Egypt. J. Psychiat. (1986), 9: 5-7

RESTORING " ALTERNATIVE ACTIVATION - TRANQUILIZATION RHYTHM " IN PSYCHIATRIC THERAPY

By Y. RAKHAWY

Psychiatric management, at large, tends more and more to tranquilize rather than activate mentally disturbed patients. This could be directly correlated with the over use of recently flooding tranquilisers along with the overwhelming rationalizing hypotheses in a trial to justify such trends on the basis of part molecular information. However, the various efforts towards rehabilitation, socialization and the like are still recommended every now and again. Such efforts are mainly directed towards chronic institutionalized patients aiming simply at achieving conformity at any level of adaptation.

Daring to go back again to ask ourselves whether a mentally ill patient is more active (to be tranquilized) or more static (to be stimulated) than he should be; is the starting point to revise the present situation. Functionally, most of our patients are almost inactivated by the ultimate nonproductive, noncreative blockage. Biologically, it is not finally settled that a psychiatric patient has "more" or "less" of such active transmitter or neurohormone. Structurally, psychiatric illness presents a dysharmonious shift of activity between various levels of "neuro-behaviour-object relational" organization levels.

More recently, limited trials are once again directed towards activation rather than tranquilization of certain patients by certain techniques. To mention some, we cite down running therapy, anxiety provoking psychotherapy, encounter group therapy ... etc. We have, here, to di fferentiate between activity and activation. While the former refers to non specific generalized behavioural stimulation, the latter should refer to

selective stimulating language' including special wave length information, specific object relation and well balanced space and time order to let a particular level of brain (human) organization be set to its optimum function. This trend -specific level activation- tends to handle human beings as multiple, coexisting available organizations. Reorienting ourselves about the hierarchical organization of human brain and corresponding existence (s) is the basic requirement to proceed in this integrative direction. Our aim should be directed to restore alternative "activation-tranquilization rhythm" of each hierarchical organization in itself as well as in relation to other levels of organization. this necessitates properly adjusting the dose, time, and extent of tranquilization required for certain levels while simultaneously activating another and so forth. This is definitely against the long acting ever lasting policy of the so called modern chemotherapy for psychiatric patients. The week-end technique, the zigzag schedule and the interrupted nature of BST (Brain Synchronizing Therapy = ECT) could be going emperically in the proper direction of restoring alternating activation.

Symptomatic behavioural phenomena are not sufficient to direct the therapist which level (organization) to tranquilize and which to activate. The diagnostic label is not infrequently misleading. The retarded depressed patient for instance is structurally, as well as biologically much more active than the apparent retardation suggests. In every patient there is a certain level to activate and another to tranquilize at a time, to be altered and properly adjusted afterwards in order to integrate, ultimately, most levels, once again, in their appropriate alternating harmonious rhythm. This approach is to inspire its basic essence from the analogy of REM/NREM/Wakefulness rythm. Selective chemical therapy inhibiting certain level than another, wa well as specific information input and particular medium

permissiveness could help the psychiatrist achieve restoring the proper activation-tranquilization alternation between various organizational levels of biological human existence. This would include periods of regression alternating with periods of realistic obligation as well as reinforcing particular model(s) of object relation. If more attention is paid to the function of sleep, dream cycles as they help in consolidation as well as integration, the therapist would benefit more from their proper adjustment, deprivation and utilizing the expected rebound in every case. The more such activation - tranquilization rhythm is properly adjusted - the less the relapse is possible and the more endless integrative growth is promoted.

Yehia Rakhawy

References

Rakhawy, Y.T. (1982) Electroconvulsive therapy: A synchronizing remedy. Egypt. J. Psychiat. 5: 17-21.

Egypt J. Psychiat. (1986), 9: 8-17

TARDIVE DYSKINESIA IN PSYCHOSIS
A STUDY OF ITS PREVALENCE, PSYCHODEMOGRAPHIC, & CLINICAL ASPECTS AMONG NEUROLEPTIC-TREATED EGYPTIAN PATIENTS

A. Okasha, A.H. Khalil, A. Ashour, **and** *M.R. Elfiky*

Abstract

A survey study of T.D. among 3037 Egyptian psychotic inpatients under long-term neuroleptic treatment was carried out. 52 dyskinetic cases were detected, and the prevalence rate was estimated to be 1.7%. Significant associations between T.D. and age at examination (above 40 years), female sex above 50 years, and duration of hospitalization were detected. The relative contributions of other variables in the development of T.D. were far from clear in the present work. T.D. movements were mostly central affecting commonly the lips and jaw, frequently in the form of chewing, smacking, pouting, puckering and grimacing movements. The degree of severity was mild in 61.5% of cases according to the 'AIMS'.

