



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: آمال القلاسي القرقيوي و سفاتلنا كستروفا الطرية

إصدار مؤسسة العلوم النفسية العربية - تونس

قراءة سيكولوجية العنف ... تجاوزا لانجراحات الذات العربية

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مقتطف : شيء من تاريخ العنف إنسانا...

من الماضي البعيد ... كان "السفاح" هو أول خلفاء بني العباس، بوجه في الكوفة عام 132 هـ، وقف خطيبا يقول للناس : "استعدوا، فأنا السفاح المبيح والثائر المبير" (1). ويروي لنا السيوطي كيف استولى على الحكم "بالبيعة أيضا" قتل في مبايعة السفاح من بني أمية وجندهما لا يخلص من الخلائق، فنزلت له الممالك إلى أقصى المغرب! ... لقد أس باغتيال جميع كبار بني أمية المسلمين، ثم لا يتجمل أن يجلس على البساط الذي لهرير، فيتناول طعامه فوقيه، وهم يثقلون في جراحهم، ويننون بالأمير، ويسجون بدمائهم ما زال قائما لا يصرح عنهم حتى فاضت نفوسهم إلى بارئها شاكية ظلم الإنسان و جبروته (2). لقد أسهل الجل حكمه بإخراج جثث خلفاء بني أمية من قبورهم وجلدهم و حرق جثثهم و شرمهم في الريح! ... ولم يكن ذلك في بداية عهد الحكم ففسب، وإنما كانت سياسته التي سار عليها، "كان السفاح سرعا إلى سفك الدماء، فاتبع في ذلك عماله بالمشرق والمغرب" (3)، ومع ذلك كان الرجل شديد الدين و كان نقش خاتم "الله، قته عبد الله، و به يثق من" (4). ولما أتى أبو العباس برأس من وان ووضعها بين يديه سجد فأطال السجود ثم رفع رأسه، فقال : "الحمد لله الذي لم يبق فأمر قبلك، و قبل رهطك، الحمد لله الذي أظفرتني بك، و أظفرتني عليك" (5).

(1) "البداية و النهاية" ج 10 ص 42 - (2) "الكامل في التاريخ" لابن الأثير، الجزء الثالث ص 501-502، دار إحياء التراث بيروت- (3) "تاريخ الخلفاء" ص 257 - (4) د. حسن إبراهيم، "تاريخ الإسلام"، الجزء الثاني ص 25 - (5) "مروج الذهب" للمسعودي، الجزء الثالث ص 271.

من الماضي القريب و حاضرا ... "و بقيت الذكرى خيس شاهد عن عفا و صلبا ... و ما خفي يقى الله شهيدا عليه.

و نحن نسمع لإقبال هذا العدد بلغنا نأ الزلزال الذي هز المحيط الهندي وغمرت أمواجه العاتية جزر جنوب شرقي آسيا، حصلت كارثة من أكبر كوارث إنسان العصر الحديث، قست الطبيعة فسوت بالأمراض جزر و قرى أصبحت خاوية، ضريت بأموال كالجبال فأهلك الحرف و لا عاصرا لا من رحمة. تضرب اليوم كما ضربت بالأمس البعيد أفراما أخرى.

و في خضر قرائنا لسيكولوجية العنف الإنسان فاجأنا عفا الطبيعة بكل قسوتها ... و نحن نبحث في الدوافع الواعية و المظمورة لفكك "عفا الإنسان" تأتي كارثة جزر آسيا لتذكرنا أن قدر الإنسان أن يصارع عفا أخيه و عفا الطبيعة، إنه إن سلم عفا الإنسان قست عليه الطبيعة و إن سلم الكوارث قضى عليه أخيه، مأساة الإنسان أن يعيش صراع العنف منذ لحظة و لادته إلى مماته و قدرنا كأخصائي الصحة النفسية أن نساخر (عفا يسمح به علمنا) في الحد من عفا الإنسان، أما عفا الطبيعة فهو شأن اختصاصات أخرى. إن تضافر جهود الجميع هو السيل الأوح للحد من "العفا" المسلط على الإنسان، إنه لم يعد مقبولا في عصرنا أن يصكر سيكوباتي معلى في قدر إنسان أكرمه الله بالحياة ... إن الإنسان الذي سلبت حرته و اختياره سلبت آدميته، و من مغول إراة الإنسان إلى قدر رأس كرامته و عفره من تحقيق ذاته و كينونه، إن الإنسان العربي المنجرح في مراهنة و مستقبله تأسرة عفا الإضطرابات النفسية إطلاقا من العصاب إلى العقال من ورا بالفكار و السلوك و العفاف، و يبقى الأمل في سعيها نحو تحقيق لياقة نفسية أن أوالها تجاوزا لإجراحات أضنتنا ...

مجلة الشبكة الإلكترونية ... شمعة أولى

هكذا العدد (الرائع) تكمل السنة الأولى من المجلة، كانت البداية مشحونة بعدد الهواجس، كما خشي أن غيب تطلعات الأطباء و أساتذة علم النفس. كانت خشية كبيرة بعد الانطلاقة الموفقة لبوابة الشبكة على الويب (شهادة أساتذة و أطباء لم يعرف عنهم مجاملة على حساب العلم) ألا تكون المجلة في المستوى الأكاديمي المعترف به و في مستوى المجلات العلمية المحكمة، كما نذكر طبيعة العدايات و نعلم أنها التجربة العربية الأولى في مجال الإصدار الإلكتروني على مستوى الاختصاص، كما منهيين خشية أن لهنس لسبب أو لآخر، و بقدر خشية كانت طموحاتنا، كان العداي كبيرا لخواص التجربة، عز منا الأمر و فوكلنا على الله. أمدناها أن تكون أكاديمية، ثلاثية اللغة، ذو مستوى علمي مراق، كانت الإمكانيات محدودة و فريق العمل صغير، كانت المعوقات أكش من أن خصي و كانت عزيمتنا أكبر و أصدرنا المجلة، و جاء كل عدد أفضل من سابقه ... و كانت الردود ملفنة و مشجعة، كانت في تكاش على أثر كل عدد و تنالي و صور الأختا و المقالات بكثافة تتجاوز قدرة المجلة لنشرها، كان لزاما أن نعتذر عن نشر بعضها، كما في حرج من الاعتذار و نحن في بداية المسيرة و كان المخج أن قرأ العمل حسب مبدأ الحاور "و نر قبول جميع الأختا مبدئيا على أن يبقى

موعد نشرها مرهين المحور الذي يتدرج في إطاره هذا البحث أو ذاك.

وكان المحور الرئيسي لهذا العدد "الشخصية العربية... قراءة سيكولوجية العنف" حافلا بعدد الأبحاث والمقالات الأصلية لغبة من أبرز وجوه الاختصاص في الوطن العربي. إنها بداية وعادة شمتها خطوة هامة في مسيرة تطور العلوم النفسية في الوطن العربي. إنا ونحن نضع بين أيديكم هذا العدد للدراسة والتقييم سعدنا بتلقي انطباعاتكم وقد كرم تطوراً به نحو الأفضل.

في هذا العدد...

جاء المحور الرئيسي لهذا العدد حول "قراءة سيكولوجية العنف... عتف انسانيًا"، موشحا بمضاء خفية من أبرز أهل الاختصاص في أوطاننا بدءاً بالاعتراف بحقوق المريض النفسي والتي يعتبرها أحمد عكاشة (مصر) جزءاً لا يتجزأ من حقوق الإنسان، ليقدم لنا بعد ذلك قاسم صالح (العراق) قراءة سيكولوجية للأسباب التركيبية والمهملات عن العنف في المجتمع العراقي ساعياً أمام مشهد العنف العراقي القديم/الحديث الإجابة عن تساؤل هل أن العراقيين عدوانيين بطبيعتهم أم هل توجد غطر طهم الوراثية جينات من العنف والعدوان أكثر من آخريين ينتمون إلى شعوب أخرى. كما يعرض كل من بشير معمرية وإبراهيم ماضي (الجزائر) دراسة أكاديمية مميزة عن أبعاد السلوك العدواني وعلاقتها بأزمة الهوية من خلال دراسة أجريت على عينة من شباب الجامعة، أما عطي الخاوي (مصر) فيطرح من خلال "صراعات الآن و جلد الآتي" عديد التساؤلات حول طبيعة الصراعات التي تعيشها الإنسانية اليوم، هل مازال تاريخ الحياة سلسلة من الصراعات المتتالية والمضلة أو المتناوبة؟ هل ينسب الصراع كما هو موما هو؟ ليوكد لنا قدرتي حفي (مصر) في عتفه، أن "الوعي بالمشكلة... خطوة أولى نحو الحل" وأن حل المشكلات التي تبدأ لذنها خفيفة في البداية ثم تأخذ في التراكم والنضج والظهور لا يمكن أن تأتي بفهم فريدي مباشر بل لابد أن يكون ذلك الجهد جماعياً مخططاً إلى جانب الفصدي لقوى ومؤسسات عاتية تسقيده من استمرار المشاكل، ثم يقدم لنا محمد أحمد نابلسي (لبنان) دراسة ميدانية أصلية وفريدة من نوعها عن الجمهور العربي وأثر الصدمة النفسية عليه من خلال دراسة الآثار النفسية الآتية، القدية والبعيدة الأمد لصدمة السيارة الممخضة ليخلص إلى عرض مفصل لـ "تأخر السيارة الممخضة" ذلك أن أي من التصنيفات الطبفسية الحديثة لا يبي بالغرض لدى قطيعة على اللبنانيين والعرب المعانين من الآثار النفسية للحرب وللانفجارات. ثم فسح المجال لإقبال الغربي (تونس) لمقاربة فسفسيلية لمفهوم "قدية إبراهيم" من خلال دراسة موقف الفداء من سيرة إبراهيم عليه السلام حسب مروياته في الأديان الثلاث: اليهودية، المسيحية والإسلام، كما يشاركنا هذا العدد من كندا وجدي لوزا ببحث تأخر عن توقع فكرام العنف عند المسجونين وما لأهمية تحديد المؤشرات الحفية المؤدية لانعكاسة العنف تحبياً للمجتمع من جرائم مستقبلية محتملة، ومن لبنان عدنان حب الله في قراءة فسفسيلية لـ "طيف صدام واحتمالات الوحدة والتفكك" مؤكداً أن زوال صدام حرر الناس ولكنه لم يحررهم من الكراهية التي غلظها و ناهها طوال عهده، أما محمد ضوفيقدرنا من سوريا دراسة ميدانية عن العنف ضد المرأة ليستق الاقتعة عن هذا الموضوع/التأثير من خلال أمراً دالة، ليخلص إلى توصيات هامة لمكافحة هذه الظاهرة للمهنية للمرأة العربية.

في ختام هذا الملف عن سيكولوجية العنف نعرض لعدد المداخلات الموجزة "المسلط... المسند... شخصية مرضية"، "العنف... الجريمة... خوفهم سيكولوجي"، "مداخل نفسية لتبذ ثقافة العنف"، "هوس السلطة... مروية في سيكولوجية الاستبداد"، "مسألة العنف في المجتمع المصري... تساؤلات"، "العنف الجنسي... مقاربتة أشوب نفسية"، "في سيكولوجية العنف والعدوان" لكل من سامر جيل رضوان (سوريا)، محمد أحمد نابلسي (لبنان)، إقبال الغربي (تونس)، علي توكي نافل (العراق)، لطفي الشربيني (مصر)، فارس كمال ظلمي (العراق) وقاسم حسين صالح (العراق).

انتقالاً إلى بقية الأرواب، نعرض في باب جمعيات فسسية لجمعية التحليل النفسي المغربية، وفي باب مؤتمرات لبرنامج الملقي المغربي الأول للتحليل النفسي، وفي برنامج الملقي الفرنسي كنوني الرابع للأطباء النفسيين إضافة إلى أجنحة المؤتمرات النفسية للتلائية الأولى من سنة 2005 لياتي باب مراجعة كتب وأطروحات موشعا ملخص كتاب الزين عمارية (الإمارات/السودان) "مرحلي مع الطب النفسي" وملخص أطروحة من إشراف عدنان فرح (الأردن) حول أثر من كرك الضبط في مستوى الاكتئاب لدى مرضى السرطان، وفي باب مراجعة مجلات نعرض للملخصات العدد 59 (يوليو 2004) من "الثقافة النفسية الممخضة (لبنان) الذي جاء محوراً الرئيسي حول "التراث النفسي العربي".

كما نعرض في نهاية العدد في باب جوائز فسسية لجائزة مصطفى زبور للعلوم النفسية (المركز العربي للدراسات النفسية) وفي باب منتدئ الحوارات لمداخلات المحور الثالث للمنتدئ حول "الوظيفة الجنسية من السواء إلى الاضطراب" وفي باب الكتاب الذهبي للشبكة لانتباعات أساتذة علم النفس أما في باب مسجديات الطب النفسي فنعرض للملخصات أهم الأبحاث الطبفسية العالمية الصادرة في التلائية الأخيرة لسنة 2004، وفي آخر أبواب المجلة "مصطلحات فسسية" نعرض لترجمة مجموعة من المصطلحات من الحرف الأول من اللغات الثلاث العربية، الفرنسية، الإنكليزية.

إلى أن تلتقي... إضحى مبارك

ON THE OCCASION OF THE INTERNATIONAL DAY FOR HUMAN RIGHTS

PROF. AHMED OKASHA –PSYCHIATRY - EGYPT

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The 10th of December marks the International Day for Human Rights. People and organizations worldwide are celebrating this day by recognizing their achievements and listing and reminding the world of the many human rights abuses that remain to be addressed and corrected.

Although not a human rights organization, the WPA has had, and continues to have, its contributions to the advocacy of human rights in its domain, inclusive of the human rights of mental patients and their caretakers, the psychiatrists.

The Declaration of Hawaii was the first positional statement of the psychiatric profession concerning ethical questions. It was prepared by Clarence Blomquist and was adopted by the General Assembly of the World Psychiatric Association in Hawaii in 1977. Its primary aim was to encourage psychiatrists in conflicts of loyalty in contemporary societies and to help them in conflicts of psychiatric decision-making. A major trigger was the political misuse of psychiatry in countries such as the former Soviet Union, Romania, and South Africa that came to public awareness during the early 1970s.

The Declaration of Hawaii explicates the ethical principles of respect for autonomy and of beneficence: By formulating the components of informed consent, by calling to mind the obligation of confidentiality, by stating rules for forensic evaluation and compulsory interventions, by demanding the possibility of independent proof of compulsory measures and by obliging psychiatrists not to misuse their professional possibilities and particularly to abstain from any compulsory intervention in the absence of a mental disorder.

The efforts of psychiatrists and health politicians initiated in many countries continued to achieve fundamental improvement of care for the mentally ill.

At the 1993 WPA World Congress in Rio, the Ethics Committee, which I was honored to chair, was mandated to update the Hawaii Declaration and to develop guidelines for specific situations. The process involved the collection of data on the issue of professional ethics in the field of medicine and psychiatry from all WPA societies. The literature on ethical codes was complemented in 1994, upon the recommendation of the Long Range Planning Committee, by a mail survey to the different societies, aiming to identify the existence of codes of ethics for psychiatrists in the different countries.

The first section of the Madrid Declaration outlines the ethical commitments of the profession and the theoretical assumptions upon which these are based. It acknowledges that medical professionals are facing new ethical dilemmas resulting from increasingly complex medical interventions, new tensions between the physician and the patients, new social expectations from the physician, development of new research modalities and rapid advancement of research technology with prospects for possible technological interventions especially in the field of genetic research and counseling. However, it also stresses that, despite cultural, social and national differences,

the need for ethical conduct and continual review of ethical standards remains universal. It states that as a practitioner of medicine, the psychiatrist must be aware of the ethical implications of being a physician, and of the specific ethical demands of the specialty of psychiatry. As members of society, psychiatrists must balance professional obligations with their responsibilities for the common good. Furthermore, that ethical behavior is based on the individual psychiatrist's sense of responsibility towards the patient and his/her judgment in determining what is correct and appropriate conduct.

The second section contains seven general guidelines that focus on the aim of psychiatry. It states that psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders, the rehabilitation of individuals suffering from mental illness and the promotion of mental health. It also stresses that the patient should be accepted as a partner by right in the therapeutic process and that the therapist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with relevant information so as to empower the patient to come to a rational decision according to personal values and preferences.

Ensuring the respect of mental patients who constitute research subjects, the Madrid Declaration states that it is unethical to conduct research that is not in accordance with the canons of science is unethical and that research activities should be approved by an appropriately constituted ethical committee.

The third section of the Madrid Declaration deals with guidelines on specific issues, which the World Psychiatric Association Ethics Committee's recognized as important to develop. Those guidelines address case specific issues such as euthanasia, torture, death penalty, sex selection, relationship with the industry, organ transplantation, psychotherapy and protection of mental patients from sexual harassment by therapists.

The Madrid Declaration opposed the participation of psychiatrists in the decision or execution of euthanasia. On the issue of Torture it states that a psychiatrist should not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts, nor should he/she sign a statement indicating that a convict is competent for execution. The Madrid Declaration states that psychiatrists should not under any circumstances participate in legally authorized executions nor participate in assessments of.

competency to be executed for convicts receiving the Death Penalty. Also, aware that preference of male offspring in some societies may lead to a termination of pregnancy assisted by a psychiatric certificate, the Madrid Declaration stresses that under no circumstances should a psychiatrist participate in decisions to terminate pregnancy for the purpose of sex selection

In agreement with the UN Resolution 46/119 on the "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care", which the WPA distributed to all its member societies, psychiatrists should oppose discriminatory practices against mental patients that limit their benefits and entitlements, deny parity with other groups of patients, curb the scope of treatment, or limit their access to proper medications. The Madrid Declaration states that discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others, is unethical. Psychiatrists shall never be involved or endorse, directly or indirectly, any activity related to ethnic cleansing.

Furthermore, the Declaration affirms that the in a symbolic sense the human genome is the heritage of humanity and that it underlies the recognition of people's inherent dignity and diversity, which is why it is imperative to undertake rigorous assessment of the potential risks and benefits pertaining to research, treatment or diagnosis affecting an individual's genome and that in all cases free and informed consent of the person concerned should be obtained in addition to the right of each individual to decide whether or not to be informed of the results of genetic examination. Furthermore the Madrid Declaration calls on psychiatrists to deal with psychotherapy according to the same ethical guidelines that guide any therapeutic process. Abuse of patient's trust and breaching the boundaries of therapist-patient is considered by the declaration as violation of the human rights of mental patients. While all of the above focuses on the rights of mental patients, the rights or psychiatrists should be equally protected to be able to practice free of coercion and pressure, whether by third party payers, drug companies or state authorities.

Another level of human rights concerns of the WPA has been surfacing over the past few years with alleged abuse of mental health institutions as places of incarceration for political dissidents (the case of the Falon Gong in China), execution of the death penalty against mental patients (the case of the US) and use of brains of deceased mental patients for research without the consent of their families or their consent before their death (the case of the UK). The WPA has been investigating those complaints thoroughly with a view to intervene in collaboration with colleagues in the respective countries.

Not only is the WPA as the largest professional organization of psychiatrists, challenged by national or individual human rights concerns of mental patients; it has also drawn the attention of the world to ongoing conflicts that entail depriving patients of mental health care services, or threatening their safety in cases of war and in conflict zones. In 2003 the WPA issues a statement regarding the cycle of violence in the Middle East shedding light on the consequences, detrimental to the mental health, especially of women and children. Then once again in 2003 the WPA issues a statement warning of the health and mental health hazards to be expected from the US war against Iraq, highlighting the traumatic impact of that war on the local population and the possible consequence of large sectors of society suffering the psychological consequences of violence, trauma, loss and displacement. While the WPA was successful in the widespread adoption of national psychiatric association to the Madrid Declaration, which in the meantime has been translated into many languages and whose endorsement has become a precondition for new association to join the WPA, it is unfortunate that the professional voice of psychiatrists did not echo strongly enough in the field of world politics.

I believe that on the occasion of the international human rights day we should renew our commitment to continue advocating and mobilizing for a world that not only protects the mentally ill, granting them access to treatment and rehabilitation and a better way of life, but also a world that considers the short and long term effects of its political decisions on the mental health of world citizens.

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العنف في المجتمع العراقي (قراءة نفستحليلية للأسباب التراكمية و المحتملة)

أ.د. قاسم حسين صالح - علم النفس / بغداد - العراق

رئيس الجمعية النفسية العراقية

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إشارة لا بد منها : قد يثير هذا الموضوع عدم رضا بعض السياسيين أو بعض المندمجين . غير أنني لست سياسيا ، بمعنى الانتماء إلى حزب سياسي . ولست ممنيا إلى تنظيم ديني ، إنما أنا اختصاصي في تحليل الشخصية وما يصيب الناس من اضطرابات نفسية وسلوكية . ولأن قتل الإنسان صار لدينا نحن العراقيين أسهل من قتل الحيوان ، فقد رأيت من واجبي أن أنبه إلى ما في فوسنا من عنف . ذلك أن الشيء إلى وجود مرض يفترض أن يساعد على التخلص منه ، في ظرف ثبات فيها أسباب العنف وكأنها قتابل موقوتة ، إذا ما انفجرت فأن نارة سئلهم ضحايا أكن وجزأ الوطن إلى أقاليم . والغرض الثاني من هذه الورقة هو الحوار من أجل الوصول إلى رؤية أفضح ، تساعد على وضع برنامج ثقافي نفسي إعلامي لحفض العنف في المجتمع العراقي .

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ارتباطات العلوم النفسية

أبعاد السلوك العدواني وعلاقتها بأزمة الهوية (لدى الشباب الجامعي)

أ.د. بشير معمريّة - أ.د. إبراهيم ماضي - علم النفس ، الجزائر

بريد إلكتروني : bashir_psy@hotmail.com

مقدمة : أولى كثير من علماء النفس اهتمامهم بالعوامل التي تحدّد صيغ تعامل الأفراد مع بعضهم البعض . وقد اجتمع هذا الاهتمام أساسا للكشف عن محددات تماسك أعضاء الجماعة أو تفككهم ، أي الكشف عن الجوانب الإيجابية في تفاعل أعضاء الجماعة في مقابل جوانب السلبية . فهذه السيكولوجية كما مرّني Horney 1945 ، تشير إلى أن الإنسان في مسعاه لإشباع حاجاته ضمن علاقاته الإنسانية ، لا يخرج عن الاتجاهات الثلاثة في تحركه تجاه الآخرين : فهو إما أن يصرّك خوهر تدفعه الحاجة إلى الحب والاندماج . أو يصرّك بعيدا عنهم تدفعه الحاجة إلى الاستقلال والاكتمال الذاتي . أو يصرّك ضدهم تدفعه الحاجة إلى القوة والسيطرة . (هول وآخ ، 1969) . ويصرّك الإنسان في هذا الاتجاه الأخير لإشباع حاجاته ، يحمل في داخله قدينا للآخرين ، وهو السلوك العدواني .

وقد مارس الإنسان العدوان منذ بداية وجوده على الأرض ليعمها ، أين قتل ابن آدم قابيل أخاه هابيل ، إرضاء لشهوته وطاعته لنفسه . قال الله تعالى : " فَطَوَّعَتْ لَهُ نَفْسُهُ قَتْلَ أَخِيهِ فَقَتَلَهُ فَأَصْبَحَ مِنَ الْخَاسِرِينَ " . (المائدة : 30) .

ويلاحظ السلوك العدواني في سلوك الطفل الصغير وسلوك الراشد ، وفي سلوك الذكور وسلوك الإناث ، وفي سلوك الإنسان السوي وسلوك الإنسان اللاسوي بغض النظر عن اختلاف الدوافع والوسائل والأهداف والنتائج . (سناء سليمان وآخ ، 1989) .

والسلوك العدواني واسع الانتشار في هذا العصر ، حتى يكاد يشمل العالم بأسره . كما أنه متعدد الأشكال والصور . فالمخاوف التي تهدد الإنسان كثيرة وحقيقية ؛ منها خوفه على حياته وحياته أفراد أسرته ، وخوفه على مزرقه ، وذلك بسبب انتشار أعمال الإجرام والظلم الاجتماعي والبطالة والعنف والحلف والقتل الفردي والجماعي والاضطراب والعصب وجنون الأحداث والتسوية على الأطفال وغيره .

والعدوان كسلوك مضاد للمجتمع ، لم يعد مقصورا على الأفراد ، بل اتسع فطاقه ليشمل الجماعات داخل المجتمع الواحد ، وكذلك المجتمعات في عمومها ، وهو ما يلاحظ في أشكال العنف والظفر والإرهاب ، الذي لا يصدر من الأفراد فقط بل يصدر كذلك من الدول والحكومات ، كالتراعات الدولية .

والسلوك العدواني لا يوجه الإنسان إلى الأفراد من بني جنسه فقط بل يوجه إلى العناصر الطبيعية من حوله بتدميرها أو تلويثها ، وكذلك إلى الحيوانات للقضاء عليها وتقرضها للاقتراض .

والعدوان مرفوض ومذموم في أحد شكله ، ومقبول ومشجع في شكله الآخر . إذن ، نحن أمام عدوان مطلوب لأن نتائجها مفيدة وبنّاءة ، وعدوان مرفوض لأن نتائجها مدمرة ومهلكة .

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**20.62	3.37	35.81	2.43	51.48	
**24.54	3.27	33.23	2.08	50.65	
**22.12	3.56	33.87	2.22	50.90	
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**23.79	2.29	33.93	2.91	50.82	
**21.35	3.94	32.43	2.38	51.43	
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- 1977 . .
- D. R. 1981 . Rosenthal & al ()
- R. Ochse & al 1986 .
- 1987 . . .
- 1998 .
- T. Tiger 1980
- .(1996)
- C. E. Franz & al 1985
- 1977
- (1996 :) 1990
- (1993) . 1980
- 1984

1. أبو المجد ابراهيم الشوريجي (1992). هوية الأنا لدى طلبة التعليم الابتدائي / الأساسي بكتليات التربية. مجلة كلية التربية بالزقازيق ، 19 ، 95 - 128.
2. أبو بكر محمد مرسى (1997). أزمة الهوية والاكتئاب النفسي لدى الشباب الجامعي. دراسات نفسية تصدر عن رابطة الأخصائيين النفسيين المصرية (رانم) 3 (7) 323 - 352.
3. أبو بكر محمد مرسى (1998). استبيان هوية الأنا للشباب. مكتبة النهضة المصرية - القاهرة.
4. أميرة طه يخش (1998). فاعلية برنامج إرشادي في خفض السلوك العدواني لدى الأطفال المتخلفين عقليا القابلين للتعليم. العلوم التربوية يصدرها معهد الدراسات التربوية بجامعة القاهرة 11 ، 157 - 197.
5. بشير معمري (1995). نظرية التعلم الاجتماعي لروتز. مجلة العلوم الاجتماعية والإنسانية جامعة باتنة - الجزائر ، 4 ، 185 - 219.
6. ثريا عبد الرؤوف جبريل (1994). العدوان لدى طلبة الجامعة وأثر بعض أساليب العلاج الجشطلتي في التخفيف من حدته. المؤتمر الدولي الأول للإرشاد النفسي جامعة عين شمس ، 2 ، 615 - 656.
7. جابر عبد الحميد جابر (1990). نظريات الشخصية : البناء ، الديناميات ، النمو ، طرق البحث التقويم. دار النهضة العربية - القاهرة.

الثانوية. بحوث المؤتمر الثامن لعلم النفس في مصر مكتبة الأنجلو المصرية 197 - 230.

23. محمد السيد عبد الرحمن (1998 - أ). نظريات في الشخصية. دار قباء للطباعة والنشر والتوزيع - القاهرة.

24. محمد السيد عبد الرحمن (1998 - ب). سمات الشخصية وعلاقتها بأساليب مواجهة أزمة الهوية لدى طلاب المرحلة الثانوية والجامعية. دراسات في الصحة النفسية الجزء الثاني دار قباء للطباعة والنشر والتوزيع - القاهرة، 2، 389 - 470.

25. محمد جميل منصور (1981). قراءات في مشكلات الطفولة. الطبعة الأولى، تهامة.

26. محمد حسن غانم (1998). رؤية عينة من المثقفين المصريين لظاهرة العنف " دراسة سيكولوجية ". مجلة علم النفس تصدر عن الهيئة المصرية العامة للكتاب، 45، 80 - 90.

27. محمد خضر عبد المختار (1998). الاغتراب والتطرف نحو العنف " دراسة نفسية ". دار غريب للطباعة والنشر والتوزيع - القاهرة.

28. محمد عاطف عطيفي (1992). دراسة تجريبية لأثر مشاهدة برامج العنف التلفزيونية على استثارة السلوك العدواني لدى أطفال مدرسة الحضنة بدولة قطر. مجلة التربية بجامعة الأزهر، 25، 31 - 61.

29. محي الدين أحمد حسين وآخرون (1983). السلوك العدواني ومظاهره لدى الفتيات الجامعيات : دراسة عملية في : بحوث في السلوك والشخصية. تحرير : أحمد عبد الخالق، دار المعارف - القاهرة، 3، 97 - 128.

30. معتز سيد عبد الله (1998). علاقة السلوك العدواني ببعض متغيرات الشخصية. مجلة علم النفس تصدر عن الهيئة المصرية العامة للكتاب، 47، 64 - 87.

31. معتز سيد عبد الله وآخر (1995). أبعاد السلوك العدواني " دراسة عملية مقارنة ". دراسات نفسية تصدر عن رابطة الأخصائيين النفسيين المصرية (رانم)، 3 (5) 521 - 580.

32. ميشيل أرجايل (1978). علم النفس ومشكلات الحياة الاجتماعية. ترجمة : عبد الستار إبراهيم. الطبعة الثانية دار القلم - الكويت.

33. ناصر علي السيد (1997). دور الجماعات العلاجية في مواجهة السلوك العدواني عند الطلاب. مجلة التربية تصدر عن مركز البحوث التربوية والمنهج بوزارة التربية - دولة الكويت، 22، 55 - 71.

34. نبيل عبد الفتاح حافظ وآخر (1993). الإحباط والعدوان. المجلة المصرية للدراسات النفسية، 6، 75 - 84.

35. هنري ماير (1981). نظريات في نمو الطفل. ترجمة : هدى محمد قناوي. مكتبة الأنجلو المصرية.

8. جابر عبد الحميد جابر وآخر (1993). العلاقة بين أزمات النمو النفسي الاجتماعي وأساليب المعاملة الوالدية لدى عينة من التلاميذ القطريين. مجلة مركز البحوث التربوية جامعة قطر، 3، 109 - 139.

9. حسن مصطفى عبد المعطي (1993). دراسة لبعض المتغيرات الأكاديمية المرتبطة بتشكيل الهوية لدى الشباب الجامعي. مجلة علم النفس الهيئة المصرية العامة للكتاب، 25، 06 - 37.

10. حسين علي فايد (1996). أبعاد السلوك العدواني لدى شباب الجامعة " دراسة مقارنة ". المؤتمر الثالث للإرشاد النفسي - جامعة عين شمس، 1، 135 - 182.

11. رشاد علي موسى (د ت). الفروق بين الجنسين في العدوان. مؤسسة مختار للنشر والتوزيع - القاهرة.

12. زكريا الشربيني (1995). الإحصاء وتصميم التجارب في البحوث النفسية والتربوية والاجتماعية مكتبة الأنجلو المصرية.

13. سامي عبد القوي علي (1995). علم النفس الفيزيولوجي. الطبعة الثالثة مكتبة النهضة المصرية - القاهرة

14. سعد المغربي (1987). سيكولوجية العدوان والعنف. علم النفس مجلة البحوث والدراسات النفسية الهيئة المصرية العامة للكتاب، 1، 25 - 36.

15. سعيد بن عبد الله ديبس (1997). أبعاد السلوك العدواني لدى الأطفال المتخلفين عقليا من الدرجة البسيطة في ضوء متغيري العمر والإقامة. دراسات نفسية تصدر عن رابطة الأخصائيين النفسيين المصرية (رانم) 3 (7) 353 - 385.

16. سناء محمد سليمان وآخر (1989). ظاهرة العنف لدى بعض شرائح من المجتمع المصري " دراسة استطلاعية ". الكتاب السنوي في علم النفس. تصدره الجمعية المصرية للدراسات النفسية، 6، 67 - 85.

17. عبد الرقيب أحمد البحيري (1995). هوية الأنا وعلاقتها بكل من القلق وتقدير الذات والمعاملات الوالدية لدى طلبة الجامعة " دراسة في ضوء نظرية إريكسون ". مجلة التربية بالزقازيق، 12، 165 - 211.

18. عزت سيد اسماعيل (1988). سيكولوجية الإرهاب وجرائم العنف. الطبعة الأولى منشورات ذات السلاسل الكويت.

19. فؤاد البهي السيد (1979). علم النفس الإحصائي وقياس العقل البشري. الطبعة الثالثة دار الفكر العربي.

20. فؤاد البهي السيد (1978). الجداول الإحصائية لعلم النفس والعلوم الإنسانية الأخرى. دار الفكر العربي 1978.

21. كاليفين هول وآخر (1969). نظريات الشخصية. ترجمة : فرج أحمد فرج وآخرون. مراجعة : لويس كامل مليكة. دار الفكر العربي - القاهرة.

22. كوتر إبراهيم رزق (1992). في ديناميات الاعتداء على المدرسين : دراسة اكلينيكية متعمقة لمجموعة من التلاميذ العدوانيين في المرحلة

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موافق

صراعات الآن، و جدل الآتى

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

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فيم يتنافس العالم الآن؟ كيف يتنافس؟ لأي غرض؟ لأي مدى؟ البقاء لمن؟ للأقوى؟ للأشطر؟ للأذكى؟ للأفيع؟ (أفيع لمن؟). للأش ما لا؟ للامضى سلاحا؟ ماذا تقدم لاطفالنا ليكونوا أحسن؟ أحسن من من؟ أحسن من ماذا؟ لماذا؟ لمن البقاء؟

هل ما زال تاريخ الحياة سلسلة من الصراعات المتتالية، أو المتصلة، أو المتناوبة؟ وهل ما زالت قوانين الصراعات هي التي لم تتغير على من تاريخ الطور؟ بعد كل هذه التغيرات الرائعة إلى هيبة: هل يستمر الصراع كما هو ما هو؟ هل كل ما تعلمناه من الهياكل الاتحاد السوفيتي هو أن قدس صراع الأسواق بديلا عن قدس صراع الأيديولوجيات؟ هل كل ما تعلمناه من فشل الحروب الدينية هو أن قتلها حروبا قتيبة تنزع بأوهام جديدة تحت عناوين صراع الحضارات أو نهاية التاريخ؟ لكن الصراع هو قانون الحياة، وليكن العدوان غريزة أساسية لحفظ الذات فالنوع، لكن لكل مرحلة تفاصيلها الفرعية التي تسنوع القانون الأصل لتقوم بتحديثه، بما يجعله يؤدي وظيفته الجديدة بما يليق بما أجز.

حين الهام الاتحاد السوفيتي وتكسكت أوروبا الشرقية اختفي نوع من الصراع (الحرب الباردة) كان يقرنا من نيل صراع الحيوانات من النوع الواحد. أغلب الحيوانات تكفي بعلامات الإذعان بديلا عن القتال حتى موت أحد أفراد النزاع. أقرأ الحديث الشريف الذي معناه أن المقاتلين المسلمين (القاتل والمقتول) هما كلاهما في النار (لأن المقتول كان يتولى قتل القاتل)، أقرأه بتعبير يشمل كل البشر، صاغوا 11 سبتمبر وغزاة أفغانستان والعراق وفلسطين (لهم واحد، ولسوف نرى!!) هم جميعا في النار (نار الدنيا والآخرة معا).

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موقع الأعمال العلمية للبروفسور يحيى الرخاوي (جمعية الطب النفسي التطوري)



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دراسة في علم السيكوباثولوجي أ.د. يحيى الرخاوي



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الوعي بالمشكلة خطوة أولى نحو الحل

(من برنامج محاضرات لجنة علم النفس، المجلس الأعلى للثقافة - أقيمت في 1- 01- 2003)

د. محمد حنفي قدري - علم النفس - القاهرة / مصر

بريد إلكتروني : kadrymh@yahoo.com

السادة الحضور ... لموضوع هذا اللقاء قصة لعل من المناسب روايتها . الموضوع بالنسبة لي فريد من عدة نواح . موضوع لم أختره بل اختاره لي الصديق الأستاذ الدكتور مصطفى سوف، ربما لأنه رأى فيه ما يتناسب صورتي للدين . وكان الأستاذ الدكتور سوف كرمًا فترك لي أن أعدل في الموضوع أو حتى أن أختار موضوعًا غيره . ولكنني وافقت علي الموضوع كما هو إذ رأيت فيه خبرة جديدة لي . فمئذ سنوات طوال كانت موضوعات كتاباتي ومحاضراتي من اختياري الشخصي . موضوع يشدني فأكتب أو أحاضر فيه . ولا شك أن الكتابة في موضوع لم أختره لهذا الشكل، بل ولم يسبق لي أن حاولت الغوص فيه، اقتضى مني استرجاع مناخ افغالي عاد بي لإيام الدراسة والامتحانات، وهو أمر لا أنسى أنني استنعت به كثيرًا .

سادني الحضور ... لقد دفعني إعلان هذه المحاضرة إلى استحضار أول لقاء لي بغير علم النفس العام دارسًا له علي يدي وكتاب أسأذنا الراحل الدكتور يوسف مراد . وما زلت أذكر استغراقي المندم في تأمل تجارب العلم الشهيرة التي أجريت علي الكلاب والفيران والقرود وما إلى ذلك . ما زلت أذكر ذلك القرد الذي احل مكانه في تاريخ علم النفس . ذلك القرد الذي وضعه عالم النفس الشهير كوهل حيال مشكلة فريدة تتطلب حلًا . القرد جائع وثمار الموز الشهية معلقة بعيدًا في سقف القفص . والقفص خلوهما تألف القردة عادة من أشجار تنجح لها النسلق لنيل مبعهاها . ليس في القفص سوي عدة صنابير خشبية مشاةة . كان علي القرد أن يتوصل إلي حل جديد يتل امر مع تلك المشكلة الجديدة .

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الصدمة النفسية التالية للانفجارات (دراسة عن الجمهور العربي)

أ.د. محمد أحمد النابلسي - الطب النفسي - لبنان

أمين عام الإتحاد العربي للعلوم النفسية

بريد إلكتروني : nabulsy@cyberia.net.lb

لعل أولى محاولات تجبير العرايا المنهكة هي تلك العرية التي هدفت لإغتيال نابليون وفشلت في تحقيق هدفها . ولقد شهدت الحرب اللبنانية انفجار عشرات السيارات المنهكة، الأمر الذي أتاح لنا إجراء دراسات حول ردود الفعل النفسية لدى الجمهور أمام هذه الانفجارات . وحول الآثار النفسية والاجتماعية لما أسمىه بصدمة السيارة المنهكة .

ونعرض في ما يلي ملخصاً لهذه الدراسات نظراً لحاجة قطاع واسع من الجمهور العربي لها، حيث يند فهدد السيارات المنهكة ليطال العديد من الدول العربية وفي مقدمتها العراق والسعودية والجزائر وسورية، وغيرها من الدول العربية، حيث يدل على الميل إلى هذا النوع من العمليات القذرة أسلوباً لترويع الجمهور في غياب القدرات العسكرية الفاعلة أو في وجود مواقف موضوعية لممارسة القوة المباشرة .

