وزارة الصحة

كلية الصحة العامة
School of Public Health
القدس – فلسطين

جامعة القدس

Diagnostic Outcomes of Psychotic Patients Attending Governmental Mental Health Services

Submitted by

Adel Abdel Ghani Oda

Gaza Palestine

Supervisor

Dr. Abdel Aziz Mousa Thabet

Assistant Professor of Psychiatry

School of Public Health

A thesis Submitted in Partial Fulfillment of Requirements for the degree of Master of Community Mental Health

At the School of Public Health - Gaza

Al-Quds University – Palestine

December 2007

Dedication

To my parents who of them I became what I am today, to my children who endure my busy life every day, to my wife , to my collogues and hospital staff members who helped me day by day.

To the Palestinian people who I hope that their suffering will end some day,

To any one who believes in improving quality of life and services any where,

To my brothers and my sisters,
To all of you, I dedicate this work.

Adel Oda

Declaration

I Certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed----------

Adel Oda

Date ----------

Acknowledgment

I would like to express my deepest gratitude to my academic supervisor **Dr.Abed El Aziz Thabet**, .

I am extremely grateful to **Dr.Reiad Al Aqurae** the general director of psychiatric hospital , who helped me to complete my thesis effectively, and judges my instrument, special thanks for his support and endless kindness. **Dr.Mohammad Abo El Sebah ,Dr. Ayesh Samor,**

Dr. Fadel Ashour and Dr. Ahmad EL Alsharquwy .

Special thanks to **Dr. Suzan Shasha`a** who was very friendly and cooperative in her academic guidance and support.

Again special thanks go to my **Wife**, **Sisters** and **Brothers** for their encouragement.

Abstract

Objective

This study is to investigate diagnostic outcomes of psychotic patients attending governmental mental health services in Gaza Strip

The convenient sample consist of 283 psychotic patients from attending the governmental health services 159 males and 124 females. The researcher used for this purpose structured psychiatric interview by using the fourth edition of diagnostic and statistical manual of mental disorders DSM IV criteria and using GAF **(**Axis V is the global assessment of functioning) (GAF) scale**.**

Results

The study shows that a total of 283 patients were classified in this study as having psychoses, receiving DSM V diagnoses of female (N =124), schizophrenia (N=46) brief psychotic disorder (N = 10), schizophreniform disorder(N=4), schizoaffective (N=11), delusional disorder (N=4), psychotic disorder not otherwise (N=6), bipolar I disorder manic episode (N=27), bipolar I disorder major depressive episode (N=9), bipolar I mixed episode (N=3) and bipolar I hypomanic episode (N=4) , but table shows that males a total of 283 patients were (N =159), schizophrenia (N=86) Brief psychotic disorder (N = 4), schizophreniform disorder(N=0), schizoaffective (N=7), delusional disorder (N=12), psychotic disorder not otherwise (N=0), bipolar I disorder manic episode (N=15), bipolar I disorder major depressive episode (N=13), bipolar I mixed episode (N=4) and bipolar I hypomanic episode (N=18).

There are little differences between the two interviews of diagnosis. Most shifted of the diagnosis was from the other to schizophrenia . Most cases more than 30 years of the age. Most of the interviewees were unemployed and had never married (N=155}

The researcher found good response to treatment that clarify from the values of the global assessment of function (GAF) before and after the treatment .

Outcomes in psychosis and GAF was better especially in Bipolar disorders and brief psychotic disorder .

Conclusions

There are good response to treatment and there are need to depended criteria for diagnosis .DSM IV is good for this purpose.

Recommendations

There are need to developing protocols of diagnostic operation and criteria for diagnosis DSM IV is good for this purpose.

Most of the interviewees were unemployed and had never married. There was widespread impairment in social relationships and in the performance of activities of daily living so that there are need to rehabilitation centers .

The critical importance to implement early intervention strategies for recurrent .psychotic disorders

ملخّص

الهدف:

تهدف الدراسة لمعرفة النتائج التشخيصية والعلاجية للمرضى الذهانين المراجعين للخدمات النفسية الحكومية.

اشتملت العينة المتوفرة على 283 مريض ذهاني بواقع 159 من الذكور , و124 من الإناث.استخدم الباحث المنهج الوصفي لإظهار نتائج الدراسة.واستخدم الباحث لهذا الغرض المقابلة المنظمة التي تم إعدادها حسب التصنيف الأمريكي الرابع للأمراض النفسية, وتم تحكيمها من خمسة أطباء نفسين.واستخدم المحور الخامس من التصنيف الأمريكي الرابع لتقيم القدرات الوظيفية عند المرضى .وكررت المقابلة مرتين للمتابعة.

النتائج:

أظهرت الدراسةَ بأنّ ما مجموعه 283 مريض في هذه الدراسةِ من الذين يعانون من أمراض ذهانية حسب التصنيف الأمريكي الرابع للأمراض النفسية من 124 انثى46 يعانين من داء الفصام, و10 من الاضطراب الذهاني الوجيز ، و4 من داء شبه الفصام ، و11 من الفصام الوجداني ، و4 من الاعتقادات الخاطئة ، و 6 من الاضطرابات الذهانية غير المحددة ، و27 من الاضطراب الذهاني ذو القطبين 1 النوبة الهوسية ، و9 من الاضطراب الذهاني ذو القطبين 1 النوبة الاكتئابية ، و3 من الاضطراب الذهاني ذو القطبين 1 النوبة المختلطة و 4 من الاضطراب الذهاني ذو القطبين 1 النوبة تحت الهوسية ، لكن الذكور من 159 مريض كَانوا 86 داء فصام ,4 من الاضطراب الذهاني الوجيز ، و 7 من الفصام الوجداني ، و12 من الاعتقادات الخاطئة ، و 15 من الاضطراب الذهاني ذو القطبين 1 النوبة الهوسية ، 13 من الاضطراب الذهاني ذو القطبين 1 النوبة الاكتئابية ، و 4 من الاضطراب الذهاني ذو القطبين 1 النوبة المختلطة و 18 من الاضطراب الذهاني ذو القطبين 1 النوبة تحت الهوسية.

