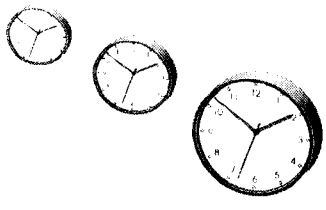
remember, moreover, another bout of depression is the reason for once again seeking help. He feels his depression have resulted from his "going nowhere". A bright, likable man, he has been fired from various jobs and has been divorced once. He has displayed a pattern of "sounding off" to authority and losing his temper which has cost him many desirable jobs. His episodes of temper outbursts and impatience have formed the basis for his divorce.

He also has suffered from frequent episodes of anxiety without panic attacks, and has dealt with those episodes, unsuccessfully, by drinking and taking drugs (another criticism of his former wife). Much of his past history of treatment has been directed at helping him understand why he feels and acts these ways. Although he believes that he has learned much about himself through the treatment courses, his behavior and his problem remain unchanged.

His problems have been with him since childhood. As a primary school student he was unruly, fought frequently, and was often the subject of disciplinary actions. He hardly finished secondary school and although tested to have an I.Q. "somewhere above 110", he couldn't settle down suffi- ciently to complete even one year of college. He had two arrests as a minor for "breaking and entering" but has had no difficulties since. Except for his episodic substance abuse, he has not used alcohol or drugs to any extent. There is no family history of mental disorders although, according to his mother, he is "just like his father", who died in an industrial accident when the patient was 12.

The patient is currently asking for help. His mental status examination is unremarkable. He is cooperative, and goal oriented. He is intelligent, his memory is good and he shows no signs of organicity. There is no evidence of psychotic thinking. At the end of your evaluation, he asks you if you have anything to offer him. COMMENT.

A Day in a Caregiver's Life



Have you ever spent a whole day with a mental patient ? do you have any idea how much stress s/he might fell all the day long? Well, if not.... try to imagine that you were a caregiver of a demented, manic, depressed, obsessive, anxious, schizophrenic, delusional, autistic, subnormal subject,...etc. Decide for yourself, write to us if it does work!

Case Report:

E.M.H. is an 8 y.o. female, Moslem, Egyptian student child at second primary year, referred from O.P. department due to her aggression towards her family members. Informants were her grad mother and mother who are reliable. They added she says that "people hate me" and she is a trouble-maker. The patient admitted in her complaint that "she sees images and hears voices". Her mother (29 y.o.) works as a teacher and described by the patient to be kind and caring. Her father (49 y.o) works as a salesman in a gulf country, described by the patient as kind, dispite he never asked to see the patient since her birth as parents were divorced few months after their marriage because of family troubles then. The grand mother had taken the patient to see her father for the first time one year ago when she realized that he has a second wife and half-sibs and he doesn't afford for the patient's living at all. Ms.E. is living with her mother and maternal grand parents in a warm, loving atmosphere with barely adequate income, yet they used to get her all her demands whatever it costs.

There is a positive family history of mental illnesses as the maternal uncle is a known schizophrenic under treatment, the maternal aunt has a non-specified mental disorder, and the mother had repeated depressive attacks (once before marriage, another during pregnancy for which she received treatment and that was repeated for several times). Noteworthy, Ms.E. encountered hallucinatory behaviour showed by the uncle. Patient's prenatal, natal, and postnatal periods went uneventful except for the antidepressants received by the mother during pregnancy. Ms.E. was born normally as a full-term baby and was breast fed for one and half years and her milestones of development were within normal. Ms.E. joined a private school at the age of six with good academic performance and quarrelsome relationship with her peers. She changed her school due to her illness to be placed in another one where the mother is working as teacher. Patient was described before her illness to have hard temperament, demanding excessively, yet hard to please, with temper tantrums. However she is shy with strangers. The current condition started one and half years ago, shortly after joining the school where her school mates started to narrate her stories about an evil-man kidnapping kids and cutting them into pieces. So, she became tense, frightened, crying, refused to sleep alone, used to open the house's door suddenly to see if there is someone hiding behind it, also she had a sense of presence of evil-man under her bed and that a thief would jump to her room. That was associated with poor appetite, screaming , crying all the time, and nail biting. She stopped going to school because of a sense of rejection by her class mates and teachers, and that they don't like her, intending to tease her, and that no one loves her even her mother. The worried family sought advice from traditional healers then from a psychiatrist with non-specified treatment.