في ما يلي نعرض ملخص دراساتنا حول صدمة السيارة المنهكة، علنا بذلك نساهم في دعم الضحايا العرب المنهكين لمثل هذه الحوادث عن طريق تفهيمهم ومساعدتهم على اتخاذ خطوات الوقاية النفسية وذلك بهدف الحقول دون تحويل هذه التجربة الصدمية إلى عصاب نفسي يترك أثراً على سلوك المصدوم ومستقبله .

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[6] مارتني - ستوار - نابلسي، مبادئ البسكوسوماتيك وتصنيفاته الرسالة، الإيمان، 1988

[7] وهذا يعكس وضعية مازوشية تدفع بالشخص إلى التهامي التوحد بالضحايا وكلما كان شعور الذنب هذا أكثر حدة كلما تنامت احتمالات الانهيار.

[8] وهذه الاختبارات هي: 1- وودورث - ماتيوس، واختبارين وضع المؤلف - راجع الفصل الرابع.

[9] ماتري ومشاركته بسكوسوماتيك الهيستيريا والوساوس المرضية سلسلة والثقافة النفسية الجزء الثالث دار النهضة العربية، 1990.

[10] مارتني بيان: الحلم والمرضى النفسي والنفسي م، د. ن، 1987.

[1] وبخاصة المحلل فبرنزي الذي كان أول المتكلمين عن عصاب الحرب.

[2] Naboulsi M sequelles pschiques et psychosomatiques de la guerre libanaise Academie Hongroise 1990

[3] د. محمد أحمد النابلسي: الأمراض النفسية وعلاجها، دراسة في مجتمع الحرب اللبنانية، م. د. ن، 1987.

[4] في اللبنانية العامة يغير عن هذه الحالة بالقول أتنني الجمدة وهو تعبير بليغ جدا لوصف هذه الحالة.

[5] من خلال دراستنا لهذا الوضع رأينا أن المعدل الوسطي لهذه الفترة هو 15 ثانية .

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دليل الجمعيات النفسية العربية - الإصدار العربي



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LE SACRIFICE D'ABRAHAM ... OU LA FABRICATION CULTURELLE DES ENFANTS. Approche psychanalytique

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Avant propos : Le récit du sacrifice est présent, selon des angles et des lectures différentes dans les trois religions du livre. Encore aujourd'hui cet épisode joue un rôle important dans la vies culturelles et dans les grandes fêtes des trois communautés religieuses. Après avoir été rattaché à Pessah, fête de Roch ha Shah pour le judaïsme, où il est appelé la « ligature d'Isaac », fête de Pâque pour le christianisme où Isaak est figure du Christ pascal ; fête de l'Aïd el id ha ou Aïd el Kébir où le sacrifice de mouton, commémore le sacrifice d'Ibrahim.

L'histoire d'Abraham est une histoire très complexe, ce texte est « l'un des plus énigmatique de l'ancien testament » selon les termes de Stéphane Mosés. Il appelle des questionnements et des interprétations infinis. Il raconte une expérience de l'extravagant, de l'exception, de l'excès, selon les mots d'André LaCoque et de Paul Ricœur.

En effet, le récit est plein de paradoxes indéchiffrables, ce travail consiste en une approche psychanalytique de cet événement qui a pris pour les trois religions monothéistes une valeur de référence.

Problématique :

Abraham est un fondateur. On s'en souvient, il est un jour sommé par Dieu de détruire les idoles, de quitter la maison de son père et de fonder un nouveau peuple. Nous pouvons lire dans Genèse, XI, versets 1et 2, « *Va-t-en de ton pays, de ta patrie et de la maison de ton père vers le pays que je te montrerai. Je ferai de toi une grande nation.* »

Mais comment être à l'origine d'une grande lignée lorsqu'on est stérile ?

Etrange contradiction que celle contenu dans l'injonction divine de fonder une lignée tout en condamnant le fondateur à la stérilité ?

Par ailleurs, il pourrait paraître stupéfiant que ce soit Abraham, ce père aux pulsions infanticides, qui a abandonné et chassé son premier enfant Ismaël et qui a failli sacrifier et immoler son second enfant Isaac, qui soit désigné dans la tradition des trois religions monothéistes comme le Père des croyants, qu'il incarne la figure de la paternité par excellence !

Nous savons tous qu'Abraham est considéré, dans la tradition monothéiste, comme un grand prophète parce qu'il aurait accepté d'immoler son fils par obéissance à Dieu. Toutefois, une autre interprétation n'est elle pas envisageable ? Son acte de prophétie, sa grandeur ne sont – ils pas aussi dans la rupture radicale qu'il instaure avec les conceptions ancienne de la famille, de la parentalité, et des enfants ?

Dans cette perspective, l'épisode d'Abraham est certes un guide pour le présent mais c'est aussi un témoignage sur l'évolution psychologique de l'être humain et sur l'historique anthropologique des notions suivantes :

- *Les structures familiales*
- *La notion de parentalité*
- *L'évolution du droit de l'enfant*
- *L'utilité de l'approche psychanalytique :*

Au cœur même de l'analyse peuvent surgir des questions anthropologiques qui relèvent davantage du champs religieux que du champs proprement analytique. Dans le huis clos de la séance analytique, le patient reprend et parle de son expérience métaphysique, Surgit, alors, d'une manière imprévisible le sens religieux et le sens éthique qui échappent à l'analyse mais que paradoxalement, elle évoque et convoque. Car justement la psychanalyse c'est « la science

de l'inconscient ». Autrement dit la science de ce qui est refoulé, occulté, incompris. En un mot la science de cette angoisse existentielle qui nous relie tous à notre origine.

La place de l'inconscient,

Parce que « la religion est toujours dans une situation de débat avec l'inconscient », le texte de la commission Biblique Pontificale de 1993 reconnaît que la psychanalyse permet de mieux comprendre les textes de la bible « en tant qu'expérience de vie et règles de comportement ». Cette décision permet une nouvelle compréhension (comprendre) du symbole et de la vérité du langage symbolique dans les textes sacrés.

Il semble aujourd'hui, dans ce domaine, que les avancées les plus prometteuses soient celles de la « mythanalyse », c'est à dire l'analyse appliquée au « mythes » fondateurs-le mot mythe est à prendre ici dans son sens premier de récit fondateur à forte charge symbolique c'est-à-dire que les mythes ne sont pas des histoires fausses, imaginaires, justificatrice d'ignorance, équivalent du fantasme mais des structures fonctionnelles propre à l'humanité.

CADRE THEORIQUE : psychanalyse et religion

Pour le père de la psychanalyse, cette science est en principe neutre par rapport à la religion. Il affirme à ce sujet que « *en tant que doctrine de l'inconscient psychique elle peut devenir indispensable à toutes les sciences traitant de la genèse de la civilisation humaine et de ses grandes institution, telle que la religion, ordre social.* » Le point de vue de la psychanalyse sur la religion est donc celui de l'anthropogenèse ; elle entend comprendre la religion en même temps comme un destin collectif dans l'histoire de la culture et comme une fonction psychique dans le rapport individuel au monde. Freud propose de mettre à jour les refoulements constitutifs des institutions religieuses et de traduire leur métaphysique en métapsychologie. Son projet est de considérer la religion comme un phénomène total : psychologique et culturel à la fois. Le plus complexe qui soit. Pour l'élucider, il met progressivement en œuvre tous les éléments de sa doctrine. Pour lui la production humaine et la psychologie des profondeurs peut donner la clé pour déchiffrer l'énigme de son origine et de sa signification.

Cependant, il nous faut admettre que Freud qu'envers la religion comme envers toute humaine, adopte le principe psychologique selon lequel l'homme y manifeste une Vérité. Il considère alors la religion comme un témoignage important sur la réalité psychique.

Les disciples de Freud ont apporté d'autres interprétations : En opposition avec son maître à penser, **C.Jung** attribue une valeur positive à toutes les religions. Il affirme que l'âme est habitée par des archétypes de nature religieuse et qu'elle est finalisée par eux.

Nombre de psychanalystes, surtout parmi les premiers disciples de Freud tels que **Ernest JONES**, **Théodore Reik** s'attachent à analyser les doctrines religieuses comme des émanations des pulsions psychologiques. Certains comme **Flugel** et **Jones** affirment que l'interprétation psychanalytique de la genèse concrète de la religion ne contredit pas une adhésion philosophique à la foi en Dieu.

Cependant les thèses du psychanalyste **Szondi** affirment que le sens du sacré s'enracine dans la pulsion agressive qui grâce à l'esprit est sublimé dans l'attitude religieuse. Celle-ci instaure dans la culture la loi divine qui impose le respect de la vie, la piété et la tolérance. En outre la fonction de croire selon cet auteur, réalise la participation à l'esprit qui émane de l'expérience archaïque de l'union duelle que l'homme tente de restaurer.

LECTURE DU RECIT DU SACRIFICE DANS LE JUDAISME, LE CHRISTIANISME ET L'ISLAM :

Interpretation judaïque

Les textes sacrés décrivent l'épisode d'Abraham dans les termes suivants :

Gn22.1 Après ces événements, Dieu mit Abraham à l'épreuve et lui dit : « *Abraham* », il répondit : « *Me voici* ».

Gn22. Il reprit : « *Prends ton fils, ton unique, Isaac, que tu aimes. Pars pour le pays de Moriyya et là, tu l'offrira en holocauste sur celle des montagnes que je t'indiquerai* ».

Gn22.3 Abraham se leva de bon matin, sangla son âne, prit avec lui deux des jeunes gens et son fils Isaac. Il fendit les bûches de l'holocauste. Il partit pour le lieu que Dieu lui avait indiqué.

Et Gn22.4 Le 3eme jour, il leva les yeux et vit de loin ce lieu.

Gn22.5 Abraham dit aux jeunes gens : « *Demeurez ici, vous, avec l'âne ; moi et le jeune homme, nous irons là-bas pour nous prosterner ; puis nous reviendrons vers vous* ».

Gn22.6 Abraham prit les bûches pour l'holocauste et en chargea son fils Isaac ; il prit en main la pierre à feu et le couteau, et tous deux s'en allèrent ensemble.

Gn22.7 Isaac parla à son père Abraham : « *Mon père* », dit-il, et Abraham répondit : « *Me voici, mon fils* ». Il reprit : « *Voici le feu et les bûches ; où est l'agneau pour l'holocauste* » ?

Gn22.8 Abraham répondit : « *Dieu saura voir l'agneau pour l'holocauste, mon fils* ». Tous deux continuèrent à aller ensemble.

Gn22.9 Lorsqu'ils furent arrivés au lieu que Dieu lui avait indiqué, Abraham éleva un autel et disposa les bûches. Il lia son fils Isaac et le mit sur l'autel au-dessus des bûches.

Gn22.10 Abraham tendit la main pour prendre le couteau immoler son fils.

Gn22.11 Alors l'ange du SEIGNEUR l'appela du ciel et cria : « *Abraham ! Abraham !* » Il répondit : « *Me voici* ».

Gn22.12 Il reprit : « *N'étend pas la main sur le jeune homme. Ne lui fais aucun mal, car maintenant je sais que tu crains Dieu, toi qui n'as pas épargné ton fils unique pour moi* ».

Gn22.13 Abraham leva les yeux, il regarda, et voici qu'un bélier était pris par les cornes dans un fourré. Il alla le prendre pour l'offrir en holocauste à la place de son fils.

Gn22.14 Abraham nomma ce lieu « *le seigneur voit* » (*ARAFAT*) ; **aussi dit-on aujourd'hui** : « *C'est sur la montagne que le SEIGNEUR est vu* ».

Gn22.15 L'ange du SEIGNEUR appela Abraham du ciel une seconde fois.

Gn22.16 et dit : « *Je le jure par moi-même, oracle du SEIGNEUR. Parce que tu as fait cela et n'as pas épargné ton unique fils unique,*

Gn22.17 *je m'engage à te bénir, et à faire proliférer ta descendance autant que les étoiles du ciel et le sable au bord de la mer. Ta descendance occupera la Porte de ses ennemis ;*

Gn22. 18 *c'est en elle que se béniront toutes les nations de la terre parce que tu as écouté ma voix* ».

La tradition juive octroie une place importante à l'interprétation de la Torah. Les commentateurs affirment que le texte interpelle le lecteur, le texte dit « interprète moi » et dit « la Torah a 70 faces »

Les interprétations ont évolué au cours de l'histoire.

Le livre de la Sagesse qui date du 1^{er} siècle av.J.C met en relief l'extrême fidélité d'Abraham dans l'épreuve et sa récompense.

Aux alentours de l'ère chrétienne, **Philon d'Alexandrie** développe longuement Genèse 22 dans son traité « sur Abraham ». C'est toujours une apologie d'Abraham et de son comportement exemplaire : « Pourquoi fallait-il louer Abraham comme s'il avait entrepris pour la première fois une action que font des rois, des peuples entiers, en Grèce, en Inde même ? » Abraham rétorque Philon, n'a été poussé ni par la coutume, ni par le désir de gloire, ni par la peur. L'amour de Dieu, l'obéissance, la piété, la sainteté ont été ses seuls mobiles. Il a agi en prêtre » sue le meilleur des fils lui le meilleur des pères.

Flavius Josèphe dans les « Antiquités bibliques » insiste lui aussi sur le sens de l'épreuve d'Abraham qui est l'obéissance et la piété. Il ajoute l'espoir en l'immortalité de l'âme d'Isaac

D'autres auteurs juifs voient dans l'épreuve imposée à Abraham, une suggestion de Mastéma, le prince des démons, adressée à Dieu. Abraham a affronté bien des épreuves certes. Toutefois acceptera-t-il de sacrifier son fils bien aimé si Dieu le lui demande ? L'auteur y trouve une similitude avec le récit de Job, où Satan met en épreuve en le frappant avec la permission de Dieu, en ses biens ; ses enfants, puis en son propre corps. La fidélité d'Abraham est ici une victoire sur Masténa.

Interprétations chrétiennes :

Dans le Nouveau Testament, Abraham est très présent. A l'ouverture de la généalogie de Matthieu Jésus est dit « fils de David, fils d'Abraham ». Les commentateurs chrétiens ont illustré le thème de la rédemption par une référence au sacrifice d'Abraham et à l'offrande rédemptrice d'Isaac. Les exégèses sont centrées sur le Christ pascal, mort et ressuscité. Le récit d'Abraham préfigure et annonce le Christ sacrifié. Sa passion sacrificielle, rédemptrice apparaît souvent dans les commentaires chrétiens. Méliton de Sardes 2eme siècle dans une homélie en prose rythmée, évoque les figures de l'Ancien Testament : « *C'est lui qui est la Pâque de notre salut. C'est lui qui supporta beaucoup en grand nombre : c'est lui qui fut*

en Abel tué, en Isaac lié, en Jacob mercenaire, en Joseph vendu, en Moïse exposé, en l'agneau immolé ... C'est lui l'agneau sans voix, c'est lui l'agneau égorgé, c'est lui né de Marie agnelle, c'est lui pris du troupeau et à l'immolation traîné et le soir tué et de nuit enseveli, qui sur le bois ne fut pas broyé, en terre ne fut pas corrompu, ressuscita des morts et ressuscita l'homme du fond du tombeau. Pour d'autres commentateurs chrétiens tels que Méliton et Origène, se dégagent les mystères de mort et de résurrection, Abraham espérait qu'Isaac ressuscitera, il savait qu'il était à l'avance la figure de la vérité à venir, il savait que le Christ naîtra de sa descendance pour être offert en victime plus authentique du monde entier et ressusciter d'entre les morts.

Interpretation musulmane :

Selon l'islam, le Coran est le point terminal de la Révélation. Il se présente comme la récapitulation et la synthèse des messages antérieurs, et plusieurs récits bibliques y sont relatés de façon condensée et allusive.

Le Coran le dit clairement ceci existe dans les premières qui sont les tables d'Abraham et de Moïse.

Abraham est le patriarche de l'islam comme pour le judaïsme et le christianisme. Abraham est aussi un ancêtre du prophète qui descend de lui par Ismail, fils de Hagar. C'est Abraham qui a fait de la Mecque un lieu de pèlerinage, appelant l'humanité à se rendre à « l'antique maison » (Sourate II versets 119, 121, 122)

Abraham, cité 26 fois dans le Coran, a été choisi comme « ami intime de Dieu » **Khalil Allah** parce qu'il a subi avec succès maintes épreuves. L'une des plus dramatique a été sans doute celle où il reçut en songe l'ordre divin d'immoler son fils.

Il est dit dans le Coran :

Quand l'enfant eut atteint (l'âge) d'aller avec son père Celui-ci dit « mon cher fils ! en vérité, je vois en songe, en train de t'immoler ! Considère ce que tu en penses ! » « Mon cher père » répondit-il « fais ce qui t'est ordonné » ! Tu me trouvera, s'il plaît à Allah, parmi les Consentants. » Or quand ils eurent prononcé le Salâm et qu'il eut placé l'enfant front contre terre, Nous lui criâmes : « Abraham » Tu as cru en ton rêve ! En vérité, c'est là l'épreuve évidente ! » Nous le libérâmes contre un sacrifice solennel Et Nous le perpétuâmes parmi les Modernes. Salut sur Abraham ! Ainsi, en vérité, Nous récompenserons les Bienfaisants !

Les commentateurs insistent sur la dimension onirique de la scène qui est absente du récit biblique.

L'épisode du sacrifice d'Abraham illustre le thème coranique de l'épreuve (ibtila) qui agit comme une véritable pédagogie spirituelle à l'adresse des croyants et, a fortiori des prophètes : leur élection et leur investiture ont pour passage obligatoire la purification.

En fait, il n'y a pas dans le Coran de position tranchée et claire sur l'identité du fils d'Abraham. Le texte ne cite pas le nom du fils qu'Abraham devait sacrifier, mais il dit clairement qu'il fût récompensé pour son obéissance.

La plupart des commentateurs déduisent des passages

coraniques que le fils dont il s'agit dans le sacrifice est *Ismail*, puisque la naissance d'*Isaac*, qui concrétise la récompense, est annoncée à la fin de l'acte et qu'*Ismail* est l'aîné des fils d'Abraham. En outre ceux qui optent pour *Ismail* se basent sur un Hadith du prophète qui dit « *je suis le descendant des deux victimes.* » Les commentateurs tel que Tabari précisent que les deux victimes sont *Ismail* et *Abdallah*, le père du prophète Mohamed.*

D'autre commentateur, comme le soufi *Ibn Arabi*, pensent que le fils sacrifié est *Isaak*.

Cependant, Abraham n'a pas interprété, cette vision, car selon l'avis des commentateurs, les songes des prophètes relèvent de la révélation. Il est perçu par eux comme une réalité imminente.

Par contre, pour certains soufi, l'épisode d'Abraham nécessite une déchiffrement ésotérique afin d'aller au-delà de la lettre. Pour *Ibn Arabi* dans son livre « *Fouçous al Hikam* », l'interprétation est un processus spirituel créatif qui recourt à la cosmologie et qui suppose constamment un sens ésotérique sous le sens patent. En effet pour ce mystique, le savoir vrai descend de Umm el Kitab (la mère du livre) l'archétype du coran, puis dans les tables gardées, puis dans les mondes des idéaux et enfin dans la réalité que nous connaissons.

Le rêve d'Abraham, comme le rêve de Joseph appelle une interprétation complexe qui est capable de révéler son sens caché.

Dans cette perspective, la longue tradition soufie considère que le grand sacrifice est le sacrifice de Soi. Le Soi étant le « nafs » qui est la psyché, laquelle est la part animale et mortelle de l'âme dont la représentation est l'agneau paisible du sacrifice, puisque c'est ainsi que le gnostique se laisse mener à l'extinction dans le divin.

C'est donc son moi que Dieu demande à Abraham d'immoler. Il faut remarquer que l'enfant est le symbole de l'âme (le fils est le Secret de son père dit un adage arabe). Abraham doit purifier son âme, cette âme prophétique élevée, certes, mais encore capable d'amour pour un autre que Dieu.

L'APPROCHE PSYCHANALYTIQUE :

Nous remarquons que **le mythe d'Abraham est toujours vivant**. Sa persistance n'est en aucune manière une survivance folklorique. Ce mythe fonctionne et continue d'accomplir son travail : sa tâche est de produire des êtres culturels que sont les humains.

Freud pensait qu'il ne fallait pas considérer les doctrines religieuses comme des fictions. Il serait plus judicieux de se demander **en quoi consiste la force interne de ces doctrines**, à quelles circonstances elles doivent leur efficacité qui ne dépend pas de leur reconnaissance par la raison et de propose une explication de cette force interne à travers l'appareil conceptuel freudien c'est-à-dire à travers **la problématique du désir et de l'effectivité des formations imaginaires**.

Certains peuvent s'étonner que Dieu qui demande à l'homme de ne point tuer semble exiger un meurtre. Ce Dieu qui a promis une postérité innombrable à Abraham condamne sa femme Sarah à la stérilité dans un premier temps, puis après avoir autorisé la conception d'*Isaak* exige un infanticide !

L'interprétation qui a dominé la tradition allait dans le sens de **la soumission**. Il faut obéir aveuglément pour ne pas déplaire à ce Dieu. Dans le sens du dolorisme aussi : pour rentrer dans les grâces divines, il faut accepter ce qui fait le plus souffrir : la perte d'un enfant.

Nous pouvons comprendre que certaines personnes se sont détournées de la Religion après avoir reçu une telle image en guise de représentation divine. Pourtant ce passage des textes sacrés semble dire autre chose. Certes ils parlent d'épreuve, Dieu mit à l'épreuve Abraham. Mais l'épreuve est inhérente à la vie. Elle est ce qui conduit chacun de nous à développer son humanité. L'injonction divine ne vise le maintien de l'homme dans un état de petitesse et d'assujettissement par rapport à la toute puissance divine. Il veut au contraire favoriser le déploiement de l'être et la libération de son énergie vitale.

Abram père des trois religions monothéistes, fut renommé **Abraham** au moment de sa première alliance avec Dieu. Téhar, son père engendra Abram, Nahor et Haran qui mourut dans son pays natal.

Téhar prit son fils Abram, son petit fils Lot, fils d'Harân, et sa bru Saraï, femme d'Abraham mais aussi fille de Téhar, et les fit sortir de la ville d'Ur pour aller au pays de Canaan. Abram subit cet exil douloureusement, car il dit « Dieu m'a fait errer loin de ma famille ». (Gn20.13)

Abraham est un homme qui souffre. Il subit le déracinement imposé par son père Téhar. Il est marié à sa demi-sœur. Sa femme est stérile, à 85 ans il n'avait toujours pas engendré d'enfants.

Sensible à la souffrance D'Abram, Saraï proposa à celui-ci d'épouser sa servante égyptienne Hagar.

Dès la conception (rapide) d'Ismaïl, fruit de sa liaison avec Hagar (qui est une concubine et qui n'est pas la femme choisie par son père Terah). Abraham peut croire enfin à sa destinée. Il peut présumer qu'il deviendrait le père d'une multitude de nations et un patriarche digne de ce nom. Afin de stigmatiser cette nouvelle position ainsi que sa paternité, il prend le nom d'Abraham. Il marque une distance avec son nom d'origine choisi par son père. **'Abram** deviendra **Abraham**, en gagnant la lettre h.

Ceci n'est pas sans conséquence sur son autonomie psychique vis-à-vis de son père. Abraham se sépara symboliquement de son père afin d'accéder à la maturité psychique et ainsi pouvoir devenir père à son tour.

Quant à Saraï, elle a dut subir elle aussi une modification de son nom de **Saraï**, dont la traduction est par ma princesse, qui se transforme en **Sarah** ou **Sara** dont la traduction est princesse. Le changement du nom, intervenant peu avant l'annonce à Saraï d'un fils, est aussi un signe révélateur d'un changement dans la personnalité de Sara. **Marie Balmory**, dans son livre « le Sacrifice Interdit », interprète la perte du possessif en y voyant une manière pour Sarah de se libérer de la possession par son père qui l'a nommée, ainsi que de son mari qui en a pris l'usage. Le passage « du possessif au génitif » lui aurait ouvert le chemin de l'appropriation d'elle-même.

Les textes sacrés nous informent que Sara est guérie de sa stérilité après la naissance d'Ismaïl.

Il faut mentionner que Hagar, fière de sa maternité, a provoqué sa maîtresse Sarah en stigmatisant sa stérilité.

Dans la culture arabo-musulmane un dicton ancien énonce que « **c'est grâce à la jalousie féminine que les femmes enfantent.** » Sara avait besoin d'une autre femme pour être féconde et devenir mère. La recherche de **Michèle Montrelay** a contribué à éclairer la question de la jalousie féminine. Pour cet auteur, au moment où la femme cherche à se reconstruire, cette reconstruction passe par le regard, à partir du corps d'une autre femme qui porte la lumière du désir de l'homme.

C'est le corps d'une femme qui est la lumière – la jalousie est dite d'ailleurs « aveuglante » - Cela nous ramène à une période tout à fait archaïque qui se rapporte aux relations primordiales avec le corps de la mère. Ce qu'il faut à la femme c'est la possibilité de donner forme à cette lumière, qui est maintenant sur l'autre, pour faire le corps maternel.

Car à ce moment, elle n'est plus qu'un corps, elle n'a plus de mots pour dire sa jalousie, mais il y a le corps de la rivale, de l'autre femme, qui est comme premier pas par lequel il te faut passer pour se reconstruire elle. Cette espèce de clarté aveuglante qui n'est plus rien qui est le vide de la jalousie, elle lui redonne contour du corps de cette femme. Mais cela implique que la femme a eu avec le corps de sa mère des relations constructives. Que son expérience de la jalousie faites avec sa mère aient été fragmentaires et non totalement dévastatrices.

Le recours à Hagar est un fait structurant dans l'histoire familiale d'Abraham. Il a permis à Sarah de liquider ses complexes avec sa propre mère, à travers la figure de l'autre femme Hagar, ce qui permet à Sarah d'accéder à la maturité psychique et d'enfanter Ismaïl sans culpabilité.

Dans cette optique théorique **le récit d'Abraham est un apprentissage de la parentalité** c'est-à-dire de la fonction parentale. Le terme parentalité est un concept récent (René Clement 1985) qui avait été précédé des termes de parentification (Serge Stoloro, 1983) maternité (Racamier, 1961) et de paternité qui recouvraient les mutations psychiques générées par l'arrivée d'un enfant. Winnicott et Serge Lebovici avaient décrit les élaborations psychiques que les parents doivent subir afin de faire place à l'arrivée d'un enfant. Daniel Rousseau définit la parentalité comme l'ensemble des dispositions psychiques des parents à accompagner au mieux leurs enfants avec évidemment de fortes références aux modes d'être d'une époque et d'une culture.

Bien entendu, pour cet auteur, la parentalité dépasse la simple fonction éducative.

En outre, la naissance impossible d'Isaac est aussi symbolique. En effet, lorsque Abraham est convaincu qu'il n'aura pas d'enfant légitime puisqu'il est alors âgé de 99 ans et sa femme de 89 ans, Dieu lui apparaît une nouvelle alliance et lui donner un fils Isaac.

La miraculeuse conception d'Isaac est mise en scène en tant que telle par le texte biblique où nous pouvons lire : « **Abraham tomba la face contre la terre et se mit à rire, car il se disait en lui-même : Un fils naîtra-t-il à un homme de cent ans, et Sarah, qui a quatre vingt dix, va-t-elle enfanter ?** »

Ce « miracle » nous montre qu'un enfant n'est pas uniquement une donnée biologique. Il n'est pas le résultat d'une union entre un gamète mâle et un gamète femelle. Ce schéma purement biologique nous voile un fonctionnement psychique et culturel fondamental. Pour **Tobie Nathan**, tout enfant humain est fabriqué au confluent d'une union biologique et d'une alliance symbolique et culturelle, renouvelée à chaque génération. Croisement d'humain et de divinités, tout enfant humain est donc nécessairement un métis. Car c'est avant tout un être de culture.

Nous retrouvons dans ce cheminement théorique la notion anthropologique de « dette » qui est omniprésente dans les récits bibliques et coraniques.

La scène du sacrifice d'Isaac ou d'Ismaïl selon les commentateurs, met en situation des conflits psychiques fondamentaux.

Freud pose dans « l'avenir d'une illusion » que les tabous fondamentaux qui fondent la culture sont le tabou du meurtre, le tabou de l'inceste et le tabou du cannibalisme. Il écrit à ce sujet : *« Avec les interdits qui instaurent les privations, la culture a inauguré le détachement avec l'état originaire d'animalité. A notre surprise, nous avons trouvé que ces privations continuent d'être à l'œuvre, continuent de former le noyau de l'hostilité à la culture. Les souhaits pulsionnels qui en pâtissent renaissent avec chaque enfant. De tels souhaits pulsionnels sont ceux de l'inceste, du cannibalisme et du plaisir-désir de meurtre. »*

Les relations parents-enfants sont évidemment régies par les mêmes tabous que nous pouvons convertir en tabou de dévoration, en tabou d'infanticide et en tabou de l'inceste parent-enfant.

Néanmoins, au cours des observations cliniques et leurs études sur terrain, psychanalystes et anthropologues déduisent que ces tabous fondateurs de la culture trouvent toujours des difficultés à être Transposés à la vie intime des familles.

Abraham incarne dans la culture judéo-chrétienne et aussi islamique celui qui a introjecté le tabou de l'infanticide et des sacrifices humains dont les enfants sont le plus souvent victimes.

En effet, si dans l'histoire et la mythologie le meurtre du père est bien connu, celui du fils est plus ou moins occulté. Et pourtant, il en est le pendant. A la base se trouve le désir en chacun d'opérer un déni de la mort et de se placer dans une illusion d'immortalité faite d'intemporel.

La survenue d'un fils peut développer des angoisses particulières de nature inconscientes. Dans l'enjeu inconscient, seul le fils peut menacer le pouvoir du père.

A travers l'histoire, il y a des récits de meurtre du fils par le père, on les retrouve dans toutes les cultures et dans toutes les religions.

La bible évoque d'autre récit de sacrifice d'enfant : Dans Jérémie XXXII, 35 est évoquée la pratique des pères vis-à-vis du dieu Moloch, *« ils ont construit les hauts lieux de baal dans la vallée de Ben Hinnom (le Ge-Henne) pour faire passer par le feu leurs filles et leurs fils en l'honneur de Moloch. »*

Juges XI la fille de Jephthé : *« Jephthé fit un vœu à Yahvé : si tu livres entre mes mains les Ammonites, celui qui sortira de ma maison pour venir à ma rencontre, je te l'offrirai en holocauste »* Jephthé gagne la bataille et avec l'accord de sa fille, son enfant unique, finit par « accomplir sur elle le vœu qu'il avait prononcé ».

Le Coran mentionne quant à lui l'infanticides des enfants. En effet, dans l'Arabie préislamique, certaines tribus arabes pratiquaient l'infanticide des fillettes sur la simple présomption que ces filles pouvaient tomber prisonnières lors des guerres inter-tribales et causer ainsi la honte et le déshonneur à leurs clan. Le Coran a d'ailleurs bien décrit cette attitude misogyne dans la sourate l'Abeille, versets 58 et 59 : *« Que l'on annonce à l'un d'eux la naissance d'une fille dans son foyer, son visage se rembrunit aussitôt : peu s'en faut qu'il n'éclate de rage ! Il n'ose plus se montrer aux gens affligé qu'il est par cette annonce. Devra-t-il ravalant sa honte, garder la nouveau-née ou l'ensevelir sous terre ? Quels piètres jugements que les leurs »* Les versets coraniques mettant fin à cette pratique furent révélés sous la forme de décrets solennels condamnant rigoureusement ces

assassinats et instituant **le droit à la vie comme un droit inviolable**. Et nous pouvons lire à la sourate L'Obscurcissement (El Ghachia) les versets suivants : *« Lorsque à la fillette enterrée vivante il sera demandée, pour quel forfait elle a été tuée. »*

En l'an 621, à la Mecque, le prophète Mohamed prête un serment avec les femmes. Dans ce serment l'islam confirme l'interdit coranique de l'infanticide. « Nous jurons Que nous ne volerons pas ... Que nous ne forniquerons pas ... Que nous ne tuerons jamais nos enfants. »

La mise en relief de cette interdiction révèle la force des pulsions mortifères des pères qui disposaient d'un droit de vie et de mort sur leurs enfants. Ces pulsions infanticides sont la manifestation de la dramatique oedipienne.

Donc l'intention première du récit d'Abraham vise l'interdiction de sacrifier son enfant à la divinité, car c'était là un rite païens et idolâtres. Or le Dieu monothéiste, ne désire pas qu'on lui sacrifie les enfants. Les textes sacrés, bibliques et coraniques insistent tous sur la limitation du pouvoir du père qui, en ces temps là, était absolu et allait jusqu'à la mise à mort de l'enfant. Les textes sacrés inculquent que même pour Dieu, le père n'a pas le droit d'attenter à la vie de son enfant. **« Vos enfants ne sont pas vos enfants »** écrivait splendidement le poète chrétien et arabe **Gabran Khalil Gabran** **« Vos enfants sont les enfants de la Vie »** c'est dire qu'ils sont les enfants de Dieu et de L'Amour fécond.

En outre, certaines interprétations montrent que l'épreuve d'Abraham ne pouvait consister, comme on le pense souvent, dans le sacrifice de son fils par soumission à Dieu. Dans un tel cas de figure, il serait plus logique d'exiger la vie d'Abraham comme preuve d'amour et de soumission à la volonté divine ! En réalité Dieu ne demande pas d'« immoler », ni de « sacrifier » l'enfant – comme le comprend Abraham. D'ailleurs dans le Coran, il est bien spécifié qu'Abraham interprète un rêve ou il croit déchiffrer l'ordre divin de sacrifier son fils.

La littérature soufie démontre qu'il a mal expliqué le songe. **Ibn Arabi** a dompté toute la question de l'interprétation du rêve ; il pense que tout d'abord que l'enfant est l'essence de son générateur. Par conséquent lorsque Abraham vit dans un songe qu'il immolait son fils, il se vit en fait se sacrifier lui-même. Et quand il racheta son fils par l'immolation d'un bélier, il vit la réalité, qui s'est manifestée sous la forme humaine, sous l'aspect du bélier. C'est donc ainsi que l'essence du générateur se manifesta sous la forme de l'enfant, ou plus exactement sous le rapport de l'enfant.

Dans la même perspective, Rachi, célèbre commentateur de la Torah, met en relief la signification littérale du verbe en hébreu et fait cette remarque : « Dieu n'a pas dit à Abraham : « égorge le ! », Car Dieu ne désirait pas l'immolation d'Isaac, mais « le faire monter à la montagne ». Quand Abraham fait monter son fils, Dieu lui dit fais le descendre.

Ainsi le sens général du récit s'éclaire : la matérialité du sacrifice n'est pas requise. Dieu n'est pas un dieu tyrannique et meurtrier mais le Dieu qui sauve. Pour la psychanalyste **Marie Balmory**, l'histoire est celle d'un père qui accepte de voir symboliquement mourir le petit enfant imaginaire qu'il portait en lui, de se délier des liens affectifs trop fort, et de l'offrir à Dieu, artisan de toute liberté.

La ligature d'Isaac- titre donné par la tradition juive à ce récit - revoie à celle qui reliait excessivement le fils à son père.

Le couteau est appelé à trancher le lien de dépendance, l'union étouffante entre Abraham et son fils, à rendre le fils plus libre et, par là même, à faire évoluer le père pour qu'il devienne entièrement père.

Grâce à cette épreuve, Abraham se montre capable de

dépasser ses angoisses, d'oublier ses besoins affectifs trop dévorants et d'accepter l'autonomie d'Isaac.

Le message pédagogique qui se dégage des textes sacré est le suivant : Nos enfants ne sont pas nos objets, nos choses, nos biens : il nous faut sacrifier cette jouissance qui nous viendrait de leur possession, pour qu'il se réalisent comme sujet de la parole, du langage et du symbolisme. Pour qu'il puisse s'élever et monter les montagnes.

*Il existe une autre séquence du récit islamique du sacrifice qui concerne la généalogie du Prophète Mohamed. L'historiographie traditionnelle rapporte qu'à l'époque préislamique, le grand père du prophète reçut l'ordre de déterrer un trésor enfoui. Il réussit à creuser un puit et fit le vœu de sacrifier un de ses enfants. Son choix se porta sur le dernier Abdallah son préféré. Au moment où il menait le fils élu vers le lieu du sacrifice pour l'immoler, des membres de la tribu s'interposèrent. Devant l'hostilité générale, il racheta son fils et offrit en expiation un sacrifice animal. Les scrupules du grand père furent si grands qu'il opta pour un mode de fixation du prix du rachat fondé sur le hasard. Il dut payer,

par conséquent, une rançon très élevée de cents chameaux qui furent offerts en sacrifice.

BIBLIOGRAPHIE

- ALEXANDRE Monique, Le sacrifice d'Abraham et la ligature d'Isaac : Lecture de ce récit dans le judaïsme et le christianisme anciens
In L'enseignement du fait religieux Ministère de l'Education nationale www.eduscol.education.fr
BALMARY Marie, Le Sacrifice interdit Edit. Grasset, Paris 1986
BENSLAMA Fath, La psychanalyse à l'épreuve de l'islam Edit. Aubier Paris 2002
Le CORAN , Traduction de Salem MAZIGH Maison Tunisienne de l'Édition Tunis 1978
FREUD Sigmund l'avenir d'une illusion (1927) Totem et Tabou (1912) Œuvres complètes PUF 1998
Ibn ARABI, Faruq al-hikam Edit. Dar el kitab al -arabi Beyrouth
MONTRELLAY Michèle, L'Ombre et le nom Edit. Minuit Paris 1977
ROUSSEAU Daniel, Parentalité et structures familiales In site Psychiatrie de l'Enfant et de l'Adolescent www.medecine.universitaireAngers

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Predicting Violence and Recidivism Among Forensic/Correctional Population

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Discussed in this paper are issues related to the clinical prediction of violent behavior and recidivism (returning back to prison or psychiatric institution after being released) among forensic populations. First a brief review of some issues related to making predictions. This is followed by a review of problems affecting accurate clinical predictions then a review of the variables associated with these predictions. In conclusion some suggestions are provided regarding ways to increase the accuracy of these predictions.

Introduction

Forensic psychiatry and psychology are subspecialties which, includes many areas where mental health and the Criminal Justice System (CJS) coincide. Organizations incorporated in the CJS is the correctional system and to some extent forensic wards in psychiatric hospitals. In most of the advanced correctional systems, forensic psychiatrists and psychologists carry out many important tasks. This includes (a) assessments aimed at predicting potential violence in the institutions and community after release, mental status examination, assessment regarding issue of self-harm, and other specialized assessments such as neuro-psychological evaluations, assessments of risk of sex offenders, and of substance abusers, (b) treatment via psychotropic medication (restricted to psychiatrists), development and implementation of treatment programs such as treatment to deal with offenders with anger, attitude problems, deficits with their cognition and attributions, sex offenders and substance abusers, (c) Providing critical Incident Stress Management intervention for staff when needed, (d) Consultation with management of the institution regarding issues with psychological implications such as management of crises, hostage taking incidents, riots, threats of self-harm, Mediation and conflict resolution, (e) staff training regarding issues with psychological implications (e.g., identifying offenders who are potentially at risk for harm to others or themselves), (f) training and supervision of graduate students, (g) conducting and participating in research projects.