وهناك فروقات بسيطة في التشخيص بين المقابلتين وكان الفارق لصلح الفصام العقلي.

واستنتج الباحث أن هناك استجابة جيدة للعلاج وهو واضح من قيم ال (G AF) قبل و بعد المعالجة وكانت النتائج الأفضل في اضطرابات المزاج.ومعظم الحالات فوق الثلاثين من العمر وغير متزوجين.

الاستنتاجات

هناك استجابة جيدة للمعالجةِ وهناك حاجة إلى المعاييرِ المُعتَمَدةِ للتشخيصِ حسب التصنيف الأمريكي الرابع للأمراض النفسية. وكما أن التحسن كان ملحوظا بنسبة أكبر في الاضطرابات المزاجية .

التوصيات

1. هناك حاجة إلى اعتماد المعاييرِ التشخيصيةِ للتشخيصِ حسب التصنيف الأمريكي الرابع للأمراض النفسية و هو جيد لهذا الغرضِ.

2. أغلب المرضى كَانوا عاطلون عن العمل و غير متزوجين. كان هناك ضعفُ واسع الانتشار في العِلاقاتِ الاجتماعية وفي أداءِ نشاطاتِ المعيشة اليوميةِ لذلك هناك حاجة إلى مراكزِ التأهيل.

3. الأهمية الحرجة لتَطبيق إستراتيجياتِ التدخّلِ المبكّرةِ للاِضطراباتِ الذهانيةِ المتكرّرةِ.

List of Abbreviations

DSM-IV	**Fourth edition of diagnostic and statistical manual of mental disorders.**
ICD	**International Classification of Diseases**
SCAN	**schedules for clinical assessment in neuropsychiatry**
SANS	**Schedule for Negative Symptoms**
CMH	**Community Mental Health**
NGO`S	**Non Governmental Organizations**.
SAPS	**Schedule for Positive Symptoms**
GCMHP	**Gaza Community Mental Health Programme**
MOH	**Ministry Of Health**
NIMH	**National Institute of Mental Health**
PCBS	**Palestinian Central Bureau of Statistics**
GHS	**governmental health services .**
NOS	**not otherwise specified**
SCID	**Structured Clinical Interview Diagnostic .**
PCBS	**Palestinian Central Bureau of Statistics .**
UNRWA	**United Nations Relief and Word Agency**
WHO	**World Health Organization**
GAF	**Global Assessment of Functions**
GCMHP	**Gaza Community Mental Health Program**

List of tables

Table of contents

Chapter (1) Introduction

Chapter(2) Literature Review

Chapter (3) Conceptual Framework

Chapter (4) Methodology

Chapter (5) The Result

Chapter (6)

Conclusion *and recommendation*

List of judges

N	Name
1	Dr.Reiad Al Aqraa
2	Dr.Mohammad Abo El Sebah
3	Dr. Ayesh Samor
4	Dr. Fadel Ashour
5	Dr. Ahmad EL Alsharquwy

List of definitions

Psychosis

Loss of reality testing and impairment of mental functioning—manifested by delusions, hallucinations, confusion, and impaired memory—two additional meanings have evolved over the past 100 years. One common use of the term psychosis denotes severe impairment of social and personal functioning characterized by social withdrawal and an inability to perform usual household and occupational roles.

Schizophrenia

Schizophrenia is the most common psychotic disorder, affecting 1% of the world population, and having a strong familial tendency (Criteria annex 2,3). Characterized by delusion, hallucination, thought disorder, and loss of reality testing.

Schizoaffective disorder

It is presently conceived as an illness with coexisting, but independent, schizophrenic (psychotic) and mood components. Schizoaffective disorder is seen primarily as part of a schizophrenia spectrum rather than an equal hybrid of mood and schizophrenia disorders.

Schizophreniform disorder

Is a diagnosis that assumes another will replace it after 6 months. Most cases of schizophreniform disorder progress to either schizophrenia or schizoaffective disorder, with some cases rediagnosed as a non–schizophrenia spectrum illness**.**

Brief psychotic disorder

Describes an impairment in reality testing that lasts at least 1 day, but less than 1 month. Characterized by delusion, hallucination, thought disorder, and loss of reality testing.

Delusional Disorder and Shared Psychotic Disorder

Delusional disorder refers to a group of disorders, the chief feature of which is the presence of a nonbizarre delusion. It is the delusion and the relative absence of other psychopathology that unifies these disorders in terms of natural history and impact on functioning.

Mood disorders

It's a number of terms, these include manic-depression, manic-depressive psychosis, bipolar disorders and mood swings .

Bipolar I

In which the user experiences amanic episode and a depressive episode of duration great than one week .

Bipolar II

During which the client experiences hypo-mania and depressive episode .

Cyclothymic disorder

Which represents multiple hypo-manic and depressive episodes of less severity and duration .