Introduction

More than a quarter century has passed since the initial description of T.D. (Schonecker, 1957; Sigwald et al., 1959). In spite of the growing literature on T.D., controversies abound regarding its pathogenesis, pathology, course, management, and prognosis. The earliest epidemiologic study of this disorder was carried out by Uhrbrand and Faurbye (1960). The reported prevalence rates for T.D. showed considerable variations with one study reporting 2.9% (Hunter et al., 1964) and another gaining 56% (Jus et al., 1976). The noted widely discrepant prevalence rates are probably due to the methodologic differences, the variables related to the population differences, and the characteristics of dyskinesia (Jeste & Wyatt, 1982). It was claimed that Egyptian psychiatrists rarely see T.D. in their clinical practice, an impression

which favoured the negligence of the study of this syndrome in Egypt. The only study published about drug-induced extrapyramidal side effects in Egypt was carried out by Okasha et al. (1979), who noted its incidence with phenothiazines to be 36.4% for acute disorders (21.8% for parkinsonism, 18.8% for acute dystonia, and 5.5% for akathesia, denoting co-existence of types of abnormal involuntary movements in the same patient). Efforts were directed in this study to assess the prevalence rate of T.D. among the Egyptian patients on a maintenance regime of neuroleptics, to investigate the relationship of T.D. with psychodemographic, clinical, and drug history variables.

Clinical Study

A point-prevalence epidemiologic survey was conducted at two State Mental hospitals (one in the East of Cairo, and the other 30 Km north of Cairo), and one private sanatorium 15 Km south of Cairo. Non-Egyptian patients who were on no medication or neuroleptics of less than 100mg CPZ equivalents, or for less than 3 months, were excluded. 3037 inpatients were selected for the present study as they met its pre-requisits. Control groups of non-dyskinetic subjects were selected by stratified random sampling procedures. The essential data for the studied population were obtained with reference to the patients' files and information rom key individuals. A clinical judgement ran hand-in-hand with the application of the Abnormal Involuntary Movement Scale (AIMS) of Guy (1976). Each patient was rated twice, on separate occasions, by at least a pair of raters, following the precautions of the rating technique. Statistical analysis of the results was based on computerized analysis of data. The present study carries the limitations of the retrospective, one time-surveys.

Results

Out of 3037 neuroleptic-treated inpatients studied, 52 subjects were suffering from T.D., the prevalence rate of neuroleptic-related T.D. in the studied population was found to be 1.7% (Table 1).

Table (I) Incidence of T.D. in Egyptian population under study

	No	%
With T.D.	52	1.7
Without T.D.	2985	98.3
TOTAL	**3037**	**100.0**

When the dyskinetic patients and their control groups were compared, the age at examination (above 40 years), female sex above 50 years at examination, and longer duration of hospitalization (that roughly indicated duration of exposure to neuroleptics) were found to be positively correlated with T.D. Patients with T.D. showed no statistically significant differences in terms of other variables. Description of the dyskinetic subjects in the study sample is presented in Table II.

Table (II) Details of Dyskinetic Patients of the study sample (N=52)

VARIABLE	MALE	FEMALE
Sex	33 (63.5%)	19 (36.5%)
Age at exam: range	24-64 yrs.	38-93 yrs.
mean ± S.D.	41.9±8.2 y	56.9±9.4 y
Age at first hospitalization : range	8-63 y	8-62 y
mean ± S.D.	33.9±23.9 y	28.3±19.9 y
Duration of hospitalization: range	1-36 y	2.6-47 y
mean ± S.D.	15.8±9.7 y	13.1±11.7 y
Primary psychiatric diagnosis schizophrenias	23(44.2%)	11(21.2%)
others	10(19.2%)	8 (15.4%)
Drug dosage (CPZ ep.) mean ± S.D.	503.9±129.4	439.1±207.2
ECT: mean ± S.D.	20.5±14.3	24.3±11.9
Parkinsonian symptoms	1 (1.9%)	2 (3.8%)