Shortly afterwards, she started to claim that she sees shadows of her grand-parents and mother whom she sees her ugly with big humpy nose. These shadows are present all around her

room, colored, and she can bring them by thinking about them, and she can see them with her eyes closed, she could talk to them and these shadows used to amuse her or they are affectively neutral to her. The family asked medical advice and haloperidol was prescribed to her with seizable improvement except for crying for trivial things and the over demanding attitude. She could pass her first year final assessment. When the family started to reduce the dose of haloperidol two months ago, the symptoms recurred, she became aggressive verbally and physically towards her family members especially the mother, pulling her hair. She claimed that she wants her parents to get together again and is afraid that her mother would marry another man out of proposals heard about from the grand-mother and the mother. Physical examination revealed no relevant abnormal findings except for being above 19th percentile (pt.wt.=40kgm, ht=125). Present state mental assessment showed a well-dressed, calm, cooperative child having proper eye to eye contact, accepting to be interviewed with the grandmother or alone. Her affect was reactive, with intact thinking and speech, yet she is preoccupied by the absence of her father and the parents remarriage. She has visual and auditory pseudohallucinations, quit fair judgment for her age and insightful concerning having psychological problems.

Psychometric evaluation showed an above average IQ (125), and mild current depressive state.

1. I.Q.:VIQ=126,PIQ=118,TIQ=125(intelligen)
2. J. EPQ: P= 1(2±2), N=13 (11±4), E=19(16±3), Li=8(14±3)
3. Beck-children (Dep. Scale): 77 (mild)
4. Anx. Scale for children: 24 (11±7) (mild)
5. Check list: a- Conduct problems: 5 (7±3)
   b- Emotional disorder: 22 (10±3)

Conclusion: Intelligent child, with neurotic traits, mild anxiety and depression (loss of interest in schooling, poor appetite, fatigability, and sense of loneliness).

FORMULATION:

Clinical Formulation:

A female child of 8 y.o. with positive F.H. of mental illnesses, hard to please temperament, and temper tantrums. Overprotective family justifies their spoiling attitude towards the patient in her health and illness. Patient shows pseudohallucinations, depressive and conduct features.

Psychodynamic Formulation:

Sandro Rado in his description of the adaptational psychodynamics wrote that the psychic apparatus proposed is formed of four levels for effective adaptation and integration, three are healthy (hedonic, emotional, and unemotional thoughts) which counteract the fourth level of emotional thoughts releasing fantasies, illusions, hallucinations, delusions, dreams, and delusional thinking. The stresses faced by the young child Ms.E. could abort the normal daily thinking controlling the emotions inside her to delay actions and tolerate pains of deprivation of complete love and pride of being a member of a cohesive family. The rational uncomotional thoughts (= reality principle) was conquered by the emotionally loaded thoughts, hindering the adaptation and causing her symptoms formation.

According to life – cycle stages of Erik Erikson, our child could not successfully resolve the first conflict at 5-6 years of age (initiative vs. guilt) with a desire to mimic adult world, at which she lived in an atmosphere where a psychotic uncle is expressing hallucinations,, aunt and mother are showing despaire, in addition to the rivalry she felt towards the half sibs and the school mates towards whom she projected her aggressive assertive behaviour. At the age of 7-8 years, she could not again solve the problem of "Industry vs. inferiority", where she felt the danger of inadequacy, and weakness in her skills and tools in life.