وزارة الصحة

جامعة القدس

كلية الصحة العامة

School of Public Health

فلسطين-القدس

Deanship of Graduate Studies

Al-Quds University

Diagnostic Outcomes of Psychotic Patients Attending Governmental Mental Health Services

Submitted by

Adel Abdel Ghani Oda

M.Sc Thesis

Jerusalem – Palestine

2007

Chapter 1

Introduction

As reflected in the preamble of the Constitution of the World Health Organization (WHO), mental well-being is, along with physical and social well-being, one of the three key facets of health as defined by the WHO. According to the WHO World Health Report for 1995 presented to the WHO member states at the last World Health Assembly, "The world's biggest killer and the greatest cause of ill-health and suffering across the globe is extreme poverty." Indeed, poverty, unemployment, and social disintegration have both direct and indirect impact on the social, mental, and physical well-being of individuals, communities, and countries. In general, mental, social, and behavioral health problems represent overlapping clusters of problems that, connected to the recent wave of global changes in the world, interact and intensify each other's effects on behavior and well-being. Today, there are an estimated 400 million cases of anxiety disorders, 340 million cases of mood disorders, 250 million cases of personality disorders, 60 million cases of mental retardation, 45 million cases of schizophrenia, 22 million cases of dementia, more than 40 million cases of epilepsy, 8 million cases of brain trauma, as well as more than 100 million cases of nicotine dependence, 100 million cases of alcohol dependence, and 15 million problem users of other drugs. The number of psychiatric beds per population unit is perhaps the most frequently quoted indicator of mental health services (Silva 2000).

Psychiatric Beds

The wide use of this ratio reflects a mental health care policy that favors the use of beds in psychiatric hospitals for the treatment of people with mental disorders, a policy that has prevailed in the last two centuries, at least in industrialized countries. It is also a consequence of both the absence of other, better indicators and its usefulness for managerial and accounting purposes. The changes in mental health policies that occurred in the last half of the twentieth century can be seen in the location of psychiatric beds. From an absolute location in large (usually state) mental hospitals (seen everywhere at the beginning of this century and in some countries until now), they started to move into general hospitals (Silva 2000).

In psychiatric hospital and community mental health centers which represent the governmental health services in Gaza Strip there are difference's between the diagnosis from the first admission and at follow up of the psychotic patients.

The development of mental health services in Gaza strip has been shaped by different political, socio-demographic, and cultural factors.

Mental health services don't exist in Gaza strip until 1978, when an out patient clinic was opened in the main general hospital.

Patient were treated by general practitioner who had only 6 months training, and psychotic patients were referred to Bethlehem mental hospital, which was the only available facility for hospitalization. Mental health services have witnessed remarkable development in Gaza strip from 1978 till now.

Now mental health services provided through many sectors as governmental (primary – secondary), non governmental, military medical services and private.

Psychiatric hospital is considered the only one in Gaza strip that provide mental health services (in patient & out patient) since 1978.

It was a part of ophthalmology hospital, total rehabilitation made from 1994 by the return of the Palestinian authority

It is classified as small hospital of El- Nasser medical group; this hospital provided treatment for more than 20.000 cases since it had been established.

The hospital has 39 beds, and it provided treatment for more than 20.000 cases, since it had been established.

The admitted cases in the hospital is about 500 cases per year, from all Gaza strip (1.400.000 pop.), including 100 new cases, male : female ratio is 2:1, the average length of stay for each case is about 3 weeks, the percentage of occupancy of the hospital beds as about 70%

(Alaqra, 2004).

There are three disorders in addition to schizophrenia listed in the fourth edition of diagnostic and statistical manual of mental disorders (DSM-IV) in the section "Schizophrenia and Other Psychotic Disorders." The first, schizoaffective disorder is a complex illness that has changed significantly over time. In its simplest definition, it is presently conceived as an illness with coexisting, but independent, schizophrenic (psychotic) and mood components. Schizoaffective disorder is seen primarily as part of a schizophrenia spectrum rather than an equal hybrid of mood and schizophrenia disorders. schizophreniform disorder is a diagnosis that assumes another will replace it after 6 months. Most cases of schizophreniform disorder progress to either schizophrenia or schizoaffective disorder, with some cases re-diagnosed as a non–schizophrenia spectrum illness (i.e., schizotypal or schizoid personality disorders), while a few resolve completely (Lauriello et al 2000).

Cultural psychiatry draws on many basic and applied disciplines to build its essential constructs. Anthropology (both cultural and medical anthropology) supplies cultural psychiatry with essential insights into the behavior of people in their natural habitats, native views on health and illness, descriptions of indigenous healing systems, and the role of the healer and rituals of healing in different ethnic and cultural groups. Sociology elucidates the

relation of basic psychological processes and psychiatric disorders to such human universals as age, gender, and social and occupational status (Trujilo, 2000).

Outcome studies that provide the strongest and most scientifically credible findings are often the most difficult to apply to general psychiatric practice where patients present with complex diagnostic problems and treatment needs. However, outcomes research conducted in more naturalistic settings generally yields more readily applicable but uncertain findings. Clinicians face the critical challenge of integrating findings from the full spectrum of psychiatric outcomes research into the ongoing delivery of clinical care(Olsfen, 2000).

Because that the validity of diagnosis is very important in our hospital and community mental health centers which represent the governmental health services in Gaza Strip (GMH) .We haven't any protocol for diagnosis and the diagnosis done clinically without any criteria , that due to miss diagnosis in some cases .In this study the researcher will discusses the diagnostic outcome of psychotic patients attending the governmental services in Gaza Strip and follow up outcome of the treatment especially from the social side.

Social and cultural anthropology include studies of local worlds—through collection and analysis of ethnographic data—and their cross-cultural comparison (Becker, & Kleinman, 2000) .