Presentation in this paper will be restricted to issues related to the clinical prediction of violent behavior and recidivism (returning back to prison or psychiatric institution after being released). First a brief review of some issues related to making predictions. This will be followed by the problems affecting accurate predictions and a review of the variables associated with making these predictions. In conclusion some suggestions to help clinicians make accurate predictions will be provided.

Predicting violence and offenders recidivism is a contribution that forensic clinicians can make to prevent further criminal acts. However, this practice has not been without controversy. The supporters of the use of predictions argue that the benefits to society outweigh the costs to the individual and that predictions could prevent a great number of violent acts. The advocates against its use argue that a) there is no evidence that clinicians can reliably and accurately predict violent/ criminal behavior. b) Prediction violates civil liberties because prediction may result in more individuals being punished, not for crimes they have committed, but for crimes

they might commit. c) Prediction destroys the helping role of mental health professionals as their role should be to help their clients, not to act as an agent for social control. d) It is not ethically appropriate to predict violent behavior, given the doubts casted on this practice.

Most of the criticisms against prediction were made when clinical judgment alone was the method commonly used for making these predictions. The last three decades, however, witnessed many improvements in the ability to predict. These improvements are largely credited to the use of the actuarial and other psychological measures which have been demonstrated to improve the predictive accuracy of general recidivism and violent offenders. It is estimated that the predictive accuracy has been improved from 60% to 80% by using actuarial tools when predicting general recidivism, and as high as 53% when predicting violent recidivism. This is an improvement when compared to a success rate of less than 40% when using clinical judgment alone. In addition to improving the accuracy of predictions, the actuarial tools provide several advantages such as objectivity, uniformity, and consistency. They reduce the opportunity for litigation and make the decision process more clear to all involved. They also avoid most of the problems associated with the use of clinical judgment alone, such as assessor biases and limitations and the illusory correlates (appropriate but false correlations between a variable and outcome).

The success of actuarial measures has several researchers urging for the use of actuarials in the prediction process. Others advocate for complete reliance on the actuarial measure for risk assessments, on the basis that actuarial measures "are too good and clinical judgment too poor to risk contaminating the former with the latter". It is now broadly accepted that actuarial measures constitute the most accurate approach to predicting general behavior.

1 - Problems affecting accurate clinical predictions

1.1 - Base rate problem

A behavior that occurs rarely is one that has a low base rate. It is difficult to predict behaviors that have a low base rate. Ideally the predictor wishes to maximize his/her true predictions (i.e., true positives and true negatives), and minimize his false predictions (i.e., false positives and false negatives). A True Positive prediction of violent behavior is a forecast that violent behavior will occur which later materializes. A True Negative prediction of violence is a prediction that violent behavior will not occur which in fact does not. False predictions are incorrect predictions and have undesirable consequences. A

False Positive prediction (e.g., a prediction that violence will occur which turns out to be false) may result in the unnecessary detention of an innocent person. A False Negative prediction (e.g., a prediction that violence will not occur but it does occur) may result in releasing prematurely someone, who will behave violently in the community. Since violent behavior is committed rarely, it has a low base rate and results in a high percentage of false predictions. This means that even when clinicians follow good predictive procedures, they will end up making many more false positives than true positive predictions. Thus, erroneously recommending the detention of many people.

1.2 - Lack of specificity in defining the criterion

There is lack of agreement among clinicians as to what constitutes violent behavior and on the definition of violence or dangerousness. Some scholars have reported existence of more than 250 different definitions of aggression in the literature. Clinicians have been complaining of the lack of an objective legal definition regarding the precise nature, extent or object of the violent act which leave them to operate in a definitional abyss. Some have cited few examples in support of this claim. A violent act has been defined to include only injury to others; to include injury to others or the destruction of property; and both physical and psychological injury. Violent fantasies thoughts or threats have also been considered as dangerous. Writing a bad cheque is seen as dangerous behavior because it affects the economy. It has been pointed out that, due to the lack of definition as to what the clinician is supposed to predict, many personal biases affect his/her prediction. Such lack of agreement causes confusion and conflict among clinicians. This in turn results in arbitrariness and unfairness in the prediction process and decision making with regard to release.

1.3 - Lack of corrective feedback

Clinicians do not get a chance to empirically test the accuracy of their predictions. There is no systematic follow up in place to give predictors feedback about the results of their predictions. This results in clinicians making the same mistake daily and for many years, without improvement.

1.4 - Medical model.

The tendency to over predict violent behavior appears to be related to the practice of prediction in medicine. Clinicians are trained to avoid false negatives and suspect illness whenever in doubt. These clinicians, when requested to make prediction about an individual's violent behavior, take the cautious side and predict that violence behavior will occur.

1.5 - Differential consequences: Predictor vs. Predicttee.

It has been suggested that clinicians who make cautious predictions are making much safer recommendations than those who recommend release for someone who later commit violent acts. Similarly, it is suggested that while a prediction that a person will not commit violent acts, which turns out to be wrong may result in severe and prolonged legal, personal, and professional repercussions on the predictor, no negative consequences exist for making the safe prediction that the individual is dangerous. A scholar summarized 17 legal cases brought against clinicians for allegedly failing to follow the "duty to warn" or "duty to protect" principle. The pressures of legal repercussions do not come only from victims of the violent acts, but also from the violent individuals themselves. Another scholar reported a case of discharged mental patient who committed murder, and later filled a law suit on the

ground that the releasing authorities should have known better than to release him. It is also reported that there is an increasing emphasis on professional liability where the provider "Knew, or should have known" of the individual tendency towards violent behavior.

1.6 - Illusory Correlations

Individual prior expectations or beliefs bias clinicians and subsequently their decisions. Illusory correlation occurs when clinicians report observing a correlation between two events which, in fact, are not correlated, or correlated to a lesser degree, or in the direction opposite to that reported.

1.7 - Failing to incorporate environmental / situational variables

One of the important problems in predicting violent behavior is ignoring the influence of the environmental factors on the behavior. This is in spite of research indicating the importance of these factors in shaping the individual's behaviors. Failing to consider environmental factors is due to the belief that behavior stems from fixed, enduring traits, stable personality characteristics of the individual suggested that the situational factors and the interaction between them and the personality characteristics be considered in the prediction process.

1.8 - Lack of adequate psychometrics or not using proper psychometrics

Prior to the 1980s psychological measures specifically designed to help in the prediction of violent prone individuals were not widely known. This led clinicians to use measures that were designed for other purposes; developed on other populations or contained questions that were unreliable and misleading (Hinton, 1983). The Minnesota Multiphasic Personality Inventory (MMPI) is still the most widely used tool by correctional psychologists. It is reported that 87% of psychologists in the United States are using the MMPI, although, none of the original clinical scales have been specifically designed for use with offenders or the prediction of violent behavior. Nevertheless, many clinicians still use some of the original MMPI scales (i.e., the psychopathic deviate, Pd and the Manic, Ma subscales), or other special subscales (i.e., the Over Controlled Hostility, OH and the Megargee's MMPI typologies) to distinguish between violent and nonviolent individuals. These subscales, however, have not been found to be reliable or valid for such use. In addition others found that the MMPI was not useful in the prediction of recidivism. Use of the MMPI (OH) scale. In fact, the use of the MMPI is not supported by the contradictory findings of researchers who reported that MMPI clinical scales have not proven to be particularly good predictors of violent recidivism. The good news however, is that new measures and actuarials have been developed with demonstrated reliability and validity for making predictions regarding violent behavior and recidivism such as the Psychopathy Check List -Revised (PCL-R) and Level of Service Inventory-Revised (LSI-R) and the Self Appraisal Questionnaire (SAQ).

1.9- Lack of Psychological/ Psychiatric classification

There is no psychological/psychiatric classification in existence to classify violent prone individuals. Some have found that most psychiatric decision making in regard to predictions for violent behavior is impressionistic rather than quantitative.

1.10 - Representativeness in the Decision making process

Although usually there are many factors to be considered

before reaching a proper decision, people use a limited number of such factors in reaching their decisions. It has been suggested that usually one factor predominates and has a significant influence in the psychiatric decision process. For instance, in the decision to classify "mentally disordered sex offenders," some found that previous conviction of the person for sexual offences was the only factor, which predominated the psychiatric decision. Others have found that experienced forensic psychiatrists relied primarily on the seriousness of the index offense in the prediction of dangerousness of mentally disordered offenders, and ignored valuable information such as the results of psychological assessments. Two studies demonstrated that factors other than the individual behavior affected the predictors' decisions. In the first study, social class and criminal history influenced evaluation of the individual potential for violence. In the second study, social power variables (e.g., IQ level, marital status, race, education level, urban rural, socioeconomic level, parental status, and age) affected the prediction decisions.

1.11 - Imprecise Training

It seems that the majority of clinicians who are usually involved in the prediction of criminal or violent behavior are not precisely trained for such a task. Psychological and psychiatric training programs do not include the prediction of violent behavior as a part of their routine training. It has been reported that many psychologists have received little training in forensic psychology. It has been reported that experienced forensic psychiatrists disagree among themselves on the prediction of violent behavior of offenders. Furthermore it was found that psychiatrists were no different than the teachers who were used in this study as lay persons, in predicting violent behavior. Psychologists also disagree among themselves. Recently it was reported that 1% of correctional psychologists in the United States (federal & state) have received formal training in forensic psychology.

1.12- The assessor limitations

The assessor's own beliefs, feelings, and biases influence the outcome of his predictions. Some assessors have negative feelings towards the individual they are assessing (i.e., negative counter transference). For instance, some dislike dealing with a particular class of offenders, such as sexual offenders. On the other hand, some assessors have positive counter transference and are more tolerant to the offenders past than others. Also, assessors differ in their beliefs as to the treatability of violent offenders, which subsequently influences judgment and recommendations.

1.13- Time

It has been argued that time is not an all or none phenomenon. He sees time as an important factor involved in the prediction process. He suggested that some predictions get better with time, such as predicting that everybody "in this room will be dead in a 100 years time." He also suggested that meteorologists can predict that it will rain next year. Clearly, such a prediction is not helpful, as the predictor should specify how much it would rain, when and where. It has been suggested that short-term predictions are more accurate than long term ones. Most of the recently developed actuarial measures now specify the time limit for the accuracy of their predictions.

2 - Clinical Variables Associated With Prediction of Violence and Recidivism

2.1 - Age

Findings about existence of a relationship between age of

onset and future violent acts have been reported by many researchers. A positive relationship between age of onset and total number of youth convictions has been reported. Youths first convicted at the age of ten to twelve had an average of 7.17 convictions, while those convicted at the age from twenty to twenty four had an average of 1.18 convictions. Furthermore, he reported that there is relationship between the age of onset and the length of the criminal career. Others reported that being a juvenile offender increases the individual's chances of becoming an adult offender by three and one-half times. Also, others suggested that number of arrests up to the age of 18 increased steadily after the age of onset. It has been found that the older the offender at first offence, the lower the probability of further criminal involvement. Another researcher reported that rate of arrests for 18 years olds for further violent charges is six times that of 30 years olds. It has been now accepted that the younger individuals commit more violent behavior and are at higher risk for re-offending.

2.2 - History of Criminal Involvement

Some researchers have reported that recidivism among juveniles up to their eighteenth birthday was 54 percent after the first arrest. This was increased to 56 percent and 72 percent after the second and third arrest respectively. It is also reported that a prior arrest of four times indicates an 80 percent chance of another arrest and 10 prior arrests lead to a 90 percent probability for the eleventh arrest. Also it was found that "chronic" offenders had 6 or more convictions prior to reaching the age of 25.

2.3 - History of Serious Violence

It has been reported that the probability of assaultiveness increase with each act of violence and that there is a positive relationship between seriousness of the first conviction and number of subsequent convictions. After a reviewed studies on juveniles and concluded that a relatively serious first offense predicted later serious juvenile offending. It has been suggested to include a history of serious violence as a predictor of the most substantial acts of violence.

2.4 - Number of Earlier Convictions and Prior release failures

A positive relationship between number of convictions at ages from 10 to 17 and number of convictions at the age of 17 to 24 was demonstrated. Similarly, it was demonstrated that future rate of offending was best predicted by the number of past crimes and a link between the number of previous prison terms served and recidivism. Prior release failures have been included in most tools designed for the prediction of violent and non-violent recidivism.

2.5 - History of Childhood Behavioral Problems.

Research has indicated that conduct problems during childhood are among the best predictors of later offending and the development of a criminal career. It has been suggested that enuresis, pyromania, and cruelty to animals were good predictors of future violent behavior. Researchers found that a history of childhood problems such as hyperactivity, enuresis, temper tantrums, fighting, school problems, and an inability to get along with others significantly differentiates chronic aggressive from non-aggressive adults. Others found that aggression at age 8 is the best predictor of aggression at the age of 19. Others reported that 36 percent of the incidences of later violence could be accounted for by childhood predictive factors. These factors are: lack of parental supervision, lack of self-confidence of their mothers and being exposed to parental conflicts and or aggression.

2.6 - Socialization Problems

There are several studies that found that factors relating to child rearing methods such as family management techniques, harsh or erratic parental discipline, cruel, passive, or neglecting parental attitude; and poor supervision were related to later juvenile convictions. Some have reported that negative parent-child relationships, familial criminality, parental illness, and separation from parents increase the likelihood of juvenile delinquency and adult criminality. Furthermore, they suggested that family factors, such as family, marriage, children and holding other social bonds within the community mitigate criminal behavior by providing people with a social investment in conformity. It was also reported that parents' and siblings' antisocial behavior, broken homes, low family income, unsatisfactory housing were other indicators of children later offending. Peer pressure also has been reported to be a predictor of offending. It has been found that pro-criminal association in the community was one of four factors that significantly differentiated between the failure or success of conditionally released offenders. Similarly, associates and social interaction have been suggested as powerful predictors of recidivism. A high unemployment rate has also been considered as a predictor for criminal acts

2.7 - Educational Achievement and Intelligence

Poor educational achievement and low intelligence have been suggested as predictors of offending and violent behavior. Many research findings have been cited in support of this hypothesis. Similarly, several studies have demonstrated a correlation between low IQ and or school maladjustment and delinquency. Also, it is reported that offenders with low average- IQ and a low level of academic achievement are at high risk for re-offending.

2.8 - History of Substance Abuse

The relationship between substance abuse and crime, violence, and recidivism has been convincingly demonstrated. Alcohol has been implicated in as many as 64 percent of cases of homicide in general; in approximately 35 percent of murders in Canada; in between 34 percent to 72 percent of rape cases; in 52 percent of violent incidents in Canada. The relationship between the use of illegal drugs such as lysergic acid (LSD), amphetamines, cocaine, and Phencyclidine (CP, angle dust) and violent behavior and crime is also well documented. It is reported that approximately 70% of incarcerated American and Canadian offenders have substance abuse problems.

2.9 - Mental Illness

Many studies investigated the link between mental illness and violent behavior and the results are mixed. While some studies reported a relationship between violent behavior and mental illness, other studies did not find that such relationship exists. For example, evidence for a link between mental illness and violence has been reported. Several studies reported a relationship between mental illness and aggressiveness in epileptics, temporal lobe epilepsy psychotic disturbances, in particular paranoid psychoses, and violent behavior and a relationship between affective disturbances and violent behavior. Some researchers found that paranoid schizophrenics are more violent than non-paranoid patients are and that schizophrenics as a group tend to be more violent than other patients. Patients with personality disorders and organic brain syndrome follow this group. Others reported that acute psychotic symptoms have greater predictive validity for violent acts than lifetime diagnoses of schizophrenia. Other

researchers reported that mental illness alone is not a reliable predictor of violent behavior. However, researchers found that a record of past violence is the best predictor of future violence among psychiatric patients similar to that reported about prediction of violent acts for the non-psychiatric criminal population. Others reported that mental illness results in only a slightly elevated risk for violence. Another researcher note that thought disordered patients were less violent than other patients. Similarly, a researcher did not find a relationship between thought disorder and violence. In the same vein, several studies have found that the rates of violence to be lower among patients with schizophrenia than among patients with diagnosis of other personality disorder. A recent meta-analysis indicated that mental illness was negatively related to the prediction of violence among offenders.

2.10 - Personality Attributes

Several researchers have reported a relationship between some personality attributes and violent behavior. Some suggested a relationship between an over-controlled character and extreme violent behavior. Others suggested the following characteristics as a framework for clinicians to consider when predicting violent behavior: "reputation defending", "norm enforcing", "self-image compensating," "self-defending," "bullying," "exploitation," "self-indulging," and catharting. Other researchers proposed a link between violent behavior and a number of personality traits. Examples of these traits are: incapacity to feel sympathy, inability to learn from experience, narcissistic traits, paranoid traits, borderline traits, inner rage, over-controlled aggression, external locus of control, and hypertrophied sense of injustice. Others reported that the violent person, who perceives the world as agitating, stressful, or threatening, would justify his violent behavior. Similarly, others suggested that offenders who are temperamental, energetic, adventurer, pleasure seeking, compulsive, egocentric, and who lack problem-solving skills are at high risk of re-offending. Other group of researchers reported that psychopaths are generally convicted for more violent and aggressive crimes such as kidnapping, rape and sexual killing than other criminals. It was also found that the group of offenders with the lowest probability of remaining out of prison for at least one year after release are those classified as psychopaths.

2.11 - Attitudes

Antisocial attitudes, beliefs, behaviors, and feelings are considered central to the major theories of criminality and prediction of recidivism. It was found that the best individual predictors of recidivism were attitudes, values, and behaviors that support a criminal lifestyle. Likewise, some researchers considered antisocial attitudes towards all forms of authority and conventional pursuit (e.g., education, work, and stable pro-social relationships) to be one of the "big four" risk factors for criminal conduct. Furthermore, it was suggested that anti-social attitudes and values are the first two factors of the dynamic predictors for recidivism.

2.12 - Emotional variables and coping styles

Some researchers have reported a link between emotional variables and recidivism. They have identified a host of negative emotions, such as hopelessness, depression, anger, frustration, anxiety, and loneliness as antecedents to recidivism. It has been recommended that a person predicting recidivism should pay attention to people who express concern about losing control over violent urges and those who express process.

fear of causing harm to others. For example, it is reported that 75 percent of males involved in fatally battering babies gave unmistakable warning of their subsequent actions. It is suggested for clinicians to collect information about the offender stressors, coping mechanisms and styles, and the precipitating events, which led others to be concerned about the individual potential for violence. Also, several researchers suggested that the situational factors and the interaction between them and the personality attributes of the offender be considered in the prediction process.

2.13 - Leisure time.

Aimless and unproductive use of leisure time has been found to be link to predicting recidivism. Thus it is suggested that clinician examine the individual recreational hangouts.

2.14 - Availability of Victims and weapons

It is suggested that examiners investigate the future availability of means for committing future violence and the availability of likely victims as a criterion to be investigated when predicting criminal behavior and consider patterns of victim selection and the available means to violence.

3. Suggestions to help clinicians make accurate predictions.

3.1 - Forensic Clinicians must be fully knowledgeable and attain a high level of competency prior to taking on the task of predicting recidivism. As a minimum, clinicians must be fully aware of the variables relating to prediction of recidivism and also the variables that stand in the way of making accurate predictions. Combined, these variables are valuable in helping to make proper predictions. Also, clinicians must maintain their level of competency because developments in this area are changing rapidly. Workshops and journals such as Law and Psychiatry, Law and Mental Health, Criminal Justice and Behavior and Journal of Interpersonal Violence usually provide updated information about developments in the area of predictions.

3.2 - It is better, in particular for beginners, to use some of the already developed approaches, guidelines or processes in their assessments.

3.3 - More attention should be given to the available knowledge about the use of actuarial and other psychological measures in the process of predicting violent behavior. Use of a combination of the actuarial and clinical methods may be the best solution until better methods are developed. Using such methods would eliminate many of the obstacles currently standing in the way of accurate clinical prediction, such as subjectivity, in addition to achieving other advantages (i. e., achieving more accuracy in predictions and providing uniformity, consistency and equity in the decision making process).

3.4 - Clinicians must strive to provide accurate predictions and keep a balance between the potential harm to a victim and the rights of the offender and the benefits of society. An inaccurate prediction may result in harm to a new victim or unnecessary longer incarceration with its negative effects (e.g., unnecessary loss of the offender's freedom, increase the costs on taxpayers, and aggravate the problems of prison over crowding).

3.5 - Clinicians must obtain the offender's informed consent prior to the commencement of an assessment. Similarly, prior to releasing the report clinicians must share their findings with the offenders. Seek his input and possibly

correct any mistakes. By following these steps, clinicians avoid unnecessary inconvenience for the offender, others and him/her self.

3.6 - Clinicians are advised to collect as much information as possible before making predictions. Using different methods of collecting the necessary data, such as conducting free and semi-structure interviews, helps the clinician to reach a better prediction. Poor evaluation is sometimes the result of not getting enough information, such as not obtaining police reports, official record of criminal history, information about his current offense, and previous forensic reports. It is further suggested that the clinician examine the detailed description of every crime and not to rely on the legal name of the offense. This is because in the plea bargaining process several charges may be reduced to a smaller number and less serious charges. Also because legal names can be confusing (i. e., assault can mean anything from involvement in a bar room fight to sadistic torture of a victim). Equally important is to examine the situational variables that the offender will face upon release and triggers, stressors, events such as mood state and substance abuse which may lead to criminality in a particular offender (i.e., circumstance under which risk increases for a particular offender). Investigating the offender's future plans (eagerness/arranged for found employment, school) and the available support system on release (wife, parents, work) usually provide an idea about the offender's motivation and seriousness to refrain from further criminal activities.

3.7- Clinicians are advised to consider using multiple predictors when assessing recidivism. It has been demonstrated that predictability improves when one uses a variety of predictors. Similarly, it is reported that using composite measures of risk, which sample several predictor domains, produce higher correlations with recidivism than other scales or measures including antisocial personality scales. Also, it is reported that the assessment of characteristics across multiple domains in populations with a high-risk for violence, has produced more accurate, and therefore, more useful predictions. Some researchers have reported that composite actuarial measures of risk outperform individual static and dynamic predictors, and therefore, should be used in offenders' assessments.

3.8 - It is important to consider both static and dynamic variables. Prediction of recidivism should be based on a) static variables (historical factors which are not generally susceptible to change over time such as age at first offence, gender, race, prior criminal history, and historical family factors such as parental and family criminality, family rearing practices & structured dynamic variables which are also known as criminogenic needs and as those variables that are susceptible to change. Examples of these dynamic variables are antisocial cognition, values & behaviors, social achievement (employment /education), marital status, family support, criminal associates, substance abuse, personal/emotional, inadequate use of leisure time. Several researchers have reported on the relationship between dynamic variables and recidivism. Although research results have generally favored static over dynamic risk factors in making accurate predictions; sudden increase of the dynamic variables are highly predictive of failure on release. Furthermore, some have suggested that dynamic factors have as much predictive accuracy as static risk factors. The consensus is that both static and dynamic variables should be considered for the prediction of recidivism. Changes in the dynamic factors can come about by factors such as treatment

and maturity. It is these dynamic factors that are targeted for interventions and treatment.

3.9 - It is important to consider the base rate issue. Understanding base rate is essential for specific groups of offenders. It has been suggested that accurate prediction is possible if: a) one is able to obtain accurate base-rate of violent or sexual re-offence in a particular subgroup of offenders, b) the base rate of violent or sexual re-offending is approximately 25 to 75 percent for that subgroup; c) one is able to identify specific predictor variables that are positively or negatively related to violent or sexual re-offending for that subgroup.

3.10 - Clinicians would do better if they report their finding on a probability scheme and to refrain from using definitive statements in their predictions, particularly those statements that are not extensively substantiated by research findings. Examples of these statements will be reported later in this paper.

Authors' Note:

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(Psychology), Carleton University; Chief Psychologist, Kingston Penitentiary, Canada. He is bilingual (Arabic and English) and has published extensively and offered workshops to Forensic psychiatrist and psychologists in several countries. He has published a psychometric measure which helps clinicians with the prediction of violence and recidivism among Forensic/Correctional populations. He provides consultation in the areas of assessments and the development and evaluation of treatment programs for Forensic/Correctional populations. Dr. Loza is currently seeking interested researchers (Psychiatrists & Psychologists) from the Arab world to collaborate with him to complete studies and develop culturally sensitive assessment measures and treatment programs targeting violent individuals. His e-mail address is cited at the end of this article.

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اللاوعي الثقافي و لغة الجسد و التواصل اللفظي في الذات العربية

علي زيـجـور



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انجراحات السلوك و الفكر في الذات العربية

علي زيـجـور



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طيف صدام واحتمالات الوحدة والتفكك (من منظور التحليل النفسي)

د عدنان حب الله - التحليل النفسي - لبنان

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الطاغية صدام حسين سواء كان على قيد الحياة أو قابلاً في أحد الدهاليز، لا يزال طيفه كامناً وراء كل عملية عسكرية، وفي الداخل يعزز الخوف والرعب في ذاتية كل عراقي، لا سيما بعد اكتشاف المذابح الجماعية. وإذا ذكر اسم صدام حسين، طلب المحدث (كما ورد في مقابلات لبعض الصحافيين) ألا يذكر اسمه، وبدلاً ينكسر عن صدام بصوت محفوف كي لا يسمعه أحد، أو يثقت يميناً وشمالاً كي يتأكد من أنه غير مراقب. هذا الخوف الداخلي يطاول مجمل الرجال من مدنيين وعسكريين بعدما تأسس في نفسية كل عراقي خلال 30 سنة من القمع والتعذيب أو الإبادة لكل من تسول له نفسه الاعتراض أو الاحتجاج. فكان فظرات الطاغية تلاحق المواطنين في كل زاوية، في كل شارع وفي كل مكتب. لا يفلت منها أي منهم، ولا تحق عنها أي نية سيئة، أو معادية للزعيم وإن كانت امتناعاً عن التصديق في حفل أو حركات احتجاج. كذلك النساء لم يكن في منأى عن هذه السلطة المطلقة، كما تقول "منسية"، وهي إحدى محظيات صدام، فلها أخبرت من بين زميلاتها في المدرسة عندما تعرضت لنظرات صدام، وكان ذلك كافياً لإدخالها في جناح حريمه. وتقول "منسية" إنها قد تكون من ضمن مجموعة من النيات وقعت عليهن مرغبة القائد. وتزيد أنها لا تستطيع أن تحصى عددهن، وتحاف أن تكشف أكثر من ذلك لأن خوف صدام حسين لا يزال قائماً في نفسها على مر غيابه، أو ربما موته.

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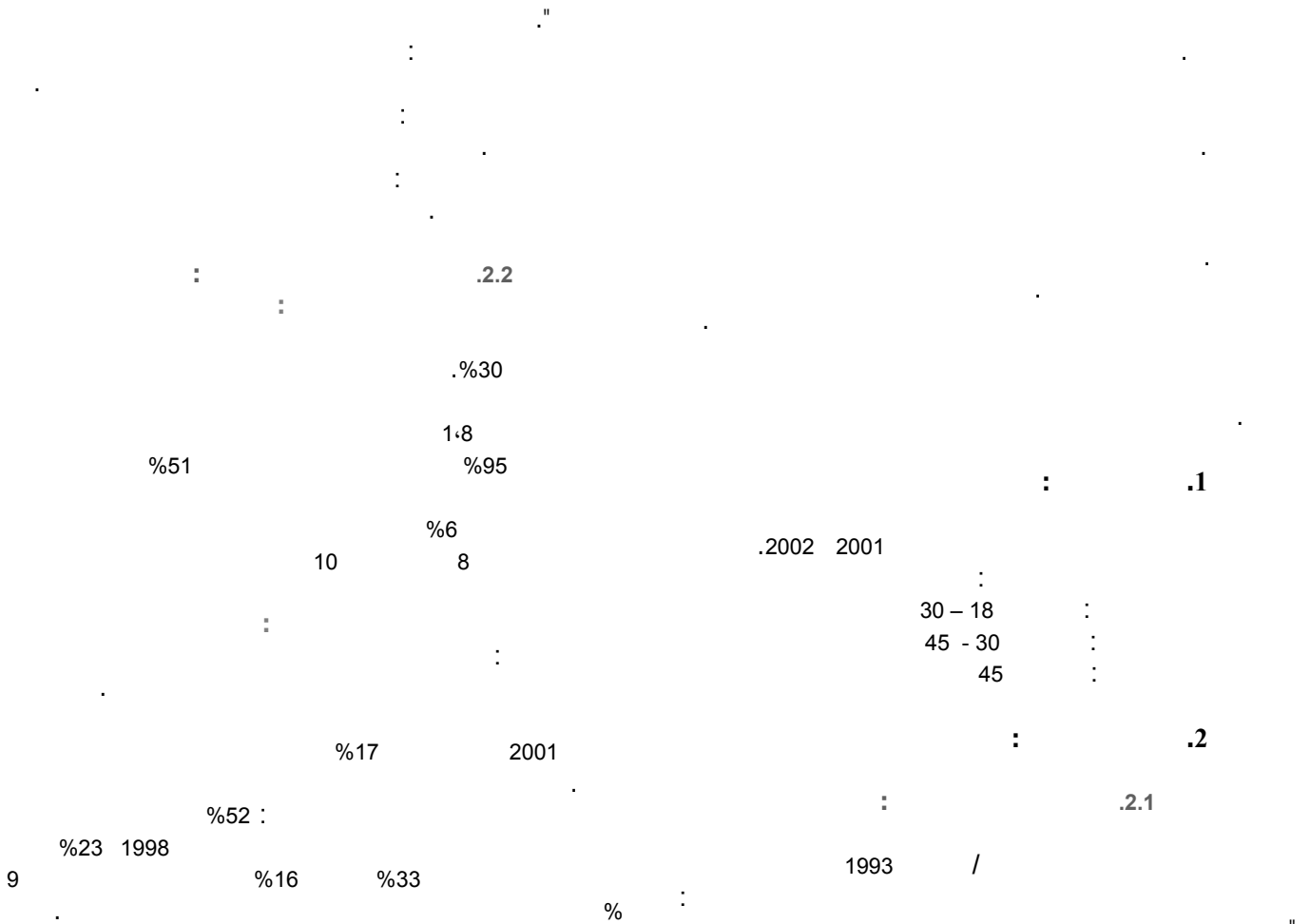
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العنف ضد المرأة في سوريا (دراسة ميدانية في مركز الطب الشرعي - حلب، سوريا)

د. محمد ضو - الطب الشرعي - سوريا

بريد إلكتروني : drdaw-md@scs-net.org

مقدمة : إن قديس حجر مشكلة العنف ضد المرأة له علاقة بدرجة إحساس المجتمع وإدراكه لهذه المشكلة، إضافة إلى توجهات ثقافة المجتمع نحو المرأة ودورها من ناحية، وحول أساليب تأديب الطفل وتربيته من ناحية أخرى. ويرتبط ذلك بجملة من المتغيرات الاجتماعية والاقتصادية والتربوية والقيم والعادات السائدة في المجتمع، إضافة إلى التشريعات القانونية المقررة ذات العلاقة المباشرة بتحديد أنماط السلوك الإجرامي وغير الإجرامي وفقاً للنصوص القانونية. من هنا يوضح دور منظومة التغير الاجتماعية والقوانين والتشريعات في تحديد معنى العنف ضد المرأة والطفل، وأنواعه، وصوره وأشكاله في أي مجتمع من المجتمعات، ويختلف ذلك من مجتمع إلى آخر، مما يعتبر من أساليب التربية والتأديب في مجتمع ما، قد يعتبر سلوكاً إجرامياً ومرفوضاً في مجتمع آخر. لذا، يبقى لأسلوب رصد البيانات المتعلقة بالعنف دور بارز في تحديد حجر المشكلة ومدى انتشارها، من حيث جمع البيانات الإحصائية وقبولها، وتصنيفها، وتحليلها. ونظراً للطبيعة السرية لهذه الموضوع، وطبيعة المجتمعات العربية المنبسكة بالتغير الدينية، وبالقاليد والعادات، فانه يصعب على هذه المجتمعات الإقرار بالحجر الحقيقي لظاهرة العنف الجسدي والجنسي الذي يقع على النساء والأطفال.



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العنف الجنسي ... مقارنة أنثروبونفسية
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المتسلط ... المستبد ... شخصية مرضية

أ.د. سامر جميل رضوان / سوريا srudwan@hotmail.com

DSM-IV

"Categories"

مما لا شك فيه أن لكل إنسان خصائص وصفات تميزه عن غيره في أسلوب تفكيره وتصرفه وإحساسه وإدراكه وردود فعله. وهذه الخصائص والصفات تشكل في مجملها جوهر شخصية الفرد. التي يمكن تعريفها بأنها تلك الشكيلة الفريدة من الانفعالات والأفكار والصفات، وهي التي تتيح للإنسان في الحالة السوية النمو والنشاط والتلاؤم مع الحياة، ولكنها قد تنحرف لدى البعض فتصبح جامدة ومنحجرة مكونة أنماطاً مضطربة من الشخصية. ويتفق معظم العاملين في الميدان الإكلينيكي على أنه ينبغي التفرقة بين عنصرين متبطينين بنباد لأن التأثير فيما بينهما فيما يتعلق بالشخصية: الأول هو المزاج Temperament والثاني هو الطبع Character.

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مجلة شبكة العلوم النفسية العربية**من المحاور الرئيسية للأعداد القادمة****اضطرابات الوجدان الثناقطبي ... المستجدات**ندعوكم للمشاركة بأبحاثكم و أعمالكم الأصلية
ترسل الأبحاث على البريد الإلكتروني للمجلة

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العنف ... الجريمة ... نحو فهم سيكولوجي

أ.د. محمد أحمد النابلسي - لبنان ceps50@hotmail.com

لدى دخولي إلى جامعة بوردو في بداية دراساتي الجامعية تعرضت وبعض الزملاء لاختبار نفسي أذكر من أسئلته سؤالين كان لهما الأثر في حياتي المهنية لاحقاً:

الأول: قرى امرأة تركب سيارة رجل ما (غير زوجها) يومياً، ما هي بن أباك العلاقة بينهما؟ وكان جوابنا جميعاً عن السؤال بأنها على علاقة به. ومما لا شك به أن محلل الاختبار قد وضعنا يومها في خانة الهوس الجنسي لأنه لم يراع البيئة التي قدمنا منها حديثاً في حينه.

الثاني: يقسم الناس إلى طيبين وأشرار فهل توافق على هذا التصنيف؟ أيضاً أجبتنا جميعاً بنعم! ومما لا شك فيه أن المحلل قد وصفنا بأننا من أصحاب الميلول المحافظة.

مداخل نفسية لنبذ ثقافة العنف

د. إقبال الغربي – تونس

لماذا تشرب الوعي العربي الإسلامي مفهوم العولمة كرهاب و كعمل قأمسي؟ هذا ما لاحظته عالم الاجتماع الطاهر ليب عندما كتب "أن النص العربي جعل من مصطلح العولمة كآرقة عامة لا تخلق من امتداد غيبي. لذلك فالحديث عن العولمة هو حديث عن الموت و الفناء و الانقمار."

لماذا تسود الصور النمطية، وقطعي النزعة الشاؤمية اليوم على الساحة حيث ينفذ
المجورم العنف اللطفي وسيلة دفاع؟ حيث يعتقد أن الحماص والخطابات العاطفية
تمثل مردا وظائفا على منطق العصر. بل هناك من يعتقد أنها أساس ما نملكه من
مقومات نصارعها الآخر. بينما تمثل العتلاتية في الإعلام لا مثلك ومائل القوة الحقيقية
التي توهم شعوبنا للثأف الإجماعي مع العالم. إن العنف بأشكاله الرمزية والمادية يبقى
هشما عاطفيا وغريزيا لا يمكن التصرف فيه فضلا عن استعالة البناء عليه.

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مجلة شبكة العلوم النفسية العربية: العدد 4 - أكتوبر - نوفمبر - ديسمبر 2004

هوس السلطة ... رؤية في سيكولوجية الاستبداد

علي تركي نافل / العراق

السلطة تلك الفاتنة الساحرة، أغوت الكثيرين على مر التاريخ، سواء من كانوا يسعون لها بعد ذائقها، أم يسعون لها من أجل منافعها المادية غير الشرعية، وسواء أكانوا عربا أم من قوميات أخرى، ولنا في التاريخ العربي شواهد تاريخية كثيرة تشير إلى أن للعرب افتنانا خاصا بالسلطة، منها مأساة الإمام حسين (ع) و الثلة التي معه، فما قتل يزيد إلا من أجل أن يثبت أمر كان حكمه و سلطانه، و ما قتل المأمون أخاه الأمين إلا في صراع من أجل السلطة.

السلطة تلك الفاتنة الساحرة، أغوت الكثيرين على مر التاريخ، سواء من كانوا يسعون لها بعد ذائقها، أم يسعون لها من أجل منافعها المادية غير الشرعية، وسواء أكانوا عربا أم من قوميات أخرى، ولنا في التاريخ العربي شواهد تاريخية كثيرة تشير إلى أن للعرب افتنانا خاصا بالسلطة، منها مأساة الإمام حسين (ع) و الثلة التي معه، فما قتل يزيد إلا من أجل أن يثبت أمر كان حكمه و سلطانه، و ما قتل المأمون أخاه الأمين إلا في صراع من أجل السلطة.

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مسألة العنف في المجتمع المصري ... تساؤلات

lotfyaa@yahoo.com

د. لطفى الشربيني / مصر

عادت ظاهرة العنف في المجتمع المصري لتكون محل اهتمام بعد أن تزايدت بشكل ملحوظ وتعدت جرائم العنف بما يري البعض أنه يمثل تهديداً للأمن والسلام الاجتماعي الذي تميزت به الشخصية المصرية علي مدى طويل . . وهنا يجب أن نوقف أمام هذه الظاهرة ونبحث في الجوانب النفسية والجذرية الحقيقية لها ، وذلك بطرح بعض التساؤلات كدعوة لمناقشة واسعة لموضوع العنف في مجتمعنا وحجم انتشاره والمقارنة مع بعض المجتمعات الأخرى . . حتى يمكننا أن نحكم إن كان يمثل فعلاً وضعا خطيراً يهدد بعواقب وآثار وخيمة . . ونطرح من وجهة النظر النفسية تساؤلات حول الأسباب والعوامل وراء ظهور وتزايد سلوك العنف في مصر . . ونصور للمواجهة وحل لمشكلة العنف قبل أن تتفاقم.

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الطب النفسي المعاصر

أ.د. أحمد عكاشة

Summary : www.arabpsynet.com/Books/Okasha.B1.htm

نحو سيكولوجية عربية

أ.د. محمد أحمد النابلسي

Summary : www.arabpsynet.com/Books/Nab.B2.htm

العنف الجنسي ... مقارنة أنثروبونفسية

فارس كمال نظمي / العراق fariskonadhmi@hotmail.com

مقتطف: (من تقرير منظمة مراقبة حقوق الإنسان - بغداد / 2003 م)

1. امرأة في الثالثة والعشرين، اختطفت أثناء سيرها في الشارع مع والدتها وبعض أفراد أسرتها، واقتيدت إلى منزل خارج بغداد، حيث احتجزت ليلة كاملة، واغتصبت. وأبلغ والدها الشرطة باخطافها، ولكنها لم تقم بأي تحريات بشأن ادعائه.

2. طفلة في التاسعة من عمرها، تعرضت للاغتصاب الوحشي على يد رجل اختطفها من سلم الفندق الذي قمر فيه، عصر الثاني والعشرين من مايو؛ ورفضت إحدى المستشفيات علاجها، كما رفض معهد الطب الشرعي توقيع الفحص الطبي عليها لعدم إحالتها إليه بصورة رسمية.

