authors :** Chodorowski Z, Anand JS, Rutkowski P. – I Klinika Chorob Wewnetrznych I Ostych Zatruc Akademii Medycznej w Gdansk, 80-211 Gdansk, ul. Debinki 7.

**Source :** Przegl Lek. 2003 ;60(4) :299-301.

**Summary :** Neuroleptic malignant syndrome (NMS) is the most dangerous side effect of phenothiazines therapy. In the period of time from 1995 to 2002 in the Intensive Toxicological Unit there were five patients, 3 men and 2 women, aged from 25 to 62 (average 44.2) years-old, admitted from the regional inpatients psychiatric units with the diagnosis of pneumonia and/or sepsis. The patients about 48-72 hours before admittance were given some phenothiazine derivatives (promazine, perphenazine, clozapine, pipamperon) and/or butyrophenone (haloperidol) because of psychotic state. Altered consciousness, muscle rigidity, hyperpyrexia (39.0-41.0 degrees C), sweating, tachycardia (120-150/min.), tachypnoea (respiratory rate more than 25/min.) and high level of creatine kinase activity (23,751-112,288 U/l) dominated. Only one patient had clinical picture of pneumonia. Because of the rapid development of acute respiratory failure, respiratorotherapy was initiated and continued for 8 and 10 days in two patients respectively. Transient thrombocytopenia (26,000/microliter) in one subject was observed. The neuroleptic drug was withdrawn and intensive supportive care with administration of bromocriptine (15-20 mg/24 h) was provided. None one of the doctors told the patients about the possibility of NMS during phenothiazines therapy.

## Psychophysiology

### ■ UPDATE ON STRESS AND DEPRESSION: THE ROLE OF THE HYPOTHALAMIC-PITUITARY-ADRENAL (HPA) AXIS

**Authors :** MELLO, Andrea de Abreu Feijó de, MELLO, Marcelo Feijó de, CARPENTER, Linda L et al.

**Source :** Rev. Bras. Psiquiatr., Oct. 2003, vol.25, no.4, p.231-238. ISSN 1516-4446.

**Summary :** Over the past 50 years, relationships between stress and the neurobiological changes seen in psychiatric disorders have been well-documented. A major focus of investigations in this area has been the role of the hypothalamic-pituitary-adrenal (HPA) axis, both as a marker of stress response and as a mediator of additional downstream pathophysiological changes. This review examines the emerging literature concerning the relationship between stress, HPA axis function, and depression, as well as the role of early life stress as an important risk factor for HPA axis dysregulation. The more recent studies reviewed suggest that

the prominence of HPA axis hyperactivity in adults with depressive and anxiety disorders may constitute a link between the occurrence of adversity in childhood and the development of adult psychopathology

## ELECTROCONVULSIVE THERAPY (ECT)

### WORLD PSYCHIATRIC ASSOCIATION POSITION STATEMENT ON THE USE AND SAFETY OF ELECTROCONVULSIVE THERAPY

**Authors :** Mohammed T. Abou-saleh, Yiannis G. Papakostas, Iannis M. Zervas, George N. Christodoulou

**Source :** The Arab Journal of Psychiatry – 2004 May;15(1): 26-35

**Summary :** This position statement on the use and safety of electroconvulsive therapy (ECT) has been prepared on behalf of the WPA Section on Biological Psychiatry at the request of the Executive Committee of the WPA. The statement is informed by available evidence and reference will be made to guidelines produced by a number of authoritative bodies, including the American Psychiatric Association, the Royal College of Psychiatrists, the UK National Institute of Clinical Excellence (NICE) and the World Federation of Societies of Biological Psychiatry. Moreover, for depressive disorders particular reference will be made to the recently published systematic review and meta-analysis by the UK ECT Review Group (2003).

## PSYCHOTROPIC DRUGS

### مضادات الاكتئاب للتوقف عن التدخين

Hughes JR, Stead LF :

Cochrane Review : 2, 2001. Oxford : Update Soft :

[www.arabicebm.com](http://www.arabicebm.com) :

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### مزيلات القلق لوقف التدخين

. Hughes JR, Stead LF, Lancaster T :

Cochrane Review 4, 2001. Oxford: Update Soft :

[www.arabicebm.com](http://www.arabicebm.com) :

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### APA : OLANZAPINE / FLUOXETINE (SYMBYAX) REDUCES DEPRESSION / ANXIETY IN BIPOLAR PATIENTS WITHOUT INCREASED MANIA RISK

**Authors :** Bruce Sylvester

**Source :** NEW YORK, N.Y. – May 7, 2004

**Summary :** A combination of olanzapine and fluoxetine HCl (Symbyax) reduces core mood symptoms as well as depression and anxiety without increasing risk of inducing mania in bipolar patients, researchers said during a presentation of 2 studies here on May 6th at the American Psychiatric Association Annual Meeting.