1.1 Objectives

General objective

To investigate diagnostic outcomes of psychotic patients attending governmental mental health services in Gaza Strip.

Specific objectives

1- To study diagnostic and therapeutic outcomes of psychotic patients attending governmental health services in Gaza Strip.

2- To investigate diagnostic difference and its relation to other demographic variables.

3- To study the social and occupational impairment among the psychotic patients attending governmental health services in Gaza Strip.

4- To study the impact the therapeutic interventions on functions among of the social and occupational impairment among psychotic patients attending governmental health services in Gaza Strip.

1.2 Justification of the study

Their are diference's between the diagnosis from the first admission and at follow up of the psychotic patients.

Because psychosis is an often severe, disabling, and incapacitating disease, diagnosis must be very accurate to prevent the long abuse of antipsychotic drugs and stigma. This study the first study in Gaza Strip include this subject. This subject is very important and there are need to establish guideines for the psychotic patients as the other countries.

1.3 Geographical Distribution

Palestinian National Authority territories comprise of two areas separated geographically: West Bank and Gaza Strip.

The population in Palestine was estimated at 3.7 million at the end of 2003, out of them 2.3 millions (63.3%) in West Bank and 1.4 millions (36.7%) in Gaza Strip (PCBS, 2004).

According to the distribution of the population by Governorate, AL Khaleil Governorate has the highest rate of population at 13.9% of the total population, followed by Gaza Governorate 13.0%; AL Quads Governorate comes third with 10.8%; Jericho Governorate has the lowest rate of population at the end of 2003 at 1.1% (PCBS, 2005).

1.4 Hospitals in Palestine

In Palestine, there are 78 hospitals. The population to hospital ratio is 47,922. The average bed capacity per hospital is 59.99 beds. In Gaza Strip (GS), there are 24 hospitals making (30.77%). The population to hospital ratio is 57.098. The average bed capacity per hospital is 79.88 beds. In West Bank including Jerusalem, there are 54 hospitals making (69.23%). The ratio of population per hospital is 43,844. The average bed capacity per hospital is 51.15 beds. MOH owns and operates 23 hospitals with 2,614 beds (55.9%) for the total beds. There are 11 hospitals with 1,152 beds (44.1%) of total MOH beds in West Bank and the rest in Gaza Strip. The rest of Palestinian hospitals are NGO`S hospitals, private sector hospitals, police and general security hospitals (PCBS, 2005).

1.5 Mental Health Services

The current political system imposes further demand on psychological care to improve mental, emotional and social health. Mental health services are provided for the Palestinian population through 15 community mental health clinics (5 in Gaza Strip and 10 clinics in West Bank) and two hospitals in Palestine (Beath-Lahem and Gaza Psychiatric Hospitals). Community mental health clinics in Gaza Strip are Sorani, Nosirate, Rashad Mosmar, Zwaida, and KhanYonis. These clinics concerned with activities of prevention, curative and rehabilitation measures, and aiming towards increasing public awareness about mental illness, changing the pervasive

sustain social stigma of mental illness, offering drug supply to unable clients and enhancing the approach of family involving in the treatment models.

Gaza psychiatric hospital (M.O.H) is the only hospital provider for mental health services with total bed capacity of 39 beds. Mental services are provided free of charge for all mentally people.

1.6 The governmental mental health services

The governmental mental health services include the community mental health clinics and Psychiatric hospital.

1.6.1 Psychiatric hospital

Psychiatric hospital is considered the only one in Gaza strip that provide mental health services in patient since 25 years. It is classified as small hospital of El Naser medical group, this hospital provided treatment for more than 20000 cases since it had been established. The outpatient clinic provides mental health services for about 3000 cases monthly, including 1800 mentally ill cases, 900 neurologically ill cases (Epilepsy and parkinsonism), 300 mixed mentally and neurologically ill cases.

Services that the hospital currently provide

Drug therapy and psychotherapy for acute and difficult cases.

It deals with the forensic cases that are transferred from police centers and courts.

Assessment of the cases referred from the central commotion to determine their fitness for work according to their mental health state.

Treatment of epileptic patients through out patient clinic.

Treatment of addict patients.

Provision of social services for the psychiatric patients. In cooperation with ministry of social affairs and other related institutions (especially UNRWA).

Participation in rehabilitation of the mentally ill patients in cooperation with the ministry of social affaires.

Provision of mental health services to the cancer patients and their family members in the pediatric hospital, and there is a psychologist who is working currently in the oncology department of the pediatric hospital, under the supervision of the psychiatric hospital. These vast services that provided by the hospital can be spreader more widely the community by establishing community mental unit inside the hospital.

Occupancy

Number of beds is 39 beds, Occupancy rate is 70%.

The average length stay is 12 days.

1.6.2 Governmental community mental health .

Mental health services are provided for the Palestinian population through 15 CMH health clinics (5 in Gaza Strip, one of them is specialized in child mental health and 10 clinics in west bank). These clinics are distributed through PHC center in different governorates in Palestine since 1994.

In 2003, 72,072 visits were made to community mental health clinics (38,105 in WB vs. 33,967 in GS). In comparison with 63,953 visits reported in 2002 with an increasing percentage of 11.3%.

In addition to CMH clinics there are 2 psychiatric hospitals in Palestine

(Betlahem & Gaza).

The psychotic disorders rate in CMH clinics in Gaza strip are 5.17%, but in psychiatric hospital are 12%. There are 5 mental health clinics established in Gaza in 1994 as a division of primary health care directorate since 1996, there are:

sourany community mental health clinic: this center had been newly established in 2003 in Gaza city it has a staff of 2 trained physician, 1 psychologist, 1 social worker, 2 nurses, 2 rehabilitation trainer and a clerk .