3. فتاة في الخامسة عشرة من عمرها، فرت من أحد المنازل خارج العاصمة بغداد في 8 حزيران، حيث ظلت محبوسة لمدة شهر مع شقيقتها وسبعة أطفال آخرين؛ ولم تعرض للاغتصاب، ولكن شقيقتها اغتصبتا. ومن المعتقد أن خاطفيها كانوا يتوون بيعها هي والأطفال الآخرين للمجرمين بالبش.

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في سيكولوجية العنف والعدوان (ملحق نظري)

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أ.د. قاسم حسين سالم - العراق iraqipa@hotmail.com

شغل موضوع العدوان اهتمام رجال الدين والسياسة وعلماء الحياة (البيولوجيا) وعلماء النفس والاجتماع... ويدعو أن العنف بين الناس يزاد بقدر الزمن. ففي عام 1961 كان عدد الموضوعات المنشورة عن العدوان بخلاف الأربعين موضوعاً، ارتفع في غضون عشر سنوات إلى أربعمئة، ليصل العدد في بداية القرن الواحد والعشرين إلى عشرات الآلاف.

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SOCIÉTÉ PSYCHANALYTIQUE MAROCAINE (SPM)

جمعية التحليل النفسي المغربية

Site Web : www.lienpsy.com

www.lienpsy.com : موقع الويب

E.mail : khalid_elalj@hotmail.com

khalid_elalj@hotmail.com : بريد إلكتروني

■ Première Annonce de Naissance ■

Nous avons le grand plaisir de vous informer de la naissance de la Société Psychanalytique Marocaine (SPM). Fondée le 7 décembre 2001 à Rabat, elle a fait récemment l'objet d'une reconnaissance officielle.

Depuis plusieurs années, un groupe composé de praticiens psychiatres et psychologues, se réunit pour réfléchir à la question de la formation. Ce cheminement a abouti à la création de la Société Psychanalytique Marocaine (SPM), structure associative régie par le dahir n° 1-58-376 du 3 Joumada 1 1378 (15 novembre 1958).

Les membres fondateurs de la S.P.M. sont :

Jalil BENNANI, Leila CHERKAOUI, Abdeslam DACHMI, Khalid EL ALJ, Mohamed JAMAI, Ahmed Farid MERINI, Abdellah OUARDINI, Hachim TYAL.

Précédant cette fondation, des journées inaugurales pour la formation se sont tenues du 18 au 20 octobre 2001. Ces journées, intitulées **Les nouvelles rencontres psychanalytiques de Rabat**, se sont déroulées dans le cadre de l'Institut Français de Rabat grâce au concours du Service de Coopération et d'Action Culturelle de l'Ambassade de France.

Au cours de ces journées, la présence régulière d'une assistance nombreuse et motivée, a montré l'intérêt du public pour cette discipline et la nécessité d'aller plus loin dans notre engagement dans la formation, au-delà de la sensibilisation. Le niveau de ces journées a été rehaussé par la participation très active de conférenciers de renom, qui ont tous soutenu ce projet et émis le souhait de rester des partenaires et conseillers. Suite à sa fondation, la SPM leur a réservé le rôle de membres honoraires de la Société.

La Société Psychanalytique Marocaine se donne pour buts et objectifs :

- d'assurer la formation des psychanalystes au Maroc
- de promouvoir et de développer la psychanalyse au Maroc
- de veiller au respect de l'éthique dans le cadre de cette formation.

Pour parvenir à ses objectifs, la SPM se propose de mettre en place les moyens pour assurer :

- la psychanalyse personnelle
- la pratique de " contrôle "
- la formation théorique
- l'habilitation à la pratique de la cure psychanalytique par une commission composée de trois praticiens confirmés.

Les praticiens qui seront amenés à dispenser une formation seront soit des praticiens marocains, soit des praticiens étrangers.

La SPM vise ainsi à faire bénéficier les futurs psychanalystes de la formation la plus ouverte et la plus large possible, tenant compte en cela des différents développements qu'a connus la psychanalyse depuis sa fondation par Freud.

La SPM veillera à :

Arabpsynet eJournal: N° 4-OCTOBER - NOVEMBER - DECEMBER 2004

مجلة شبكة العلوم النفسية العربية: العدد 4 - أكتوبر - نوفمبر - ديسمبر 2004

- mettre en place les documents de base réglementant les différentes activités de la Société
- instituer des groupes de travail (cartels) composés de quatre personnes au moins, en vue d'assurer un travail régulier entre les membres de la Société
- organiser des séminaires, des conférences, des colloques, des congrès nationaux et internationaux
- organiser la tenue de journées annuelles de la Société et, si possible, semestrielles
- assurer la publication des travaux de ses membres qui réunissent les conditions de publication
- promouvoir différentes actions culturelles au profit de ses membres
- développer le champ de la recherche en psychanalyse
- encourager le travail sur les traductions françaises, anglaises ou espagnoles de textes psychanalytiques allemands. Elle favorisera également toute initiative susceptible d'aider à la traduction en arabe des textes psychanalytiques
- assurer des contacts périodiques avec tous les organismes ou associations ayant des activités similaires
- créer une bibliothèque et se doter d'une banque de données informatisées
- se doter d'un siège social

Condition d'affiliation à la SPM :

Membres Adhérents:

- les praticiens de la santé mentale au Maroc
- les psychanalystes exerçant à l'étranger et inscrits dans un processus de formation analytique et dont la pratique fait l'objet d'une reconnaissance, soit dans le cadre d'une institution, soit par leurs travaux.

Pour être Membre Adhérent, il faut présenter sa candidature au Bureau de la Société, être agréé par celui-ci, avoir payé sa cotisation annuelle et se soumettre aux décisions de la Société conformément aux dispositions statutaires et réglementaires.

Seuls les membres adhérents sont habilités à voter dans les différentes institutions de la SPM (Assemblée Générale Ordinaire, Assemblée Générale Extraordinaire...)

Membres Associés :

- les personnes qui, par leurs préoccupations professionnelles ou par leurs recherches personnelles sont intéressées par la psychanalyse
- les étudiants en formation en psychiatrie, en psychologie ou dans une autre branche de la santé mentale.

Pour être Membre Associé, il est nécessaire d'avoir le parrainage de deux membres du Bureau. Les Membres associés n'ont pas de voix élective. Les Membres Associés doivent s'acquitter de leur cotisation annuelle.

Les Membres Bienfaiteurs

Les Membres Bienfaiteurs sont les personnes qui apportent leur soutien moral, matériel ou technique à la Société. Pour être Membre Bienfaiteur, il faut être agréé par le Bureau et avoir réglé sa cotisation annuelle.

Les Membres Honoraires

Les Membres Honoraires sont les personnes qui se sont distinguées par leurs travaux et qui soutiennent la Société. Ils seront choisis sur proposition du Bureau.

Les Membres Correspondants

Les Membres Correspondants sont des personnes chargées de diffuser les travaux de la Société et favoriser les relations et les échanges avec d'autres associations au niveau international. Ils peuvent être proposés par le Bureau ou admis, suite à leur propre demande, après acceptation du Bureau

Le bureau de la SPM :

Le Bureau, élu pour trois ans par l'Assemblée Générale, est le suivant :

- Jalil BENNANI : Président
- Abdeslam DACHMI : Vice-président
- Hachim TYAL : Secrétaire Général
- Ahmed Farid MERINI : Secrétaire Général Adjoint
- Mohamed JAMAI : Trésorier
- Abdellah OUARDINI : Trésorier Adjoint
- Khalid EL ALJ : Conseiller

Le Bureau de la SPM - Rabat, le 25 mars 2002

2002/03/25

Statuts de la Société Psychanalytique Marocaine

ARTICLE 1 : A l'initiative des membres fondateurs réunis en Assemblée Constitutive le 24 Novembre 2001 au 3, rue Tamesna, quartier Longchamps à Casablanca il est créé une Association dénommée **Société Psychanalytique Marocaine (S.P.M.)** conformément aux dispositions du dahir n° 1-58-376 du 3 Joumada 1 1378 (15 novembre 1958), tel qu'il a été modifié par le dahir portant loi n° 1-73-285 du 6 Rabi' I 1393 (10 avril 1973) réglementant le droit d'association.

Les membres fondateurs sont les personnes suivantes : Abdel Jalil BENNANI, Khalid EL ALJ, Abdeslam DACHMI, Mohamed JAMAI, Ahmed Farid MERINI, Abdellah OUARDINI, Mohamed Hachem TYAL.

Le siège de la SPM est situé à Rabat et domicilié à la Boîte Postale de l'Association. Il pourra être transféré en tous lieux dans la même ville ou dans une autre ville par décision de l'Assemblée Générale Ordinaire.

I. BUTS ET COMPOSITION DE LA SPM

ARTICLE 2 : Buts et objectifs

La SPM se donne pour buts :

- d'assurer la formation des psychanalystes au Maroc
- de promouvoir et de développer la psychanalyse au Maroc
- de veiller au respect de l'éthique dans le cadre de cette formation.

Pour parvenir à ses objectifs, la SPM se propose de mettre en place les moyens pour assurer :

- la psychanalyse personnelle
- la pratique de " contrôle "
- la formation théorique
- l'habilitation à la pratique de la cure psychanalytique par une commission composée de trois praticiens confirmés.

Les praticiens qui seront amenés à dispenser une formation seront soit des praticiens marocains, soit des praticiens étrangers.

La SPM vise ainsi à faire bénéficier les futurs psychanalystes de la formation la plus ouverte et la plus large possible, tenant compte en cela des différents développements qu'a connu la psychanalyse depuis sa fondation par Freud.

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Ils seront choisis sur proposition du Bureau.

Les Membres Correspondants :

Ce sont des personnes qui sont chargées de diffuser les travaux de l'Association et favoriser les relations et les échanges avec d'autres Associations au niveau international.

Ils peuvent être proposés par le Bureau ou admis, suite à leur propre demande, après acceptation du Bureau.

ARTICLE 5 : Démission, exclusion

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La qualité de Membre Adhérent de la SPM se perd :

- par décès
- par démission
- par radiation prononcée par le Bureau aux 2/3 de ses voix, soit pour refus ou défaut de paiement régulier des cotisations, soit pour motif grave, l'intéressé ayant été préalablement appelé à fournir des explications.

Pourront être exclus de la Société les membres :

- ne participant pas à ses activités
- ne respectant pas l'éthique de la profession
- ne payant pas leur cotisation.

La radiation doit obligatoirement être entérinée par l'AG la plus proche.

ARTICLE 6 : Soutiens

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La Société peut recevoir des soutiens, sur le plan théorique et matériel, venant de personnes ou d'Associations marocaines ou étrangères, susceptibles de l'aider à atteindre ses buts et ses objectifs dans le respect des lois en vigueur.

ARTICLE 7 : Affiliation

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La Société peut être affiliée à d'autres Sociétés ou Associations internationales après décision du Bureau. Elle pourra aussi établir des relations de partenariat avec ces institutions.

II. ADMINISTRATION ET FONCTIONNEMENT

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ARTICLE 8 : Administration

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L'administration de la Société Psychanalytique Marocaine est dévolue à un Bureau. Le programme d'activités de la SPM est défini par celui-ci. Le Bureau est investi des pouvoirs les plus étendus pour l'administration et le contrôle financier de la SPM.

Le Bureau est élu pour trois ans par l'Assemblée Générale et comprend:

- un Président / un Vice-Président / un Secrétaire Général / un Secrétaire Général Adjoint / un Trésorier / un Trésorier Adjoint / un conseiller.

ARTICLE 9 : Attributions des Membres du Bureau

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Le Président : Il est le responsable et le représentant de l'Association. Il préside les Assemblées Générales, les réunions du Bureau. Il veille à la bonne marche de l'Association, à l'exécution des décisions de l'Assemblée Générale, au respect des directives du Bureau et des statuts. Le Président signe tous les documents et procès-verbaux.

La fonction de Président ne peut être assumée plus de six ans d'affilée. Un ancien Président peut cependant assumer de nouveau la présidence trois ans après la fin de son dernier mandat

Le Vice-Président : Il seconde le Président dans ses tâches et le remplace en cas d'absence ou d'empêchement avec les mêmes pouvoirs que les siens.

Le Secrétaire Général : Il assure l'application des statuts et du règlement. Il effectue l'envoi des convocations et la diffusion de l'ordre du jour pour les Assemblées Générales et les réunions. Il rédige les procès-verbaux et signe éventuellement les correspondances de l'Association. Il a la garde des registres de l'Association.

Le Secrétaire Général Adjoint : IL seconde le Secrétaire Général dans l'accomplissement de sa mission et le remplace en cas d'absence ou d'empêchement.

Le Trésorier : Il a la garde des fonds de l'Association et des livres de compte. IL effectue les recettes et les dépenses, recouvre les cotisations, donne quittance et reçu ; Il soumet à l'Assemblée Générale le rapport financier de chaque exercice et prépare le budget annuel. Il dépose dans les institutions choisies par le Bureau les deniers de l'Association et les gère conformément aux Statuts de celle-ci.

Le Trésorier Adjoint : Il seconde le Trésorier dans sa tâche avec les mêmes pouvoirs et le remplace en cas d'absence ou d'empêchement.

ARTICLE 10 : Réunions

Le Bureau est élu pour trois ans. Il se réunit tous les six mois au minimum, et chaque fois qu'il est convoqué par son Président.

La moitié plus un des membres présents du Comité Directeur sont nécessaires pour la validité des délibérations. Les délibérations sont prises à la majorité des voix. A nombre égal de voix, celle du Président compte double. Ces réunions sont constatées par des procès-verbaux.

En cas de défection d'un ou de plusieurs membres du Bureau d'autres membres adhérents pourront les remplacer. Leur intégration au Bureau se fera par simple cooptation et sera soumise à l'approbation de la prochaine Assemblée Générale.

ARTICLE 11 : Assemblées Générales

L'Assemblée Générale de la Société Psychanalytique Marocaine comprend les Membres Adhérents. Pourront néanmoins participer aux délibérations à titre d'observateurs :

- les Membres Honoraires
- les Membres Bienfaiteurs
- les Membres Adhérents
- les Membres Associés

L'Assemblée Générale Ordinaires se réunit une fois par an à la fin des journées annuelles ; Son ordre du jour sera établi par le Bureau mais il pourra être complété par quelques points rajoutés par les membres de l'Assemblée. L'Assemblée Générale entend les rapports sur le fonctionnement de la Société de Psychanalytique Marocaine et sur sa situation financière. Elle approuve les comptes de l'exercice clos, vote le budget de l'exercice suivant, délibère sur les questions mises à l'ordre du jour. Elle procède à l'élection du nouveau Bureau tous les trois ans.

Les délibérations sont prises à la majorité des voix des membres présents. Il est dressé procès-verbal de chaque réunion de l'Assemblée Générale.

Une Assemblée Générale Extraordinaire peut être convoquée si nécessaire par le Président ou par les 2/3 des Membres du Bureau ou encore par les 2/3 de ses membres à des fins de modification des Statuts de l'Association ou de sa dissolution.

III. RESSOURCES DE LA SPM

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ARTICLE 12 : la Société Psychanalytique Marocaine pourra posséder tous les biens nécessaires au but qu'elle poursuit et à l'œuvre qu'elle se propose d'accomplir, dans les limites fixées par la Loi.

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ARTICLE 13 : Les ressources annuelles de l'Association se composent :

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- des cotisations et souscriptions de ses membres
- des subventions qui pourront lui être accordées
- des intérêts de revenus des biens non compris dans le fonds de réserve
- des dons et legs autorisés
- des recettes de toute manifestation organisée par l'Association, dans le cadre de la législation en vigueur.

ARTICLE 14 : Les dépenses de la Société Marocaine de Psychanalyse sont ordonnées par le Président après accord du Bureau.

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ARTICLE 15 : Il est tenu au jour le jour une comptabilité des deniers par recettes et par dépenses, et s'il y a lieu une comptabilité matières.

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ARTICLE 16 : Les ordres de retrait de fonds sont signés conjointement par le président et le trésorier de l'Association ou à défaut le vice président et le trésorier adjoint

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ARTICLE 17 : Les fonctions de membres du Comité Directeur sont gratuites. Toutefois ils peuvent bénéficier du remboursement de leurs frais de déplacement ou de toute autre dépense effectuée pour le compte de l'Association.

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IV. MODIFICATIONS DES STATUTS & DISSOLUTION

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ARTICLE 18 : Les Statuts ne peuvent être modifiés que par l'Assemblée Générale Extraordinaire avec l'approbation des 2/3 des membres. Au cas où le quorum n'est pas atteint, une deuxième Assemblée Générale est convoquée au moins 15 jours avant par lettre recommandée. Les décisions sont alors prises à la majorité simple des présents.

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ARTICLE 19 : La dissolution de la Société Marocaine de Psychanalyse ne pourra être prononcée qu'en Assemblée Générale Extraordinaire, convoquée à cet effet un mois à l'avance, et la délibération doit être prise à la majorité des deux tiers des membres présents.

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En cas de dissolution, l'Assemblée Générale désigne un ou plusieurs commissaires chargés de la liquidation des biens de l'œuvre.

Elle attribue l'actif net à une Association poursuivant le même objet ou à défaut à une œuvre de bienfaisance.

Casablanca le 24 novembre 2001

2001/11/24

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1^{er} colloque MAROCAIN de psychanalyse Psychanalyse, TRANSMISSION ET LIEN SOCIAL

LA SOCIÉTÉ PSYCHANALYTIQUE MAROCAINE

MAROC 10 - 11 DÉCEMBRE 2004

الملتقى المغربي الأول للتحليل النفسي تحليل نفسي، تبليغ وارتباط اجتماعي

جمعية التحليل النفسي المغربية

المغرب 10- 11 ديسمبر 2004

■ ARGUMENT DU COLLOQUE ■

La transmission de la psychanalyse est une expérience singulière. Depuis Freud, les psychanalystes se sont confrontés à cette question. La transmission se fait par l'expérience d'une analyse personnelle, par la pratique dite de contrôle et par la formation théorique.

Au Maroc une institution psychanalytique existe depuis décembre 2001 : la **Société Psychanalytique Marocaine (SPM)**. Elle est née d'un désir de fondation et d'une demande insistante de formation émanant de praticiens exerçant dans le champ de la psychiatrie et de la psychologie. Pour opérer une transmission, il a fallu « réinventer » comme le disait Lacan, chercher de nouveaux abords de **l'inconscient**, en s'appuyant sur un double fonds : **l'histoire du pays et celle de ses institutions**.

Interroger cette transmission conduit inévitablement à soulever des questions relatives **la langue** et à **la culture**, aux **identifications** et aux **identités**. Comment en effet, peut s'opérer la transmission dans un pays **attaché à ses traditions** tout en étant habité par un **désir de modernité** ? Comment être à **l'écoute de la parole** de l'individu tout en accompagnant les mutations sociales ainsi que les avancées de la science notamment dans le domaine des neurosciences et de la biotechnique ?

■ INTERVENANTS ANNONCES ■

La transmission de la psychanalyse et « la théorie des climats » - Montesquieu : Jean-Richard FREYMAN

Est-ce que la transmission de la psychanalyse est tributaire de l'histoire, des traditions et des pionniers d'une région ou d'un pays ?

Ou à présent peut-on affirmer que comme « science du particulier » les problèmes de transmission, à savoir : « ce que la psychanalyse nous enseigne, comment l'enseigner » est une constante, une transmission qui n'est pas une filiation et qui échappe.

De la foule comme formation de l'inconscient : Erik PORGE

Le symptôme analysable et donc **l'examen de ce qui s'en transmet**, n'est ni seulement individuel ni seulement collectif, c'est un mixte des deux dont l'abord nécessite justement un dépassement de l'opposition individuel/collectif. C'est ce dont nous essaierons de poser les jalons en tirant les conséquences des lectures par **Lacan** du fameux schéma freudien de l'hypnose (dans le chapitre 8 de Psychologie collective et analyse du moi). De la même façon que l'individuel ne s'oppose pas tant au collectif qu'au singulier, la jouissance particulière **du symptôme** s'oppose à l'universel **d'un dire**.

■ CONTACT : ■

Dr. Khalid El ALJ (Conseiller de la SPM)

P.mail : 70, Bd Zerkouni, app.8 – Casablanca 20000

E.mail : khalid_elalj@hotmail.com - **Fax :** 022472585

Web site : www.lienpsy.com

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IV RENCONTRE FRANCOPSIES DES PSYCHIATRES PRIVÉS

PSYCHIATRIE, JEUNESSE ET SOCIÉTÉ

Organisé par :

ALFAPSY (Alternative Fédérative des Ass. de Psychiatrie)

L'AAPEP (Ass. des Psychiatres d'Exercice Privé)

ALGER : 19 - 26 mars 2005 - hôtel Sheraton (Club des Pins, Alger)

الملتقى الفرنكفوني الرابع للأطباء النفسيين

الطب النفسي - الشباب والمجتمع

اتحاد الأطباء النفسيين الخواص الناطقين بالفرنسية
الجمعية الجزائرية للأطباء النفسيين بالممارسة الحرة

الجزائر 19-26 /03/ 2005 - نزل شيراتون (نادي الصنوبر - الجزائر)

Argument du Congrès

En accueillant les « Rencontres Francopsies » pour leur 4e édition, l'Algérie et l'AAPEP offrent aux professionnels du champ de la psychiatrie un terrain de choix pour aborder un sujet de réflexion et d'échanges sur un thème sensible et complexe : « Psychiatrie, Jeunesse et Société ».

Le choix du thème des IV^e Francopsies "psychiatrie, jeunesse et société" s'avère particulièrement d'actualité. Il l'est plus encore pour les pays maghrébins où la pyramide des âges met en évidence une nette prédominance de la population juvénile (70% de la population a moins de 30 ans) et que l'incidence des changements socio-économiques et culturels observés durant ces deux dernières décades ne cesse de croître.

L'adolescence est une phase de vulnérabilité par excellence et le creuset de la psychopathologie avec ses expressions individuelles et collectives. Il apparaît par conséquent primordial d'étudier et de tenter d'analyser les liens entre ces différentes notions : psychiatrie, jeunesse et société.

Jusqu'à une période relativement récente, les problèmes que soulevaient le vécu et la prise en charge des jeunes ont été, avouons le, plus ou moins occultés car la priorité était volontairement donnée à la "psychiatrie lourde".

Mais ces aspects deviennent pressants et prennent un caractère aigu, d'autant que les référents sociaux et culturels de base jouent de moins en moins leur rôle. Il est vrai aussi que les mutations socioéconomiques imposées par la mondialisation et l'émergence des conflits politico-religieux, jouent un rôle prépondérant dans les perturbations psychopathologiques de la jeunesse.

Face à cette situation quel rôle doit être dévolu au psychiatre ? S'agissant d'une problématique multifactorielle, sa fonction ne peut se concevoir que comme celle d'un intervenant parmi tant d'autres, faisant partie intégrante d'une approche pluridisciplinaire.

C'est autour de ces thèmes que s'articuleront les interventions et les débats des IV^e Francopsies d'Alger.

Dr Farid Bouchène - Président de l'AAPEP

E.mail : bouchene_farid@yahoo.fr

Intervenants : Jalil Bennani, Alain Braconnier, Malek Chebel (sous réserve), Mohamed F. Haffani (sous réserve), Jean-Michel Hirt, Seddik Jeddi (sous réserve), Farid Kacha, Marie-Lise Lacas, Jean-Pierre Lebrun (sous réserve), Raja Stitou

Comité Scientifique AAPEP : Ali Bellakhdar, Nadjib Benlatreche, Farid Kacha, Aïd Maamar, Youssef Merdji, Idriss Sadki, Mohamed Taleb, Zineb Tsouria

bouchene_farid@yahoo.fr :

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Conseil Scientifique ALFAPSY : Hatem Achache, Hassen Ati, Chebil Ben Dhia, Jalil Bennani, Antoine Besse, Hervé Bokobza, Hervé Granier, Jean-Paul Guittet, Wahid Koubaa, Mohamed Jamaï, Jean-Jacques Laboutière, Ferid Mrini, Olivier Schmitt, Mahmoud Touari, Hachem Tyal, Sofiane Zribi, Jean-Jacques Xambo

Comité d'Organisation : Ahmed Ahoua, Ahmed Bennegeouch, Rabah Hamadi, Belaïd Herbane

Présidents du congrès : Farid Bouchene et Paul Lacaze

Renseignements : inscriptions, règlement d'acomptes, soumissions de communication sont à adresser à : ALFAPSY, Allée du Pioch Redon, 34430 Saint Jean de Védas, France

Tel : 00 33 (0)467 423 579 ou 00 33 (0)609 560 603

Fax : 00 33 (0)467 423 231

Email : Paul.Lacaze@wanadoo.fr

Site Web : www.alfapsy.com

34430
00 33 (0)609 560 603 أو 00 33 (0)467 423 579 :
00 33 (0)467 423 231 :
Paul.Lacaze@wanadoo.fr :
www.alfapsy.com :

PRE-PROGRAMME (Alger 19 au 26 mars 2005)

(2005 26 -19)

Samedi 19 mars accueil aéroport **Alger** et transfert vol intérieur vers **Ghardaïa** (dans le pays M'Zab)

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Dimanche 20 mars visite de l'oasis (« la perle du désert »)

(" ") : 20

Lundi 21 mars : découverte des dunes et des thermes de **Zelfana** (palmeraie, dattiers)

: 21

Mardi 22 mars : vol de retour vers Alger et installation à l'hôtel

: 22

15h accueil des participants et inscriptions locales des congressistes

: 15

18h cérémonie d'ouverture : allocutions et conférences inaugurales (tout public)

: 18

21h cocktail d'înatoire

: 21

Mercredi 23 mars :

: 23

8h à 11h conférences plénières et débats + pause-café

: 11 - 8

11h30 à 13h30 ateliers puis déjeuner

: 30 13 - 30 11

15h « rencontres de terrain » ou visite guidée dans le centre et la **Qasbah d'Alger**

: 15

20h dîner et **soirée culturelle**

- : 20

Jeudi 24 mars :

: 24

8h à 11h conférences plénières et débats + pause-café

: 11 - 8

11h30 à 13h30 ateliers puis déjeuner

: 30 13 - 30 11

15h « rencontres de terrain » ou excursion à **Tipaza** (le site antique romain)

(") : 15

20h30 cérémonie de clôture : synthèse - table ronde et allocutions (tout public), suivie du dîner de **gala** avec soirée dansante

: : 30 20

Vendredi 25mars :

: 25

10h à 12h Assemblée Générale de **ALFAPSY**

" " : 12 - 10

Après-midi : libre et premiers transferts vers l'aéroport d'Alger pour le retour

: :

Samedi 26 mars : derniers transferts vers l'aéroport.

: 26

- **droits simples professionnels** (inscription congrès + documents + pauses-café) : **150 €**
- **forfait n°1 Francopsies Alger.** congressistes (droits simples + hébergement PC + excursions) : **400 €**
- **forfait n°2 Francopsies Alger + Ghardaïa.** (idem n°1+ vol national + hébergement 1/2P + excursions) : **750 €**
- **option nuit supplémentaire Alger.** (le vendredi en 1/2P) : **100 €**
- **participant non-congressiste.** : réduction sur forfait n°1 ou n°2 moins **100 €**
- tarifs par personne en chambre double, hors voyage international, donnés à titre indicatif selon le choix de prestations hôtelières

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Psy CONGRESS AGENDA

FIRST QUARTLY 2005

January – February – March

أجندة المؤتمرات النفسية

الثلاثية الأولى 2005

جانفري - فيفري - مارس

ARAB Psy CONGRESS AGENDA

Title: 3rd International Congress on the Improvement of the Quality of Life on Dementia Epilepsy and MS

Date: January 27, 2005 - January 31, 2005

Country: Egypt - **City:** Alexandria

Contact: Forum I.C.O.

Phone: 302-310-257-128 - **Fax:** 302-310-231-849

E-Mail: info@forumcongress.com

Title: "Psyche and Art Seminar"

WPA Section on Art and Psychiatry

WPA SPONSORED SECTION MEETING (Zone 11)

Schattauer Verlag Publishers

Date: February 2005 (Final date pending)

Country: Tunisia - **City:** Djerba

Contact: Dr. Hans Otto Thomashoff

E-Mail: thomashoff@utanet.at

Title: IV Rencontre Francopsies Des Psychiatres Prives

Date: 19-26 Mars 2005

Country: ALGERIE

Contact: Dr Farid Bouchène - Président de l'AAPEP

E-Mail: bouchene_farid@yahoo.fr

Title: IVth Congress of Anxiety Disorders

Date: 9-13 March 2005

Country: TUNISIA **City:** Hamamet - Royal hotel

Contact: President: Assoc.Pr. Nesrin Dilbaz - Ankara; TURKEY director of psychiatry clinic of Ankara State Hospital

E-Mail: dilbaz@superonline.com

INTERNATIONAL Psy CONGRESS AGENDA

Title: The 3rd Congress of Psychopharmacology

Date: February 16, 2005 - February 17, 2005

Country: Iran - **City:** Isfahan

Contact: Vice chancellor department- Isfahan university of Medical Sciences- Hezar jarib St

Phone: 983-117-923-081-2 - **Fax:** 98-31-166-879-898

E-Mail: seminars@mui.ac.ir

Title: 1st International Congress on Immunodeficiency Disorders

Arabpsynet eJOURNAL: N° 4 - OCTOBER - NOVEMBER - DECEMBER 2004

Date: February 28, 2005 - March 02, 2005

Country: Iran - **City:** Tehran

Contact: Nima Rezaei, MD

Phone: 98-216-938-545 - **Fax:** 98-216-938-545

E-Mail: congress@iranianpia.org

Title: Psychiatric Update Conference For Family Physicians

Date: January 09, 2005 - January 16, 2005

Country: Mexico - **City:** Mayan Riviera

Contact: Dr. Alan Buchanan

Phone: 604-682-6042 - **Fax:** 604-662-7627

E-Mail: info@psychupdate.com

Title: Psychiatric Update Conference For Family Physicians

Date: January 16, 2005 - January 23, 2005

Country: Mexico - **City:** Cancun

Contact: Dr. Alan Buchanan

Phone: 604-682-6042 - **Fax:** 604-662-7627

E-Mail: info@psychupdate.com

Title: Suicidology Series: Suicide Interventions with Older Persons

Date: January 19, 2005 - January 19, 2005

Country: Canada - **City:** Toronto, ON

Contact: Centre for Addiction and Mental Health

Phone: 416-595-6020 - **Fax:** 416-595-6644

E-Mail: ets@camh.net

Title: 19th Annual San Diego Conference on Child and Family Maltreatment

Date: January 24, 2005 - January 28, 2005

Country: United States - **City:** San Diego, CA

Contact: Linda Wilson

Phone: 858-576-1700 - ext 4972 - **Fax:** 858-966-8018

E-Mail: SDCONFERENCE@CHSD.ORG

Title: Summit for the Future: Healthcare

Date: January 26, 2005 - January 28, 2005

Country: Netherlands - **City:** Amsterdam

Contact: Felix Bopp

Phone: 31-20-615-4487 - **Fax:** 31-20-408-0733

E-Mail: summit2005@clubofamsterdam.com

مجلة شبكة العلوم النفسية العربية: العدد 4 - أكتوبر - نوفمبر - ديسمبر 2004

Title: 3th Congress on Substance Abuse: New Approaches in Prevention and Treatment
Date: January 27, 2005 - January 29, 2005
Country: Iran - **City:** Yazd
Contact: Yazd University of Medical Sciences, Yazd, Iran
Phone: 00-982-417-271-414 - **Fax:** 00-982-417-276-424
E-Mail: congress@irasar.com

Title: Bridging: Psychiatry and Environment
Date: January 28, 2005 - January 29, 2005
Country: Portugal - **City:** Lisbon
Contact: Prof. Maria Luisa Figueira
Phone: 351-217-990-611 - **Fax:** 351-217-990-612
E-Mail: canessa@mail.telepac.pt

Title: Adolescent Self-Destruction
Date: January 28, 2005 - January 29, 2005
Country: United States - **City:** Boston, MA
Contact: Office of Continuing Education
Phone: 617-384-8600 - **Fax:** 617-384-8686
E-Mail: hms-cme@hms.harvard.edu

Title: "What Works" in Drug & Alcohol Treatment
Date: February 02, 2005 - February 03, 2005
Country: Canada - **City:** Toronto, ON
Contact: Edythe Nerlich
Phone: 416-972-1935 - **Fax:** 416-924-9808
E-Mail: enerlich@hincksdellcrest.org

Title: Psychiatric Research Annual Meeting
Date: February 09, 2005 - February 12, 2005
Country: United States - **City:** Park City, UT
Contact: Lyn Gardner
Phone: 801-585-0598
E-Mail: Lyn.gardner@hsc.utah.edu

Title: Playing with Trouble: Playful Approaches to Working with Challenging Children and Their Families
Date: February 18, 2005 - February 18, 2005
Country: Canada - **City:** Toronto, ON
Contact: Edythe Nerlich
Phone: 416-972-1935 - **Fax:** 416-924-9808
E-Mail: enerlich@hincksdellcrest.org

Title: Procedural Sedation
Date: February 18, 2005 - February 19, 2005
Country: United States - **City:** Albuquerque, NM
Contact: Office of Continuing Medical Education
Phone: 505-272-3942 - **Fax:** 505-272-8604
E-Mail: CMEWeb@salud.unm.edu

Title: Fetal Alcohol Spectrum Disorder National Conference - Equality of Access: Rights and the Right Thing to Do
Date: February 24, 2005 - February 26, 2005
Country: Canada - **City:** Victoria, BC
Contact: Michelle Griffiths
Phone: 604-822 6156 - **Fax:** 604-822-4835
E-Mail: ipdocs@interchange.ubc.ca

Title: 2005 International Whiplash Trauma Congress
Date: February 25, 2005 - February 26, 2005
Country: United States - **City:** Breckenridge, CO
Contact: Whitney Elkins
Phone: 303-429-6448 ext 119 - **Fax:** 303-429-6373
E-Mail: welkins@spinalinjuryfoundation.org

Title: Treating the Addictions
Date: March 04, 2005 - March 05, 2005
Country: United States - **City:** Boston, MA
Contact: Office of Continuing Education
Phone: 617-384-8600 - **Fax:** 617-384-8686
E-Mail: hms-cme@hms.harvard.edu

Title: Psychiatric Update
Date: March 04, 2005 - March 05, 2005
Country: United States - **City:** Madison, WI
Contact: Terese Bailey
Phone: 608-240-2141 - **Fax:** 608-240-2151
E-Mail: tm Bailey@wisc.edu

Title: 10th Annual ICPD Conference - Essential Topics in Clinical Psychiatry
Date: March 07, 2005 - March 11, 2005
Country: Mexico - **City:** Mayan Riviera
Contact: Canadian Psychiatric Association, 141 Laurier Avenue West, Suite 701, Ottawa, ON K1P 5J3
Phone: 613-234-2815 - **Fax:** 613-234-9857
E-Mail: icpd@cpa-apc.org

Title: Suicidology Series: Creating Awareness about Youth Suicide: LGBTTTIQ Factor
Date: March 09, 2005 - March 09, 2005
Country: Canada - **City:** Toronto, ON
Contact: Centre for Addiction and Mental Health
Phone: 416-595-6020 - **Fax:** 416-595-6644
E-Mail: ets@camh.net

Title: "14th World Congress of the World Association for Dynamic Psychiatry: Trauma-Attachment- Personality"
World Association for Dynamic Psychiatry (WADP)
WPA CO-SPONSORED CONFERENCE (Zone 9)

Date: March 16-19, 2005

Country: Poland - **City:** Cracow

Contact: Dr. Maria Ammon

E-Mail: dapberlin@aol.com

Web site: www.dapberlin.de

Title: "Financing Mental and Addictive Disorders"
WPA Section on Mental Health Economics
WPA SPONSORED SECTION MEETING (Zone 8)

Date: March 18-20, 2005

Country: Italy - **City:** Venice

Contact: Dr. Massimo Moscarelli

E-Mail: moscarelli@icmpe.org

Web site: www.icmpe.org

Title: 7th International Conference on Progress in Alzheimer's and Parkinson's Disease

Date: March 09, 2005 - March 14, 2005

Country: Italy - **City:** Sorrento

Contact: 7th International Conference AD/PD 2005 Kenes
International 17 Rue du cendrier P.O. Box 1726 CH-1211
Geneva 1 Switzerland

Phone: 41-229-080-488 - **Fax:** 44-8-451-275-687

E-Mail: adpd@kenes.com

Title: Anti-Aging World Conference 2005

Date: March 11, 2005 - March 13, 2005

Country: Monaco - **City:** Monaco

Contact: Catherine DECUYPER

Phone: 00-33-143-345-099 - **Fax:** 00-33-143-345-039

E-Mail: AAWC@euromedicom.com

Title: Developmental-Behavioral Pediatrics: Clinical Problems in Primary Care

Date: March 11, 2005 - March 12, 2005

Country: United States - **City:** Cambridge, MA

Contact: Continuing Medical Education, Boston University
School of Medicine, 715 Albany Street, A305, Boston, MA 02118

Phone: 617-638-4605 - **Fax:** 617- 638-4905

E-Mail: cme@bu.edu

Title: Psychiatry Review Course DISNEY Cruise

Date: March 12, 2005 - March 19, 2005

Country: Barbados - **City:** Bridgetown

Contact: Course Organiser

Phone: 416-237-1427

E-Mail: info@psychiatryreviewcourse.com

Title: XIX Central American Psychiatric Congress

Date: March 15, 2005 - March 18, 2005

Country: Costa Rica - **City:** San Jose

Contact: Dr. Luis Vasquez

Phone: 847-249-2111 - **Fax:** 847-249-2772

E-Mail: milalatin@aol.com

Title: 14th World Congress of the World Association for Dynamic Psychiatry and 27th International Symposium of German Academy of Psychoanalysis

Date: March 16, 2005 - March 19, 2005

Country: Poland - **City:** Krakow

Contact: Meeting Organiser

Phone: 49-89-539-674

E-Mail: wadcongress2005@dynpsych.de

Title: Psychotherapy of Schizophrenia Patients: Foundations, Spectrum, Evidence and Perspectives

Date: March 17, 2005 - March 18, 2005

Country: Switzerland - **City:** Bern

Contact: Mrs. Francine Perret

Phone: 00-41-319-309-915 - **Fax:** 00-41-319-309-988

E-Mail: francine.perret@gef.be.ch

Title: ADAA 25th Annual Conference

Date: March 17, 2005 - March 20, 2005

Country: United States - **City:** Seattle, WA

Contact: Anxiety Disorders Association of America, 8730
Georgia Avenue, Suite 600, Silver Spring, MD 20910, USA

Phone: 240-485-1001 - **Fax:** 240-485-1035

Title: Europe Oceania Medical & Legal Conference

Date: March 20, 2005 - March 26, 2005

Country: Italy - **City:** Cervinia

Contact: Jane Hewett

Phone: 00-11-61-732-362-601 - **Fax:** 00-11-61-732-101-555

E-Mail: conference@barweb.com.au

Title: First Stage Trauma Treatment: A Gender-Sensitive Approach

Date: March 23, 2005 - March 24, 2005

Country: Canada - **City:** Toronto, ON

Contact: Centre for Addiction and Mental Health

Phone: 416-595-6020 - **Fax:** 416-595-6444

E-Mail: ets@camh.net

Title: Pan Europe Pacific Medical & Legal Conference
Date: March 28, 2005 - April 03, 2005
Country: Italy - **City:** Venice
Contact: Jane Hewett
Phone: 00-11-61-732-362-601 - **Fax:** 00-11-61-732-101-555
E-Mail: conference@barweb.com.au

Title: "XV International Psychiatric Conference"
 Pakistan Psychiatric Association
Date: January 28-30, 2005
Country: Pakistan - **City:** Karachi
Contact: Dr. Musarrat Hussain
E-Mail: profdrmusarrat@hotmail.com
Web site: www.ppsconference.com

Title: WPA CO-SPONSORED CONFERENCE
 "6º Congreso Virtual de Psiquiatria, Interpsiquis 2005"
 WPA CO-SPONSORED CONFERENCE (Zone 15)
Date: February 1-28, 2005
Country: Spain
Contact: Dr. Pedro Moreno
E-Mail: pmoreno@psiquiatria.com
Web site: www.interpsiquis.com

Title: "Bienestar y Calidad de Vida en el Siglo 21"
 WPA Section on Mass Media & Mental Health
 WPA SPONSORED CONFERENCE (Zone 3)
Date: February 3-5, 2005
Country: Mexico - **City:** Tuxtla
Contact: Dr. Miguel A. Materazzi
E-Mail: materazzi@arnet.com.ar

Title: "Advances in Psychiatry: State of the Art"
 Hellenic Psychiatric Association
 All WPA Sections
 WPA SPONSORED REGIONAL & INTERSECTIONAL
 CONGRESS
Date: March 12-15, 2005
Country: Greece - **City:** Athens
Contact: Dr. George N. Christodoulou
E-Mail: gchristodoulou@ath.forthnet.gr - info@era.gr
Web site: www.era.gr/wpa2005athens.htm

Title: "IV National Psychiatric Congress" and "XIX Central
 American Psychiatric Congress"
 Costa Rica Psychiatric Association
 WPA SPONSORED CONFERENCE
Date: March 16-18, 2005
Country: Costa Rica - **City:** San Jose
Contact: Dr. Rigoberto Castro Rojas
E-Mail: rcastro@racsa.co.cr
Web site: www.asocopsicr.com - www.ccmcr.com/congresos/costarica2005

مصر- القاهرة، 10-15 سبتمبر 2005
www.wpa-cairo2005.com

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عضو الهيئة التحضيرية للمؤتمر- لجنة العلاقات العامة و التظاهرات الاجتماعية

رحلتي مع الطب النفسي

د. الزين عباس عمارة - الطب النفسي - السودان / أبو ظبي

zinomara@hotmail.com - zinomara@emirates.net.ae : بريد الكتروني

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 الأمراض النفسية والعصبية- ود مدني الجزيرة / مستشفى جوبا-
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 الطب النفسي الجديد- أبو ظبي

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ندعوكم للمشاركة بأبحاثكم و أعمالكم الأصلية
ترسل الأبحاث على البريد الإلكتروني للمجلة

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THE EFFECT OF LOCUS OF CONTROL AT LEVEL OF DEPRESSION AMONG CANCER PATIENTS

Prepared by : Firas Yasein Abu Qa'adan

Supervisor : Pr. Adnan Farah

E.mail : drfarah@arabia.com

أثر مركز الضبط في مستوى الاكتئاب لدى مرضى السرطان

إعداد : فراس ياسين أبو قعدان

إشراف : أ.د. عدنان فرح

بريد إلكتروني : drfarah@arabia.com

The aim of this study was to examine the effect of locus of control (internal- external) on the level of depression in cancer patients and the relation of that with locus of control. The study specifically attempted to answer the following questions:

- 1- Is there a significant difference in the level of depression among patients of cancer due to their locus of control (internal-external)?
- 2- Are there significant differences in the level of depression in the patients of cancer with internal and external locus of control due to sex of patient, history of illness, age and type of cancer?