VARIABLE		MALE	FEMALE
T.D. movements			
location:	central	23(44.3%)	9 (17.3%)
	peripheral	1 (1.9%)	1 (1.9%)
	mixed	9 (17/3%)	9 (17.3%)
severity:	mild	19 (36.5%	13 (25%)
	moderate	11(21.2%)	5 (9.6%)
	severe	3 (5.8%)	1 (1.9%)

Discussion

Egypt represents a developing country with a population that seems to have its characteristic physiological and psychosocial variables. While T.D. constitutes a major problem in psychiatric practice in the Western world, as the reported studies showed prevalence rates that varied from 2.9% in the study of Hunter et al. (1964), 5.6% by Tuyrnen & Achte (1967), 6.6% by Lehmann et al. (1970), 7% by Demars (1966), and Paulson (1968), and 9.3% by Odejide (1980), to 10-13% by Degkwitz & Wenzel (1967), Smith et al. (1979), Frangos et al. (1983), and many others, and reached 44% in the study of McCreadie et al. (1982), and 46% by Gardos et al. (1977-b). In Egypt they are found to be 1.7%.

Several features in the Egyptian population and the current Egyptian psychiatric therapy may be relevant to explain this low rate.

a) Patient-related variables:

(1) A genetic factor affecting drug metabolism in the Egyptian constitution may render them less vulnerable for the development of T.D. The role of constitutional predisposition in T.D. was considered by Gunne & Baranys (1976), Klawans et al. (1980), Casey & Gerlach (1982), and others. The assumed constitutional factor may explain why some but not all patients receiving neuroleptic treatment develop T.D. Chronic neuroleptic treatment seems to precipitate T.D. only in those already predisposed to develop such movement disorder as suggested by Marsden (1985), and others.

The role of this constitutional factor must be evaluated in the light of other predisposing factors to avoid its over-estimation. It is still not known to us whether this factor consists of a genetic vulnerability, a specific defect in the basal ganglia, or some other factors that are lacking among the Egyptian population.

(2) Diet and drinking habits (e.g. rarity of alcohol consumption by the Egyptians) may have played a role in this respect.

b) Treatment-related variables:

(1) The liberal use of ECT in the current psychiatric practice in Egypt as a substitute for very high doses of neuroleptics. However, the role of ECT is still controversial. While ECT was significantly correlated with increased T.D. in some studies (Faurbye et al., 1964, Gardos et al., 1977-a, Gerlach, 1982; and others), it was reported as a treatment tool in occasional dyskinetic patients (Price & Levin, 1978).

(2) The drug treatment style in Egyptian psychiatric practice may exert a minor influence. The low doses of neuroleptics, and the use of low potency drugs were common features noticed in the present study. Minor role is suggested here as there was no evidence yet that a particular type or dose of neuroleptics is responsible for T.D. (Jus et al., 1976; Simpson et al., 1978; Frank & Djavadi, 1980; and others). It may be relevant to point out that the use of depot neuroleptics was less popular in Egyptian psychiatric practice until recently.

c) Study design-related variables:

(1) Precised diagnostic criteria in the present work had excluded the over-inclusive data that are likely to inflate the figures of prevalence. Smith & Kane (1982) assumed that if all the varieties of neurological disorders that may result in involuntary movements (e.g. senile chorea and Huntington's chorea) were excluded, a prevalence rate of not greater than 5% of T.D. would be found.

(2) The type of the present study (i.e. retrospective work) may miss reversible or withdrawal dyskinesis and the development of T.D. through the one-time survey which may result in an under estimation of the prevalence of T.D.

(3) Exclusion of doubtful cases may result in a low prevalence rate in the present work and its inclusion could result in an unrealistically high prevalence rates in other works.

(4) The masking effect of neuroleptics on T.D. may contribute to the reported estimation of the prevalence rate in this study.

It was difficult in the current study to implicate other drug-related and patient-related factors as producing greater risk especially on considering the previously mentioned factors.

References

Casey, D., Gerlach, J. (1982): Clinical management of T.D., T.D. and related involuntary movement disorders. 8, 85-108.
De Veaugh-Geiss (ed.).

Degkwitz, R., Wenzel, W. (1967): Persistent extrapyramidal side effects after long term application of neuroleptics. Neuropsychopharmacology, Excerpta Medica Foundation.