Edith Jacobson (developmental metapsychology and object relation) has suggested that frustration with the mother will lead to devaluation of her role and development of aggression in frustrating situations to expel our child's desire to separate from the noxious part of her mother.

D.W. Winnicott (good-enough mothering) saw the case of our patient as an environmental disorder due to multiple deficiencies from outside. While, W. Fairbairn (real self) interprets unintegrated self of Ms.E. and her aggression as a sign of lost unity or split of internal ego-object relation with bad experiences. M. Klein has the view of a mixed persecutary ideas and depressive reactions in the face of Ms.E. intrapsychic feelings. Micheal Balint considered the adoption of adult language in Ms.E. verbal expressions with regression in front of problems, causing anxiety and aggression in an attempt to change the interactions in her object world for more care and tranquility.

The love object hypothesis of John Bowlby might consider the whole story of Ms.E. as a disorder of mother – child attachment due to interpersonal deficits. The depressed mother and child might enhance the infantile narcissistic dependency on the part of Ms.E. on her love object (mother) requiring a constant supply of attention, love, and moral support from the idealized love objects and highly valued others around her. For resocialization and healthy interpersonal relation, this hypothesis of J. Bowlby would prefer an interpersonal psychotherapeutic handling of the child.

After a vigorous, stimulating discussion during which the opinions were swinging between exaggeration of an adaptational reaction (code V problem), to factitious disorder either in the depressed mother (proxy) or in the patient, to atypical anxiety disorder, or other conduct disorder in the family context. Bearing in mind the rush into a diagnosis of psychotic disorder made by the family physician who prescribed conventional antipsychotic with improvement. This possibility appreciated the inherited predisposition referred to before.

At last, the team of the unit of child psychiatry of Ain Shams psychiatric center reviewed all the available clues to suggest the diagnosis of (Atypical Depressive Disorder with features of conduct disorder) and furtherly put Ms.E. under an SSRI gradually scheduled over the days, augmented by individual supportive psychotherapy and in interpersonal psycho-therapeutic sessions of the patient, mother, and the other caregivers.
They are looking to your comments on EJP website.

Pen Club

Around "Clinical Trials"

- **Objective:** The panelists' goal is to consider ethical approaches to clinical trials, especially those of placebo-controlled, in the light of the evolution "Declaration of Helsinki", with special attention to application to Egyptian psychiatric researches.
- **Panelists:**
  - Saied A. Azeem(Cairo Univ.)
  - Y.A. Mohsen (Cairo Univ.)
  - A.H. Khalil (Ain Shams Univ.)
  - A. Sheshaie (Alexandria Univ.)
  - A. El Medani (Al Azhar Univ.)
- **Discussant:**
  - M.R. El Fiky
- **Panel Menu:**
  - Background
  - Discussions and comments
  - Recommendations
  - Conclusions

• All professionals who are interested in the topic are invited to participate by writing to EJP please, submit your opinions via the EJP web site for the next issue.

Drug Focus

• **Pregabalin in GAD:**
Current drug therapies for GAD have limitations. Pregabalin, a novel anxolytic was studies in a double-blind, placebo-controlled trial on GAD patients (DSM-IV), randomly assigned to receive pregabalin (150-600mg/d), lorazepam (6mg/d), or placebo. Total HAM-A scores decrease significantly greater than in those given placebo within ± 4 wks, with no serious adverse events nor withdrawal symptoms (Pande, etal., 2003, Am.J.Psychiat., 160, pp.533-40).

• **Different neural substrate of treatment response of SSRI for OCD & Maj. Depression:**
PET use to identify cerebral glucose metabolic markers of SRI treatment response in patients with both disorders treated with 30-60 mg/d. of paroxetine for 8-12 wks could correlate higher levels in rt. Caudate nuc. in OCD patients, and lower levels in amygdala and thalamus with higher levels in medial prefrontal cortex and rostral ant. cingulate gyrus in depressives, indicating different neurobiological substrates for response in the two disorders (Sexena, etal., 2003, Am.J.Psychist., 160,pp.522-32).