Symbyax is the only treatment approved by the Food and Drug Administration for the treatment of depressive phase bipolar disorder.

"We saw 2 important things in these studies," said the lead investigator for both studies, Sara Corya, MD, lead researcher, Lilly Research Labs, Indianapolis, Indiana. "[Montgomery-Asberg Depression Rating Scale] score improvements [showed] mean core mood improvements, not only improvements in somatic symptoms of depression. And Symbyax subjects achieved relatively greater improvement in depression and anxiety symptoms when compared to placebo or olanzapine subjects -- and did not show increased treatment-emergent mania. The last point is a very important one for clinical practice, where the fear of inducing mania with these patients is understandably high."

▪ **ATYPICAL DEPRESSION, ATYPICAL TEMPERAMENT AND A DIFFERENTIAL ANTIDEPRESSANT RESPONSE TO FLUOXETINE AND NORTRIPTYLINE.**

**Authors :** Joyce PR, Mulder RT, McKenzie JM, Luty SE, Cloninger CR. - Department of Psychological Medicine, Christchurch School of Medicine and Health Sciences, Christchurch, New Zealand.

**Source :** *Depress Anxiety*. 2004;19(3):180-6

**Summary :** We examined the personality characteristics of depressed patients with and without atypical depression. Of 195 depressed outpatients in a randomized treatment trial of fluoxetine or nortriptyline, 16 met DSM-IV criteria for atypical depression. We compared the personality traits and disorders in those with and without atypical depression. In atypical depression, fluoxetine was superior to nortriptyline. On the Temperament and Character Inventory, those with atypical depression had high attachment, low persistence, and high anticipatory anxiety. A temperament construct of these dimensions was associated with a differential antidepressant response, regardless of other atypical features. A temperament derived measure of "rejection sensitivity" defines a group of depressed patients with a differential antidepressant response, regardless of reversed vegetative symptoms.

▪ **GLOZAPINE IN DRUG INDUCED PSYCHOSIS IN PARKINSON'S DISEASE : A RANDOMISED, PLACEBO CONTROLLED STUDY WITH OPEN FOLLOW UP.**

**Authors :** Pollak P, Tison F, Rascol O, Destee A, Pere JJ, Senard JM, Durif F, Bourdeix I. Department of Neurology, University Hospital of Grenoble, 38043 Grenoble Cedex 9, France. [pierre.pollak@ujf-grenoble.fr](mailto:pierre.pollak@ujf-grenoble.fr)

**Source :** *J Neurol Neurosurg Psychiatry*. 2004 May; 75(5) :689-95.

**Summary :** To compare the efficacy and safety of clozapine in drug induced psychosis in Parkinson's disease (PD). **METHODS :** A four week, randomised, double blind, parallel comparison of clozapine and placebo, followed by a 12 week clozapine open period, plus a one month period after drug discontinuation, in 60 patients with PD. The primary efficacy outcome was the « clinical global impression scale » (CGI) ; the positive subscore of the « positive and negative syndrome scale » (PANSS) was used as the secondary efficacy parameter and the « unified Parkinson's disease rating scale » (UPDRS) and the « mini mental test examination » (MMSE) as safety outcomes. **RESULTS :** The mean (SD) dosage of clozapine was 35.8 (12.5-50) mg at the end of the double blind period. The mean (SD) scores on the CGI improved by 1.8 (1.5) for the clozapine group compared with 0.6 (1.1) for the placebo group (p = 0.001). The mean (SD) positive subscore of PANSS improved by 5.6 (3.9) for the clozapine group (0.8 (2.8) for the placebo group ; p < 0.0001). At the end of the open period, 25 patients had completely recovered from delusions and hallucinations, and 19 experienced a relapse within one month after the clozapine washout period. The UPDRS motor and MMSE mean scores did not change significantly in either group. Somnolence was more frequent with clozapine than with placebo. **CONCLUSIONS :** Clozapine at a mean dose lower than 50 mg/day improves drug induced psychosis in PD without significant worsening of motor function, and the effect wears off once the treatment stops.

▪ **CONSIDERATIONS IN THE COMBINATION OF GLOZAPINE AND BENZODIAZEPINES**

**Authors :** Rupprecht R, Soyka M, Grohmann R, Ruther E, Moller HJ. - Klinik für Psychiatrie und Psychotherapie der Ludwig-Maximilians-Universität München, München, Deutschland.