Demars, J. (1966): Neuromuscular effect of long term phenothiazine medication, ECT, and leucotomy. J. Nerv.Ment. Dis., 143, 73-9.

Faurbye, A., Rasch, P., Petersen, P. (1964): Neurological symtoms in pharmacotherapy of psychoses. Acta Psych. Scand., 40, 10-27.

Frangos, E., Athanasenas, G., Fsourides, S., (1983): T.D. in Greece: A prevalence study. Proceedings of VII World Congress of Psychiatry, Vienna.

Frank, S., Djavadi, N. (1980): T.D. in autistic children. Proceedings of the annual meeting of the Am. Acad. of child psych., Chicago.

Gardos, G., Cole, I., and Brie, R. (1970-a): Drug variables in the etiology of T.D. Application of discriminant function analysis, Prog. Neuro. Psych. Pharm., 1-2, 147-54.

Gardos, G., (1977-b): Assessment of T.D. Arch Gen. Psych., 34, 1206-12.

Gerlach, J. (1982): Epidemiology and pathophysiology of T.D. Actua Sandoz, essays on T.D. 1,2,3648, A.R., Cools (ed.).

Gunne, L., Baranys, M. (1976): Haloperidol-induced T.D. in monkeys. Psychopharm., 50, 237-40.

Guy, W. (1976): (AIMS) ECDEU Assessment Manual for Psychopharm. Rockville: DHEW. U.S. Governments Printing Office, 534-7.

Hunter, R., Earl, C., and Thornicroff, S. (1964): Apparently irreversible syndrome of abnormal movements following phenothiazine medication. Proceedings of the Royal Society, 57, 758-62.

Jeste, D. and Wyatt, R. (1982): Understanding and Treating T.D., Guilford Press, N.Y.

Jus, A., Pineau, R., Lachance, R. (1976): Epidemiology of T.D.: Part II. Dis. Nerv. Syst., 37, 257-61.

Klawans, H., Gorvey, P., Nausieda, P. (1980): Effect of dose and type of neuroleptics in an animal model of T.D. Neurology, 30, 384.

Lehmann, H., Ban, T. and Saxena, B. (1970): A survey of extrapyramidal manifestations in the inpatient population of psychiatric hospital, Laval Medica, 41, 909-16.

Marsden, C. (1985): Is T.D. a unique disorder? Dyskinesia Research and Treatment. Psychopharmacology Supplementum 2, 64. Casey, Chase, Christensen Gerlach, (ed.) by Springer Verlag Berlin Heidelberg.

Mc Creadie,R.,Barron,E. and Winslow,G.(1982):The Nithsdole schizophrenia survey. Abnormal movements Br. J. Psych., 14, 58790.

Odejide, A. (1980): Prevalence of persistent abnormal involuntary movements among patients in a Nigerian long stay psychiatric unit. Int. Pharmacol. Psych., 15, 292-300.

Okasha, A., El-Okbi, H., Sadek, A. (1979): Drug-induced extra-pyramidal side effects in Egyptian schizophrenic patients. Egypt. J. Psych., 2, 191-7.

Paulson, G. (1968): Permanent or complex dyskinesias in the aged. Geriatrics, 23, 105-10.

Price, T., Levin, R. (1978): Effects of ECT on T.D. Am. J. Psych., 135, 991-3.

Schonecker, V. (1957): Ein eigentumliches syndrom in oralen Bereich bei Megaphen Applikation, Nervenarzt, 28, 35.

Sigwald, J., Bouttier, D., Ravmondeand, C., (1959): Quatre cas de dyskinesie facio-buccolingui masticatrice a evolution prolongee secondaire a un traitment par les neuroleptique, Ravue Neurologique 100, 751-5.

Smith, J., and Kane, J. (1982): Epidemiology of T.D. (Part II). T.D. and related invol. mov. disorders., 4, 41-9 De Veaugh-Geiss (ed.).

Smith, J.,Kucharski, L., Eblen, C., (1979): An assessment of T.D. in schizophrenic outpatients. Psychopharm., 64, 99-104.

Turunen, S., and Achte, K. (1967): Buccolingual masticatory syndrome as a side effect of neuroleptic therapy. Psych. Quarterly, 41, 268-79.