• **Topiramate in treatment of Binge Eating Disorder associated with obesity:**
61 out patients (53 women, 8 men) with binge eating and obesity (BMI $\geq 30 kg/m^2$) were randomly put on topiramate (an antiepil. with wt. loss potentiality) (N=30) or placebo (N=31) for 14 wks; double-blind, flexible dose (25-600 mg/d) trial. It showed greater reduction in binges frequency (94%, placebo 46%), BMI, wt (5.9 kg), CGL and YB-OCD scales (McElroy etal., 2003, Am.J.Psychait., 160, 255-61).

• **Reboxetine to attenuate olanzapine induced weight gain in schizophrenics:**
Increased NE availability may account for weight reducing effect of appetite suppressants. Reboxetine as a selective NERI was given to 13 olanzapine-treated schizophrenics for 6 wks trial (4 mg/d), compared to same number on placebo. Significantly lower increase in body wt (2.8 ± 2.7 kg) than placebo (5.5 ± 3.1 kg), matched with well tolerability. (Poyurovasky, etal., 2003, Am.J.Psychiat., 160, pp.297-302).

• **Combination (Memantine + donepezil) in Alzeimer's disease:**
According to new study findings, 403 randomized patients treated with both drugs for 8 weeks (donepezil a cholinesterase inhibitor and member a NMDA receptor antagonist) showed an improved cognitive ability relative to baseline scores than those treated with only donepezil ($p< 0.001$), less decline in daily function and improved global assessments by an independent rater in patients with moderate – to – severe AD with an average MMSE score of 10 at enrollment. The combination was safe and well tolerated. (By M.R. Farlow, Am. Acad. Of Neurol. In Honolulu, April 2, 2003, Reuters Health story).

• **Buprenorphine approval expands options for addiction treatment (NIDA NOTES, vol. 17, No. 4, Nov. 2002).**
After two decades of NIDA-sponsoured research and clinical trials, FDA approved buprenorphine (subutrex) and combination burprenorphine / naloxone (suboxone) as a treatment for opiate dependence and addiction, to be the first medication approved under the Drug Abuse Treatment Act of 2000 (DATA). It is pharmacologically related to morphine, as a partial opioid agonist, working on mu-opiate brain receptors. It reduces or eliminates opiates withdrawal symptoms, but is not strong enough to produce euphoria and sedation caused by

opioids. Increasing its dose does not enhance drug effects, and is unlikely to be abused. Combined with naloxone further reduces potential that medication could be abused. Injecting combined formulation triggers withdrawal symptoms. Both are provided in tablet form as taken-home medication.

New In The Egyptian Market

Recognizing that the pharmaceutical industries in Egypt are moving forward rapidly and many new introductions are coming into the market so frequently, EJP has the pleasure to provide you with the "New In The Psythotropics Market".

- Alprax (Alprazolam 1mg) as an anxiolytic from sigma (20 tabs/11.00LE).
- Chitoca[1] (Chitosan, ascorbic[a]., gymnem, and sylrestre) for weight control and obesity management from Arab geltin debeiky (60 caps / 90.00LE)
- Ginkofit (Ginkgo bilob[a], ginseng, roy[a]l jelly) as a memory enhancer from pharaoniaph. (10 caps / 15.00LE).
- Premenstrual (herbal + Vit B6, Mg, K, Fe) for relief of premenstrual SX from sun Naturals (20 caps/15.00 LE)
- Prozac (Fluxetine 20 mg dispersible Tab) as antidepressant from EL :Lilly (7 td / 30.00LE).
- Recofol (propofol 10 mg /ml.) for induction & maintenance of gen. anesthesia (IV vial / 16.00LE) by Leiras.
- Remeron (Mirtazapine 30 mg) as antidepressant from Organon (10 td / 47.00LE).
- Serlift (Sertraline HCL 100mg) as antidepressant from Global napi rexcel (10td / 40.00LE).
- Zelmac (regaserod 6mg) as a relief from IBS from Novartis (30ts / 156.00LE).