To achieve the objectives of the study, the researcher used two instruments: the Arabic versions of Rotter's scale of internal-External locus of control, and Beck's depression Inventory.

The Population of this study consisted of all cancer patients registered at Al-Bashir Hospital and Al-Amal Center in Amman before may/2001. The sample consisted of 169 female and male patient drawn using the deliberate sampling method.

To answer the research questions, the researcher used t-Test to compare subjects with **internal and external locus of control**. Means, standard deviations and four-way ANOVA were used to answer the second question.

The results revealed significant differences at ($\alpha \leq 0.05$) in the level of depression in patients of cancer due to locus of control (internal – external). These differences were in favor of cancer patients with internal locus of control as they received a mean (20.07). This was higher than that of cancer patients with external locus of control (11.95). This shows that depression level was higher for patients with internal, but not external locus of control.

This indicates that differences regarding the **variable of duration** of infection were between the categories year and more and the following durations (less than three months, 3-6 months, and 6 months- one year). These differences were in favor of patients for one year and more. The results also indicated that there were significant differences between patients in the category (less than 3 months) and those in the category (3-6 months) and (6 months- one year) in favor of the former. This indicates that level of depression becomes high at the beginning of infection and increases with time.

Concerning the results related to **age differences** were in favor of 17-25 years of age and between 26-64 years and older than 65 years of age in favor of those with ages less than 17 years. This shows that depression increases with younger ages.

Regarding **sex, differences** were in favor of females as they got higher means than males. This indicates that females were more depressed than males. In light of the results the researcher introduced the following recommendations.

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

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د. مجدي عرفة / أستاذ الطب النفسي - القاهرة / مصر

تصور فيراريكي لنمو وتطور الهوية الجنسية

د. مجدي عرفة / أستاذ الطب النفسي - القاهرة / مصر

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إعادة تعريف الانحراف الجنسي

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

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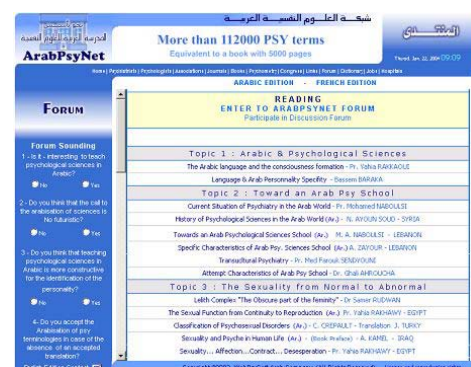
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DR. ELMOSTAFA REZRAZI - TOKYO , JAPAN

I have the honor to discover and join your colleagues, and wish the concept could move one day to establish an Arab institute of Psychiatry and Behavior Sciences. An institute that will take care of academic research, publications, and annual symposiums. Thank you for your efforts.

DR. RAYMOND HAMDANE - EMIRATES

Thank you for your excellence in working for the profession of Psychology in the Middle East and worldwide.

PR. DALIA A. MOSTAFA - CAIRO, EGYPT

Reading through articles and surfing through the URL's links has been a revelation. I have been looking for such a nutritious collection for over two years; and am very thankful to have been able to locate this wonderful archive of fine texts. The website and its links are very well organized, not redundant, to the point, and very 'user-friendly.' The content and translation of articles is very well presented, not to mention immensely interesting. Thank you in advance for your time. / I wish you the best of luck./ With all my respect.

DR. MUSAED AL NAJJAR / KUWAIT CITY - KUWAIT

First of all congratulation on the establishing the Electronic Arabpsynet Journal, I well be happy to submit something to be published in your respected Journal. / Regards

DR. DONALD WILLIAMS /USA- JUNGIAN SOCIETY

The resources are extensive; however, even though the website is in Arabic, English and French, many of the most interesting papers are in Arabic only.

DR. ADNAN FARAH / AMMAN - JORDAN

I would like to take this opportunity to thank you for all what you do to promote psychological sciences in the Arab region. We are proud of you here in Jordan. Keep up the good job. With my best regard

أ. سبيكة يوسف الخليفة / الدوحة – قطر

عبد الحميد ديب محمد محارب / غزة – فلسطين

EATING DISORDERS

OVEREATING

■ PATHOLOGICAL OVEREATING: AN OVERVIEW.

Authors : K. Gunnar Götestam, Finn Skårderud, Jan H. Rosenvinge, Einar Vedul-Kjelsås

Summary: An eating disorder apart from anorexia nervosa and bulimia nervosa is «binge eating disorder» (BED): eating in a short period of time a large quantity of food and a feeling of lack of control over food intake. There is also an atypical rest category, «eating disorders not otherwise specified» (EDNOS). Diagnostic criteria for BED and EDNOS are incomplete, particularly with respect to the definition of «bingeing» relative to bulimia nervosa. More restrictive criteria for anorexia nervosa and bulimia nervosa skew the diagnostic distribution towards BED and EDNOS, though the total prevalence of eating disorders remains unchanged.

For BED and EDNOS taken together the lifetime prevalence in women is about 6 %. The relationship between BED, EDNOS and overweight has mainly been overlooked; further investigations are needed.

Lasting treatment effects have been found for overweight people with BED. Other eating disorders apart from anorexia nervosa and bulimia are prevalent and clinically important, and research has opened up a potential for effective treatment.

Leptin & Eating Disorders

■ THE ROLE OF LEPTIN IN REGULATING NEUROENDOCRINE FUNCTION IN HUMANS.

Authors : Bluher S, Mantzoros CS. - Division of Endocrinology, Department of Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA 02215.

Source : J Nutr. 2004 Sep;134(9):2469S-74S

Summary: Eating disorders are a group of disease states including anorexia nervosa, bulimia nervosa and binge eating on one end as well as episodic or chronic overeating resulting in obesity at the other end of the spectrum. These disorders are characterized by decreased and/or increased energy intake and are frequently associated with hormonal and metabolic disorders. The discovery of leptin, an adipocyte-secreted hormone acting in the brain to regulate energy homeostasis, and its subsequent study in human physiology have significantly advanced our understanding of normal human physiology and have provided new opportunities for understanding and possibly treating disease states, such as anorexia and bulimia nervosa. It has been recently discovered that leptin levels above a certain threshold are required to activate the hypothalamic-pituitary-gonadal and hypothalamic-pituitary-thyroid axes in men, whereas the hypothalamic-pituitary-adrenal, renin-aldosterone, and growth hormone-IGF-1 axes may be largely independent of circulating leptin levels in humans. In this review, we summarize the latest findings related to the role of leptin in the regulation of several neuroendocrine axes, such as the hypothalamic-pituitary-gonadal and the hypothalamic-pituitary-thyroid axes in humans and discuss its potential pathophysiological role in eating disorders.

NUTRITION & EATING DISORDERS

■ NUTRITION EXPERTISE IN EATING DISORDERS

Authors : Breen HB, Espelage DL. - Department of Human Nutrition, University of Illinois at Chicago, Chicago, IL, USA. HBBreen@aol.com

Source : Eat Weight Disord. 2004 Jun;9(2):120-5

Summary: Anorexia nervosa (AN) and bulimia nervosa (BN) dominate published reports on disordered eating, although they actually account for a small number of cases. Binge eating disorder (BED) and subclinical syndromes of disturbed eating and distress are far more prevalent. Medical nutrition therapy including education is a cornerstone of therapy, however there has been no evaluation of baseline knowledge of nutrition and diet composition in this population relative to individuals who do not exhibit pathological eating behavior. In addition, previous reports suggest that individuals with clinical eating disorders have above-average knowledge of nutrition. In the present investigation, individuals with subclinical eating disorders did not differ from control participants. Poor scores overall indicate that nutritional counseling may be a useful component of treatment. These results further suggest that nutrition expertise is not an early feature of the disorder and, therefore, does not likely contribute to its development.

CBT & BED

■ COGNITIVE-BEHAVIORAL THERAPY WITH SIMULTANEOUS NUTRITIONAL AND PHYSICAL ACTIVITY EDUCATION IN OBESE PATIENTS WITH BINGE EATING DISORDER.

Authors : Fossati M, Amati F, Painot D, Reiner M, Haenni C, Golay A. - Division of Therapeutic Education for Chronic Diseases, University Hospital, Geneva, Switzerland

Source : Eat Weight Disord. 2004 Jun;9(2):134-8

Summary: An important problem with obese patients suffering from binge eating disorders (BED) is to treat their dysfunctional eating patterns while initiating a weight loss. We propose to assess a cognitive-behavioral therapy combined with a nutritional and a physical activity program. Our purpose is to verify that the addition of a nutritional and a physical program leads to a significant weight loss and enables psychological improvement. The patients (n=61) participated in a 12 weekly sessions group treatment of either a purely cognitive-behavioral therapy, or a cognitive-behavioral therapy associated to a nutritional approach mainly focused on fat restriction, or to a cognitive-behavioral therapy combined with a nutritional and a physical activity approach. The mean weight loss is significant ($p<0.01$) after the association of the cognitive-behavioral therapy and the nutritional education, but is even more significant ($p<0.001$) after the combination of a cognitive-behavioral therapy with a nutritional education and a physical activity program. Depression scores decrease in the three approaches, anxiety ($p<0.05$) results improve only in the combined nutritional, physical activity and cognitive-behavioral approach. Eating disorders improved significantly in all three approaches even if improvements in subscales seem more important in the combined approach. Finally, exercise seems to be a positive addition to the nutritional cognitive-behavioral therapy since it decreases negative mood, improves eating disorders and leads to an effective body weight loss.

EATING DISORDERS & LAXATIVE DEPENDENCY

▪ A BLINDED LAXATIVE TAPER FOR PATIENTS WITH EATING DISORDERS.

Authors : Harper J, Leung M, Birmingham CL. - Department of Pharmacy, University of British Columbia. St. Paul's Hospital. Vancouver, B.C., Canada

Source : Eat Weight Disord. 2004 Jun;9(2):147-50

Summary: OBJECTIVE: To evaluate a blinded laxative taper, supervised entirely by pharmacists, in eating disorder patients with laxative dependency. METHODS: All subjects received a blinded laxative taper according to a set protocol, in addition to the usual treatment for their eating disorder. No specific treatment was given for laxative dependency other than the pharmacist's supervisions of the blinded taper. RESULTS: Ten patients were enrolled, of whom seven completed the study. Five of the seven patients (71%) decreased their laxative intake by at least 50%. Of these seven patients, three withdraw completely from laxative use. DISCUSSION: A standardized blinded laxative taper shows promise as a treatment option for laxative dependency in patients with eating disorders. The laxative taper may be less costly and more available than inpatient or psychologically based treatment because it can be given on an outpatient basis under the supervision of a pharmacist.

ORTHOOREXIA NERVOSA

▪ ORTHOREXIA NERVOSA: A PRELIMINARY STUDY WITH A PROPOSAL FOR DIAGNOSIS AND AN ATTEMPT TO MEASURE THE DIMENSION OF THE PHENOMENON

Authors : Donini LM, Marsili D, Graziani MP, Imbriale M, Cannella C. - Istituto di Scienza dell'Alimentazione, Università degli Studi di Roma La Sapienza, Italy.

lorenzomaria.donini@uniroma1.it

Source : Eat Weight Disord. 2004 Jun;9(2):151-7

Summary: AIM: To propose a diagnostic proceeding and to try to verify the prevalence of orthorexia nervosa (ON), an eating disorder defined as "a maniacal obsession for healthy foods". MATERIALS AND METHODS: 404 subjects were enrolled. Diagnosis of ON was based on both the presence of a disorder with obsessive-compulsive personality features and an exaggerated healthy eating behaviour pattern. RESULTS: Of the 404 subjects examined, 28 were found to suffer from ON (prevalence of 6.9%). The analysis of the physiological characteristics, the social-cultural and the psychological behaviour that characterises subjects suffering from ON shows a higher prevalence in men and in those with a lower level of education. The orthorexic subjects attribute characteristics that show their specific "feelings" towards food ("dangerous" to describe a conserved product, "artificial" for industrially produced products, "healthy" for biological produce) and demonstrate a strong or uncontrollable desire to eat when feeling nervous, excited, happy or guilty.

MED & PEM

▪ INTEGRATED MEDICAL-PSYCHIATRIC TREATMENT OF THE "CRISIS PHASE" IN SEVERE PROTEIN-ENERGY MALNUTRITION SECONDARY TO MAJOR EATING DISORDERS

Authors : Alfano V, Bellini O, De Filippo E, Alfonsi L, Pasanisi F, Contaldo F. - CSIRO, Clinical Nutrition, Department of

Clinical and Experimental Medicine, University "Federico II", Napoli, Italy

Source : Eat Weight Disord. 2004 Jun;9(2):158-62

Summary: C.A., a 23-year old male was admitted in the clinical nutrition medical ward for severe, complicated protein-energy malnutrition (PEM) [body mass index (BMI) 11.08 kg/m²; body weight kg 35.81 due to major eating disorders. C.A.'s personality was narcissistic, with a rigid psychic structure. During hospitalization (lasted 72 days) two acute episodes (a possibly self-inflicted damage and a persecution feeling) occurred that we consider as part of the "crisis phase", the period in which the patient's restrictive behaviour is no longer able to keep his personality equilibrium stable. The patient was treated by an integrated medical and psychiatric approach, including periods of never forced parenteral nutrition, nutritional and intensive psychotherapeutic interventions. For a short period the patient received also a pharmacological support (aloperidol orally). Treatment was successful and the patient was discharged completely autonomous and followed up on an outpatient basis. After about one year follow-up he is still in good clinical condition and in sufficient psychological equilibrium.

CHRONIC/ RECURRENT HEADACHE

CHRONIC TENSION-TYPE HEADACHE

▪ NON-INVASIVE PHYSICAL TREATMENTS FOR CHRONIC/RECURRENT HEADACHE

Authors : Bronfort G, Nilsson N, Haas M, Evans R, Goldsmith CH, Assendelft WJJ, Bouter LM

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd

Summary: A substantive amendment to this systematic review was last made on 25 May 2004. Cochrane reviews are regularly checked and updated if necessary.

Background: Non-invasive physical treatments are often used to treat common types of chronic/recurrent headache.

Objectives: To quantify and compare the magnitude of short- and long-term effects of non-invasive physical treatments for chronic/recurrent headaches.

Search strategy: We searched the following databases from their inception to November 2002: MEDLINE, EMBASE, BIOSIS, CINAHL, Science Citation Index, Dissertation Abstracts, CENTRAL, and the Specialised Register of the Cochrane Pain, Palliative Care and Supportive Care review group. Selected complementary medicine reference systems were searched as well. We also performed citation tracking and hand searching of potentially relevant journals.

Selection criteria: We included randomized and quasi-randomized controlled trials comparing non-invasive physical treatments for chronic/recurrent headaches to any type of control.

Data collection and analysis: Two independent reviewers abstracted trial information and scored trials for methodological quality. Outcomes data were standardized into percentage point and effect size scores wherever possible. The strength of the evidence of effectiveness was assessed using pre-specified rules.

Main results: Twenty-two studies with a total of 2628 patients (age 12 to 78 years) met the inclusion criteria. Five

types of headache were studied: migraine, tension-type, cervicogenic, a mix of migraine and tension-type, and post-traumatic headache. Ten studies had methodological quality scores of 50 or more (out of a possible 100 points), but many limitations were identified. We were unable to pool data because of study heterogeneity. For the prophylactic treatment of migraine headache, there is evidence that spinal manipulation may be an effective treatment option with a short-term effect similar to that of a commonly used, effective drug (amitriptyline). Other possible treatment options with weaker evidence of effectiveness are pulsating electromagnetic fields and a combination of transcutaneous electrical nerve stimulation [TENS] and electrical neurotransmitter modulation. For the prophylactic treatment of chronic tension-type headache, amitriptyline is more effective than spinal manipulation during treatment. However, spinal manipulation is superior in the short term after cessation of both treatments. Other possible treatment options with weaker evidence of effectiveness are therapeutic touch; cranial electrotherapy; a combination of TENS and electrical neurotransmitter modulation; and a regimen of auto-massage, TENS, and stretching. For episodic tension-type headache, there is evidence that adding spinal manipulation to massage is not effective. For the prophylactic treatment of cervicogenic headache, there is evidence that both neck exercise (low-intensity endurance training) and spinal manipulation are effective in the short and long term when compared to no treatment. There is also evidence that spinal manipulation is effective in the short term when compared to massage or placebo spinal manipulation, and weaker evidence when compared to spinal mobilization. There is weaker evidence that spinal mobilization is more effective in the short term than cold packs in the treatment of post-traumatic headache.

Reviewers' conclusions: A few non-invasive physical treatments may be effective as prophylactic treatments for chronic/recurrent headaches. Based on trial results, these treatments appear to be associated with little risk of serious adverse effects. The clinical effectiveness and cost-effectiveness of non-invasive physical treatments require further research using scientifically rigorous methods. The heterogeneity of the studies included in this review means that the results of a few additional high-quality trials in the future could easily change the conclusions of our review.

Acupuncture & Idiopathic Headache

■ ACUPUNCTURE FOR IDIOPATHIC HEADACHE

Authors : Melchart D, Linde K, Fischer P, Berman B, White A, Vickers A, Allais G

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Summary : A substantive amendment to this systematic review was last made on 27 November 2000. Cochrane reviews are regularly checked and updated if necessary.

Background : Acupuncture is widely used for the treatment of headache, but its effectiveness is controversial.

Objectives : To determine whether acupuncture is more effective than no treatment more effective than 'sham' (placebo) acupuncture as effective as other interventions used to treat idiopathic (primary) headaches.

Search strategy : Electronic searches were performed in MEDLINE, EMBASE, the Cochrane Controlled Trials Register, and the database of the Cochrane Field for Complementary Medicine. We also contacted researchers in the field and

checked the bibliographies of all articles obtained.

Selection criteria : Randomized or quasi-randomized clinical trials comparing acupuncture with any type of control intervention for the treatment of idiopathic (primary) headaches were included.

Data collection and analysis : Information on patients, interventions, methods, and results was extracted by at least two independent reviewers using a pre-tested standard form. Results on headache frequency and intensity were summarized descriptively. Responder rate ratios (responder rate in treatment group/responder rate in control group) were calculated as a crude indicator of results for sham-acupuncture-controlled trials. Quantitative meta-analysis was not possible due to trial heterogeneity and insufficient reporting.

Main results : Twenty-six trials including a total of 1151 patients (median, 37; range, 10-150) met the inclusion criteria. Sixteen trials were conducted among patients with migraine, six among patients with tension-type headache, and four among patients with various types of headaches. The majority of trials had methodological and/or reporting shortcomings. In eight of the 16 trials comparing true and sham (placebo) acupuncture in migraine and tension-type headache patients, true acupuncture was reported to be significantly superior; in four trials there was a trend in favor of true acupuncture; and in two trials there was no difference between the two interventions. (Two trials were uninterpretable.) The 10 trials comparing acupuncture with other forms of treatment yielded contradictory results.

Reviewers' conclusions : Overall, the existing evidence supports the value of acupuncture for the treatment of idiopathic headaches. However, the quality and amount of evidence are not fully convincing. There is an urgent need for well-planned, large-scale studies to assess the effectiveness and cost-effectiveness of acupuncture under real-life conditions.

Epilepsy

Epilepsy & Behavioral Comorbidity in Children

■ DEFINING THE PROBLEM: PSYCHIATRIC AND BEHAVIORAL COMORBIDITY IN CHILDREN AND ADOLESCENTS WITH EPILEPSY.

Authors : Pellock JM. Division of Child Neurology, Department of Neurology, Virginia Commonwealth University, Medical College of Virginia Campus, Richmond, VA 23298, USA.

Source : Epilepsy Behav. 2004 Oct;5 Suppl 3:3-9.

Summary : A variety of comorbid psychiatric conditions are frequently identified in children and adolescents with epilepsy, including depression, anxiety, psychosis, and attention-deficit hyperactivity disorder. Data regarding the epidemiology and precise prevalence of comorbid disorders in childhood epilepsy are incomplete and just now beginning to be compiled. Psychiatric and behavioral comorbidities are believed to affect approximately 40-50% of children and adolescents with epilepsy. Optimal diagnosis, clinical evaluation, and choice of treatment are predicated on the proper identification of coexisting psychiatric and behavioral disorders. Comorbid conditions in children and adolescents with epilepsy should be evaluated and treated as soon as they are recognized.

Epilepsy & Differential Diagnosis

▪ DIFFERENTIAL DIAGNOSIS AND TREATMENT OF PSYCHIATRIC DISORDERS IN CHILDREN AND ADOLESCENTS WITH EPILEPSY.

Authors : Dunn DW, Austin JK. Indiana University School of Medicine, Indianapolis, IN 46202, USA.

Source : Epilepsy Behav. 2004 Oct;5 Suppl 3:10-7.

Summary : Behavioral problems, such as the inattentive form of attention-deficit hyperactivity disorder (ADHD), anxiety, and depression, are common in children and adolescents with epilepsy and especially associated with central nervous system damage, family dysfunction, and severe seizures. This article discusses the risk factors to be considered when focusing on the prevalence of behavioral problems, the family factors that influence their incidence, as well as the differential diagnosis of behavioral disorders commonly associated with epilepsy. It also considers the assessment of these behavioral disorders and their treatment with psychotherapy, education, and a variety of psychopharmacological agents.

Epilepsy & Behavioral Comorbidities

▪ EFFECTS OF EPILEPSY SURGERY ON PSYCHIATRIC AND BEHAVIORAL COMORBIDITIES IN CHILDREN AND ADOLESCENTS.

Authors : Shields WD. Division of Pediatric Neurology, David Geffen School of Medicine at UCLA, Los Angeles, CA 90095-1752, USA.

Source : Epilepsy Behav. 2004 Oct;5 Suppl 3:18-24.

Summary : When considering surgery in children, it is important to think about the potential effect on psychiatric and behavioral outcome. A growing body of evidence suggests that the type of epilepsy (benign or catastrophic) and the age of the patient affect developmental outcome. In younger children with catastrophic epilepsy, the primary goal of therapy is not only to control seizures, but also to offer the child the opportunity for the best possible development. In older children with partial seizures, the therapeutic goal is to control seizures, which may allow a more normal life and improve behavior. Epilepsy surgery generally appears to have a positive effect on behavior and development in many younger children with catastrophic epilepsy. Psychiatric and behavioral outcomes in older children with complex partial epilepsy are less clear; many patients improve, but there does appear to be a small risk of developing new psychiatric or behavioral disorders postoperatively.

Epilepsy & Effects of Antiepileptic Medications

▪ EFFECTS OF ANTIEPILEPTIC MEDICATIONS ON PSYCHIATRIC AND BEHAVIORAL COMORBIDITIES IN CHILDREN AND ADOLESCENTS WITH EPILEPSY.

Authors : Glauser TA. Children's Hospital Medical Center, Cincinnati, OH 45229-3039, USA.

Source : Epilepsy Behav. 2004 Oct;5 Suppl 3:25-32.

Summary : The three goals of this article are (1) to delineate the limitations in determining the actual incidence of antiepileptic drug (AED) psychiatric and behavioral side effects; (2) to summarize existing data on the direct effects of AEDs on psychiatric and behavioral comorbidities and examine the relationship between these direct effects and specific AED

mechanisms of action; and (3) to recognize the indirect effects of AEDs on psychiatric and behavioral medications that can result in aggravation of these comorbidities through drug-drug interactions. All of these data are then combined and formatted into a practical algorithm useful in many clinical situations.

Epilepsy & Behavioral Issues

▪ BEHAVIORAL ISSUES INVOLVING CHILDREN AND ADOLESCENTS WITH EPILEPSY AND THE IMPACT OF THEIR FAMILIES: RECENT RESEARCH DATA.

Authors : Austin JK, Dunn DW, Johnson CS, Perkins SM. Indiana University School of Nursing, Indianapolis, IN 46202, USA.

Source : Epilepsy Behav. 2004 Oct;5 Suppl 3:33-41.

Summary : **OBJECTIVE :** Using data from a larger study on new-onset seizures, we reported preliminary findings concerning relationships between family factors and child behavioral problems at baseline and 24 months. We also explored which baseline and changes in family factors were associated with changes in child behavioral problems over the 24-month period. **METHODS :** Subjects were 224 children and their primary caregivers. Data were collected using structured telephone interviews and analyzed using multiple regression. **RESULTS :** Deficient family mastery and parent confidence in managing their child's discipline were associated with behavior problems at baseline and at 24 months; they also predicted child behavior problems over time. Decreasing parent confidence in disciplining their child was associated with increasing child behavior problems. Decreases in parent emotional support of the child were associated with increases in child internalizing problems. **CONCLUSION :** Child behavior problems, family environment, and parenting behaviors should be assessed when children present to the clinical setting with new-onset seizures.

Epilepsy, Carbamazepine & Valproate Monotherapy

▪ CARBAMAZEPINE VERSUS VALPROATE MONOTHERAPY FOR EPILEPSY

Authors : Marson AG, Williamson PR, Hutton JL, Clough HE, Chadwick DW; on behalf of the epilepsy monotherapy trialists

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Summary : A substantive amendment to this systematic review was last made on 18 April 2000. Cochrane reviews are regularly checked and updated if necessary.

Background : Carbamazepine and valproate are drugs of first choice for epilepsy. Despite the lack of hard evidence from individual randomized controlled trials, there is strong clinical belief that valproate is the drug of choice for generalized epilepsies and carbamazepine for partial epilepsies.

Objectives : To overview the best evidence comparing carbamazepine and valproate monotherapy

Search strategy : We searched the Cochrane Epilepsy Group trials register (27 June 2003); the Cochrane Central Register of Controlled Trials (The Cochrane Library issue 2, 2003) and MEDLINE (27 June 2003). In addition, we contacted pharmaceutical companies and colleagues in the field to ascertain any unpublished or ongoing studies. **Selection criteria :** Randomized controlled trials comparing carbamazepine and valproate monotherapy for epilepsy. **Data collection and analysis :** This was an individual patient

data review. Outcome measures were time to withdrawal of allocated treatment, time to 12 month remission, and time to first seizure post randomization. Data were analysed using the stratified logrank test with results expressed as hazard ratios (HR) with 95% confidence intervals (CIs), where $HR > 1$ indicates an event is more likely on valproate. A test for an interaction between treatment and epilepsy type (partial versus generalized) was also undertaken.

Main results: Results data were available for 1265 participants from 5 trials, representing 85% of the participants recruited into the 8 trials that met our inclusion criteria. The main overall results (HR) were: time to treatment withdrawal 0.97(95% CI 0.79 to 1.18); 12 month remission 0.87(95% CI 0.74 to 1.02); first seizure 1.09(95% CI 0.96 to 1.25) suggesting no overall difference for these outcomes. The test for an interaction between treatment and epilepsy type was non significant for time to treatment withdrawal and 12 month remission, but significant for time to first seizure. The age distribution of adults classified as having a generalized epilepsy indicate that significant numbers of individuals may have had their epilepsy misclassified.

Reviewers' conclusions: We have found some evidence to support the policy of using carbamazepine as the first treatment of choice in partial epilepsies, but no evidence to support the choice of valproate in generalized epilepsies, but confidence intervals are too wide to confirm equivalence. Misclassification of people with epilepsy may have confounded our results, and has important implications for the design and conduct of future trials.

Epilepsy & Depression

■ IMPAIRMENT OF INHIBITORY CONTROL OF THE HYPOTHALAMIC PITUITARY ADRENOCORTICAL SYSTEM IN EPILEPSY.

Authors : Zobel A, Wellmer J, Schulze-Rauschenbach S, Pfeiffer U, Schnell S, Elger C, Maier W. - Klinik und Poliklinik für Psychiatrie und Psychotherapie, Universitätsklinikum Bonn, Sigmund-Freud-Strasse 25, 53105, Bonn, Germany, astrid.zobel@ukb.uni-bonn.de

Source : Eur Arch Psychiatry Clin Neurosci. 2004 Oct; 254(5):303-11

Summary: Excess comorbidity between depression and epilepsy proposes common pathophysiological patterns in both disorders. Neuroendocrine abnormalities were often observed in depression as well as in epilepsy. Lack of inhibitory control of the hypothalamic pituitary adrenocortical (HPA) system is a core feature of depression; main relay stations of this system are located in the amygdala and hippocampus, which are key regions for both disorders. Therefore we explored the feedback mechanism of the HPA system in epilepsy. In order to control for the impact of depression we focused on epilepsies without depression. We compared patients with epilepsy (subdivided by medication with or without hepatic enzyme inducing antiepileptic medication) with 16 healthy controls and 16 patients with unipolar major depression but without epilepsy. We observed a lack of inhibitory control of the HPA system in patients with epilepsy, also in the absence of enzyme inducing medication. An impact of the temporal lobe location of the epileptic focus could not be observed. Thus, epilepsies share with depression the deficiencies in the feedback mechanism of the HPA system, proposing common pathophysiological features of up to now unknown nature.

Sleep Deprivation & Epileptiform Discharges

■ DOES SLEEP OR SLEEP DEPRIVATION INCREASE EPILEPTIFORM DISCHARGES IN PEDIATRIC ELECTROENCEPHALOGRAMS?

Authors : Gilbert DL, DeRoos S, Bare MA. - Division of Neurology, Cincinnati Children's Hospital Medical Center, ML 2015, 3333 Burnet Ave, Cincinnati, OH 45229-3039, USA. d.gilbert@cchmc.org

Source : Pediatrics. 2004 Sep;114(3):658-62

Summary: Sleep deprivation before obtaining an electroencephalogram (EEG) is believed both to increase the likelihood of sleep during an EEG and to increase the detection of interictal epileptiform discharges. However, depriving a child of sleep poses a burden on both the parent and the child. The objective of this study was to compare the effects of sleep, standard sleep deprivation, partial sleep deprivation, and no sleep deprivation on the odds of an epileptiform abnormality in outpatient pediatric EEGs. **METHODS:** Data were collected from all pediatric EEGs performed at a busy, university-based neurologic practice during two 2-month periods. During the first period, all EEGs were performed as ordered, either standard sleep-deprived (SSD) or non-sleep-deprived (NSD). During the second 2 months, SSD EEGs were performed per routine. However, non-SSD families were instructed to keep their children awake 2 hours later the night before the EEG. Those who complied were classified as partially sleep-deprived (PSD). Patient characteristics across protocols were compared with chi(2) and analysis of variance tests as appropriate. The odds of epileptiform and abnormal findings associated with sleep, NSD, PSD, and SSD EEGs were calculated using logistic regression. **RESULTS:** Of 820 eligible EEGs, sleep occurred in 22% of NSD, 44% of PSD, and 57% of SSD EEGs. The sample size of this study allowed for an 85% power, with alpha of .05, to detect an absolute increased EEG yield of 10%. Neither the presence of sleep (odds ratio [OR]: 0.99; 95% confidence interval [CI]: 0.69-1.42) nor the use of PSD (OR: 0.90; 95% CI: 0.50-1.62) or SSD (OR: 0.96; 95% CI: 0.63-1.47) protocols increased the odds of epileptiform EEGs. **CONCLUSIONS:** Sleep deprivation should not be used routinely to increase the yield of pediatric EEGs.

COGNITIVE BEHAVIOUR THERAPY (CBT)

CBT & BECOMING A SELF-THERAPIST

■ BECOMING A SELF-THERAPIST: USING COGNITIVE BEHAVIOURAL THERAPY FOR RECURRENT DEPRESSION AND/OR DYSTHYMIA AFTER COMPLETING THERAPY.

Authors : Glasman D, Finlay WM, Brock D. University of Surrey, UK.

Source : Psychol Psychother. 2004 Sep;77(Pt 3):335-51.

Summary : **OBJECTIVES:** To explore the ways in which people use cognitive-behavioural therapy (CBT) for recurrent depression and/or dysthymia after leaving therapy. **DESIGN:** A qualitative interview was used in this study. **METHOD:** Semi-structured interviews were carried out with nine people who had completed a course of CBT at least three months previously. The interviews explored their use of CBT techniques or models outside of therapy and their everyday management of

depression. **RESULTS:** Eight of the nine participants reported engaging in some self-therapeutic activity, and identified depression, or the threat of depression, as a continuing presence in their lives. They used a range of techniques, either directly transferred from therapy or modified in some way, and identified a number of changes in the way they reacted to difficult situations or negative emotions. These included enactive responses such as leaving the room, making self-efficacy statements, or remembering what the therapist had said to them. Participants also described situations in which they could not use the things they had learnt in CBT. Finally, a range of factors that influenced the ways in which participants became self-therapists were identified. **CONCLUSIONS:** A number of implications for clinical practice are described. An understanding of how people modify CBT and use it (or not) in their everyday lives is important to understanding and improving effectiveness.

CBT & Smoking Cessation

■ GROUP BEHAVIOUR THERAPY PROGRAMMES FOR SMOKING CESSATION

Authors : Stead LF, Lancaster T

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Summary: A substantive amendment to this systematic review was last made on 11 December 2001. Cochrane reviews are regularly checked and updated if necessary.

Background: Group therapy offers individuals the opportunity to learn behavioural techniques for smoking cessation, and to provide each other with mutual support.

Objectives: We aimed to determine the effects of smoking cessation programmes delivered in a group format compared to self-help materials, or to no intervention; to compare the effectiveness of group therapy and individual counselling; and to determine the effect of adding group therapy to advice from a health professional or nicotine replacement. We also aimed to determine whether specific components increased the effectiveness of group therapy. We aimed to determine the rate at which offers of group therapy are taken up.

Search strategy: We searched the Cochrane Tobacco Addiction Group trials register, with additional searches of PsycInfo and MEDLINE, including the terms behavior therapy, cognitive therapy, psychotherapy or group therapy, in December 2001.

Selection criteria: We considered randomised trials that compared group therapy with self-help, individual counselling, another intervention or no intervention (including usual care or a waiting list control). We also considered trials that compared more than one group programmes. We included those trials with a minimum of two group meetings, and follow-up of smoking status at least six months after the start of the programme. We excluded trials in which group therapy was provided to both active therapy and placebo arms of trials of pharmacotherapies, unless they had a factorial design.

Data collection and analysis: We extracted data in duplicate on the people recruited, the interventions provided to the groups and the controls, including programme length, intensity and main components, the outcome measures, method of randomisation, and completeness of follow-up. The main outcome measure was abstinence from smoking after at least six months follow-up in patients smoking at baseline. We used the most rigorous definition of abstinence in each trial, and biochemically validated rates where available. Subjects lost to follow-up were counted as smokers. Where possible, we

performed meta-analysis using a fixed effects (Peto) model.

Main results: A total of fifty two trials met inclusion criteria for one or more of the comparisons in the review. Sixteen studies compared a group programme with a self-help programme. There was an increase in cessation with the use of a group programme (N=4,395, odds ratio 1.97, 95% confidence interval 1.57 to 2.48). Group programmes were more effective than no intervention controls (six trials, N=775, odds ratio 2.19, 95% confidence interval 1.42 to 3.37). There was no evidence that group therapy was more effective than a similar intensity of individual counselling. There was limited evidence that the addition of group therapy to other forms of treatment, such as advice from a health professional or nicotine replacement produced extra benefit. There was variation in the extent to which those offered group therapy accepted the treatment. There was limited evidence that programmes which included components for increasing cognitive and behavioural skills and avoiding relapse were more effective than same length or shorter programmes without these components. This analysis was sensitive to the way in which one study with multiple conditions was included. There was no evidence that manipulating the social interactions between participants in a group programme had an effect on outcome.

Reviewers' conclusions: Groups are better than self-help, and other less intensive interventions. There is not enough evidence on their effectiveness, or cost-effectiveness, compared to intensive individual counselling. The inclusion of skills training to help smokers avoid relapse appears to be useful although the evidence is limited. There is not enough evidence to support the use of particular components in a programme beyond the support and skills training normally included.