**Source :** *Nervenarzt*. 2004 Mar 23 [Epub ahead of print]

**Summary :** Serious adverse events and even sudden death have been reported during administration of the combination of clozapine and benzodiazepines. However, this combination does not necessarily result in increased frequency of serious adverse events. Thus it is not regarded as an absolute contraindication and might be useful in distinct clinical situations, e.g., during the occurrence of a malignant neuroleptic syndrome, "catatonic dilemma," or severe agitation during clozapine treatment. In the following report, certain suggestions on how to deal with this combination therapy are provided which may provide a basis for discussion that ultimately may lead to the formulation of guidelines for this combination therapy. Such guidelines may help psychiatrists in dealing with this combination in clinical situations. Moreover, the formulation of such guidelines would help with forensic issues in case of serious adverse events occurring during this combination therapy.

▪ **SEIZURE SECONDARY TO CITALOPRAM OVERDOSE.**

**Authors :** Cuenca PJ, Holt KR, Hoefle JD. Madigan-University of Washington Emergency Medicine Residency, Madigan Army Medical Center, Fort Lewis, Washington 98433, USA.

**Source :** *Emerg Med*. 2004 Feb;26 (2):177-81.

**Summary :** Selective serotonin reuptake inhibitors (SSRIs) are widely used in the community for treating many forms of mental illness. Citalopram, a newer generation SSRI, is commonly prescribed but, despite its low toxicity profile, has a danger of seizure and dysrhythmias in overdose. This case report documents the key aspects in treatment of a citalopram overdose resulting in a seizure and an episode of supraventricular tachycardia (SVT). The seizure was successfully treated with benzodiazepines. The SVT was terminated with administration of adenosine. We review the literature and make recommendations on treatment of citalopram overdose.

▪ **THE EFFECTS OF ANTIDEPRESSANTS ON HUMAN SEXUALITY**

**Authors :** Anita H. Clayton, MD, and Sara G. West, MD

**Source :** *Primary Psychiatry*. 2003;10(12):62-70

**Summary :** **Focus Points**

- Antidepressant medications affect sexual functioning through specific mechanisms of action.
- Antidepressant-associated sexual dysfunction (SD) may contribute to medication nonadherence or diminished quality of life.
- Many factors may contribute to SD in depressed patients, including residual symptoms of depression, medical illness, substance abuse, psychosocial factors, and medications.
- Algorithms may be helpful in the assessment and treatment of SD associated with antidepressant therapy.

**Abstract :** Sexual dysfunction has become an increasingly important and recognized contributor to the side-effect profile in patients treated with antidepressant medications. The



condition may take several forms and must be differentiated from a prior or unrelated condition. The effects of each class of antidepressants differ based on their mechanisms of action. There exist a number of options for relief of sexual dysfunction associate with the use of antidepressants.

**▪ ATYPICAL ANTIPSYCHOTICS AND RISK OF CEREBROVASCULAR ACCIDENTS**

**Authors :** Herrmann N, Mamdani M, Lanctot KL

**Source :** Am J Psychiatry. 2004 Jun;161(6):1113-5

**Summary :** Randomized controlled trials have suggested that at least one atypical antipsychotic may be associated with an increased risk of stroke in older people with dementia. This study examined the association between atypical antipsychotic use and stroke in the elderly. **METHOD:** The authors conducted a retrospective population-based cohort study of patients over the age of 66 by linking administrative health care databases. Three cohorts-users of typical antipsychotics, risperidone, and olanzapine-were identified and compared. **RESULTS:** Subjects treated with typical antipsychotics (N=1,015) were compared with those given risperidone (N=6,964) and olanzapine (N=3,421). Model-based estimates adjusted for covariates hypothesized to be associated with stroke risk revealed relative risk estimates of 1.1 (95% CI=0.5-2.3) for olanzapine and 1.4 (95% CI=0.7-2.8) for risperidone. **CONCLUSIONS:** Olanzapine and risperidone use were not associated with a statistically significant increased risk of stroke compared with typical antipsychotic use.

**▪ COMPARATIVE EFFECT OF ATYPICAL AND CONVENTIONAL ANTIPSYCHOTIC DRUGS ON NEUROCOGNITION IN FIRST-EPISODE PSYCHOSIS**

**Authors :** Keefe RS, Seidman LJ, Christensen BK, Hamer RM, Sharma T, Sitskoorn MM, Lewine RR, Yurgelun-Todd DA, Gur RC, Tohen M, Tollefson GD, Sanger TM, Lieberman JA.