N.B. Disclosure statement: the preparation of " Drug Focus" has not been financially supported by ANY commercial organization.

Invited Symposia & Conference Reports

* " Challenging the Limits in Depression and Anxiety Disorders" is the topic of a symposium that took place in Annual Congress of Psychiatry 19, March, 2003-Cairo (Egypt) where Prof. Said A. Azeim (Cairo Univ.) has put a wider perspective of "Post-Traumatic-Stress-Disorder (PTSD)" that became more common as it is related not only to wars but to many traumatic experiences like accidents at work, or motor vehicles, fires, floods and other natural disasters, sexual or non-sexual assaults, and is reported in 35-50% of those exposed to such traumatic experiences. Prof. A. Azeim discussed and compared various pharmacologic and psychtherapeutic treatments that have therapeutic effect in PTSD, and recommended further controlled studies to evaluate their real benefits particularly the combinations of techniques.

Prof. Adel Sheshai (Alexandria Univ.) has argued the distinction of anxiety from depression on the basis of differences in symptoms, signs, illness course, and treatment response as (two problems and one solution). Prof. Sheshai discussed a concise and reliable up-date on mixed anxiety depression disorder emphasizing the treatment that is available and can be employed in primary care settings. Prof. M.R. El Fiky (Ain Shams Univ.), has introduced (New Frontiers in Management of Social Anxiety Disorder "SAD") and illustrated its demographics, typology, components, differential diagnosis as well as comorbidities, gender-related and age-related differences, and various effective therapeutic options available and offered a competent and comprehensive clinical approach based on the understanding of SAD with the potential to improve its outcome.

Conference reports

• In the 1st Sharm El Sheikh International Epilepsy Conference 5-8, March, 2003 (Egypt), B. Zamani (Iran Univ. of Med. Sc.) argued the term "Al-Sarā" in Moslem countries, reviewed its origin and archeology, and compared them with modern concepts of epilepsy and adviced modern neurololgists in our countries not to call their patients by a stigma that has a bad meaning and consequences. Another Persian ass. Prof. M. Moghaddasi gave a compact review on Avicenna (Abu Ali Al-Husain Ibn Sina (980-1037 AD) who has born in Uzbakistan, his tomb is in Hamedan (West of Iran), and had many works in medical sciences, theology, metaphysics, astronomy, philosophy, and physics. He wrote several books of which, the Canon of Medicine (AL-Quanoon) that was regarded as the principle text up to 1650 at Montpellier, France. He described epilepsy in the third volume of this book, provoked and unprovoked seizures, febrile convulsion, a primary classification of epilepsy, predisposing factors, nutrition and epilepsy, as well as rules of treatment. B. Schmitz (Germany) referred to depression in epileptics as an under-recognized and often not adequately treated common comorbid disorder, classified depressive disorders in relation to seizure activity (ictal, postictal, alternative and interictal depression), its psychopathology, and treatment procedures. She also pointed to association of TLE, and depression (left TL and secondary frontal L. dysfunction) and that GABA-ergic antiepileptics may contribute to development of depression and should therefore be used with caution in vulnerable patients. She considered avoiding antidepressants in epileptics as a type of irrational worries, realized that epileptics cannot accept a diagnosis of depression being more stigmatizing than epilepsy. The newer generation of antidepressants as SSRIs are recommended because of their little proconvulsive properties