Jaser Elagha community mental health clinic: in Khanunis, it was opened in 1996. It covers the mental health services in south Gaza strip (Rafah, Khanunis). The staffs consist of 1 trained physician, 2 nurses, 1 social worker, pharmacist, clerk and other administration staff. The total number of visits to this center in 2003 was about 1230 case.

Ezawaidh community mental health clinic: This clinic was opened in 1994 covered by 1 trained physician, a psychologist, and 1 nurse, the total number of visits to this center in 2003 was about 893 cases. Elnossayrat community mental health clinic: this center is newly established center . Both Elnossayrat and Ezawaidh offers services for Gaza mid zone.

Rashad Mosmar community mental health clinic: this is a part time clinic in north of Gaza which opens three days weekly. It is covered by 1 trained physician, a psychologist and electroencephalogram technician. There is only an out patient clinic which serves the population of the north of Gaza (150.000), and the daily visitors are not less then 50 cases.

1.6.3 Non governmental community mental health services(Gaza community mental health program)

Offering Occupational Therapy Services

The Unit of occupational therapy in GCMHP is considered to be from the unique units in the area of mental health and was established in 1991. The aim of this unit is to integrate the patient in a functional therapeutic activity in order to enhance their skills and confidence and

enable them to be more hopeful in managing their energies in a constructive manner. This is conducted through the participant's involvement in a goal-directed activity. Such activities include handicrafts, recreational, and social task such as drawing, wood work, and other hand made activities. In the year 2005, the occupational therapy unit dealt with 26 new cases, 464 follow-up cases, and conducted 151 home visits for the beneficiaries of the services in order to follow up with their families and offering guidance and for dealing with their family members.

Follow up and Evaluation of Treatment Services

As part of the cooperation between the research team and the professionals in GCMHP community centers, the research team followed up the cases of torture victims and victims of human rights violations as well as general mental health patients over 18 years of age that visited the centers. The professionals implement the WHO well-being scale and the Global Assessment of Functioning (GAF) scale.

The results of evaluation shows that an approximately 35% of the cases scored between 51%-60% on the Global Assessment of Functioning (GAF) scale in the first visit. In the second visit, the percentage increased to be between 61%-70%. The increase in the third evaluation and follow-up reached between 71%-81%. This gradual increase in the GAF is an indication of improvement and more ability to cope with their conditions than their previous state before the treatment. Additionally, there has been congruence between these results and the results of Well-being tests that were implemented as the scores in the well-being tests increased in the second and the third visits (Annual report 2005).

1.7 Limitation of study

1.There were no previous local studies in this subject (Psychotic patients attending governmental health services in Gaza Strip) locally .

2.Current episode may have been preceded by a relatively brief period of remission which, in turn .

3.The current study’s design avoided several of the may have been preceded by a very lengthy episode.

Chapter 2

Literature Review

Chapter 2

Literature Review

2.1 Diagnostic Interview

Clinical structure interview considers one of the tools that researchers used it in their studies such as Sood, M . (2001) aimed of her study was to discovering the outcome of patients in military population at a zonal hospital of Armed Forces . The sample of schizophrenic psychoses (N=295), paranoid states (N=297) and other nonorganic psychoses (N=298) as per ICD-9. 83.33% of total sample showed good outcome. No significant difference was found between the good and poor outcome groups on either clinical factors or factors associated with military service.

Jairam et al. (2004) using the diagnostic interview for children and adolescents (revised) (DICA-R), the Missouri assessment for genetic interview in children(MAGIC), the young's mania rating scale (YMRS) and the children's global assessment (CGAS). The study phenotype required DSM-IV criteria of mania with elation and or grandiosity as a criterion to distinguish them from those with attention deficit hyperactivity disorder. Subjects received the standard treatment as prescribed by their primary treating team. They found that during the course of the study period, all 25 subjects (100%) recovered from the index episode. The mean time to recovery was44 ± 46 days. The mean duration of follow-up was 51.6 ± 4.1

months. Sixteen subjects (64%) relapsed after a mean period of18 ± 16.4 months. Majority of the relapses (72.4%) were while the subjects were on treatment.

2.2 Diagnostic assessment

McClellan et al. (1999) in their study of subjects received an extensive diagnostic assessment upon entry into the study and at years 1 and 2. They report data only from those measures pertinent to this report. Diagnostic assignment was made by using sections of the structured clinical interview for DSM-IV (SCID). Premorbid functioning (defined as the highest functioning in the year prior to onset of illness) and functioning at the time of first onset (which generally occurred before entry into the study) were rated retrospectively, via medical records and parent report (when available). The course of the subject's illness was rated at years 1 and 2 as either resolved (with regard to their psychotic illness; subjects still may have had other areas of dysfunction), episodic (a cyclical pattern with one or more episodes that resolved), or chronically impaired. Symptom checklists were also used, including the Schedule for Positive Symptoms (SAPS) and the Schedule for Negative Symptoms (SANS). An extensive chart review was used to gather data regarding demographic information and clinical information. Medical records were also used at all 3 assessments (when available) to supplement information derived via the interviews. They found that fifty-five subjects with the following disorders have been recruited: schizophrenia (n = 18), bipolar disorder (n = 15), psychosis not otherwise specified (n = 15), schizoaffective disorder (n = 6), and organic psychosis (n = 1). Follow-up assessments were obtained on 42 subjects at year 1 and 31 subjects at year 2. Youths with schizophrenia had more chronic global dysfunction, whereas subjects with bipolar disorder overall had better functioning, with a cyclical course of illness. However, according to results of a regression model, premorbid functioning and ratings of

negative symptoms, but not diagnosis, significantly predicted the highest level of functioning over years 1 and 2.