Uhbrand, L. and Faurbye, A. (1960): Reversible and irreversible dyskinesia after treatment with perphenazine, chlorpromazine, reserpine, and ECT therapy. Psychopharm., 1, 408-18.

Authors

AHMED OKASHA, F.R.C.P., F.R.C.Psych., D.P.M.
Professor and Chairman, Dept. of Psychiatry.
AFAF HAMED KHALIL, M.D., D.P.M.
A. ASHOUR, M D., M.R.C.Psych., D.P.M.
M.R. ELFIKY, M.D. Psychiatry
DEPARTMENT OF PSYCHIATRY
AIN SHAMS UNIVERSITY, CAIRO,EGYPT.

الحركات اللاارادية المتأخرة ـ دراسة وبائية واكلينيكية فى المرضى الذهانيين المعالجين بالعقاقير المهدئة العظمى

« مـــوجـــز »

تم عمل مسح شمل ٣٠٣٨ مريضا ذهانيا مصريا يعالجون بالأقسام الداخلية للمستشفيات ويتناولون العقاقير المهدئة العظمى وجد بينهم ٥٢ مريضا تظهر عليهم الحركات اللاارادية المتأخرة.

وتعتبر نسبة الإصابة ١,٧ . وقد وجدت ارتباطات ذات دلالة بين حدوث الحركات اللاارادية المتأخرة والعمر عند الفحص (أكثر من ٤٠ سنة)، النوع (الاناث فوق ٥٠ سنة) ومدة البقاء بالمستشفى.

ولم يمكن توضيح الدور النسبى لباقى المتغيرات.

ومن الناحية الاكلينيكية وجد ان الحركات اللاارادية كان معظمها من النوع المركزى تظهر غالباً على الشفاه والفك فى صورة حركات مضغ وزم ومط للشفاه وحركات تعبيرية بالوجه.

كانت درجة شدة الحركات خفيفة فى ٦١ر٥٪ من الحالات بالرجوع إلى مقياس «ايمز».

ABSTRAIT

La dyskinésie tardive dans la psychose (une étude de sa prévalence, les aspects psychodémographiques et cliniques chez les patients égyptiens traités avec les neuroleptiques).

L'étude comporte 3037 patients psychotiques égyptiens hospitalisés sous traitement prolongé de neuroleptiques. La dyskinésie tardive a été présente dans 52 cas. Une prévalence de 1.7% a ete estimée. Quelques associations significatives ont été détectées entre la dyskinesie tardive et l'age au temps de l'examen (plus que 40 ans), les femmes plus ageés que 50 ans ainsi que la durée de l'hospitalization. Les autres variables qui contribuent relativement au dévelopment de la dyskinésie tardive ne sont pas clairs dans l'étude presénte. Les mouvement sont surtout centrals touchant les lèvres et la mâchoire fréquement sous forme de mastiquer, claquer, bourder, rider ou faire des grimaces. Selon le (AIMS) 61.5% des cas ont un degré léger de sévérité.

Egypt. J. Psychiat. (1986), 9: 18-30

THE P.S.E. & SOCIAL SKILLS OF CHRONIC SCHIZOPHRENICS : DESCRIPTION & CORRELATIONS

BY

A. Ashour, A. Okasha, M. Hussein,

M. Sobhi & A.H. Khalil

Abstract

DSM III referenced chronic schizophrenics were examined by the Present State Examination, ARGYLE's Relationship Rules and Behavior Analysis of Susan Spence.

The P.S.E. profile is similar to the (S) Schizophrenic Profile of the I.P.S.S. and US/UK with some features from (P) Paranoid Psychoses and other psychoses (O) profiles.

The Nuclear schizophrenic group showed higher figures of deficit in brother - sister relationship, questions asked, eye contact and total P.S.E. Scores than the non-nuclear schizophrenics. Multiple correlations could be demonstrated between the social skills components and psychiatric symptoms. Factor analysis on a larger sample is recommended.

Introduction

Social skills are defined in different ways by different researchers out of emphasis on one aspect or another, rather than out of any discrepancy in meanings. Liberman et al. (1979), listed 3 dimensions of social skills:

1. Discrete non-verbal behaviors,
2. Content of speech in conversation, and
3. Reciprocity in communication.

The non-verbal elements of social behavior include the face, gestures, gaze, spatial behavior, bodily contact, non-verbal aspects of speech and appearance.