**Source :** Am J Psychiatry. 2004 Jun;161(6):985-95

**Summary :** The effect of antipsychotic medication on neurocognitive function remains controversial, especially since most previous work has compared the effects of novel antipsychotic medications with those of high doses of conventional medications. This study compares the neurocognitive effects of olanzapine and low doses of haloperidol in patients with first-episode psychosis. **METHOD:** Patients with a first episode of schizophrenia, schizoaffective disorder, or schizophreniform disorder (N=167) were randomly assigned to double-blind treatment with olanzapine (mean modal dose= 9.63 mg/day) or haloperidol (mean modal dose=4.60 mg/day) for the 12-week acute phase of a 2-year study. The patients were assessed with a battery of neurocognitive tests at baseline and 12 weeks after beginning treatment. **RESULTS:** An unweighted neurocognitive composite score, composed of measures of verbal fluency, motor functions, working memory, verbal memory, and vigilance, improved significantly with both haloperidol and olanzapine treatment (effect sizes of 0.20 and 0.36, respectively, no significant difference between groups). A weighted composite score developed from a principal-component analysis of the same measures improved to a significantly greater degree with olanzapine, compared with haloperidol. Anticholinergic use, extrapyramidal symptoms, and estimated IQ had little effect on the statistical differentiation of the medications, although duration of illness had a modest effect. The correlations of cognitive

improvement with changes in clinical characteristics and with side effects of treatment were significant for patients who received haloperidol but not for patients who received olanzapine. **CONCLUSIONS:** Olanzapine has a beneficial effect on neurocognitive function in patients with a first episode of psychosis. However, in a comparison of the effects of olanzapine and low doses of haloperidol, the difference in benefit is small.

**BEHAVIOR THERAPY - PSYCHOTHERAPY**

**▪ العلاج السلوكي الفردي لإيقاظ التدخين**

Lancaster T, Stead LF :

Cochrane Review : 2, 2003. Oxford: Update Soft. :

[www.arabicebm.com](http://www.arabicebm.com) :

1.35 :%95 ) 1.62  
 .(1.56 61.95 0.98 ) .(1.94  
 .(2.13 0.83 %95 1.33 )

**▪ المعالجة السلوكية لألم أسفل الظهر المزمن**

Tulder MW van, Ostelo RWJG, Vlaeyen JWS, :

Cochrane Review : 4, 2001. Oxford: Update Soft. :

[www.arabicebm.com](http://www.arabicebm.com) :

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 35. )  
 ) (0.74 0.04 %95

(0.7 0.1 %95 0.4

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 .0 ) (0.36 0.3 %95  
 .(0.45 0.08 %95  
 :

▪ **THERAPY OF ANXIETY AND OBSESSIVE-COMPULSIVE DISORDER IN BEHAVIOR THERAPY PRACTICE**

**Authors :** C. Roth, J. Siegl, N. Aufdermauer, H. Reinecker  
**Source :** Verhaltenstherapie 2004;14:16-21

**Summary :** The importance of exposure in the treatment of anxiety and obsessive-compulsive disorders is widely accepted. The present study investigates how therapists in German ambulatory care actually treat patients with anxiety disorders or obsessive-compulsive disorders. **Material and Methods:** For this purpose 138 medical and psychological psychotherapists (behavior therapy) were investigated by use of a self-constructed questionnaire. The questionnaire contained 85 closed-ended and half-open questions on the concrete proceeding in therapies for anxiety and obsessive-compulsive disorder especially regarding exposure. Data were analyzed descriptively. **Results:** 83.3% of the therapists used exposure therapy in the treatment of anxiety disorders, 79% used it in the treatment of obsessive-compulsive disorders. Mostly, therapists choose gradual exposure. Only sometimes they use exposure in vivo. Only a minority allows 2 hours or

more for an exposure session or leaves their private practice for the exposure training.

▪ **THE IMPACT OF PSYCHOLOGICAL PSYCHOTHERAPY ON ANXIETY PROVOKING DIZZINESS IN PANIC DISORDER WITH AGORAPHOBIA**

**Authors :** N. Heinrichs, K. Hahlweg, C. Moschner, K. Wessel, W. Fiegenbaum

**Source :** Verhaltenstherapie 2003; 13:244-252 (DOI: 10.1159/000075840)

**Summary :** Dizziness is frequently reported as a typical somatic complaint in panic disorder with agoraphobia. However, it is unclear, how often dizziness is experienced as anxiety provoking, and to what extent fear of dizziness affects treatment success. The present study examined the frequency and the influence of behavior therapy on anxiety provoking dizziness in patients with panic disorder with agoraphobia. **Patients and Methods:** 398 agoraphobics with panic disorder participated in the study. To analyze the impact of psychotherapy on dizziness, patients were classified into four groups depending on anxiety provoking dizziness (strong/weak) before or after treatment (pre/post). **Results:** Fear of dizziness was the most frequent somatic complaint in these patients at the beginning of the treatment. According to different self-rating scales, all four groups improved considerably with treatment. However, the group that reported dizziness as very anxiety provoking before treatment but no longer anxiety provoking after treatment yielded the strongest overall therapy effect. The other three groups did not differ in their overall benefit from treatment. Similar effects were found if different somatic sensations such as heart palpitations or hard breathing were selected. **Discussion:** The frequency of fear of dizziness emphasizes its relevance in this patient sample. It is therefore important that practitioners be informed about possible differential diagnoses that may include this fear. However, fear of dizziness did not take a special role in treatment outcome because treatment efficacy depended on losing the fear of disorder-typical physical symptoms in general, not specifically the fear of dizziness.