Carrie & Joseph (2003) studied group consisted of 56 patients with bipolar disorder type I (n = 46), II (n=7) or not otherwise specified (NOS; n = 3). Diagnoses of bipolar disorder, as well as of comorbid substance abuse or dependence, were made using the structured clinical interview for the DSM-IV. Diagnoses were confirmed after review of SCID interviews and related materials with a senior research psychiatrist . Subjects were consecutively ascertained over a 3- month period from outpatients seen during any phase of illness in the Bipolar Disorders Research Clinic of the New York Presbyterian Hospital. Study group characteristics At the time of assessment, subjects had a mean (S.D.) age of 40.8 (12.8) years. Forty-five percent were female and 77% were Caucasian. Eighty-four percent of the study group had completed at least some college, and 39% had never been married. Their mean (S.D.) HAM-D31 and YMRS scores at the time of assessment were 17.8 (13.0) and 3.7 (5.2), respectively. The group had a mean (S.D.) age at onset for first affective illness of 21.7 (9.6) years. Twenty-six of the 56 subjects (46%) had their illness onset before age 19. Overall early illness onset. The mean age at time of assessment was significantly lower for subjects with early age at onset than later age at onset Mean lifetime illness duration was similar for those with early age at onset . Subjects with illness onset before age 19 had a significantly earlier age at first depressive episode. There was a strong, significant relationship between age at first mania onset and first depression onset. An earlier age at first episode also tended more often to have an illness onset that was judged to be insidious rather than acute.

Swartz et al. (2005) studied subjects that meeting criteria for an acute affective episode were treated with a combination of algorithm-driven pharmacotherapy and weekly psychotherapy

until stabilization (defined as four consecutive weeks with a calculated average of the 17-item version of the Hamilton Rating Scale for Depression and Bech-Rafaelsen Mania scale).

2.3 Risk for psychoses

There are some risk factors important in psychosis as aria , age, genetic, and ethnic groups.

Harrison G. et al (1997) in prospective study was undertaken in Nottingham assembling an inception cohort of psychotic patients (N = 168) presenting from a defined catchments area. The 1991 census, which includes codlings for self-ascribed ethnic origin, was used to calculate the denominator, employing correction factors for potential under-enumeration. Case-ascertainment was based upon all service contacts and subjects had in-depth assessments. Collateral history was obtained from informants.

Subjects born in the Caribbean, or who had one or both parents born in the Caribbean, had a greatly elevated risk (incidence ratios above 7) for all psychotic disorders and for ICD-10 (DCR)-defined F20 schizophrenia.

The size of the increase and the methodological safeguards employed support the validity of this now highly replicated finding. A personal or family history of migration from the Caribbean is a major risk factor for psychosis; the consistency of this finding justifies a systematic evaluation of potential a etiological factors. Any hypothesis derived from the evidence so far must explain: increased incidence in first and second generation migrants; increased risk for all psychoses (including affective psychoses); and an effect specifically associated with a migration history from the Caribbean to Northern Europe.

Harrison, G. et al (1997) found that subjects born in the Caribbean, or who had one or both parents born in the Caribbean, had a greatly elevated risk (incidence ratios above 7) for all psychotic disorders and for ICD-10 (DCR)-defined F20 Schizophrenia.

Nicky et al (1999) aims to compare the incidence, nature and long-term outcome of psychosis in different ethnic groups. A five-year, prospective study of an epidemiological cohort of people with a first contact for psychosis. They found that age-standardized incidence rates for schizophrenia and non-affective psychosis were higher for Black and Asian people than Whites. Stability of diagnosis and course of illness were similar in all ethnic groups. During the fifth year, Black people were more likely than others to be detained, brought to hospital by the police and given emergency injections.

Nicky et al (1999) in their study found that age-standardized incidence rates for schizophrenia and non-affective psychosis were higher for Black and Asian people than Whites. Stability of diagnosis and course of illness were similar in all ethnic groups. During the fifth year, Black people were more likely than others to be detained, brought to hospital by the police and given emergency injections.

Ramin et al (2003) In this study found that**.** The growing evidence from different setting may provide guidelines for revising the current diagnosis .

The concept of acute and transient psychotic disorders in ICD-10 , which draws on classic conceptions of acute remitting psychosis , is a suitable starting point. Extending the duration criterion of acute and transient psychotic disorders to 6 months would capture a large proportion of the cases of non-effective acute remitting psychosis that are currently excluded because they have duration longer than 1-3 months. Removing the current sub-classification of acute and transient psychotic disorders, which is based on little evidence, would make the

diagnosis easier to apply. We believe that incorporating such a revised diagnostic category in future editions of ICD and DSM would advance the study of non-affective remitting psychoses and improve the applicability of these diagnostic systems in the developing countries, where these psychoses are much more common than they are in the industrialized world.

Joshua et al (2005) to study ethnic differences in psychiatric morbidity are analyzed using data from the National Comorbidity Survey (NCS). The three largest ethnic groups in the United States – Hispanics, Non-Hispanic Blacks and Non-Hispanic Whites – were compared with respect to lifetime risk and persistence of three categories of psychiatric disorder: mood disorder, anxiety disorder, and substance use disorder.