and kinetic and dynamic interactions with AEDs, compared to TCAs. In their sample of 187 inpatients with TLE, K. Kühn & B. Quednow (Bonn Univ., Germany), 68 were diagnosed with major depression at admission (36.4%) but ONLY 2 (1%) were treated with AD prior to admission and their results strongly encourage use of AD in depressed TL epileptics with excellent efficacy and compliance. S. Miskou, M. Bedekovic & V- Demarin (Zagreb Univ., Croatia) found cerebrovascular disease as the commonest cause of the new-onset seizures in elderly and preferred phenytoin and Na valproate as first choice agents for generalized tonic-clonic seizures, carbamazepine for partial seizures, and the newer AEDs as gabapentin, and lamotrigin because of their efficacy and favorable side effect profiles. N. Kitchner (Mataryia teaching Hosp., Egypt) presented 18 patients with a prolonged state of behavioral disturbances proved to be a special type of non-convulsive status epilepticus, that last for a week or more in which monotherapy with AEDs was effective in 83% of them and reffered to the term of "Status Psychosus Epilepticus" rather than a brief psychotic disorder to name these cases.

Columns

Book Reviews

Science and Practice of Cognitive Behavior Therapy

D. M. Clark and C.G. Fairburn

Department of Psychiatry University of Oxford (2001)

Introduction :

The term cognitive behavior therapy was first used in the scientific literature in the mid- 1970s and the first controlled trials of the treatment were published towards the end of that decade. In the relatively short period of time since then, cognitive behavior therapy has become a leading psychotherapy in most Western Countries.

I. General Considerations :-

1) The evolution of cognitive behavior therapy (CBT)

The evolution of (CBT) took place in three stages. Initially, behavior therapy emerged in independent but parallel developments in the United Kingdom and United States, in the period 1950-70. The second stage, the growth of cognitive therapy , took place in the United States in the mid 1960s onwards. The third stage, the merging of behavior and cognitive therapy into cognitive behavior therapy, gathered momentum in the late 1980s and is now well advised in Europe and North America. CBT is widely accepted and is practised by growing numbers of clinicians; in all likelihood, it is today the most broadly and confidently endorsed form of psychological therapy. CBT dominates clinical research and practice in many parts of the world.

2) The scientific foundations of CBT

To obtain an adequate understanding of the techniques of CBT we have to satisfy two minimum prerequisites. First, we should have a reasonable grounding in essential scientific method. Second, we should have acquired a knowledge of modern learning theory (especially Hull and Skinner). Studies of normal subjects were followed by a number of well-conducted clinical trials, mainly with phobic and obsessional disorders, which produced a batter understanding of the value and limitations of the procedures. Increasing experience convinced many clinicians that the main limitation was the failure to take account of patients' attitudes and beliefs and a search began for ways of incorporating these important elements in treatment. In recent years CBT has been linked much more effectively with cognitive and behavior science and this linkage has led to substantial advances in treatment. The experimental studies can be divided into three groups, designed to:

* Characterize key cognitions in psychiatric disorders.
* Test predictions about the role of these cognitions.
* Study factors that maintain cognitions.

3) Information -processing biases in emotional disorders

Because some degree of selection among varieties of available information is inevitable, decisions have to be taken as to what is to be processed, and what is discarded. Bias is used here to describe any systematic preference in the priorities used in making such decisions, particularly those influencing the selection or rejection of information having emotional meaning. Individuals prone to negative emotional states such as anxiety or depression should be more likely to select information congruent with negative mood. Selection of this sort can occur at many points in the processing of emotional information, and for purposes of convenience, the relevant findings will be grouped in three points :

A) Perceptual encoding

The simplest way of investigating perceptual encoding is to present emotional stimuli, such as words or pictures, and assess the ease with which different subject groups can identify them. Depressed patients recognize a higher proportion of negative to neutral words than did controls, when these were presented very rapidly (7-100 milliseconds). It was found that the more accurate identification of negative words in depressed students applied only to words given extreme ratings by that individual on a self-description task. Equivalent effects emerged when the students were divided according to their score on a measure of trait (but not state) anxiety, suggesting that some enduring characteristic is involved. Although response bias may thus account for some effects, it does not seem sufficient to account for all of them, since significant effects in a mood-congruent direction were found when two stimuli were presented simultaneously in a lexical decision task.

B) Interpretation of meaning.

A different sort of selection is made when encountering ambiguous events: many alternative meanings may be