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## مداخلات المحور الأول : اللغة العربية و العلوم النفسية

للمشاركة في المنتدى

[www.arabpsynet.com/HomePage/Psy-Forum.Ar.asp](http://www.arabpsynet.com/HomePage/Psy-Forum.Ar.asp)

سعيًا لتفعيل الحوار، نعرض لمواقف وأفكار أساتذة وأطباء تميزوا بمساهماتهم الأصيلة لتطوير العلوم النفسية في الوطن العربي.

**خواء المشهد اللغوي العربي و تجاؤل ثورة علوم اللسانيات**  
أ.د. نبيل علي / أستاذ المعلوماتية و علوم الاتصال - القاهرة / مصر

**اللغة هي وحدة الوعي و تشكيلاته المتداخلة**  
أ.د. يحيى الرخاوي - القاهرة / مصر

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أ.د. علي زيعور / أستاذ الفلسفة و علم النفس - لبنان / بيروت

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د. جمال التركي / الطب النفسي - تونس

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د. بسام بركة / لبنان

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د. المنصف الشلي / تونس

### الذات بين الاستئصال و تموقع اللغة

د. محمد رضوان حسن / لبنان

**دعوة إلى احترام كل اللغات بعيداً عن الرهاب و عن العنصرية**  
أ.د. محمد أحمد النابلسي : أستاذ الطب النفسي- طرابلس / بيروت

**العربية بين الدقة العلمية و النزعة الجمالية**  
أ.د. علي زيعور / أستاذ الفلسفة و علم النفس - لبنان / بيروت

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أ.د. محمد أحمد النابلسي : أستاذ الطب النفسي- طرابلس / بيروت

### العربية بين اللغوانية و الانضباطية

أ.د. علي زيعور / أستاذ الفلسفة و علم النفس - لبنان / بيروت  
( )

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### قراءات في المحور

#### اللغة العربية و تشكيل الوعي القومي

أ.د. يحيى الرخاوي

[www.arabpsynet.com/Archives/VP/VP.Rakkaoui.ArabLangage.htm](http://www.arabpsynet.com/Archives/VP/VP.Rakkaoui.ArabLangage.htm)

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[www.arabpsynet.com/Archives/VP/VP.Baraka.langage.htm](http://www.arabpsynet.com/Archives/VP/VP.Baraka.langage.htm)

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#### المحور الأول

اللغة العربية و العلوم النفسية

#### المحور الثاني

نحو سيكولوجيا عربية

#### المحور الثالث

الوظيفة الجنسية من السواء إلى الاضطراب

#### المحور الرابع

مداخلات حرة

### دعوة إلى اعتماد مبدأ فهم الكلمات

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شارك برأيك: [www.arabpsynet.com/propositions/PropForm.htm](http://www.arabpsynet.com/propositions/PropForm.htm)

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أ.د. أحمد عكاشة / القاهرة - مصر

2005 -

أ.د. ديجيى الرخاوي / القاهرة - مصر

أ.د. أديب الحسالي / سوريا - دمشق

أ.د. طارق عكاشة / القاهرة - مصر

website

( [www.arabicebm.com](http://www.arabicebm.com) : ) .

د. حسان المالم / سوريا - السعودية

أ.د. سامي عبد القوي / الإمارات - مصر

د. خالد أصليم / غزة - فلسطين

### العدد القادم

انطباعات أساتذة علم النفس ...

## APPRECIATIONS : PROFESSORS OF PSYCHIATRY & PSYCHIATRISTS

### PR. NORMAN SARTORIUS : SUISSE

I shall certainly try to follow the development of your site and congratulate you on the initiative. / With kind regards. (World Psychiatric Association )

### DR. GHITA ELKHAYAT ! CASABLANCA - MAROC

Je voulais te remercier en te souhaitant tout le courage de continuer à nous faire « arabpsynet »... Encore bravo, merci et essayons de travailler ensemble.