They found that where differences across ethnic groups were found in lifetime risk, socially disadvantaged groups had lower risk. Relative to Non-Hispanic Whites, Hispanics had lower lifetime risk of substance use disorder and Non-Hispanic Blacks had lower lifetime risk of mood, anxiety and substance use disorders. Where differences were found in persistence of disorders, disadvantaged groups had higher risk. Hispanics with mood disorders were more likely to be persistently ill as were Non-Hispanic Blacks with respect to both mood disorders and anxiety disorders. Closer examination found these differences to be generally consistent across population subgroups.

Joshua et al (2005**)** found that where differences across ethnic groups were found in lifetime risk, socially disadvantaged groups had lower risk. Relative to Non-Hispanic Whites, Hispanics had lower lifetime risk of substance use disorder and Non-Hispanic Blacks had lower lifetime risk of mood, anxiety and substance use disorders. Where differences were found in persistence of disorders, disadvantaged groups had higher risk. Hispanics with mood disorders were more likely to be persistently ill as were Non-Hispanic Blacks with respect to

both mood disorders and anxiety disorders. Closer examination found these differences to be generally consistent across population subgroups.

2.4 Non – affective and affective psychoses

Some studies deal of the outcomes of non – affective and effective psychoses such as

In study for Swaran & et al (2000) non – affective and effective psychoses did not differ significantly in the rates of compulsory detention and treatment, number of hospital admissions or the overall length of stay . Significantly more patients with non – affective than affective psychoses had a chronic, unremitting course. On the McGlashan outcome categories, patients with affective psychoses were two to three times as likely to have good symptomatic, occupational, social and global outcome as compared to those with non-affective psychoses. There was a statistically non- significant trend towards patients with affective psychoses being more satisfied with the services than patients with non-affective psychoses.

2.5 Intervention programs and strategies

In study for Harrison (2001) the course of these disorders depends upon short-term outcome and sociocultural setting, then early and intensive engagement may have favorable impact upon the evolution of symptoms over the next 15-25 years at least for some patients. The dual challenge remaining is first to open up further the ‘black box’ of culture subsumed under center effects and then to find ways of translating customary practices into interventions by design

2.6 Poor functional outcome

Conus & McGorry (2002) in their study of the first-episode mania a neglected priority for early intervention found that when functional as well as symptomatic variables are considered, the outcome of mania is not as good as was formerly believed, a characteristic which is already present from the first episode. Various factors (lower socio-economic status, younger age at onset of illness, poor adherence to treatment, presence of comorbidity) have been identified as possible predictors of poor outcome. The prognostic value of the presence of psychotic symptoms and their congruence to mood, as well as the diagnostic subgroup, is less well established. This research striking similarities between manic and schizophreniform first episodes. Poor functional outcome in a significant proportion of patients following the first episode, high risk of suicide, high prevalence of comorbid diagnoses, worse outcome with a younger age at onset and with longer delay until treatment is initiated, and finally early presence of neuro-anatomical changes, are observed in both syndromes.

Murthy et al (2005) In their study eight rural communities were visited by an outreach team, who identified cases of drug naive or currently poor functional outcome. Recruited cases were provided with appropriate psychotropic medication and psychosocial support, and after obtaining informed consent were assessed every 3 months over one and a half years on symptomatology, disability, family burden, resource use and costs. A repeated-measures analysis was carried out to test for significant change in these outcome measures over this period. They found that a total of 100 cases of untreated schizophrenia were recruited, of whom 28% had never received antipsychotic medication and the remaining 72% had not been on medication for the past 6 months. Summary scores for psychotic symptoms, disability and family burden were all reduced significantly, with particular improvement observed at the first follow-up assessment. Increases in treatment and community outreach costs over the follow-up period were accompanied by reductions in the costs of informal-care sector visits and family care-giving time. Eight rural communities were visited by an outreach team, who

identified cases of drug naive or currently untreated schizophrenia. Recruited cases were provided with appropriate psychotropic medication and psychosocial support, and after obtaining informed consent were assessed every 3 months over one and a half years on symptomatology, disability, family burden, resource use and costs. A repeated-measures analysis was carried out to test for significant change in these outcome measures over this period.

2.7 Duration of untreated psychotic symptoms

Anne et al(2000) to determine whether the duration of illness before antipsychotic drug treatment for schizophrenia was associated with the severity of cognitive deficits and volumetric brain structure anomalies observed in some patients with a first episode of schizophrenia. Duration of psychotic symptoms and of other symptoms marking a behavioral change was estimated from structured interviews with 50 patients who had a first episode of schizophrenia and their family members. Interviews were conducted within a month of the patients' hospitalization. duration of untreated psychotic symptoms and of behavioral change was correlated with neuropsychological summary scores from a comprehensive cognitive battery and with measurements of lateral ventricular, temporal lobe, and cerebral hemispheric volumes. They found that no significant correlations were observed between measures of untreated illness and the severity of either cognitive or structural brain deficits at baseline.

Skeate et al (2002) in their study found that those with a long duration of untreated psychosis DUP are more likely to use avoidance as a general coping strategy when faced with health threat and are less likely to have visited their GP on a regular basis over a long period of time (6 years).

2.8 Quality of Life

Ross & Ashok (2002) in study of 90 patients for whom at least one version (client or provider) of the Wisconsin Quality of Life Scale WQLS was available at initial assessment, the mean age was 24.4 years (range = 15.6 to 45.3). The mean duration of untreated psychosis DUP (onset) was 68.1 weeks (median = 3.9, range = 104 to 539), and the mean DUP (active) was 56.7 (median = 23.1, range = 1.4 to 404.6). At 1 year, 72 of these people had a diagnosis of schizophrenia, 16 of schizoaffective disorder, and 2 of schizophreniform disorder. Definitive diagnosis of a psychotic disorder such as schizophrenia often requires that a patient be followed over time. For this reason, many patients are provided with an initial diagnosis of psychotic disorder not otherwise specified. For purposes of this report, they selected only those patients who, at the end of a 1-year follow-up, were diagnosed with a schizophrenia spectrum disorder (schizophrenia, schizoaffective, and schizophreniform disorder) based on the Structured Clinical Interview for DSM-IV.