CBT & Depression In Alzheimer

■ COGNITIVE BEHAVIOURAL THERAPY FOR DEPRESSION IN A PERSON WITH ALZHEIMER'S DEMENTIA

Authors : Deborah A. Walker a1c1 South London & Maudsley NHS Trust, UK

Source : Medline query on article authors walker da

Summary: The treatment of depression in an older person with Alzheimer's dementia using cognitive behavioural therapy (CBT) is described. Treatment focused on identifying beliefs associated with dementia, behavioural experimenting to test the validity of these beliefs, and increasing pleasurable activities. Results were promising, suggesting that it may be possible to treat depression in people with cognitive impairment.

Key Words: Depression; Alzheimer's dementia; behavioural; cognitive; older adults.

CBT of Depression & BPD

■ COGNITIVE-BEHAVIORAL TREATMENT OF DEPRESSION WITH COMORBID BORDERLINE PERSONALITY TRAITS

Authors : Michelle M. Lee - Department of Psychology, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106-7123 and James C. Overholser - Department of Psychology, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, OH 44106-7123; overholser@po.cwru.edu

Source : Journal of Contemporary Psychotherapy 34 (3): 231-245, Fall 2004

Summary: Personality dysfunction can influence the onset and

maintenance of depressive symptoms. When both depression and personality dysfunction are present, it is important to develop an integrated treatment plan that addresses both conditions. A case example is used to illustrate how features of borderline personality disorder can influence the assessment and treatment of major depression. Specific challenges encountered by the therapist include: 1) differentiating borderline personality from depressive symptoms, 2) maintaining the therapeutic alliance, 3) managing impulsivity and self-destructive tendencies, 4) staying focused on long-term therapeutic goals, and 5) coping with noncompliance. Over the course of 27 sessions, the client was able to make positive changes in mood, self-image, and impulsive tendencies. Although the client's borderline personality traits complicated the course of treatment for depression, neglecting these personality problems would have left the client vulnerable to depressive relapse.

Keywords : depression, borderline personality disorder, cognitive-behavioral treatment

Alcohol Abuse (AA)

Alcohol Dependence & Topiramate

■ USES OF TOPIRAMATE IN THE TREATMENT OF ALCOHOL DEPENDENCE

Authors : BA Johnson

Source : Expert Review of Neurotherapeutics 4(5),751-758 (2004)

Summary: Alcohol dependence is a major cause of morbidity and mortality in the USA and throughout the world. Over the last 10 years there has been an intense interest in developing pharmacotherapies that address the neurochemistry of alcohol dependence. Using a novel pharmacological approach to treating alcohol dependence, topiramate (Topamax®, Ortho-McNeil Pharmaceutical) has recently been shown to improve the drinking outcomes of alcohol-dependent individuals. This drug profile highlights the scientific concepts and clinical evidence in the development of topiramate for treating alcohol dependence. Alcohol dependence, anticonvulsant, craving, pharmacotherapy, topiramate.

Alcohol Dependence & Topiramate

■ ORAL TOPIRAMATE REDUCES THE CONSEQUENCES OF DRINKING AND IMPROVES THE QUALITY OF LIFE OF ALCOHOL-DEPENDENT INDIVIDUALS: A RANDOMIZED CONTROLLED TRIAL.

Authors : Johnson BA, Ait-Daoud N, Akhtar FZ, Ma JZ. Department of Psychiatry, The University of Texas Health Science Center at San Antonio, 78229-3900, USA. bjohnson@uthscsa.edu

Source : Arch Gen Psychiatry. 2004 Sep;61(9):905-12.

Summary: **BACKGROUND:** Topiramate, a fructopyranose derivative, was superior to placebo at improving the drinking outcomes of alcohol-dependent individuals. **OBJECTIVES:** To determine whether topiramate, compared with placebo, improves psychosocial functioning in alcohol-dependent individuals and to discover how this improvement is related to heavy drinking behavior. **DESIGN:** Double-blind, randomized, controlled, 12-week clinical trial comparing topiramate vs placebo for treating alcohol dependence (1998-2001).

PARTICIPANTS: One hundred fifty alcohol-dependent individuals, diagnosed using the DSM-IV. **INTERVENTIONS:** Seventy-five participants received topiramate (escalating dose of 25 mg/d to 300 mg/d), and 75 had placebo and weekly standardized medication compliance management. **MAIN OUTCOME MEASURES:** Three elements of psychosocial functioning were measured: clinical ratings of overall well-being and alcohol-dependence severity, quality of life, and harmful drinking consequences. Overall well-being and dependence severity and quality of life were analyzed as binary responses with a generalized estimating equation approach; harmful drinking consequences were analyzed as a continuous response using a mixed-effects, repeated-measures model. **RESULTS:** Averaged over the course of double-blind treatment, topiramate, compared with placebo, improved the odds of overall well-being (odds ratio [OR] = 2.17; 95% confidence interval [CI], 1.16-2.60; P = .01); reported abstinence and not seeking alcohol (OR = 2.63; 95% CI, 1.52-4.53; P = .001); overall life satisfaction (OR = 2.28; 95% CI, 1.21-4.29; P = .01); and reduced harmful drinking consequences (OR = -0.07; 95% CI, -0.12 to -0.02, P = .01). There was a significant shift from higher to lower drinking quartiles on percentage of heavy drinking days, which was associated with improvements on all measures of psychosocial functioning. **CONCLUSIONS:** As an adjunct to medication compliance enhancement treatment, topiramate (up to 300 mg/d) was superior to placebo at not only improving drinking outcomes but increasing overall well-being and quality of life and lessening dependence severity and its harmful consequences.

Alcohol & Hepatitis C

■ ALCOHOL AND HEPATITIS C.

Authors : Safdar K, Schiff ER. - Center for Liver Diseases, Division of Hepatology, Department of Medicine, University of Miami, Miami, Florida.

Source : Semin Liver Dis. 2004 Aug;24(3):305-15

Summary: Alcohol abuse and hepatitis C virus (HCV) infection coexist with chronic liver disease in many patients. The mechanism of injury in these patients is probably multifactorial and involves, but is not limited to, a combination of diminished immune clearance of HCV, oxidative stress, emergence of HCV quasi-species, hepatic steatosis, increased iron stores, and increased rate of hepatocyte apoptosis. In patients with HCV infection, alcohol consumption is known to cause accelerated progression of liver fibrosis, higher frequency of cirrhosis, and increased incidence of hepatocellular carcinoma (HCC). These patients also have decreased survival as compared with patients with either alcohol abuse or HCV liver injury alone. Alcohol abuse causes decreased response to interferon treatment in HCV patients. It is therefore necessary for patients with HCV infection to abstain from alcohol consumption.

Alcoholic Liver Disease

■ DIAGNOSIS AND THERAPY OF ALCOHOLIC LIVER DISEASE.

Authors : Levitsky J, Mailliard ME. - University of Nebraska College of Medicine, Department of Internal Medicine, University of Nebraska Medical Center, Omaha, Nebraska.

Source : Semin Liver Dis. 2004 Aug;24(3):233-47

Summary: Alcoholic liver disease (ALD) presents considerable challenges to clinicians. Screening for alcohol abuse and

alcoholism should be routine and repeated annually with close attention to signs and symptoms of liver disease. In patients with evidence of liver dysfunction or injury, consideration should be given to performance of liver biopsy for diagnosis and prognosis and prior to initiation of medication with the potential for significant side effects. Therapy depends on the spectrum of pathological liver injury: alcoholic fatty liver, alcoholic hepatitis, and cirrhosis. Abstinence is the foundation of therapy for an alcohol problem. Alcoholic fatty liver should improve with abstinence, but the similarity to the pathogenesis of nonalcoholic fatty liver and potential for progressive injury merits consideration of lipotropic agents. The continuing mortality, poor acceptance of corticosteroids, and identification of tumor necrosis factor-alpha (TNF-alpha) as an integral component has led to studies of pentoxifylline and, recently, anti-TNF antibody to neutralize cytokines in the therapy of severe alcoholic hepatitis. Antioxidant therapy of alcoholic cirrhosis has significant promise but will require large clinical trials.

TRANSPLANTATION & ALCOHOLIC LIVER DISEASE (ALD) —

■ TRANSPLANTATION IN THE ALCOHOLIC PATIENT.

Authors : Watt KD, McCashland TM. - Departments of Internal Medicine and Hepatology, University of Nebraska Medical Center, Omaha, Nebraska.

Source : Semin Liver Dis. 2004 Aug;24(3):249-55

Summary: Alcoholic liver disease (ALD) is the second leading indication for transplantation in the United States. Most transplant programs in the United States require a minimum of 6 month's abstinence before transplantation is performed. Most studies have shown a recidivism rate of between 20 and 30% by 2 years after orthotopic liver transplantation (OLT). Higher rates of recidivism are reported if pre-OLT abstinence was < 6 months. The impact of recidivism on patient and graft survival is not clear because most reports include patients who consume alcohol in small amounts or infrequently. Equal post-OLT survival for ALD patients and non-ALD patients has been demonstrated, and ALD patients are not thought to suffer greater morbidity post transplant than non-ALD patients. Careful pretransplant assessment for concomitant medical and psychosocial ailments associated with alcoholism is important. Posttransplant monitoring for cardiovascular disease and withdrawal syndromes is required in the early postoperative setting, whereas monitoring for recidivism and malignancy are late postoperative issues.

IMMUNOLOGY & ALCOHOLIC LIVER DISEASE (ALD) —

■ IMMUNOLOGIC MECHANISMS OF ALCOHOLIC LIVER INJURY.

Authors : Thiele GM, Freeman TL, Klassen LW. - Professor, University of Nebraska Medical Center, Department of Internal Medicine, Section of Rheumatology and Immunology, Nebraska Medical Center and Department of Veterans Affairs Alcohol Research Center, Omaha Veterans Administration Medical Center, Omaha, Nebraska. gthiele@unmc.edu

Source : Semin Liver Dis. 2004 Aug;24(3):273-287

Summary: Clinically, the association of alcoholic liver disease (ALD) with circulating autoantibodies, hypergammaglobulinemia, antibodies to unique hepatic proteins, and cytotoxic lymphocytes reacting against autologous hepatocytes strongly suggests altered immune regulation with an increased activity

toward normal self-proteins (loss of tolerance). Experimentally, there are several immune responses generated specifically recognizing self-proteins that are modified by metabolites of alcohol. These data strongly suggest that immune reactions may play a significant role in inducing and sustaining an inflammatory cascade of tissue damage to the liver. Additional support for this comes from the observation that the histological appearance of livers with ALD is that of a chronic active hepatitis-like inflammatory disease. Therefore, the hypothesis that immune mechanisms are involved in recurrent alcoholic hepatitis, although not summarily proven, is reasonable, supported by clinical and experimental evidence, and the subject of this article.

NUTRITION & ALCOHOLIC LIVER DISEASE (ALD) —

■ NUTRITION AND ALCOHOLIC LIVER DISEASE.

Authors : Halsted CH. - Professor, Departments of Internal Medicine and Nutrition, University of California Davis, Davis, California. chhalsted@ucdavis.edu

Source : Semin Liver Dis. 2004 Aug;24(3):289-304

Summary: Malnutrition is a common finding in chronic alcoholics, and protein calorie malnutrition (PCM) is universal and predictive of survival in patients with established alcoholic liver disease (ALD). These patients also demonstrate frequent deficiencies of folate, thiamine, pyridoxine, and vitamin A, which enhance the likelihood of anemia, altered cognitive states, and night blindness. The etiologies of malnutrition in ALD patients are multiple and interactive and include anorexia with inadequate dietary intake, abnormal digestion of macronutrients and absorption of several micronutrients, increased skeletal and visceral protein catabolism, and abnormal interactions of ethanol and lipid metabolism. Numerous, and mostly inadequately controlled, studies have evaluated the potential efficacies of oral, enteral, and parenteral nutrition approaches to treatment of ALD, with mixed results on liver function, clinical improvements, and short- or long-term survival. Targeted metabolic treatments include supplementation with S-adenosylmethionine (SAM) or phosphatidylcholine derivatives, each with promising experimental bases but inconclusive clinical trials.

Alcohol & ICP —

■ DIFFERENT CFTR MUTATIONAL SPECTRUM IN ALCOHOLIC AND IDIOPATHIC CHRONIC PANCREATITIS?

Authors : Casals T, Aparisi L, Martinez-Costa C, Gimenez J, Ramos MD, Mora J, Diaz J, Boadas J, Estivill X, Farre A. - Medical and Molecular Genetics Center-IRO, Hospital DIR, Barcelona, Spain. tcasals@iro.es

Source : PubMed

Summary: Cystic fibrosis transmembrane conductance regulator (CFTR) mutations are responsible for cystic fibrosis (CF) and have been postulated as a predisposing risk factor to chronic pancreatitis (CP), but controversial results demand additional support. We have therefore investigated the role of the CFTR gene in a cohort of 68 CP patients. METHODS: We have performed the CFTR gene analysis using 2 screening techniques. Fragments showing abnormal migration patterns were characterized by sequencing. Patients were classified in RESULTS: Sixteen mutations/variants were identified in 27 patients (40%), most of them (35%) presenting a single CFTR

mutant gene. The 1716G/A variant showed the highest frequency accounting for 22% in ICP and 5% in ACP, in contrast with other more common mutations such as F508del found in 8% of ACP and the 5T variant identified in 7% of patients. Acute pancreatitis, abdominal pain, tobacco, pancreatic calcifications, and pancreatic pseudocysts showed significant higher values in ACP than ICP patients. No significant differences were found between patients with and without CFTR mutations. CONCLUSIONS: Apart from reinforcing previous findings our data highlight the increased susceptibility of CFTR heterozygous to developing CP. Heterozygosity, combined with other factors, places these individuals at greater risk.

Alcohol & BAP

▪ EXOCRINE PANCREATIC FUNCTION AFTER ALCOHOLIC OR BILIARY ACUTE PANCREATITIS.

Authors : Migliori M, Pezzilli R, Tomassetti P, Gullo L. - Institute of Internal Medicine, University of Bologna, Sant' Orsola Hospital, Bologna, Italy.

Source : PubMed

Summary: There have been various studies of exocrine pancreatic function after acute pancreatitis, but few have examined the relationship between this function and the etiology of the pancreatitis. The aim of this work was to study pancreatic function in patients who had had acute alcoholic or acute biliary pancreatitis.

METHODS: Seventy-five patients who had had a single attack of acute pancreatitis were studied. The etiology was alcohol in 36 and cholelithiasis in 39. Pancreatic function was studied between 4 and 18 months after pancreatitis by duodenal intubation in 18 patients (8 alcohol, 10 lithiasis) and by the amino acid consumption test (AACT) in the remaining 57 (28 alcohol, 29 lithiasis). For those who underwent AACT, the test was repeated 1 year after the first examination.

RESULTS: Among the 36 patients with alcoholic pancreatitis, most had impaired pancreatic function at both duodenal intubation (8/8, 100%) and at AACT (22/28, 78.6%); at the second test, the AACT remained pathological (18/23, 82.1%). Of the 39 patients with biliary pancreatitis, only 4 of the 10 (40%) who underwent duodenal intubation and only 5 of the 29 (17.2%) who performed AACT had pancreatic insufficiency; at the second test, only 4 of the 26 (15.4%) who repeated the AACT were pathological. The differences in the frequency and degree of pancreatic insufficiency between patients with alcoholic and those with biliary pancreatitis were statistically significant.

CONCLUSIONS: The results show that after alcoholic acute pancreatitis, the pancreatic insufficiency was significantly more frequent and more severe than after biliary pancreatitis. These findings together with the fact that the insufficiency was also more persistent suggest that acute alcoholic pancreatitis may occur in a pancreas that already has chronic lesions.

GENERAL ANXIETY DISORDER (GAD)

GAD & Comorbidity

▪ COMORBIDITY OF ANXIETY AND DEPRESSIVE DISORDERS: ISSUES IN CONCEPTUALIZATION, ASSESSMENT, AND TREATMENT.

Authors : BELZER, KENNETH PhD; SCHNEIER, FRANKLIN R. MD.

Source : Journal of Psychiatric Practice. 10(5):296-306, September 2004.

Summary : Objectives: The purpose of this review is to provide a clinically relevant analysis of issues concerning comorbidity among anxiety and depressive disorders. The co-occurrence of social anxiety disorder (SAD) and generalized anxiety disorder (GAD) with depressive disorders is highlighted as an illustration. Data on prevalence, rates of comorbidity, order of onset, course, and functional impairment associated with these disorders, in both the general population and clinical samples, are examined. The second half of the review focuses on discussion of practical issues concerning assessment and treatment of comorbid anxiety and depressive syndromes.

Conclusions: Available evidence suggests that comorbidity among SAD, GAD, and the depressive disorders is substantial and pervasive. Co-occurrence of these syndromes is typically characterized by a chronic course with clinically significant impairment in social and occupational functioning. SAD and GAD precede the onset of major depression in a majority of cases and appear to be risk factors for developing major depression. Clinicians encountering patients with primary complaints of anxiety or depression should carefully assess for the presence of comorbid symptoms and syndromes. Treatment outcome research suggests that pharmacotherapy and psychosocial therapy (cognitive-behavior therapy in particular) both represent viable first-line treatment alternatives. However, with increasing severity of depression, pharmacotherapy is indicated as a primary intervention. The authors recommend increased efforts in screening and detection, more clinical trials that include patients with comorbid syndromes and symptoms, and continued research on the integration of pharmacological and psychotherapeutic treatments.

GAD & Somatic Symptoms

▪ SOMATIC SYMPTOMS AND PHYSIOLOGIC RESPONSES IN GENERALIZED ANXIETY DISORDER AND PANIC DISORDER: AN AMBULATORY MONITOR STUDY.

Authors : Hoehn-Saric R, McLeod DR, Funderburk F, Kowalski P. Department of Psychiatry, The Johns Hopkins Medical Institutions, Baltimore, MD 21287-7113, USA. rhoehn@mail.jhmi.edu

Source : Arch Gen Psychiatry. 2004 Sep;61(9):913-21.

Summary : BACKGROUND: Physiologic responses of patients with anxiety disorders to everyday events are poorly understood. OBJECTIVE: To compare self-reports and physiologic recordings in patients with panic disorder (PD), patients with generalized anxiety disorder (GAD), and nonanxious controls during daily activities. DESIGN: Participants underwent four 6-hour recording sessions during daily activities while wearing an ambulatory monitor. Physiologic and subjective data were recorded every 30 minutes and during subject-signaled periods of increased anxiety or tension or panic attack. SETTING: Participants' everyday environment. PARTICIPANTS: Twenty-six patients with PD and 40 with GAD, both without substantial comorbidity, and 24 controls. INTERVENTIONS: Recordings obtained during everyday activities. MAIN OUTCOME MEASURES: Recordings of heart interbeat intervals, skin conductance

levels, respirations, motion, and ratings of subjective somatic symptoms and tension or anxiety. **RESULTS:** Patients with anxiety disorders rated higher on psychic and somatic anxiety symptoms than did controls. Common to both anxiety disorders was diminished autonomic flexibility that manifested itself throughout the day, accompanied by less precise perception of bodily states. The main differences between patients with PD and GAD were a heightened sensitivity to body sensations and more frequent button presses. There also was a trend toward heightened basal arousal in patients with PD, manifesting itself in a faster heart rate throughout the day. **CONCLUSIONS:** Patients with PD or GAD are more sensitive to bodily changes than nonanxious individuals, and patients with PD are more sensitive than those with GAD. Patients with PD experience more frequent distress than those with GAD and controls, but their physiologic responses are comparable in intensity. The findings suggest that the perception of panic attacks reflects central rather than peripheral responses. The diminished autonomic flexibility observed in both anxiety conditions may result from dysfunctional information processing during heightened anxiety that fails to discriminate between anxiety-related and neutral inputs.

GAD & Venlafaxine XR

▪ 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 ($> \text{or} = 50\%$ 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 $\times$ 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.

Anxiety disorders & Progesterone

▪ ROLE OF PROGESTERONE AND OTHER NEUROACTIVE STEROIDS IN ANXIETY DISORDERS

Authors : J-M Le Mellédo & GB Baker

Source : *Expert Review of Neurotherapeutics* 4(5), 851-860 (2004)

Summary: It remains unexplained why a greater prevalence of anxiety disorders exists in women than in men, and how female hormone-related events (i.e., menstrual cycle and postpartum) can influence the course of anxiety disorders. It would appear logical that female hormones and their derivatives play a major role in these observations. The abundance of preclinical data demonstrating a role for sex hormones and their derivatives in anxiety-like behavior is in contrast to the relative paucity of experimental clinical data on the role of female hormones and neuroactive steroids in anxiety disorders. There is a dramatic potential for therapeutic anxiolytic activity of pharmacological compounds derived from powerful anxiolytic agents, such as the progesterone derivative, allopregnanolone. As a result, there is currently tremendous interest from the pharmaceutical industry in developing and testing such agents in anxiety disorders.

anxiety, neuroactive steroids, neurosteroids, panic, progesterone.

GAD & Sertraline

▪ EFFICACY OF SERTRALINE IN A 12-WEEK TRIAL FOR GENERALIZED ANXIETY DISORDER.

Authors : Allgulander C, Dahl AA, Austin C, Morris PL, Sogaard JA, Fayyad R, Kutcher SP, Clary CM. - Karolinska Institutet, Neurotec Department, Section of Psychiatry at Huddinge, University Hospital, 141 86 Huddinge, Sweden. Christer.Allgulander@neurotec.ki.se

Source : *Am J Psychiatry*. 2004 Sep;161(9):1642-9

Summary: **OBJECTIVE:** Sertraline's efficacy and tolerability in treating generalized anxiety disorder were evaluated. **METHOD:** Adult outpatients with DSM-IV generalized anxiety disorder and a total score of 18 or higher on the Hamilton Anxiety Rating Scale were eligible. After a 1-week single-blind placebo lead-in, patients were randomly assigned to 12 weeks of double-blind treatment with placebo ($N=188$, mean baseline anxiety score=25) or flexible doses (50-150 mg/day) of sertraline ($N=182$, mean anxiety score=25). The primary outcome measure was baseline-to-endpoint change in the Hamilton anxiety scale total score. A secondary efficacy measure was the Clinical Global Impression (CGI) improvement score; response was defined as a score of 2 or less. **RESULTS:** Sertraline patients had significantly greater improvement than placebo patients on all efficacy measures at week 4. Analysis of covariance of the intent-to-treat group at endpoint (with the last observation carried forward) showed a significant difference in the decrease from baseline of the least-square mean total score on the Hamilton anxiety scale between sertraline (mean=11.7) and placebo (mean=8.0). Significantly greater endpoint improvement with sertraline than placebo was obtained for mean scores on the Hamilton anxiety scale psychic factor (6.7 versus 4.1) and somatic factor (5.0 versus 3.9). The rate of responders, based on CGI improvement and last observation carried forward, was significantly higher for sertraline (63%) than placebo (37%). Sertraline was well

tolerated; 8% of patients versus 10% for placebo dropped out because of adverse events. **CONCLUSIONS:** Sertraline appears to be efficacious and well tolerated in the treatment of generalized anxiety disorder.

COMT & Phobic Anxiety

■ ASSOCIATION BETWEEN CATECHOL-O-METHYLTRANSFERASE & PHOBIC ANXIETY.

Authors : Am J Psychiatry. 2004 Sep;161(9):1703-5

Source : McGrath M, Kawachi I, Ascherio A, Colditz GA, Hunter DJ, De Vivo I. - Channing Laboratory, Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, 181 Longwood Ave., Boston, MA 02115. nhmmc@channing.harvard.edu

Summary: **OBJECTIVE:** The authors assessed the association between the catechol-O-methyltransferase (COMT) Val158Met polymorphism and scores on the phobic anxiety scale of the Crown-Crisp Experimental Index. **METHOD:** A total of 1,234 women completed the Crown-Crisp Experimental Index phobic anxiety scale and were genotyped for the COMT polymorphism. The authors used unconditional logistic regression to compute odds ratios and 95% confidence intervals (CIs) to evaluate the association between the COMT genotype and phobic anxiety. **RESULTS:** The mean scores for the three genotypes were statistically significantly different. Compared to the COMT Met/Met genotype, the age-adjusted odds ratio for scoring ≥ 6 compared to scoring 0 or 1 were 1.15 (95% CI=0.71-1.85) and 1.99 (95% CI=1.17-3.40) for the COMT Val/Met and COMT Val/Val genotypes, respectively; a significant gene dosage effect was observed. **CONCLUSIONS:** Our results suggest that the functional COMT polymorphism is associated with the development of phobic anxiety.

OCD & Trichotillomania

■ DISSOCIATIVE EXPERIENCES IN OBSESSIVE-COMPULSIVE DISORDER AND TRICHOTILLOMANIA: CLINICAL AND GENETIC FINDINGS.

Authors : Lochner C, Seedat S, Hemmings SM, Kinnear CJ, Corfield VA, Niehaus DJ, Moolman-Smook JC, Stein DJ.

Source : Compr Psychiatry. 2004 Sep-Oct;45(5):384-91

Summary: A link between dissociation proneness in adulthood and self-reports of childhood traumatic events (including familial loss in childhood, sexual/physical abuse and neglect) has been documented. Several studies have also provided evidence for an association between dissociative experiences and trauma in patients with various psychiatric disorders, including post-traumatic stress disorder, borderline personality, dissociative identity and eating disorders. Based on the relative paucity of data on dissociation and trauma in obsessive-compulsive disorder (OCD) and trichotillomania (TTM), the primary objective of this study was to examine the relationship between trauma and dissociative experiences (DE) in these two diagnostic groups. Furthermore, the availability of clinical and genetic data on this sample allowed us to explore clinical and genetic factors relevant to this association. A total of 110 OCD and 32 TTM patients were compared with respect to the degree of dissociation (using the Dissociative Experiences Scale[DES]) and childhood trauma (using the Childhood Trauma Questionnaire [CTQ]). Patients were classified on the DES as either "high" (mean DES score ≥ 30) or "low" (mean DES

score < 30) dissociators. Additional clinical and genetic factors were also explored with chi-square and t tests as appropriate. A total of 15.8% of OCD patients and 18.8% of TTM patients were high dissociators. OCD and TTM groups were comparable on DES and CTQ total scores, and in both OCD and TTM groups, significant positive correlations were found between mean DES scores and mean CTQ subscores of emotional abuse, physical abuse, sexual abuse, and physical neglect. In the OCD group, high dissociators were significantly younger than low dissociators, and significantly more high dissociators than low dissociators reported a lifetime (current and past) history of tics ($P < .001$), Tourette's syndrome ($P = .019$), bulimia nervosa ($P = .003$), and borderline personality disorder ($P = .027$). In the TTM group, significantly more high dissociators than low dissociators reported (lifetime) kleptomania ($P = .005$) and depersonalisation disorder ($P = .005$). In the Caucasian OCD patients ($n = 114$), investigation of genetic polymorphisms involved in monoamine function revealed no significant differences between high and low dissociator groups. This study demonstrates a link between childhood trauma and DE in patients with OCD and TTM. High dissociative symptomatology may be present in a substantial proportion of patients diagnosed with these disorders. High dissociators may also be differentiated from low dissociators on some demographic features (e.g., lower age) and comorbidity profile (e.g., increased incidence of impulse dyscontrol disorders). Additional work is necessary before conclusions about the role of monoaminergic systems in mediating such dissociation can be drawn.

Biology (B)

Biology & Endophenotype

■ ENDPHENOTYPE--A NEW CONCEPT FOR BIOLOGICAL CHARACTERIZATION OF PSYCHIATRIC DISORDERS

Authors : Zobel A, Maier W. Klinik und Poliklinik für Psychiatrie und Psychotherapie, Universität Bonn.

Astrid.Zobel@ukb.uni-bonn.de

Source : Nervenarzt. 2004 Mar;75(3):205-14.

Summary : In the field of psychiatric genetics, the concept of endophenotypes is presently receiving high popularity. Current difficulties in the search for susceptibility genes of complex diseases have been attributed to the etiological heterogeneity of the clinical, psychopathologically defined phenotype of the disease. Neurobiological correlates of the disease which are genetically influenced and stable over time are considered to be more promising targets of phenotypes. They are more directly influenced by gene effects and presumably defined by a genetic determination which is less complex than the phenotype of the disorder. The endophenotype strategy has already been successful in complex disorders of other areas in medicine, including alcoholism and late-onset Alzheimer's disease. For schizophrenia, a series of endophenotypes for molecular/genetic investigation has been suggested, but the concept "endophenotype" also provides a basis for biological classification of mental disorders.

Biology & Clinical Study

■ CLINICAL STUDY: ATYPICAL DEPRESSION IN GROWTH HORMONE

DEFICIENT ADULTS, AND THE BENEFICIAL EFFECTS OF GROWTH HORMONE TREATMENT ON DEPRESSION AND QUALITY OF LIFE.

Authors : Tripti Mahajan¹, Anna Crown¹, Stuart Checkley², Anne Farmer² and Stafford Lightman¹

Henry Wellcome Laboratories for Integrative Neuroscience & Endocrinology, University of Bristol ¹ and Institute of Psychiatry, London ²

Source : (Correspondence should be addressed to S Lightman)

Summary : Objective: Some growth hormone deficient adults (GHDA) have an impaired quality of life, which may improve with growth hormone (GH) treatment. The objective of our study was to make an in depth psychiatric evaluation of patients with adult-onset (AO) and childhood-onset (CO) GHDA, and to assess the time course of changes in their quality of life and symptoms of depression in response to GH treatment.

Design: The study design was a 4 month, double-blind, cross-over, placebo-controlled trial of GH therapy.

Methods: We used a detailed psychiatric interview to characterise 25 patients with proven GH deficiency at baseline. They were reassessed at monthly intervals during treatment with GH or placebo, using the Nottingham Health Profile and two well-recognised depression rating scales.

Results: 11 / 18 (61%) of the patients with AO GH deficiency, but 0 / 7 of the patients with CO GH deficiency, were found to have atypical depression at baseline. There were significant improvements in the depression rating scale scores after 2 months of GH therapy, with significant improvements in emotional reaction and social isolation scores from 1 month, and in energy levels and sleep disturbance from 2 and 3 months respectively.

Conclusions: The results of our study confirm that a large proportion of GHDA have unequivocal psychiatric morbidity, and suggest that a response to treatment can be seen after a short trial of GH therapy. We hypothesise that this rapid improvement of symptoms of atypical depression represents a direct central effect of GH therapy.

Heschl's Gyrus & SLI, MDD, BP

CELL DENSITY AND CORTICAL THICKNESS IN HESCHL'S GYRUS IN SCHIZOPHRENIA, MAJOR DEPRESSION AND BIPOLAR DISORDER.

Authors : Cotter D, Mackay D, Frangou S, Hudson L, Landau S. - Beaumont Hospital, Dublin 9, Ireland. drcotter@rcsi.ie

Source : Br J Psychiatry. 2004 Sep;185:258-9

Summary: There is evidence that the superior temporal gyrus and Heschl's gyrus within it are implicated in schizophrenia. We investigated neuronal and glial cell density and cortical thickness within Heschl's gyrus, using the optical disector to estimate cell density within cortical layers 3 and 5 in tissue derived postmortem from people with diagnoses of major depressive disorder, schizophrenia and bipolar disorder, compared with normal controls (n=15 per group). No significant difference in neuronal or glial cell density or in cortical thickness was observed between the groups; our findings therefore provide no support for the presence of cellular pathology within Heschl's gyrus in schizophrenia.

Fragile X Syndrome

NEUROPSYCHIATRIC SYMPTOMS OF FRAGILE X SYNDROME: PATHOPHYSIOLOGY AND PHARMACOTHERAPY.

Authors : Tsiouris JA, Brown WT. - George A. Jervis Clinic, New York State Institute for Basic Research in Developmental Disabilities, Staten Island, New York, USA

Source : CNS Drugs. 2004;18(11):687-703

Summary: Fragile X syndrome is the leading inherited form of mental retardation, and second only to Down's syndrome as a cause of mental retardation attributable to an identifiable genetic abnormality. Fragile X syndrome is caused by a defect in the fragile X mental retardation 1 gene (FMR1), located near the end of the long arm of the X chromosome. FMR1 normally synthesises the fragile X protein (FMRP), but mutations in FMR1 lead to a lack of FMRP synthesis, resulting in fragile X syndrome. While the specific function of FMRP is not yet fully understood, the protein is known to be important for normal brain development. The physical, cognitive and behavioural features of individuals with fragile X syndrome depend on gender (females have two X chromosomes, one active and one inactive) and the molecular status of the mutation (premutation, full mutation or mosaic). Features of the behavioural profile of individuals with fragile X syndrome include hypersensitivity to stimuli, overarousability, inattention, hyperactivity and (mostly in men) explosive and aggressive behaviour to others or self. Social anxiety, other anxiety disorders, depression, impulse control disorder and mood disorders are the most common psychiatric disorders diagnosed in individuals with fragile X syndrome, although no formal studies have been undertaken. There have been very few psychopharmacological studies of the treatment of behaviours associated with fragile X syndrome. These limited studies and surveys of psychotropic drugs used in individuals with fragile X syndrome suggest that stimulants are helpful for hyperactivity, that alpha(2)-adrenoceptor agonists and beta-adrenoceptor antagonists help to control overarousability, impulsivity and aggressiveness, and that SSRIs can control anxiety, impulsivity and irritability, alleviate depressive symptoms and decrease aggressive and self-injurious behaviour. Typical and atypical antipsychotics in combination with other psychotropics have been used for control of psychotic disorders and severe aggressive behaviours. Mood stabilisers have been found to be useful when mood dysregulation or mood disorders are present with or without aggressive behaviour. Folic acid and L-acetylcarnitine (levacecarnine) have not been found to improve deficits or behaviours. As there is no specific psychotropic drug for any of the deficits or behaviours associated with fragile X syndrome, clinicians are advised to diagnose any psychiatric syndromes or disorders present and treat them with the appropriate psychotropic drug. If no psychiatric disorder can be diagnosed and the patient's challenging behaviours cannot be controlled with environmental manipulation or behaviour modification techniques, the most benign psychotropic drug should be used. Antipsychotics should be reserved for psychotic disorders, for impulse control disorders (used in combination with other psychotropics), or when challenging behaviours constitute an emergency. In the future, new medications targeting molecules implicated in the modulation of anxiety, fear and fear responding will be useful for treating the social anxiety and overarousability exhibited by individuals with fragile X syndrome.

Mood Stabilisers (MS)

MS & VALPROATE

■ VALPROIC ACID, VALPROATE AND DIVALPROEX IN THE MAINTENANCE TREATMENT OF BIPOLAR DISORDER

Authors : Macritchie K.A.N., Geddes J.R., Scott J, Haslam D.R.S., Goodwin G.M.

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd

Summary: A substantive amendment to this systematic review was last made on 19 March 2001. Cochrane reviews are regularly checked and updated if necessary.

Background: Although lithium has been the most commonly used maintenance treatment in bipolar disorder for several decades, valproate is being used increasingly - especially in the United States of America. There is a need to clarify whether the increasingly prominent prophylactic role of valproate in bipolar disorder is justified.

Objectives: To review the effectiveness of valproate, relative to placebo, other mood stabilisers and antipsychotics, in the prevention and/or attenuation of acute episodes of bipolar disorder. The effectiveness of valproate was considered in terms of mood symptoms, mortality, general health, social functioning, adverse effects and overall acceptability to patients.

Search strategy: The CCDAN group search strategy was used. The following databases were searched: The Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Register (CCDANCTR), The Cochrane Controlled Clinical Trials Register (CCCTR), EMBASE, MEDLINE, LILACS, PsycLIT and Psynex. Reference lists of relevant papers and major textbooks of mood disorder were examined. Authors, other experts in the field and pharmaceutical companies were contacted for knowledge of suitable published or unpublished trials.

Selection criteria: Randomised controlled trials which compared valproate with placebo, alternative mood stabilisers (including lithium and carbamazepine) or neuroleptics, where the stated intent of intervention was the maintenance treatment of bipolar disorder. Participants were males and females of all ages with a diagnosis of bipolar disorder however diagnosed, approximating to ICD 10 Code F31 and DSM IV 296, but including patients diagnosed as ICD-9 manic depressive psychosis and DSM-III and DSM-III-R bipolar disorder.

Data collection and analysis: Data were extracted from the original reports individually by two reviewers. The main outcomes to be assessed were: 1. The effectiveness of valproate treatment in preventing or attenuating further episodes of bipolar disorder, including its effectiveness in rapid cycling disorder. 2. The acceptability of valproate treatment to patients. 3. The prevalence of side-effects. 4. Mortality on valproate treatment. Outcomes concerning relapse/recurrence were analysed excluding data from discontinuation studies, which were to be analysed separately. Sub-group analyses were to be performed to examine the effects of valproate treatment in rapid cycling bipolar disorder and previous mood stabiliser non-responders. Data were analysed using Review Manager version 4.1.

Main results: One trial of 12 months duration with 372 participants was identified comparing lithium, divalproex and placebo. It had several methodological limitations. The primary

analysis of time to occurrence of mood episode described in the main trial report found no reliable difference between the treatments, although there was a trend for divalproex to be more effective than lithium. In the analysis in this review, patients taking divalproex who left the study because of the occurrence of an mood episode were significantly less in number than those on placebo (RRR 37%; RR 0.63; 95% CI 0.44 to 0.90). There was no significant difference in the numbers of patients in receipt of divalproex compared with those in receipt of lithium who left the study because they suffered any mood episode. (RRR 22%; RR 0.78; 95% C.I. 0.52 to 1.17). There was insufficient information to allow sub-group analyses of rapid-cycling disorder. The divalproex group had significantly more patients suffering tremor (RRI 223%; RR 3.23; 95% C.I. 1.85 to 5.62), weight gain (RRI 187%; RR 2.87; 95% C.I. 1.34 to 6.17) and alopecia (RRI 143%; RR 2.43; 95% C.I. 1.05 to 5.65) than the placebo group. In comparison with the lithium, divalproex was associated with more frequent sedation (RRI 58%; RR 1.58; 95% C.I. 1.08 to 2.32) and infection (RRI 107%; RR 2.07; 95% C.I. 1.16 to 3.68), but less suffered thirst (RRR 62%; RR 0.38; 95% C.I. 0.18 to 0.81) and polyuria (RRR 57%; RR 0.43; 95% C.I. 0.22 to 0.82).

Reviewers' conclusions: In view of the equivocal findings of this review, conclusions about the efficacy and acceptability of valproate compared to placebo and lithium cannot be made with any degree of confidence. With current evidence, patients and clinicians would probably wish to use lithium before valproate for maintenance treatment. At present, the observed shift of prescribing practice to valproate is not based on reliable evidence of efficacy.

Valproic Acid & Hyperammonemia

■ VALPROIC ACID-INDUCED HYPERAMMONEMIA: A CASE REPORT.

Authors : McCall M, Bourgeois JA. - Department of Psychiatry and Behavioral Sciences, University of California, Davis Medical Center, Sacramento CA.

Source : J Clin Psychopharmacol. 2004 Oct;24(5):521-6

Summary: The authors present a case of a patient treated with valproic acid for seizure disorder who presented with acute mental status changes consistent with encephalopathy. Notably, her serum ammonia level was 3 times the upper limit of normal, despite an only mildly elevated aspartate aminotransferase and normal bilirubin. Her serum valproic acid level was in the therapeutic range. Her symptoms resolved with discontinuation of valproic acid and supportive care. The authors review the possible mechanisms of valproic acid-associated hyperammonemia with encephalopathy and propose clinical practice modifications to minimize the incidence of this adverse reaction to this generally well-tolerated and clinically important psychotropic medication.