### DR. W. K. ABDUL-HAMID : CHELMSFORD - UK

I would like to thank you for your creative efforts to facilitate better Arab Psychiatry and to wish you and the Arabpsynet all prosperity. I would like to offer my help in the development of your net a part from the fact that I don't speak French I am an Iraqi psychiatrist practicing currently in Chelmsford, UK. I wanted recently to attend your last psychiatry conference in Tunis but I was worried that I will not be able to understand as the conference programmed sound to be in French. I think we should start to try to bridge the gap between magrib French psychiatry and mashrik mainly English based psychiatry by using our mother tongue Arabic when and where possible. With my best wishes. (Consultant Psychiatrist & senior lecturer )

### PR. LOTFI GAHA ! MONASTIR - TUNISIE

Je tiens à vous féliciter pour tout ce que vous faites en faveur de la psychiatrie à l'échelle Tunisienne et Arabe et vous remercie en particulier d'avoir diffusé l'information concernant le 23è Congrès Franco-Maghrébin de psychiatrie qui se tiendra à Monastir les 7 et 8 octobre 2004. Un grand merci pour tout. Bien cordialement.

### PR. SAID ABDEL AZIM ! CAIRO - EGYPT

I appreciate your great effort to make the ArabPsyNet a window for communication between Arab Psychiatrists and others. The World Congress of Psychiatry of WPA going to held in Cairo 2005 should be our target to make it unforgettable event. Prof Okasha succeeded in inviting this Congress for the first time to Egypt and Africa and we should do all the effort to make it a successful one. Thanks for your invitation to all Psychiatrists in the Arab world to participate actively through scientific work. ( President of the Egyptian Psychiatric Association / CoChair of the Scientific Committee of WPA Congress Cairo 2005)

### DR. MUHAMMAD AL-SAMARRAI : IRAQ

It is a great event in our time to have such revolutionary motion in the time of helplessness in our world. I am ready to take part in any thing in you may need.

### PR. DONNAS STEWART : MONTREAL- CANADA

Looks good. Congrats. (President of Women Mental Health Section / WPA)

### PR. ALLAN TASMAN ! LOUISVILLE - USA

Congratulations on launch of your new web site. I am sure it will be an excellent means to increase communication and share the latest works in the Arab world and elsewhere. I know that a tremendous amount of work has gone into putting this project together, and you are to be commended in the highest degree. I hope at some point in the future, once things are running smoothly, you might be able to post English versions of some, or all if possible, of the most important works that you cite. Best wishes and great success to you and all involved with this project, Sincerely. (Professor and Chairman Dept. of Psychiatry & Behavioral Sciences - University of Louisville School of Medicine Louisville - USA /United States Representative to the World Psychiatric Association Board / Past President, American Psychiatric Association)

### DR SYED N ABIDI BSc, MBBS, FMMS : UK

I found this website very interesting, comprehensive and informative in deed. Site is added to `My Favourites / Kind regards.

### DR. ADEL ELMOKHTAR : KÉNITRA - MAROC

J'ai trouvé ce site particulièrement intéressant. Ce site est pour moi une approche plus enrichissante, particulièrement pour les psychiatres arabes qui souffrent du manque de publications. Il est donc normal que je remercie le DOCTEUR Jamel TURKY pour ses efforts constants qui ne datent pas d'hier. Bon courage pour toutes l'équipe technique. Et surtout bonne continuation.

### DR. KARAM RADWAN, M.D. : MICHIGAN - USA

I was glad to see your website and your work evolve to be the light of our important sciences in the Arab World. Our speciality is way behind in educating the Arab nations on their mental health. I want to congratulate you on the great website, your contributions will be never forget by the upcoming generations. I would be more than happy if I can be of any help to you and your efforts. Many thanks.

### DR KHALED MOUNEIMNE : LIBAN - ITALIE

I want to express my happiness enjoying your pages while surfing and reading such an important psy-site, and congratulate you for the efforts to divulgate and spread scientific arab psychiatric and psychological knowledge. Your site will help arab and non-arab researchers to understand really the deepness and the importance of the arab psychiatry, the psychiatry of Ibn Sirine and other scientists and psychosociologists as Ibn Khaldoun etc., the base of modern psychiatry and psychoanalysis. Thanks and go ahead

## قواعد النشر بمجلة شبكة العلوم النفسية العربية

تعمل "مجلة شبكة العلوم النفسية العربية" على الإحاطة بمسجلات الاختصاص في كافة فروع العلوم النفسية، ومحاولين بذلك الاستجابة لحاجات المخصصين والمهنيين خصوصاً بعد تداخل تطبيقات الاختصاص مع مختلف فروع العلوم الإنسانية. وذلك من خلال اطلاع المصنف على اتجاهات البحوث العالمية وتعرفه بأخبار ومسجلات هذه البحوث عبر بعض الترجمات للأبحاث الأصلية. أما بالنسبة للبحوث العربية فإن المجلة تسعى لتقديم الدراسات والبحوث الرصينة المساندة للمسجلات والحاجات الفعلية لمجتمعنا العربي .

تقبل للنشر الأبحاث بإحدى اللغات الثلاث العربية، الفرنسية أو الإنكليزية.

- 1- الأبحاث الميدانية والتجريبية
- 2- الأبحاث والدراسات العلمية النظرية
- 3- عرض أو مراجعة الكتب الجديدة
- 4- المقارن العلمية عن المؤتمر المعنية بدراسات الطفولة
- 5- المقالات العامة المتخصصة

المجلة مفتوحة أمام كل الباحثين العرب من أطباء، فنانين و أساتذة علم النفس داخل الوطن العربي و خارجه وهي ترحب بكل المساهمات الملتزمة بشروط النشر التي حددها الهيئة العلمية للموقع على الشكل التالي:

### ■ قواعد عامة

- الالتزام بالقواعد العلمية في كتابة البحث.
- الجودة في الفكرة والأسلوب والمنهج، والتوثيق العلمي، والحلو من الأخطاء اللغوية والنحوية.
- إرسال البحث بالبريد الإلكتروني [webmaster@arabpsynet.com](mailto:webmaster@arabpsynet.com) أو بواسطة قرص من (لا تقبل الأبحاث الورقية).
- إرسال السيرة العلمية المختصة بالنسبة للكتاب الذين لم يسبق لهم النشر في مجلة الشبكة.

### ■ قواعد خاصة

- 1- كتابة عنوان البحث واسم الباحث ولقبه العلمي والجهة التي يعمل لديها مع الملخصات و الكلمات المفتاحية باللغات الثلاث العربية، الفرنسية أو الإنكليزية.
- 2- يراعى في إعداد قائمة المراجع ما يلي : تسجيل أسماء المؤلفين والمترجمين منبوعة بسنة النشر بين قوسين ثم بعنوان المصدر ثم مكان النشر ثم اسم الناشر.
- 3- استيفاء البحث لمطلوبات البحوث الميدانية والتجريبية بما يضمنه من مقدمة والإطار النظري والدراسات السابقة ومشكلة البحث وأهدافه، وفروضه وتعريف مصطلحاته.
- 4- يراعى الباحث توضيح أسلوب اختيار العينته، وأدوات الدراسة وخصائصها السيكموتريّة وخطوات إجراء الدراسة.
- 5- يقوم الباحث بعرض النتائج بوضوح مستعينا بالجداول الإحصائية أو الرسومات البيانية متى كانت هناك حاجة لذلك
- 6- تخضع الأعمال الطنفسية المعروضة للنشر لتكبير اللجنة الاستشارية الطنفسية للمجلة، كما تخضع الأعمال العلمنفسية لتكبير اللجنة الاستشارية العلمنفسية، وذلك وفقاً للنظام المعتمد في المجلة ويبلغ الباحث في حال اقتراحات تعديل من قبل المحكمين.
- 7- توجه جميع المراسلات الخاصة بالنشر إلى رئيس الموقع على العنوان الإلكتروني للمجلة.
- 8- الإجراء الواردة في المجلة تعين عن رأي كاتبها ووجهات نظرهم.
- 9- لا تعاد الأبحاث المفروضة لأصحابها .
- 10- لا تدفع مكافآت مالية عن البحوث التي تنشر.

**قواعد التوثيق:**

عند الإشارة إلى المراجع في نص البحث بذكر الاسم الأخير (فقط) للمؤلف أو الباحث وسنة النشر بين قوسين مثل (عكاشة، 1985) أو (Sartorius, 1981) وإذا كان عدد الباحثين من اثنين إلى خمسة تذكر أسماء الباحثين جميعهم للمرة الأولى مثل (دسوقي، النابلسي، شاهين، المصري، 1995)، وإذا تكررت الاستعانة بنفس المراجع بذكر الاسم الأخير للباحث الأول وآخرين مثل (دسوقي و آخرون، 1999) أو (Sartorius et al., 1981) وإذا كان عدد الباحثين ستة فأكثر بذكر الاسم الأخير للباحث الأول وآخرين مثل (الدمرداش، و آخرون، 1999) أو (Skinner, et al., 1965)، وعند الاقتباس يوضع النص المتبني بين قوسين صغيرين " " وتذكر أرقام الصفحات المتبني منها مثل: (أبو حطب، 1990: 43)