Sleep Disorders

SLEEP-RELATED BREATHING DISORDERS

■ SLEEP-RELATED BREATHING DISORDERS: IMPACT ON MORTALITY OF CEREBROVASCULAR DISEASE.

Authors : Parra O, Arboix A, Montserrat JM, Quinto L, Bechich S, Garcia-Eroles L. - Depts of Pneumology, Hospital del Sagrat Cor, Barcelona, Spain. 22515opo@comb.es

Source : Eur Respir J. 2004 Aug;24(2):267-72

Summary: The aim of the study was to analyse the impact of sleep-related breathing disorders in a 2-yr survival follow-up of patients with a first ever stroke or transient ischaemic attack. The study followed 161 patients. Complete neurological assessment was performed in order to determine cerebrovascular risk factors, functional disability, and parenchymatous and vascular localisation, as well as stroke subtype categorisation. A sleep study was carried out using a portable respiratory recording device. The entire cohort was followed over a mean period of 22.8 months. The main outcome event was death and time of survival since the neurological event. A multivariate Cox's model was estimated. The patients were ages 72+/-9 yrs (mean+/-SD), and had a body mass index of 26.6+/-3.9 kg x m(-2) and apnoea/hypopnoea index (AHI) of 21.2+/-15.7. Overall, mortality occurred in 22 cases, and the survival rate was 86.3%. Vascular disease accounted for 63.6% of deaths. Multivariate analysis selected four independent variables associated with mortality: 1) age; 2) AHI, with an implied 5% increase in mortality risk for each additional unit of AHI; 3) involvement of the middle cerebral artery; and 4) the presence of coronary disease. In conclusion, the findings suggest that sleep-related breathing disorders are an independent prognostic factor related to mortality after a first episode of stroke.

SLEEP-DISORDERED BREATHING

■ PERFORMANCE VIGILANCE TASK AND SLEEPINESS IN PATIENTS WITH SLEEP-DISORDERED BREATHING.

Authors : Sforza E, Haba-Rubio J, De Bilbao F, Rochat T, Ibanez V. - Sleep Laboratory, Dept of Psychiatry, Geneva University Hospital, Geneva, Switzerland. Emilia.Sforza@hcuge.ch

Source : Eur Respir J. 2004 Aug;24(2):279-85

Summary: Altered vigilance performance has been documented in patients with sleep-related breathing disorders (SRBDs). Sleep fragmentation, sleepiness, respiratory disturbances and nocturnal hypoxaemia have been suggested as the pathogenesis of these deficits, yet it remains difficult to find a good correlation between performance deficits and the above factors. In the present study, which performance measure better characterised SRBD patients and the main factors implicated in these disturbances were examined. The study group consisted of 152 patients and 45 controls, all examined using a performance vigilance task and subjective sleepiness assessment. Speed and accuracy in the psychomotor vigilance task (PVT) were measured in patients and controls. Objective daytime sleepiness was assessed in the patient group using the maintenance of wakefulness test. In comparison with controls, PVT accuracy rather than speed seems to be affected in SRBD patients, with lapses and false responses significantly greater in patients with more severe objective sleepiness and higher apnoea/hypopnoea index. Although slowing and increased variability in reaction time were associated with shorter sleep latency in the maintenance of wakefulness test, subjective sleepiness, sleep fragmentation, nocturnal hypoxaemia and apnoea/hypopnoea index influenced mainly PVT accuracy. It is concluded that vigilance impairment, sleep fragmentation and severity of disease may partially and differentially contribute to the diurnal performance consequences found in sleep-related breathing disorders.

Since the psychomotor vigilance task worsening is more marked in accuracy than in speed, measurement of lapses and false responses would better characterise the degree of diurnal impairment in these patients.

OBSTRUCTIVE SLEEP APNEA & NEUROPSYCHOLOGICAL SEQUELAE

■ NEUROPSYCHOLOGICAL SEQUELAE OF OBSTRUCTIVE SLEEP APNEA-HYPOPNEA SYNDROME: A CRITICAL REVIEW

Authors : Aloia MS, Arnedt JT, Davis JD, Riggs RL, Byrd D. - Brown Medical School, Providence, Rhode Island 02906, USA. Mark_Aloia@Brown.edu

Source : J Int Neuropsychol Soc. 2004 Sep;10(5):772-85

Summary: Obstructive sleep apnea-hypopnea syndrome (OSAHS) is a well-recognized clinical sleep disorder that results in chronically fragmented sleep and recurrent hypoxemia. The primary daytime sequelae of the disorder include patient reports of excessive daytime sleepiness, depression, and attention and concentration problems. It has been well established that OSAHS negatively impacts certain aspects of cognitive functioning. The primary goals of this article are to (1) clarify the pattern of cognitive deficits that are specific to OSAHS; (2) identify the specific cognitive domains that improve with treatment; and (3) elucidate the possible mechanisms of cognitive dysfunction in OSAHS. At the conclusion of the paper, we propose a potential neurofunctional theory to account for the etiology of cognitive deficits in OSAHS. Thirty-seven peer-reviewed articles were selected for this review. In general, findings were equivocal for most cognitive domains. Treatment, however, was noted to improve attention/vigilance in most studies and consistently did not improve constructional abilities or psychomotor functioning. The results are discussed in the context of a neurofunctional theory for the effects of OSAHS on the brain.

PARKINSON DISEASE (PD)

PD, THERAPY & DEPRESSION

■ THERAPIES FOR DEPRESSION IN PARKINSON'S DISEASE

Authors : Shabnam Ghazi-Noori, TH Chung, KHO Deane, H Rickards, CE Clarke

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Summary: A substantive amendment to this systematic review was last made on 21 February 2003. Cochrane reviews are regularly checked and updated if necessary.

Background: Depression is one of the most common neuropsychiatric disturbances in Parkinson's disease. 40% of observed variation in quality of life is due to depression. However, there is little hard evidence of the efficacy and safety of antidepressant therapies in Parkinson's disease.

Objectives: To assess the efficacy and safety of antidepressant therapies in idiopathic Parkinson's disease. Safety refers to both the direct side-effects of the therapy and also the therapy's interactions with the symptoms of Parkinson's disease and with the antiparkinsonian medications. Search strategy: Relevant clinical trials were identified by electronic searches the Cochrane Controlled Trials Register MEDLINE(1996-2001),

EMBASE (1974-2001), PsychLit (1800's-2001), CINAHL (1982-2001) databases. The reference list of all trial reports and reviews were examined. Queries were sent out to all manufacturers and distributors of antidepressants within the UK requesting information on any relevant clinical trials.

Selection criteria: Randomised controlled trials (RCT) examining licensed oral antidepressants, electroconvulsive therapy (ECT) or behavioural therapy in the treatment of depression in idiopathic Parkinson's disease.

Data collection and analysis: Data was extracted and assessed independently by three of the authors. Disagreements were resolved by discussion.

Main results: Three randomised controlled trials were found examining oral antidepressant medications in Parkinson's disease in a total of 106 patients. No eligible trials of ECT or behavioural therapy were found. In the first arm of the crossover trial by Andersen 1980 (n=22) patients in the nortriptyline group showed a larger improvement than placebo group in median depression score in a self-made 31-item depression rating scale after 16 weeks of treatment but statistical significance was not calculated. A parallel group trial by Wermuth 1998 (n=37) did not show any statistically significant difference between the citalopram and placebo groups in the Hamilton Depression Scale after 52 weeks of treatment. The third study by Rabey 1996 (n=47) was a randomised open-label trial to compare fluvoxamine versus amitriptyline. Similar numbers of patients in amitriptyline and fluvoxamine groups (60% vs 55%) had a 50% reduction of Hamilton score after 16 months of treatment. However, further assessment of this trial was not possible because only summary results were available from an abstract and attempts to contact the authors failed. Visual hallucinations or confusion had been reported in patients with fluvoxamine and amitriptyline. Otherwise, no other major side effects were found in the other two trials.

Reviewers' conclusions: Insufficient data on the effectiveness and safety of any antidepressant therapies in Parkinson's disease are available on which to make recommendations for their use. Further large scale randomised controlled trials are urgently required in this area.

Citalopram & Parkinson's Disease

■ CITALOPRAM TREATMENT OF DEPRESSION IN PARKINSON'S DISEASE: THE IMPACT ON ANXIETY, DISABILITY, AND COGNITION.

Authors : Menza M, Marin H, Kaufman K, Mark M, Lauritano M. - Department of Psychiatry, Robert Wood Johnson Medical School, Camden, New Jersey, USA. menza@cmhc.umdj.edu

Source : J Neuropsychiatry Clin Neurosci. 2004 Summer;16(3):315-9

Summary: Depression in Parkinson's disease (PD) is associated with faster progression of physical symptoms, greater decline in cognitive skills, and greater decline in the ability to care for oneself. The depression in these patients is also frequently comorbid with anxiety. There are no trials that provide data on the impact of depression treatment on anxiety, disability, and cognition in these patients. In this prospective, 8-week, open label trial, 10 patients with PD and major depression, without dementia, were given flexible doses of citalopram. Depression improved significantly and was associated with significant improvements in anxiety symptoms and functional impairment. The drug was well tolerated. This is

the first study that provides data suggesting that treating depression in patients with PD may lead to improvements in anxiety and functional capacity. As with all nonrandomized, open-label trials at tertiary research centers, many nonspecific factors may have influenced the results.

Suicide

Suicide & Seasonal differences

■ SEASONAL DIFFERENCES IN PSYCHOPATHOLOGY OF MALE SUICIDE COMPLETERS.

Authors : Kim CD, Lesage AD, Seguin M, Chawky N, Vanier C, Lipp O, Turecki G.

Source : Compr Psychiatry. 2004 Sep-Oct;45(5):333-9

Summary: Suicide is known to vary according to season, with peaks in the spring and troughs in the winter. The presence of psychopathology is a significant predictor of suicidality, and it is possible that the seasonal variation of suicide completion may be related to seasonality in the manifestation of psychiatric disorders common to suicide completers. In the current study, we evaluated 115 French-Canadian male suicide completers from the Greater Montreal Area for DSM-IV psychiatric disorders using proxy-based diagnostic interviews. Subjects were assessed for seasonal differences in the prevalence of DSM-IV psychiatric diagnoses just before their deaths. Diagnoses of major depressive disorder (MDD) without comorbid cluster B personality disorders, and schizophrenia were differently distributed between seasons. Most (63.4%) subjects with MDD committed suicide in the spring/summer (P = .038). However, closer examination revealed that depressed suicides with comorbid cluster B personality disorders did not show seasonality, while 83.3% of depressed suicides without comorbid cluster B personality disorders committed suicide in the spring/summer (P = .019). 87.5% of those suicides with schizophrenia committed suicide in the fall/winter (P = .026), and the only suicide with schizophrenia who died in the spring/summer was also the only one without positive symptomatology. Our study is limited to male suicide completers, and results should not be generalized to women. We conclude that seasonal variation in suicide manifests itself differently in patients with different psychopathology. These findings indicate that assessment of suicide risk may need to include consideration of possible seasonal effects, depending on psychopathology.

Attempted Suicide & Personality

■ PERSONALITY AND ATTEMPTED SUICIDE IN DEPRESSED ADULTS 50 YEARS OF AGE AND OLDER: A FACET LEVEL ANALYSIS.

Authors : Useda JD, Duberstein PR, Conner KR, Conwell Y.

Source : Compr Psychiatry. 2004 Sep-Oct;45(5):353-61

Summary: We examined the contribution of personality traits to attempted suicide, the number of suicidal attempts, and suicidal ideation in a sample of depressed inpatients. Personality was assessed via the Revised NEO Personality Inventory (NEO-PI-R). Bivariate analyses showed that suicide attempters were more self-conscious, self-effacing, impulsive, and vulnerable to stress, and less warm, gregarious, and inclined to experience

positive emotions. Multivariate regression analyses controlling for age, gender, severity of depression, and psychiatric comorbidity showed that patients with a lifetime history of attempted suicide were less inclined to experience positive emotions and be more self-effacing. Patients with more severe suicidal ideation were less warm and more self-effacing. Results indicated that specific personality traits confer risk for suicidal behaviors in middle age and older adults. Interventions tailored to specific personality profiles in this high-risk group should be developed, and their efficacy examined.

NARCOLEPSY

NARCOLEPSY SUSCEPTIBILITY

▪ A NARCOLEPSY SUSCEPTIBILITY LOCUS MAPS TO A 5 MB REGION OF CHROMOSOME 21q.

Authors : Dauvilliers Y, Blouin JL, Neidhart E, Carlander B, Eliaou JF, Antonarakis SE, Billiard M, Tafti M. Service de Neurologie B, Hopital Gui-de-Chauliac, Montpellier, France.

Source : Ann Neurol. 2004 Sep;56(3):382-8.

Summary : The genetic basis of human narcolepsy remains poorly understood. Multiplex families with full-blown narcolepsy-cataplexy are rare, whereas families with both narcolepsy-cataplexy and excessive daytime sleepiness without cataplexy are more common. We performed a genomewide linkage analysis in a large French family with four members affected with narcolepsy-cataplexy and 10 others with isolated recurrent naps or lapses into sleep. Only three regions showed logarithm of odds (LOD) scores greater than 1 in two-point linkage analysis (D6S1960, D11S2359, and D21S228). Genotyping additional markers provided support for linkage to 9 markers on chromosome 21 (maximum two-point LOD score, 3.36 at D21S1245). The multipoint linkage analysis using SimWalk2 provided further evidence for linkage to the same region (maximum parametric LOD score, 4.00 at 21GT26K). A single haplotype was shared by all affected individuals and informative crossovers indicated that the elusive gene that confers susceptibility to narcolepsy is likely to be located between markers D21S267 and ABCG1, in a 5.15 Mb region of 21q.

NARCOLEPSY & GLUCOSE HYPOMETABOLISM

▪ GLUCOSE HYPOMETABOLISM OF HYPOTHALAMUS AND THALAMUS IN NARCOLEPSY.

Authors : Joo EY, Tae WS, Kim JH, Kim BT, Hong SB. Department of Neurology, Samsung Medical Center, Sungkyunkwan University School of Medicine, 50 Irwon-Dong, Gangnam-Gu, Seoul, Korea.

Source : Ann Neurol. 2004 Sep;56(3):437-40.

Summary : It has been hypothesized that hypothalamus is involved in narcolepsy. The relative difference between cerebral glucose metabolism of 24 narcoleptic patients and 24 normal controls was studied using 18F-fluorodeoxy glucose positron emission tomography. Patients with narcolepsy showed significantly reduced cerebral glucose metabolism in bilateral rectal and subcallosal gyri, the medial convexity of right superior frontal gyrus, bilateral precuneus, right inferior

parietal lobule, and in left supramarginal gyrus (uncorrected $p < 0.001$). Bilateral posterior hypothalami and mediodorsal thalamic nuclei showed hypometabolism with significance at the level of corrected $p < 0.05$, with small volume correction. This study showed cerebral glucose hypometabolism of the hypothalamus-thalamus-orbitofrontal pathways in the narcoleptic brain.

PSYCHOTHERAPY

PSYCHOTHERAPY & DIABETES MELLITUS

▪ INTEGRATIVE TREATMENT OF INSTABLE DIABETES MELLITUS: EDUCATION OR PSYCHOTHERAPY?

Authors : Leweke F, Kurth R, Milch W, Brosig B. - Klinik fur Psychosomatik und Psychotherapie der Universitat Giessen. frank.leweke@psycho.med.uni-giessen.de

Source : Prax Kinderpsychol Kinderpsychiatr. 2004 May-Jun;53(5):347-58

Summary : The term "brittle diabetes" describes a subtype of instable type-I diabetes, characterized by high variations of blood sugar without any evident cause and despite careful clinical management. Clear guidelines for a precise definition of the condition are still lacking; this fosters insecurities concerning diagnosis and therapy of the disease. Psychosocial influences, triggering these conditions, were discussed. The patient-doctor-relationship appears to be tensed due to an often missing compliance. Using a paradigmatic case study as background, the specific diagnostic and therapeutic problems in brittle diabetes were presented. Brittle diabetes advocates a close cooperation between internal and psychosomatic medicine units and a combination of patient education and psychotherapy. Seen under a psychosomatic paradigm, brittle diabetes can be detected early and effective treatment may avoid further complications in these young patients.

PSYCHOTHERAPY & DIABETES MELLITUS

▪ INTEGRATIVE TREATMENT OF INSTABLE DIABETES MELLITUS: EDUCATION OR PSYCHOTHERAPY?

Authors : Leweke F, Kurth R, Milch W, Brosig B. - Klinik fur Psychosomatik und Psychotherapie der Universitat Giessen. frank.leweke@psycho.med.uni-giessen.de

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Seen under a psychosomatic paradigm, brittle diabetes can be detected early and effective treatment may avoid further complications in these young patients.

BORDERLINE PERSONALITY DISORDER & Psychotherapy —

▪ STRATEGIES FOR SECURING COMMITMENT TO TREATMENT FROM INDIVIDUALS DIAGNOSED WITH BORDERLINE PERSONALITY DISORDER

Authors : Denise D. Ben-Porath - Assistant Professor of Psychology, John Carroll University, 20700 North Park Blvd., University Heights, OH 44118; dbenporath@jcu.edu

Source : Journal of Contemporary Psychotherapy 34 (3): 247-263, Fall 2004

Summary: Individuals diagnosed with borderline personality disorder (BPD) are notoriously difficult to engage in treatment. The purpose of this paper is to highlight therapeutic strategies that are likely to facilitate early alliance in therapy with individuals diagnosed with BPD. The seven strategies include, collaborative assessment, the use of contracts, motivational interviewing, linking treatment targets to client goals, commitment strategies, validation, and the use of metaphors. Clinical vignettes are presented to elucidate the concepts described and demonstrate their use in clinical practice.

Keywords : premature termination, borderline personality disorder, psychotherapy, engagement.

BPD & Psychotherapy —

▪ AVOIDING PATIENT DISTORTIONS IN PSYCHOTHERAPY WITH BORDERLINE PERSONALITY DISORDER PATIENTS

Authors : David M. Allen - Department of Psychiatry, University of Tennessee Health Science Center, 135 N. Pauline, Sixth Floor, Memphis, Tennessee; DMAllen@utmem.edu and Stephanie Whitson - Department of Psychiatry, University of Tennessee Health Science Center, 135 N. Pauline, Sixth Floor, Memphis, Tennessee

Source : Journal of Contemporary Psychotherapy 34 (3): 211-229, Fall 2004

Summary: Patients with borderline personality disorder (BPD) have a reputation among psychotherapists for distorted thinking and misleading reports about their interpersonal relationships. This article discusses the difficulty in ascertaining whether seeming distortions are caused by true cognitive deficiencies or are instead caused by purposeful or subconscious manipulation of relationships. The tendency of BPD patients to use an impressionistic cognitive style that leaves out important details and leads to seemingly distorted reports may be related to the phenomenon of family invalidation. Empirical research into BPD distortions is reviewed. The article then describes techniques useful in psychotherapy for obtaining more factual and objective accounts of current relationship episodes. Transcripts from a therapy session are used to illustrate the techniques.

Keywords : borderline personality disorder, psychotherapy, cognitive distortion, Unified Therapy.

S.L.E

NEUROPSYCHIATRIC DAMAGE & SLE —

▪ PREDICTORS OF NEUROPSYCHIATRIC DAMAGE IN SYSTEMIC LUPUS ERYTHEMATOSUS: DATA FROM THE MARYLAND LUPUS COHORT.

Authors : Mikdashi J, Handwerker B. - University of Maryland School of Medicine, Baltimore, MD, USA.

Source : Rheumatology (Oxford). 2004 Sep 1

Summary: Objective. To identify factors predictive of significant neuropsychiatric (NP) damage in systemic lupus erythematosus (SLE). Methods. One hundred and thirty patients with SLE were followed at the University of Maryland Lupus Clinic from 1992 until 2003. NP manifestations were defined according to the revised American College of Rheumatology (ACR) nomenclature and case definitions for NP-SLE syndromes. Disease activity was measured using the SLE Disease Activity Index (SLEDAI), organ damage using the Systemic Lupus International Collaborating Clinics Damage Index SLICC/ACR (SDI); NP damage (NPDI) was measured with the corresponding domain of the SDI. At end of study period, 64 patients exhibited no NP damage (NPDI = 0) and 66 patients developed significant NP damage (defined as NPDI ≥ 1). The baseline features for these two patient groups were compared, and variables found to be significantly different were examined by multivariable analyses to determine their contribution to NP damage. Results. Significant NP damage is common in SLE; mortality is infrequent and the cause of death is unrelated to NP damage. Independent predictors of significant NP damage were disease activity, Caucasian ethnicity and the presence of antiphospholipid antibodies and anti-Ro/SSA antibody. Certain clinical features at baseline predicted specific NP damage. For example, higher disease activity at baseline was predictive of psychosis and cognitive impairment, anti-dsDNA was predictive of polyneuropathy, and antiphospholipid antibodies were predictive of seizures and cerebrovascular accidents. Conclusions. In this longitudinal SLE cohort, significant cumulative NP damage occurred. Early aggressive therapy targeted towards NP manifestations may prevent the occurrence of NP damage.

NOCTURNAL ENURESIS (NE)

NE & Complex Behavioural —

▪ COMPLEX BEHAVIOURAL AND EDUCATIONAL INTERVENTIONS FOR NOCTURNAL ENURESIS IN CHILDREN

Authors : Glazener CMA, Evans JHC, Peto RE

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Summary: A substantive amendment to this systematic review was last made on 26 November 2003. Cochrane reviews are regularly checked and updated if necessary.

Background: Nocturnal enuresis (bedwetting) is a socially disruptive and stressful condition which affects around 15-20% of five year olds, and up to 2% of young adults. Objectives: To assess the effects of complex behavioural and educational interventions on nocturnal enuresis in children, and to compare them with other interventions.

Search strategy: We searched the Cochrane Incontinence Group trials register (December 2002) and the reference lists of relevant articles. Date of the most recent searches: December 2002.

Selection criteria: All randomised or quasi-randomised trials of complex behavioural or educational interventions for nocturnal enuresis in children were included, except those focused solely on daytime wetting. Comparison interventions included no treatment, simple and physical behavioural methods, alarms, desmopressin, tricyclics, and miscellaneous other interventions. **Data collection and analysis:** Two reviewers independently assessed the quality of the eligible trials, and extracted data.

Main results: Sixteen trials involving 1081 children were identified which included a complex or educational intervention for nocturnal enuresis. The trials were mostly small and some had methodological problems including the use of a quasi-randomised method of concealment of allocation in three trials and baseline differences between the groups in another three. A complex intervention (such as dry bed training (DBT) or full spectrum home training (FSHT)) including an alarm was better than no-treatment control groups (eg RR for failure or relapse after stopping DBT 0.25; 95% CI 0.16 to 0.39) but there was not enough evidence about the effects of complex interventions alone if an alarm was not used. A complex intervention on its own was not as good as an alarm on its own or the intervention supplemented by an alarm (eg RR for failure or relapse after DBT alone versus DBT plus alarm 2.81; 95% CI 1.80 to 4.38). On the other hand, a complex intervention supplemented by a bed alarm might reduce the relapse rate compared with the alarm on its own (eg RR for failure or relapse after DBT plus alarm versus alarm alone 0.5; 95% CI 0.31 to 0.80). There was not enough evidence to judge whether providing educational information about enuresis was effective, irrespective of method of delivery. There was some evidence that direct contact between families and therapists enhanced the effect of a complex intervention, and that increased contact and support enhanced a package of simple behavioural interventions, but these were addressed only in single trials and the results would need to be confirmed by further randomised controlled trials, in particular the effect on use of resources.

Reviewers' conclusions: Although DBT and FSHT were better than no treatment when used in combination with an alarm, there was insufficient evidence to support their use without an alarm. An alarm on its own was also better than DBT on its own, but there was some evidence that combining an alarm with DBT was better than an alarm on its own, suggesting that DBT may augment the effect of an alarm. There was also some evidence that direct contact with a therapist might enhance the effects of an intervention.

TARDIVE DYSKINESIA (TD)

TD & NEUROLEPTIC

■ NEUROLEPTIC REDUCTION AND/OR CESSATION AND NEUROLEPTICS AS SPECIFIC TREATMENTS FOR TARDIVE DYSKINESIA

Authors : McGrath JJ, Soares-Weiser KVS

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Summary: A substantive amendment to this systematic review was last made on 25 February 1998. Cochrane reviews are regularly checked and updated if necessary.

Background: Since the 1950s neuroleptic medication has been extensively used to treat people with chronic mental illnesses,

such as schizophrenia. These drugs, however, have been also associated with a wide range of adverse effects, including movement disorders such as tardive dyskinesia (TD). Various strategies have been examined to reduce a person's cumulative exposure to neuroleptics. These studies include dose reduction, intermittent dosing strategies, such as drug holidays, and neuroleptic cessation.

Objectives: To determine whether, for those people with both schizophrenia (or other chronic mental illnesses) and tardive dyskinesia (TD), a reduction or cessation of neuroleptic drugs was associated with reduction in TD symptoms. A secondary objective was to determine whether the use of specific neuroleptics for similar groups of people could be a treatment for already established TD.

Search strategy: Electronic searches of Biological Abstracts (1982-1997), Cochrane Schizophrenia Group's Register of trials (1997), EMBASE (1980-1997), LILACS (1982-1996), MEDLINE (1966-1997), PsycLIT (1974-1997), and SCISEARCH (1997) were undertaken. References of all identified studies were searched for further trial citations.

Principal authors of trials were contacted.

Selection criteria: Reports were included if they assessed the treatment of neuroleptic-induced tardive dyskinesia in people with schizophrenia or other chronic mental illnesses and already established TD, who had been randomly allocated to (a) neuroleptic cessation (placebo or no intervention) versus neuroleptic maintenance; b. neuroleptic reduction (including intermittent strategies) versus neuroleptic maintenance; or c. specific neuroleptics for the treatment of TD versus placebo or no intervention.

Data collection and analysis: The reviewers extracted the data independently and the Odds Ratio (95% CI) or the average difference (95% CI) were estimated. The reviewers assumed that people who dropped out had no improvement.

Main results: Two trials were able to be included in this review. Sixty two were excluded and 16 are awaiting assessment. Seven trials are still pending classification. No randomised controlled trial-derived data were available to clarify the role of neuroleptics as treatments for TD. This includes the atypical antipsychotics including clozapine. Despite neuroleptic cessation being a frequently first-line recommendation, there were no RCT-derived data to support this. Two studies (Cookson 1987, Kane 1983) found a reduction in TD associated with neuroleptic reduction.

Reviewers' conclusions: The lack of evidence to support the efficacy of neuroleptic cessation as a treatment for TD, combined with the accumulating evidence of an increased risk of relapse should antipsychotic drugs be reduced, makes this intervention a hazardous treatment for TD. Dose reduction may offer some benefit as a treatment for TD compared to standard levels of neuroleptic use. There is a need to evaluate the utility of clozapine and the 'atypical' antipsychotics as treatments for established TD.

TD & BENZODIAZEPINES

■ BENZODIAZEPINES FOR NEUROLEPTIC-INDUCED TARDIVE DYSKINESIA

Authors : Walker P, Soares KVS

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd

Summary: A substantive amendment to this systematic review.

was last made on 06 February 2003. Cochrane reviews are regularly checked and updated if necessary.

Background: Tardive dyskinesia (TD) is a potentially disfiguring movement disorder of the orofacial region often caused by the use of neuroleptic drugs. A wide range of strategies have been used to help manage tardive dyskinesia and, for those who are unable to have their antipsychotic medication stopped or substantially changed, the benzodiazepine group of drugs has been suggested as a useful adjunctive treatment.

Objectives: To determine the effects of benzodiazepines for people with neuroleptic-induced tardive dyskinesia and schizophrenia or other chronic mental illnesses.

Search strategy: Electronic searches of Biological Abstracts (1982-2002), the Cochrane Schizophrenia Group's Register of trials (February 2002), EMBASE (1980-2002), LILACS (1982-2002), MEDLINE (1966-2002), PsycLIT (1974-2002), SCISEARCH (2002), hand searching the references of all identified studies and contacting the first author of each included trial.

Selection criteria: All randomised clinical studies focusing on people with both schizophrenia or other chronic mental illnesses and neuroleptic-induced tardive dyskinesia and comparing benzodiazepines with placebo or no intervention.

Data collection and analysis: Studies were reliably selected, quality assessed and data extracted. Data were excluded where more than 50% of participants in any group were lost to follow up. For binary outcomes a fixed effects risk ratio (RR) and its 95% confidence interval (CI) was calculated. Where possible, the weighted number needed to treat/harm statistic (NNT/H), and its 95% confidence interval (CI), was also calculated. For continuous outcomes, endpoint data were preferred to change data. Non-skewed data from valid scales were synthesised using a weighted mean difference (WMD). If statistical heterogeneity was found by Mantel-Haenszel chi-square test, random effects models were used.

Main results: Two small trials (total n=32) were included. Using benzodiazepines as adjunctive treatment did not result in any clear changes for a series of tardive dyskinesia medium term outcomes (RR not improved to a clinically important extent 1.08 CI 0.57 to 2.05, n=30, 2 RCTs; RR not improved at all 1.19 CI 0.3 to 5.3, n=30, 2 RCTs; RR deterioration 1.85 CI 0.3 to 10.1, n=30, 2 RCTs). Adverse effects were not reported.

Reviewers' conclusions: The 2002 update has added almost no extra data. This is clearly not an area of active research. Benzodiazepines may have something to contribute to the care of people with tardive dyskinesia but the use of this group of compounds should be considered experimental. Large definitive studies are indicated.

CHRONIC FATIGUE SYNDROME (CFS)

CFS & EXERCISE THERAPY

■ EXERCISE THERAPY FOR CHRONIC FATIGUE SYNDROME

Authors : Edmonds M, McGuire H, Price J

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Summary: A substantive amendment to this systematic review was last made on 08 May 2004. Cochrane reviews are regularly checked and updated if necessary. **Background:** Chronic fatigue syndrome (CFS) is an illness characterised by persistent medically unexplained fatigue. CFS is a serious

health-care problem with a prevalence of up to 3%. Treatment strategies for CFS include psychological, physical and pharmacological interventions.

Objectives: To investigate the relative effectiveness of exercise therapy and control treatments for CFS.

Search strategy: CCDANCTR-Studies and CENTRAL were searched using "Chronic Fatigue" and Exercise. The Journal of Chronic Fatigue Syndrome and CFS conferences were handsearched. Experts in the field were contacted. Clinicaltrials.gov and controlled-trials.com were searched.

Selection criteria: Only Randomised Controlled Trials (RCT) including participants with a clinical diagnosis of CFS and of any age were included.

Data collection and analysis: The full articles of studies identified were inspected by two reviewers (ME and HMG). Continuous measures of outcome were combined using standardised mean differences. An overall effect size was calculated for each outcome with 95% confidence intervals. One sensitivity analysis was undertaken to test the robustness of the results.

Main results: Nine studies were identified for possible inclusion in this review, and five of those studies were included. At 12 weeks, those receiving exercise therapy were less fatigued than the control participants (SMD -0.77, 95% CIs -1.26 to -0.28). Physical functioning was significantly improved with exercise therapy group (SMD -0.64, CIs -0.96 to -0.33) but there were more dropouts with exercise therapy (RR 1.73, CIs 0.92 to 3.24). Depression was non-significantly improved in the exercise therapy group compared to the control group at 12 weeks (WMD -0.58, 95% CIs -2.08 to 0.92). Participants receiving exercise therapy were less fatigued than those receiving the antidepressant fluoxetine at 12 weeks (WMD -1.24, 95% CIs -5.31 to 2.83). Participants receiving the combination of the two interventions, exercise + fluoxetine, were less fatigued than those receiving exercise therapy alone at 12 weeks, although again the difference did not reach significance (WMD 3.74, 95% CIs -2.16 to 9.64). When exercise therapy was combined with patient education, those receiving the combination were less fatigued than those receiving exercise therapy alone at 12 weeks (WMD 0.70, 95% CIs -1.48 to 2.88).

Reviewers' conclusions: There is encouraging evidence that some patients may benefit from exercise therapy and no evidence that exercise therapy may worsen outcomes on average. However the treatment may be less acceptable to patients than other management approaches, such as rest or pacing. Patients with CFS who are similar to those in these trials should be offered exercise therapy, and their progress monitored. Further high quality randomised studies are needed.

CONDUCT DISORDER & DELINQUENCY (CDD)

Family, Conduct Disorder & Delinquency Aged

■ FAMILY AND PARENTING INTERVENTIONS IN CHILDREN AND ADOLESCENTS WITH CONDUCT DISORDER AND DELINQUENCY AGED 10-17

Authors : Woolfenden SR, Williams K, Peat J

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd

Summary: A substantive amendment to this systematic review was last made on 28 February 2001. Cochrane reviews are

regularly checked and updated if necessary.

Background: Conduct disorder and delinquency are significant problems for children and adolescents and their families, with the potential to consume much of the resources of the health, social care and juvenile justice systems. A number of family and parenting interventions have been recommended and are used for these conditions. The aim of this review was to determine if these interventions are effective in the management of conduct disorder and delinquency in children and adolescents, aged 10-17. **Objectives:** To determine if family and parenting interventions improve the child/adolescent's behaviour; parenting and parental mental health; family functioning and relations; and have an effect on the long term psychosocial outcomes for the child/adolescent.

Search strategy: Randomised controlled trials were identified through searching the Cochrane Controlled Trial Register (CCTR), databases (MEDLINE, EMBASE, PsycINFO, CINAHL, Sociofile, ERIC, Healthstar), reference lists of articles and contact with authors.

Selection criteria: Randomised controlled trials with a major focus on parenting and/or family functioning were eligible for inclusion in the review. Trials needed to include at least one objective outcome measure (e.g. arrest rates) or have used a measure that had been published in peer review publications and validated for the relevant purpose. Studies were required to have a control group, which could be a no intervention group, a wait list group or a usual intervention group (e.g. probation). Trials in children and adolescents aged 10 to 17 years with conduct disorder and/or delinquency and their families were considered. Conduct disorder was defined by a standardised psychological assessment (for example, using a child behaviour checklist), or a psychiatric diagnosis. Delinquency was defined by a referral from a juvenile justice or another legal system for a child/adolescent who has committed a serious crime e.g. assault and/or offended on at least two occasions.

Data collection and analysis: Two reviewers independently reviewed all eligible studies for inclusion, assessed study quality (allocation concealment, blinding, follow up, clinically important outcomes) and extracted data. Heterogeneity was assessed using the Chi squared test of heterogeneity along with visual inspection of the data. A significance level less than 0.1 was interpreted as evidence of statistically significant heterogeneity. For data where heterogeneity was found the reviewers looked for an explanation. If studies with heterogeneous results were thought to be comparable the statistical synthesis of the results was done using a random effects model. This model takes into account within-study sampling error and between-studies variation in the assessment of uncertainty and will give wider confidence intervals to the effect size and hence a more conservative result. Sensitivity analysis was performed to explore the effects of the varying quality of the studies included on the results.

Main results: Of the nine hundred and seventy titles initially identified through the search strategy, eight trials met the inclusion criteria. A total of 749 children and their families were randomised to receive a family and parenting intervention or to be in a control group. In seven of these studies the participants were juvenile delinquents and their families and in only one the participants were children/adolescents with conduct disorder who had not yet had contact with the juvenile justice system. At follow up, family and parenting interventions significantly reduced the time spent by juvenile delinquents in institutions (WMD 51.34 days, 95%CI 72.52 to 30.16). There was also a

significant reduction in the risk of a juvenile delinquent being re arrested (RR 0.66, 95%CI 0.44 to 0.98) and in their rate of subsequent arrests at 1-3 years (SMD -0.56, 95% CI -1.100 to -0.03). For both of these outcomes there was substantial heterogeneity in the results suggesting a need for caution in interpretation. At present there is insufficient evidence that family and parenting interventions reduce the risk of being incarcerated (RR=0.50, 95% CI 0.20 to 1.21). No significant difference was found for psychosocial outcomes such as family functioning, and child/adolescent behaviour.

Reviewers' conclusions: The evidence suggests that family and parenting interventions for juvenile delinquents and their families have beneficial effects on reducing time spent in institutions. This has an obvious benefit to the participant and their family and may result in a cost saving for society. These interventions may also reduce rates of subsequent arrest but at present these results need to be interpreted with caution due to the heterogeneity of the results.

Dysthymia

Dysthymia & Pharmacotherapy

■ PHARMACOTHERAPY FOR DYSTHYMIA

Authors : Lima MS, Hotopf M

Source : The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd

Summary: A substantive amendment to this systematic review was last made on 27 April 2003. Cochrane reviews are regularly checked and updated if necessary.

Background: Many drug treatments have been proposed for the treatment of dysthymia, but with so many potential comparisons it is not possible at the present time to determine which is the treatment of choice. There is a need to know whether the different classes of antidepressants have similar efficacy. In addition, the tolerability of treatments may be even more important, since dysthymia is a chronic condition characterised by less severe symptoms than major depression. **Objectives:** To conduct a systematic review of all randomised controlled trials comparing two or more active drug treatments for dysthymia.

Search strategy: Electronic searches of Cochrane Library, EMBASE, MEDLINE, PsycLIT and LILACS, Biological Abstracts; reference searching; personal communication; unpublished trials from pharmaceutical industry.

Selection criteria: Only randomised and quasi-randomised controlled trials were included. Trials had to compare at least two active drug treatments in the treatment of dysthymia. Exclusion criteria were: non-randomised studies, studies which included patients with mixed major depression/dysthymia and studies on depression/dysthymia secondary to other disorders (e.g. substance abuse).

Data collection and analysis: The reviewers extracted the data independently and odds ratios, weighted mean difference and number needed to treat were estimated. The reviewers assumed that people who died or dropped out had no improvement and tested the sensitivity of the final results to this assumption. **Main results:** A total of 14 trials were eligible for inclusion in the review. All studied drugs promoted similar clinical responses, although with different side effect profiles. The evidence for TCAs and SSRIs was the most robust, considering the number of trials and participants. Reviewers'

conclusions: The conclusion is that the choice of drug must be made based on consideration of drug-specific side effect properties.

SOMATOFORM DISORDERS (SD)

SD & PHARMACOTHERAPY

■ PHARMACOTHERAPY OF SOMATOFORM DISORDERS.

Authors : Fallon BA. Department of Psychiatry, Division of Therapeutics, Somatic Disorders Program, New York State Psychiatric Institute, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032, USA. baf1@columbia.edu

Source : J Psychosom Res. 2004 Apr;56(4):455-60.

Summary : OBJECTIVE: This paper reviews the published literature on the pharmacologic management of somatoform disorders. METHODS: Using Medline, the author identified all articles published between 1970 and 2003 on this topic, selecting the best-designed studies for inclusion. RESULTS: The review reveals that patients with the obsessional cluster of somatoform disorders (hypochondriasis and body dysmorphic disorder [BDD]) respond well to serotonin reuptake inhibitors (SRIs). Less is known about the pharmacologic responsiveness of patients with the primarily somatic cluster of somatoform disorders (somatization, pain), a patient group that is common in the health provider's office. CONCLUSIONS: Improvements in the design of future clinical trials are needed. A particular focus needs to be applied to study the neglected area of the pharmacologic treatment of syndromal and subsyndromal somatization and pain disorders. Copyright 2004 Elsevier Inc.