وجرد قائمة المراجع في نهاية البحث بذكر فيها **جميع المراجع** التي أشير إليها في متن البحث ورتبها ترتيباً أبجدياً. دون ترتيب مسلسل. حسب الاسم الأخير للمؤلف أو الباحث وتأتي المراجع العربية أو لأثر المراجع الأجنبية بعدها وتذكر بيانات كل مرجع على النحو الآتي:  
- عندما يكون المرجع كتاباً:

اسم المؤلف (سنة النشر) عنوان الكتاب (الطبعة، أو المجلد) اسم البلد: اسم الناشر، مثال: مراد، صلاح أحمد، (2001) الأساليب الإحصائية في العلوم النفسية والتربوية والاجتماعية، القاهرة: الأجلو المصرية  
- عندما يكون المرجع بحثاً في مجلة:

اسم الباحث (سنة النشر) عنوان البحث، اسم المجلة، المجلد الصفحات، مثل: القطامي، نايبة (2002). تعليم التفكير للطفل الحلبي، مجلة الطفولة العربية، 12، 114 - 87

ج- عندما يكون المرجع بحثاً في كتاب:

اسم الباحث (سنة النشر) عنوان البحث، اسم معد الكتاب، عنوان الكتاب، اسم البلد: الناشر، الصفحات التي يشغلها البحث  
1- الإشارة إلى الهوامش بأرقام متسلسلة في متن البحث ووضعها من قمة على حسب التسلسل في أسفل النص التي وردت لها مع مراعاة اختصار الهوامش إلى أقصى قدر ممكن، وتذكر المعلومات الخاصة بمصدر الهوامش في نهاية البحث قبل الجزء الخاص بالمصادر والمراجع  
2- وضع الملاحق في نهاية البحث بعد قائمة المراجع

**■ الدراسات والمقالات العلمية النظرية:**

تقبل الدراسات والمقالات النظرية للنشر إذا ملست من المراجعة الأولية أن الدراسة أو المقالة تعالج قضية من قضايا الطب النفسي أو علم النفس منهج فكري واضح يتضمن المقدمة وأهداف الدراسة ومناقشة القضية ومروية الكاتب فيها، هذا بالإضافة إلى التزامها بالأصول العلمية في الكتابة وتوثيق المراجع وكتابة الهوامش التي وردت في قواعد التوثيق

**■ عرض الكتب الجديدة ومراجعتها:**

تنشر المجلة مراجعات الباحثين للكتب الجديدة وينقلها إذا توافرت الشروط الآتية:

- 1- الكتاب حديث النشر، ويعالج قضية تخص أحد مجالات الطب النفسي، علم النفس، العلاج النفسي أو التحليل النفسي
- 2- استعراض المراجع لمحتويات الكتاب وأهم الأفكار التي يطرحها وإيجابياتها وسلبياتها
- 3- مخنوي العرض على اسم المؤلف وعنوان الكتاب والبلد التي نشر فيها واسم الناشر، وسنة النشر، وعدد صفحات الكتاب.

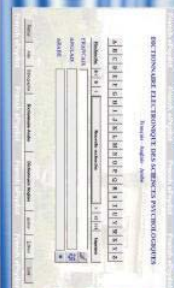
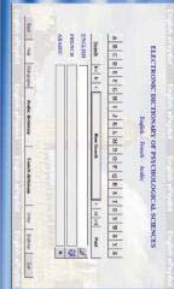
كتابة تقرير المراجعة بأسلوب جيد

**■ المقامير العلمية عن الندوات والمؤتمرات المعنية بقضايا الطفولة:**

تنشر المجلة المقامير العلمية عن المؤتمرات والندوات والحلقات الدراسية في مجال علم النفس والطب النفسي التي تعقد في البلاد العربية أو غير العربية بشرط أن يعطى التقرير بشكل كامل ومنظر أخبار المؤتمر أو الندوة أو الحلقة الدراسية وتصنيف الأبحاث المقدمة ونتائجها وأهم القرارات والنوصيات كما تنشر المجلة محاضرات الحوار في الندوات التي تشارك فيها لمناقشة قضايا تتعلق بالاختصاص.



# ePsydiect



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Electronic Dictionary of Psychological Sciences  
المعجم الإلكتروني للعلوم النفسية  
Dictionnaire électronique des sciences psychologiques



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This dictionary comprises 44132 English terms with their translations concerning all fields of psychological sciences. In this dictionary the search for the translation is made in English and the result is displayed simultaneously in French and in Arabic.

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Ce dictionnaire comporte 3646 terminologies françaises avec leurs traductions intéressantes tous les domaines des sciences psychologiques. La recherche de la traduction dans ce dictionnaire se fait en Français et le résultat est affiché simultanément en Anglais et en Arabe.

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