ELECTRO CONVULSIVE THERAPY (ECT)

ECT & VALUE OF DIAGNOSTIC

■ VALUE OF DIAGNOSTIC IMAGING IN EVALUATION OF ELECTROCONVULSIVE THERAPY [ARTICLE IN GERMAN]

Authors : Frodl T, Meisenzahl EM, Moller HJ. Psychiatrische Klinik, Ludwigs-Maximilians-Universität, München, Germany

Source : Nervenarzt. 2004 Mar;75(3):227-33.

Summary : Magnetic resonance imaging (MRI), positron emission tomography (PET), and single photon emission computed tomography (SPECT) may be able to investigate the clinical efficacy and underlying neuronal processes of

electroconvulsive therapy (ECT). The following review focuses on neuroimaging in ECT. Neuroimaging findings support that ECT does not result in significant macroscopic structural changes. However, in patients with subtle structural changes such as subcortical lesions and dilatation of lateral ventricles before ECT, the possibilities of poor therapeutic outcome, increased incidence of delirium, and longer-lasting cognitive deficits should be considered. Functional studies show reduced blood flow and glucose metabolism during the first days after ECT. Afterwards, their normalization can be observed, which seems to correlate to clinical improvement. The importance of this suppression effect needs to be further elucidated. Future studies of receptor systems and longitudinal studies will open new perspectives in future imaging research.

HUNTINGTON CHOREA (HC)

HC & NEUROPSYCHIATRIC ASPECTS

■ NEUROPSYCHIATRIC ASPECTS OF HUNTINGTON CHOREA. PRESENTATION OF 2 CASES AND REVIEW OF THE LITERATURE [ARTICLE IN GERMAN].

Authors : Tost H, Schmitt A, Brassen S, Wendt CS, Braus DF. NMR-Forschung am Zentralinstitut für Seelische Gesundheit Mannheim, Universität Heidelberg.

Source : Nervenarzt. 2004 Mar;75(3):258-66.

Summary : Huntington's disease (HD) is an autosomal, dominant, inherited disorder of the central nervous system with characteristic neurodegenerative alterations in the basal ganglia and cortex. Dependent on the individual CAG expansion load, disease onset occurs between the third or fourth decade of life, entailing an invariably lethal progression within 10 to 20 years. Although the clinical picture is characterized equally by cognitive and psychiatric disturbances, the apparent neurodegenerative alterations and presentation as a choreatic movement disorder account for the traditional link of Huntington's disease to the field of neurology. In contrast to the traditionally emphasized core features of chorea and dementia, recent empirical evidence points to the frequent emergence of nonchoreatic motor signs and subtle cognitive and psychiatric complaints, especially in asymptomatic gene carriers and early disease stages. The case studies presented here emphasize the spectrum of neuropsychiatric phenomena associated with HD and illustrate the resulting difficulties of differential diagnosis in clinical settings. Furthermore, current scientific knowledge of HD pleiotropy is reviewed and the diagnostic power of specific neuropsychological approaches is explained.

علم النفس الفيزيولوجي

أ.د. أحمد عكاشة



Summary : www.arabpsynet.com/Books/Okasha.B2.htm

Arabpsynet eJournal: N° 4-OCTOBER - NOVEMBER - DECEMBER 2004

سيكولوجية السياسة العربية - العرب والمستقبلات

أ.د. محمد أحمد النابلسي



Summary : www.arabpsynet.com/Books/Nab.B1.htm

مجلة شبكة العلوم النفسية العربية: العدد 4 - أكتوبر - نوفمبر - ديسمبر 2004

المعجم الإلكتروني للعلوم النفسية العربية

مصطلحات عربية : عربي - إنكليزي - فرنسي

الدكتور جمال التركي - الطب النفسي - تونس

بريد إلكتروني: turky.jamel@gnet.tn

masturbation mutuelle mutual masturbation
 masturbation cachée hidden masturbation
 masturbation dirigée directed masturbation
 masturbation psychique psychic masturbation
 psychique

projection, extrajection	projection, extrajection
projection	persecutive
persécutrice	projection
projection du désir	desire projection
projection des affects	affects projection
projection d'angoisse	anguish project
projection de jeu	play projection
projection des sentiments	feeling projection
projection des tendances	tendency projection
projection des fantasmes	phantasm projection
projection des affects	affection projection
projection sexuelle	sexual projection
egomorphisme	egomorphism
projection symbolique	symbolic projection
projection excentrique	eccentric projection
projection thérapeutique	therapeutic projection
projection impersonnelle	impersonal projection
projection inconsciente	unconscious projection
projection morcelante	dismantled projection
projection fantasmatique	fantasmatic projection
conditionnement	conditioning
conditionnement social	social conditioning
conditionnement instrumental	instrumental conditioning
conditionnement positif	conditioning positive
conditionnement	operative

إستقراء - إستلاب
 إستمناء - إسقاط
 إضراب - إضراب

induction	induction	)	(
induction perceptuelle	perceptual induction		
induction des idées	ideas induction		
induction de panique	panic induction		
induction complète	complete induction		
auto-induction	self induction		
induction corticale	cortical induction		
induction amplifiante	amplifiant induction		
spoliation, altération, étrangement, aliénation	spoliation, despoliation, estrangement, alienation		
aboulie	aboulia		
auto-spoliation	self spoliation		
dépersonnalisation	depersonalization		
déréalisation	disrealization		
aliénation mentale	mental alienation		
psycho-spoliation	psycho-spoliation		
aliénation maniaque	maniacal alienation		
masturbation, onanisme	masturbation, onanism		
masturbation fantasme	phantasm masturbation		
masturbation compulsive	compulsive masturbation		
masturbation infantile	infantile masturbation		
masturbation à la main, mentulomanie	hand masturbation, mentulomania		
masturbation symbolique	symbolic masturbation		
masturbation névrotique	neurotic masturbation		
onanisme compulsif, masturbation compulsive	compulsive onanism, compulsive masturbation		
pseudo masturbation	pseudo-masturbation		

condition	simultaneous
simultanée	conditioning
conditionnement croisé	cross conditioning
préconditionnement	preconditioning
conditionnement	autonomic
autonome	conditioning
contre	counter
conditionnement	conditioning
conditionnement	cognitive conditioning
cognitif	
condition décortiquée	decorticate conditioning
conditionnement	aversion conditioning
aversif	
conditionnement	psychic conditioning
psychique	
conditionnement	instrumental
instrumental	conditioning
trouble, déséquilibre, perturbation	turbid, muddy, trouble, disorder, disturbance
trouble social	social disorder
trouble réactionnel	reaction disorder
désordre agressif	aggressive disorder
trouble dépressif	depressed disorder
trouble végétatif	vegetative disorder
trouble expansive	expansive disorder
trouble d'involution	involution disorder
trouble impulsive	impulsive disorder
trouble toxique	toxic disorder
trouble explosif	explosive trouble
trouble affectif,	affective disorder,
trouble émotionnelle	emotional disorder
trouble métabolique	metabolic disorder
trouble obsessionnel	disorder obsessive
trouble de la	communication
communication	disorder
trouble de l'excitation	excitation disorder
trouble de perception	perception disorder
trouble addictif	addictive disorder
parabulie	parabulia
trouble de	anticipation
l'anticipation	disorder
trouble de	sexual excitation
l'excitation sexuelle	disorder
trouble de	ejaculation
l'éjaculation	disorder
trouble de l'attention	attention disorder
trouble de l'érection	erection disorder
trouble de la	generality

opérateur	conditioning
conditionnement	instrumental
instrumental	conditioning
conditionnement	reflex conditioning
réflexe	
conditionnement	abstinence conditioning
d'abstinence	
conditionnement	avoidance
d'évitement	conditioning
conditionnement	differential
différentiel	conditioning
conditionnement	semantic conditioning
sémantique	
conditionnement	aversive conditioning
aversif	
conditionnement	pavlovian conditioning
pavlovien	
conditionnement	contiguous
contigu	conditioning
conditionnement	avoid conditioning
d'évitement	
conditionnement	approximation
approximatif	conditioning
conditionnement	classical
classique	conditioning
conditionnement	sensory conditioning
sensitif	
conditionnement	sensory conditioning
sensoriel	
condition	semantic conditioning
sémantique	
conditionnement	backward conditioning
rétrograde	
conditionnement	negative conditioning
négatif	
conditionnement	inverted conditioning
inversé	
condition différentielle	differential conditioning
conditionnement	operating
opérant	conditioning
pseudoconditionnement	pseudoconditioning
conditionnement	sufficient conditioning
suffisant	
conditionnement	verbal conditioning
verbal	
conditionnement	direct conditioning
direct	
conditionnement	precocious conditioning
précoce	

hystéropie	hysteropia
trouble du désir	desire trouble
trouble caractérielle	behaviour disorder,
trouble du	disturbance
comportement	behaviour
trouble du cours	thinking context
de la pensée	disorder
trouble de la	personality
personnalité	disorder
trouble de la	consciousness
conscience	disorder
trouble du caractère	character disorder
trouble de l'habitude	habit disturbance
trouble de	affectivity disorder
l'affectivité	
trouble de la pensée	thought disorder
trouble de la	comprehension
compréhension	trouble
trouble de	ejaculation disorder
l'éjaculation	
trouble anxieux	anxiety disorder
néographisme	neographism
trouble de la parole	speech disorder
trouble du langage	language disorder
trouble de jugement	judgement disorder
trouble de	humour disorder,
l'humeur, trouble	mood disorder,
thymique, dysphorie	dysphoria
trouble	cyclothymic
cyclothymique	disorder
trouble	oppositional
oppositionnel	disorder
trouble amnésique	amnesic disorder
trouble du rythme	rhythm disorder
trouble du	development trouble
développement	
dyssomnie	dyssomnia
trouble panique	panic trouble
trouble de l'identité	identity disorder
trouble de	sexual identity
l'identité sexuelle	disorder
trouble de la réalité	reality disorder
trouble de l'affectivité	affectivity disorder
kakergasie,	kakergasia,
cacergasie,	cacergasia,
dysfonction	dysfunction
trouble de la	conscious disorder
conscience	
trouble de	self conscious

généralité	disorder
trouble de l'impulsion	impulse disorder
trouble de l'orgasme	orgasm disorder
trouble de stress	stress disorder
trouble de la synergie	synergy disorder
trouble ataxique	ataxic disorder
trouble de conversion	conversion disorder
trouble des	association
associations	disorder
trouble de la	concentration
concentration	trouble
trouble du conduit	conduct disorder
trouble de	imagination
l'imagination	disorder
trouble de	expression
l'expression	disorder
trouble de la	recognition
reconnaissance	trouble
trouble	attachment disorder
d'attachement	
trouble de l'idéation	ideation disorder
trouble de la	thinking disorder,
pensée, thymergasie	thymergasia
trouble de	adaptation disorder
l'adaptation	
trouble de	verbal articulation
l'articulation verbale	trouble
trouble de la	spontaneity
spontanéité	disorder
trouble factice	factitious disorder
trouble de	identification
l'identification	disorder
trouble d'imitation	imitation disorder
trouble de la	coordination
coordination	disorder
trouble	equilibration
d'équilibration	disorder
planotopokinésie	planotopokinesia
trouble du coït	coitus disorder
trouble de la sexualité	sexuality disorder
trouble de jugement	judgement disorder
parakinésie	parakinesia
trouble sensitif	sensitivity disturbance
kakesthésie	kakesthesia
trouble sensoriel	sensory disorder
trouble du caractère	character disorder
trouble des impulsions	impulse disorder
trouble mnésique	memory disorder
trouble de l'intelligence	intelligence trouble

trouble du cours	thought
de la pensée	disturbance
trouble orgastique	orgastic disorder
trouble de	depersonalization
dépersonnalisation	trouble
trouble	medicopsychic
médico-psychique	trouble
trouble familial	family disorder
trouble transitoire	transitory disorder
trouble affectif,	affective disorder,
parapathie	parapathia
trouble agressif	aggressive disorder
trouble	symptomatic
symptomatique	disorder
trouble dysthymique	dysthymic trouble
désordre névrotique	neurotic disorder
trouble nerveux	nervous disorder
trouble	neuro-vegetative
neuro-végétatif	disorder
trouble organique	organic disorder
trouble paranoïaque	paranoid trouble
trouble mentale,	mental disorder,
psychalie,	psychalia, phrenoblabia,
phrénoblabie,	psychonosema mentalia
psychonosema mentalie	
trouble sémantique	semantic trouble
trouble latent	latent trouble
trouble atypique	atypical disorder
trouble	hyperkinetic
hyperkinétique	disorder
trouble physiologique	physiologic trouble
trouble	schizophrenic trouble
schizophrénique	
trouble amnésique	amnesic trouble
trouble intellectuel	intellectual trouble
trouble	semantogenic
semantogénique	disorder

conscience du soi	disorder
trouble de la vigilance	vigilance's disorder
trouble de Briquet	Briquet's disorder
trouble infra clinique	infradlinical trouble
trouble subliminaire	subliminal disorder
désordre de	conversion
conversion	disorder
trouble convulsif	convulsive disorder
trouble conceptuel	conceptual disturbances
trouble réactionnel	reactional trouble
trouble dissociatif	dissociative disorder
trouble dégénératif	degenerative disorder
trouble secondaire	secondary trouble
trouble bipolaire	bipolar disorder
trouble somatique	somatic disorder
trouble somatoforme	somatoform disorder
trouble sexuel	sexual disorder
trouble limite	borderline disorders
trouble moteur,	kinetic disorder,
trouble kinétique	motor disorder
paralgie, paralgésie	paralgesia
trouble sensitive	sensitivity disturbance
trouble viscéral	visceral disorder
trouble caché	covered trouble
trouble de caractère	character disorder
trouble phobique	phobic trouble
trouble	semantogenic
sémantogénique	disorder
trouble cyclique	cyclic disorder
trouble mnésique	mnesic trouble
trouble psychotique	psychotic trouble
trouble mental	mental disorder
trouble paranoïde	paranoid disorder
trouble	behaviourism
comportemental	disorder
trouble	auditory
perceptible auditif	perceptual disorder

الكتاب الإلكتروني لمعجم العلوم النفسية

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مجلة شبكة العلوم النفسية العربية : العدد 4 - أكتوبر - نوفمبر - ديسمبر 2004

E.DICTIONARY of Psychological Sciences

English PSY TERMINOLOGIES (English – French – Arabic)

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A

Agitated – Agitation - Agnosia
 Agraphia - Akinetic – Alcohol
 Alcoholic – Alcoholism – Amnesia
 Amnesic - Amnestic

Agitated	agité
Agitated cephalgia	céphalalgie agitée
Agitated confused	confus agité
Agitated dementia	démence agitée
Agitated depression	dépression agitée
Agitated drunkenness	ivresse agitée
Agitated form	forme agitée
Agitated melancholia	mélancolie agitée
Agitated reaction	réaction agitée
Agitated senile dementia	démence sénile agitée
Agitated sleep	sommeil agité

Agitation	agitation
Agitation (acute-)	agitation aiguë
Agitation (anxious-)	agitation anxieuse
Agitation (confuse-)	agitation confuse
Agitation (disordered-)	désordonnée
Agitation (forced-)	agitation forcée
Agitation (hysterical-)	hystérique
Agitation (maniac-)	agitation maniaque
Agitation (melancholy-)	mélancolique
Agitation (mental-)	agitation mentale
Agitation (motive-)	agitation motrice
Agitation (nocturnal-)	agitation nocturne
Agitation (psycho- motive-)	psycho -motrice
Agitation (psychotic-)	psychotique
Agitation (schizophrenic-)	schizophrénique
Agitation	agitation

(turbulent-)	turbulente
Agitation	conduite d'agitation
conducting	
Agitation depression	dépression agitée
Agitation leading	conduite d'agitation
Agitation situation	état d'agitation
Agitation state	état d'agitation

Agnosia	agnosie
Agnosia (color-)	agnosie des couleurs
Agnosia (digital-)	agnosie digitale
Agnosia (finger-)	agnosie digitale
Agnosia (physiognomy-)	physionomies
Agnosia (sensitive-)	agnosie sensitive
Agnosia (spatial-)	agnosie spatiale
Agnosia (tactile-)	agnosie tactile
Agnosia (topographical-)	topographique
Agnosia (unilateral-)	agnosie unilatérale
Agnosia (visual-)	agnosie visuelle
Agnosia alexia	alexie - agnosie
Agnosia auditory	agnosie auditive

Agraphia	agraphie
Agraphia (absolute-)	agraphie absolue
Agraphia (acoustic-)	agraphie
Agraphia (acquired-)	agraphie acquise
Agraphia (cerebral-)	agraphie cérébrale
Agraphia (congenital-)	congénitale
Agraphia (jargon-)	jargonagraphie
Agraphia (mental-)	agraphie mentale
Agraphia (motor-)	agraphie motrice
Agraphia (musical-)	agraphie musicale
Agraphia (optic-)	agraphie optique
Agraphia (parietal-)	agraphie pariétale
Agraphia (unilateral-)	unilatérale
Agraphia (verbal-)	agraphie verbale
Agraphia	agraphie

amnemonica	amnemonique
Agraphia atactica	agraphie atactique
Agraphia litteral	agraphie littérale
Akinetic	akinétique
Akinetic abulic	syndrome akinétique
syndrome	aboulique
Akinetic apraxia	apraxie akinétique
Akinetic attack	crise akinétique
Akinetic	dépression
depression	akinétique
Akinetic epilepsy	épilepsie akinétique
Akinetic mania	manie akinétique
Akinetic mutism	mutisme akinétique
Akinetic psychosis	psychose akinétique
Akinetic seizure	attaque akinétique
Akinetic stupor	stupeur akinétique
Akinetic syndrome	syndrome akinétique

Alcohol	alcool
Alcohol	dépendance
(dependence-)	d'alcool
Alcohol (parental-)	alcool des parents
Alcohol (primary-)	alcool primaire
Alcohol (secondary-)	alcool secondaire
Alcohol (tertiary-)	alcool tertiaire
Alcohol abuse	abus d'alcool
Alcohol addiction	assiduité alcoolique
Alcohol amnesic	amnésie alcoolique
Alcohol delirium	délire alcoolique
Alcohol derivatives	dérivé d'alcool
Alcohol epilepsy	alcool épilepsie
Alcohol hallucinosis	hallucinoze d'alcool
Alcohol	intoxication
idiosyncratic	idiosyncratique
intoxication	d'alcool
Alcohol intoxication	intoxication alcoolique
Alcohol paranoid	paranoïde alcoolique
Alcohol test	alcool test
Alcohol therapy	alcoolothérapie
Alcohol withdrawal	retrait alcoolique

Alcoholic	alcoolique
Alcoholic	alcoolique
(dangerous-)	dangereux
Alcoholic (delirious-)	délire alcoolique
Alcoholic	alcoolique
(encephalopathic-)	encéphalopathie
Alcoholic (poisoning-)	alcoolique intoxication
Alcoholic addiction	addiction alcoolique
Alcoholic amblyopia	amblyopie alcoolique

Alcoholic amnesic	amnésie alcoolique
Alcoholic anonymous	alcoolique anonyme
Alcoholic appetite	appétence alcoolique
Alcoholic ataxia	ataxie alcoolique
Alcoholic beriberi	béribéri alcoolique
Alcoholic blackout	oubli alcoolique
Alcoholic brain	syndrome du
syndrome	cerveau alcoolique
Alcoholic coma	coma alcoolique
Alcoholic conducting	conduite alcoolique
Alcoholic convulsion	convulsion alcoolique
Alcoholic delirious	délire des alcooliques
Alcoholic delirious	délire des alcooliques
Alcoholic delirious	délire des alcooliques
Alcoholic delirious	délire des alcooliques
Alcoholic	détérioration
deterioration	alcoolique
Alcoholic disease	maladie alcoolique
Alcoholic	ivresse alcoolique
drunkenness	
Alcoholic	encéphalopathie
encephalopathy	alcoolique
Alcoholic epilepsy	épilepsie alcoolique
Alcoholic fury	fureur alcoolique
Alcoholic habituation	habitude alcoolique
Alcoholic	hallucination
hallucination	alcoolique
Alcoholic	psychose
hallucinatory	hallucinatoire
psychosis	alcoolique
Alcoholic hallucinosis	hallucinoze alcoolique
Alcoholic	hospitalisation
hospitalization	alcoolique
Alcoholic	imprégnation
impregnation	alcoolique
Alcoholic intolerance	intolérance alcoolique
Alcoholic	intoxication alcoolique
intoxication	
Alcoholic jealousy	jalousie alcoolique
Alcoholic Korsakov	syndrome de
syndrome	korsakov des alcooliques
Alcoholic	législation des
legislation	alcooliques
Alcoholic	mélancolie alcoolique
melancholia	
Alcoholic myopathy	myopathie
	alcoolique
Alcoholic neuritis	névrite alcoolique

Alcoholic neuropathie	neuropathie alcoolique
Alcoholic neurosis	névrose alcoolique
Alcoholic organic mental disorder	trouble mental organique alcoolique
Alcoholic paranoia	paranoïa alcoolique
Alcoholic post-cure	post-cure alcoolique
Alcoholic pseudoparesis	pseudoparésie alcoolique
Alcoholic pseudopellagre	pseudopellagre alcoolique
Alcoholic psychopolyneuritis	psychopolynévrite alcoolique
Alcoholic psychosis	psychose alcoolique
Alcoholic psychotherapy	psychothérapie de l'alcoolique
Alcoholic satisfaction	imprégnation alcoolique
Alcoholic's stimulant	stimulant alcoolique
Alcoholic syndrome	syndrome alcoolique
Alcoholic trance	transe alcoolique
Alcoholic trembling	tremblement alcoolique
Alcoholic twilight- state	état crépuscule alcoolique
Alcoholic weaning	sevrage alcoolique

Alcoholism alcoolisme

Alcoholism (acute-)	alcoolisme aigu
Alcoholism (alpha-)	alcoolisme alpha
Alcoholism (beta-)	alcoolisme bêta
Alcoholism (chronic-)	alcoolisme chronique
Alcoholism (delta-)	alcoolisme delta
Alcoholism (foetal-)	alcoolisme foetal
Alcoholism (gamma-)	alcoolisme gama
Alcoholism (periodic-)	alcoolisme périodique
Alcoholism (primary-)	alcoolisme primaire
Alcoholism neurosis	névrose alcoolique

Amnesia amnésie

Amnesia (affective-)	amnésie affective
Amnesia (ancient events-)	amnésie des événements anciens
Amnesia (anterior-)	amnésie antérieure
Amnesia (anterograde-)	antérograde
Amnesia (anteroretrograde-)	antéroretrograde
Amnesia (aphasia-)	amnésie aphasie
Amnesia (auditory-)	amnésie auditive

Amnesia (auto- hypnotic-)	autohypnotique
Amnesia (catathymic-)	catathymique
Amnesia (circumscribed-)	circonstancielle
Amnesia (continuous-)	amnésie continue
Amnesia (cortical-)	amnésie corticale
Amnesia (elective-)	amnésie élective
Amnesia (episodic-)	amnésie épisodique
Amnesia (epochal-)	amnésie époquale
Amnesia (form-)	amnésie des formes
Amnesia (global -)	amnésie globale
Amnesia (hypnotic-)	amnésie hypnotique
Amnesia (hysterical-)	amnésie hystérique
Amnesia (identity -)	amnésie d'identité
Amnesia (immediate-)	immédiate
Amnesia (immunity-)	amnésie immunitaire
Amnesia (infantile-)	amnésie infantile
Amnesia (integration-)	d'intégration
Amnesia (lacunar-)	amnésie lacunaire
Amnesia (late-)	amnésie retardée
Amnesia (localized-)	amnésie localisée
Amnesia (logophonic-)	logophonique
Amnesia (memorable-)	mémorisation
Amnesia (memorisation-)	mémorisation
Amnesia (number-)	amnésie des chiffres
Amnesia (obstetric-)	amnésie obstétrique
Amnesia (olfactory-)	amnésie olfactive
Amnesia (organic-)	amnésie organique
Amnesia (partial-)	amnésie partielle
Amnesia (periodic-)	amnésie périodique
Amnesia (post emotional-)	post- émotionnelle
Amnesia (post hypnotic-)	post- hypnotique
Amnesia (post- traumatic-)	post traumatique
Amnesia (precise-)	amnésie précise
Amnesia (progressive-)	progressive
Amnesia (psychic-)	amnésie psychique
Amnesia	amnésie

(psychogenic-)	psychogène
Amnesia (reading-)	amnésie de la lecture
Amnesia (recent events-)	amnésie des événements récents
Amnesia (recent-)	amnésie récente
Amnesia (rememoration-)	amnésie de remémoration
Amnesia (retroactive -)	amnésie rétroactive
Amnesia (retroagressive-)	amnésie rétroagressive
Amnesia (retroantérograde-)	amnésie rétro- antérograde
Amnesia (retrograde-)	amnésie d'évocation
Amnesia (selective-)	amnésie sélective
Amnesia (tactile-)	amnésie tactile
Amnesia (time-)	amnésie du temps
Amnesia (total-)	amnésie totale
Amnesia (transitory-)	amnésie transitoire
Amnesia (tropical-)	amnésie tropicale
Amnesia (unconscious-)	amnésie inconsciente
Amnesia (verbal-)	amnésie verbale
Amnesia (verbalis-)	amnésie verbale
Amnesia (visual-)	amnésie visuelle
Amnesia (visualis-verbalis-)	amnésie verbale visuelle
Amnesia (words-)	amnésie des mots
Amnesia aphasia	amnésie-aphasie

Amnesia axial	amnésie axiale
Amnesia state	état d'amnésie
Amnesic	amnésique
Amnesic alcoholic	alcoolique amnésique
Amnesic amimia	amimie amnésique
Amnesic aphasia	aphasie amnésique
Amnesic apraxia	apraxie amnésique
Amnesic cerebral eclipse	éclipse cérébrale amnésique
Amnesic confabulation	confabulation amnésique
Amnesic confabulatory syndrome	syndrome confabulatoire amnésique
Amnesic disorder	trouble amnésique
Amnesic ictus	ictus amnésique
Amnesic lacuna	amnésique lacune
Amnesic organic syndrome	syndrome amnésique organique
Amnesic repression	refoulement amnésique
Amnesic syndrome	syndrome amnésique
Amnestic	amnésique
Amnestic (korsakoff's-)	amnésie de korsakoff
Amnestic aphasia	aphasie amnésique
Amnestic apraxia	apraxie amnésique
Amnestic syndrome	syndrome amnésique

المعجم الإلكتروني المبرمج للعلوم النفسية

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A

Anti-
Anxiété -
Apathie -
Aphasie

Anti-	anti-, ant-	:
Antiadrénergique	antiadrenergic	
Antialcoolique	anti-alcohol	
Antialcoolisme	teetotalism	
Antianalytique	antianalytic	
Antiandrogène	antiandrogenous	
Antiandrogénique	antiandrogenic	
Antianxiété	anxiety	
Antiasthénique	antiasthénic	
Antiataraxique	anti-ataraxic	
Antiautistique	anti-autistic	
Anticathexie	anticathexis	
Anticathexis	anticathexis	
Anticéphalalgique	antiheadache	
Anticholinergique	anticholinergic	
Anticipatif	anticipatory	
Anticipation	anticipation	
Anticipation (effet d'-)	anticipation effect	
Anticipation	anticipation	
(méthode d'-)	method	
Anticipation	anticipation	
(phénomène d'-)	phenomenon	
Anticipation	behavioural	
comportementale	anticipation	
Anticipation de	anxiety	
l'anxiété	anticipation	
Anticipation de la	penetration	
pénétration	anticipation	
Anticipation du désir	desire anticipation	
Anticipation érotique	erotic anticipation	
Anticipation	negative	
négative	anticipation	
Anticipatoire	anticipatory	
Anticipé	early, in advance	

Anticiper	to anticipate
Anticonformisme	anticonformism
Anticonformiste	nonconformist
Anticonformité	anticonformity
Anticonvulsant	anticonvulsant
Anticonvulsif	anticonvulsive
Anticonvulsivant	anticonvulsivant
Anticorps	antibody
Antidéficitaire	anti-deficit
Antidélirant	anti-delirious
Antidémental	antidemmental
Antidépresseur	antidepressant
Antidépresseur	heterocyclic
hétérocyclique	anti- depressant
Antidépresseur	psychotonic
psychotonique	anti- depressant
Antidépresseur	sedative
sédatif	anti- depressant
Antidépresseur	stimulant depressant
stimulant	
Antidépresseur	tranquilizing
tranquillisant	anti- depressant
Antidépresseur	tricyclic
tricyclique	anti- depressant
Antidépresseur	antidepressive
Anti-désir	anti-desire
Antidéterminisme	antideterminism
Antidiscrimination	antidiscrimination
Antidote	antidote
Antidromique	antidromic
Antidromique	antidromic
(conduction-)	conduction
Antidynamique	antodynamic
Antémétique	antemetetic
Anti-enzyme	anti-enzyme
Anti-épileptique	antiepileptic
Anti-excitation	antiexcitement
Antifantasme	antifantasm
Antiféminisme	antifeminism

Antifetishisme	antifetishism
Antifibrillatoire	antifibrillatory
Antifusionnel	antifusional
Antihistamine	antihistamine
Antihistaminique	antihistaminic
Antihumain	antihuman
Antihystérique	antihysteric
Anti-intellectualisme	anti-intellectualism
Anti-intracception	anti-intracception
Antiléthargique	antilethargic
Antilogie	antilogy
Antilogique	antilogic
Antimachinisme	antimachinism
Antimaniaque	antimaniac
Antimethodologie	anti-methodology
Antimigraineux	anti-head-ache
Antinarcissisme	anti-narcissism
Antinarcotique	antinarcotic
Antinévralgique	antineuralgic
Antinévrite	antineuritic
Antinévropathique	antineuropathic
Antinévrotique	antineurotic
Antinomie	antinomy, paradox
Antinomique	antinomic
Anti-obsessionnel	anti-obsessional
Antipanique	anti-panic
Antiparkinsonien	anti-parkinsonian
Antipathétique	antipathetic
Antipathie	antipathy
Antipathie cognitive	cognitive antipathy
Antipathique	antipathetic
Antipathogène	antipathogen
Antiphonie	antiphony
Antiphrase	antiphrasis
Antipode	antipodal
Antiproductive	anti-productive
Antipsychiatrie	antipsychiatry
Antipsychiatrique	antipsychiatric
Antipsychose	antipsychosis
Antipsychotique	antipsychotic
Antirationalisme	antirationalism
Antirationnel	antirational
Antireligieux	antireligious
Antisémitisme	anti-semitism
Antisérotonine	antiserotonin
Antisociable	antisociable
Antisociale	antisocial
Antisocial (acte-)	antisocial act

Antisociale	antisocial
(adolescence-)	adolescence
Antisocial (adulte-)	antisocial adult
Antisociale	antisocial
(constitution-)	constitution
Antisociale	antisocial
(personnalité-)	personality
Antispasmodique	antispasmodic
Antispastique	antispastic
Antispiritualisme	antispiritualism
Antispiritualiste	antispiritual
Antistress	anti-stress
Antisymphilitique	antisymphilitic
Antithèse	antithesis
Antithétique	antithetical
Antitrémorique	antitremoric
Antivitamine	antivitamine
Anxiété	anxiety
Anxiété (échelle d'-)	anxiety scale
Anxiété (état d'-)	anxiety state
Anxiété	anxiety inventory
(inventaire de l'-)	
Anxiété « sans lendemain »	anxiety « without next day »
Anxiété à minima	low-level anxiety
Anxiété actuelle	actual anxiety
Anxiété aiguë	acute anxiety
Anxiété anticipatoire	anticipatory anxiety
Anxiété automatique	automatic anxiety
Anxiété basique	basic anxiety
Anxiété brève récurrente	recurrent brief anxiety
Anxiété catastrophique	catastrophic anxiety
Anxiété chronique	chronic anxiety
Anxiété consciente	conscious anxiety
Anxiété continue	continuous anxiety
Anxiété créative	creative anxiety
Anxiété d'abandon	abandon anxiety
Anxiété d'anérotisme	anerotism anxiety
Anxiété d'annihilation	annihilation anxiety
Anxiété d'échec	failure anxiety
Anxiété d'évaluation	evaluation anxiety

Anxiété de base	basic anxiety	Anxiété	hetero sexual
Anxiété de castration	castration anxiety	hétéro sexuelle	anxiety
Anxiété de démasculinisation	demasculinization anxiety	Anxiété	heterosocial
Anxiété de dépendance	dependency anxiety	hétérosociale	anxiety
Anxiété de déplaire	displeasure anxiety	Anxiété	homosexual
Anxiété de destruction	destruction anxiety	homosexuelle	anxiety
Anxiété de féminisation	feminization anxiety	Anxiété hystérique	hysterical anxiety ()
Anxiété de féminité	femininity anxiety	Anxiété inconsciente	unconscious anxiety
Anxiété de fond	fundamental anxiety	Anxiété instinctuelle	instinctual anxiety
Anxiété de la mort	death anxiety	Anxiété inter critique	inter critical anxiety
Anxiété de l'enfant	infant anxiety	Anxiété justifiée	justified anxiety
Anxiété de l'examen	examination anxiety	Anxiété libre	free anxiety
Anxiété de performance	performance anxiety	Anxiété majeure	major anxiety
Anxiété de persécution	persecution anxiety	Anxiété manifeste	manifest anxiety
Anxiété de pré- libération	pre-release anxiety	Anxiété matinale	morning anxiety
Anxiété de questionnaire	questionnaire anxiety	Anxiété mineure	minor anxiety
Anxiété de séparation	separation anxiety	Anxiété morale	moral anxiety
Anxiété de suppression	suppression anxiety	Anxiété morbide	morbid anxiety
Anxiété de surface	surface anxiety	Anxiété neutralisée	neutralized anxiety
Anxiété dépressive	depressive anxiety	Anxiété névrotique	neurotic anxiety
Anxiété des parents	parent anxiety	Anxiété objective	objective anxiety
Anxiété diffuse	diffuse anxiety	Anxiété obsessionnelle	obsessional anxiety
Anxiété dissociative	dissociative anxiety	Anxiété orale	oral anxiety
Anxiété du 8 ème mois	the eighth-month anxiety	Anxiété organique	organic anxiety
Anxiété du ça	id anxiety	Anxiété originale	original anxiety
Anxiété du choix	partner choice anxiety	Anxiété paranoïde	paranoid anxiety
Anxiété du partenaire	anxiety	Anxiété paroxystique	paroxysmal anxiety
Anxiété du moi	ego anxiety	Anxiété patente	patent anxiety
Anxiété du super-moi	super-ego-anxiety	Anxiété pathologique	pathologic anxiety
Anxiété érotisée	erotized anxiety	Anxiété permanente	permanent anxiety
Anxiété état	state anxiety	Anxiété phobique	phobic anxiety
Anxiété existentielle	existential anxiety	Anxiété précisée	precise anxiety
Anxiété expérimentale	experimental anxiety	Anxiété primaire	primary anxiety
Anxiété fixe	fixed anxiety	Anxiété prototype	prototype anxiety
Anxiété flottante	floating anxiety	Anxiété psychogène	psychogenic anxiety
Anxiété généralisée	generalized anxiety ()	Anxiété psychosomatique	psychosomatic anxiety
		Anxiété réelle	realistic anxiety, real anxiety
		Anxiété rétrospective	retrospective anxiety
		Anxiété secondaire	secondary anxiety
		Anxiété sexuelle	sexual anxiety
		Anxiété signal	signal anxiety
		Anxiété simple	simple anxiety
		Anxiété sociale	social anxiety
		Anxiété somatique	somatic anxiety
		Anxiété spontanée	spontaneous anxiety

قواعد النشر بمجلة شبكة العلوم النفسية العربية

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

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

- 1- الأبحاث الميدانية والتجريبية
 - 2- الأبحاث والدراسات العلمية النظرية
 - 3- عرض أو مراجعة الكتب الجديدة
 - 4- التقارير العلمية عن المؤتمرات المعنية بدراسات الطفولة
 - 5- المقالات العامة المتخصصة
- المجلة مفتوحة أمام كل الباحثين العرب من أطباء، فسيانيين و أساتذة علم النفس داخل الوطن العربي وخارجه 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 والصوتية
- إرسال البحث بالبريد الإلكتروني APNjournal@arabpsynet.com أو بواسطة قرص مرص (لا تقبل الأبحاث الورقية).
- إرسال السيرة العلمية المختصة بالنسبة للكاتب اللذين لم يسبق لهم النشر في مجلة الشبكة.

■ قواعد خاصة

- 1- كتابة عنوان البحث واسم الباحث ولقبه العلمي والجهة التي يعمل لديها مع الملخصات والكلمات 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 يتضمنه من مقدمة والإطار النظري والدراسات السابقة ومشكلة البحث وأهدافه وفرضه وتعريف مصطلحاته.
- 4- يراعى الباحث توضيح أسلوب اختيار العينة، وأدوات الدراسة وخصائصها السيكومترية وخطوات إجراء الدراسة.
- 5- يقوم الباحث بعرض النتائج بوضوح مستعينا بالجدول الإحصائية أو الرسومات البيانية متى كانت هناك حاجة لذلك.
- 6- خضوع الأعمال الطبفسية المعروضة للنشر لفحص اللجنة الاستشارية الطبفسية للمجلة، كما خضوع الأعمال العلمفسية لفحص اللجنة الاستشارية العلمفسية 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- الأراء الواردة في المجلة تعبن عن رأي كاتبها ووجهات نظرهم.
- 9- لا تعاد الأبحاث المرفوضة لأصحابها.
- 10- لا تدفع مكافآت مالية عن البحوث التي تنشر.

قواعد التوثيق:

عند الإشارة إلى المراجع في نص البحث يذكر 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 يذكر الاسم الأخير للباحث الأول وآخرين مثل (دسوقي وآخرون، 1999) أو (Sartorius et al., 1981) وإذا كان عدد الباحثين ستة فأكثر يذكر الاسم الأخير للباحث الأول وآخرين مثل (الدعاش، وآخرون، 1999) أو (Skinner, et al., 1965)، وعند الاقتباس يوضع النص المقتبس بين قوسين صغيرين " " وذلك أرقام الصفحات المقتبس منها مثل: (أبو حطب، 1990: 43)

وجود قائمة المراجع في نهاية البحث يذكر فيها جميع المراجع التي أشير إليها في متن البحث وترتب ترتيباً أبجدياً. دون ترتيب مسلسل. حسب الاسم الأخير للمؤلف أو الباحث وتأتي المراجع العربية أولاً ثم المراجع الأجنبية بعدها وتلك البيانات 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 والربوية والاجتماعية، القاهرة: الأجلو المصرية

-عندما يكون المرجع غثاً في مجلة:

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

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-ج- عندما يكون المرجع غثاً 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 قمتة 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 بمنهج فكري واضح يتضمن المقدمة وأهداف الدراسة ومناقشة القضية ورؤية الكاتب فيها، هذا بالإضافة إلى التزامه بالآصول العلمية في الكتابة وتوثيق المراجع وكتابة الهوامش التي وردت في قواعد التوثيق

■ عرض الكتب الجديدة ومراجعتها:

تنشر المجلة مراجعات الباحثين للكتب الجديدة وتقدمها 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 وإيجابياته وسلبياته
- 3- عنون العرض على اسم المؤلف وعنوان الكتاب والبلد التي نشر فيها واسم الناشر، وسنة النشر، وعدد صفحات الكتاب.

كتابة تقرير المراجعة بأسلوب جيد

■ التقارير العلمية عن الندوات والمؤتمرات المعنية بقضايا الطفولة:

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



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