2.9 Age and Psychosis

Miller (1987) Research has indicted that individuals with a 'monitoring' coping style are more likely to detect physical symptoms, demand more tests and information and seek help for relatively trivial problems, leading to early detection and treatment.

Carlson et al (2000) in their study found that , the mean ages at onset of bipolar disorder and the index manic episode were significantly different for the two groups . Six (26.1%) of the early-onset and five (16.6%) of the adult-onset subjects had a prior depressive episode.

Demographically, male subjects predominated in the early-onset group. Overall, however, the subjects were similar with respect to race (86.8% [N=46 of 53] of the subjects were Caucasian), household socioeconomic status. As expected, given their mean age of18, more of the early-onset subjects had not completed high school and were never married. Prevalence

of affective disorder, schizophrenia, or substance abuse among first-degree relatives did not significantly differ between the two groups. Subjects with early-onset psychotic mania were significantly more likely to have had a clinically significant behavior disorder in childhood . The average number of conduct disorder symptoms (out of a possible five) was 2.13 in the early-onset subjects and 0.78 in the adult-onset group. These findings remained significant even after adjustment for gender .

More early- than adult-onset subjects had been in special education, but this difference was not statistically significant. However, as judged by high school transcripts in 66% of cases, poor school performance was noted somewhat more often in the early-onset subjects. The significance disappeared after adjustment for gender. The validity of reports of childhood psychopathology in the adults was tested by comparing subject self-reports of school problems on the Wender Utah Rating Scale (26) against high school transcripts of poor school performance. Adults with poor school performance reported more school problems than those with average or better school performance . more likely to have a diagnosis of substance use disorder before age 16, which clearly antedated the onset of mood disorder . While early age of substance abuse was related to gender, substance abuse at index hospitalization remained a distinction for the early-onset subjects. Table 5 shows that early-onset subjects were significantly more likely than adult-onset subjects to have substance use disorder present at the onset of their mood disorder. Although high lifetime rates of heavy substance use (70%) or abuse (30%) were seen in the adult-onset subjects, most had ceased this behavior by the time they developed their index mania episode. At 24 months, six of the youth but none of the adults continued to meet criteria for substance use disorder. Early-onset subjects were significantly more likely than adult-onset subjects to report paranoid (100% [N=23] versus 80% [N=24], respectively) and grandiose (73.9% versus 40%, respectively) delusions, but not mood incongruent psychotic symptoms, formal thought disorder, or hallucinations.

The duration of the initial hospitalization was not different for the two groups (mean=42.47 days and mean=36.08 days , respectively). *Illness Course* Similar percentages of both groups had illness onsets that were defined as acute, sub acute, or insidious, with acute onsets being the most common (60%) and insidious onsets the least (11%).

Among the subjects from whom information was obtained, more early- than adult-onset subjects experienced either partial or no remissions during the follow up period (40.9% versus 10.3%, respectively). Conversely, more adult- than early-onset subjects experienced either a single episode (44.8% versus 22.7%, respectively) or more than one episode but with complete remission in between (44.8% versus 36.4%, respectively). Overall, the differences in remission status between groups were significant . Early-onset subjects spent significantly more time in the hospital over the 24-month follow-up than adult-onset subjects (mean=6.8 weeks versus mean=3.7 weeks) .

Manic episodes recurred more frequently in early-onset subjects (64.7% versus 12.5%) and depressive episodes recurred more frequently in adult-onset subjects (62.5% versus 17.6%) . Equal numbers of subjects experienced both kinds of episodes. The early- and adult-onset subjects had similar rates of mania according to baseline consensus research diagnoses (56.5% and 73.3%, respectively) and facility discharge diagnoses (56.5% and 67.9%, respectively).

At the 6-month research consensus diagnosis conference, however, 100% of the adult-onset subjects but only 81.8% of the early-onset group were identified as having bipolar disorder . Mixed episodes were much more likely to be experienced by the early-onset subjects (26.1% versus3.3%) and had been the most difficult to diagnose, being initially diagnosed as psychosis not otherwise specified, drug-induced psychosis, or schizoaffective disorder.

2.10 Treatment site hospital or alternative.

Fenton et al (1998) fond that**,** of 185 patients, 119 (64%) were successfully placed at their assigned treatment site. Case mix data indicated that patients treated in the hospital (N=50) and the alternative (N=69) were comparably ill. Treatment episode symptom reduction and patient satisfaction were comparable for the two settings. Nine (13%) of 69 patients randomly assigned to the alternative required transfer to a hospital unit; two (4%) of 50 patients randomly assigned to the hospital could not be stabilized and required transfer to another facility. Psychosocial functioning, satisfaction, and acute care use in the 6 months following admission were comparable for patients treated in the two settings and did not differ significantly from functioning before the acute episode.

Conway et al (1994) found that 65% (33/51) of the study group had been readmitted at least once in the three years between surveys. Recent contacts with community psychiatric nurses and rates of hospital admission increased (8 at one year v 24 at four years, $p<0.01$; 5 v 13, $p<0.06$). Conversely, fewer patients were in contact with social workers (17 v 7, $p<0.03$). Proportions in supported housing, day care, or sheltered work did not change. Unemployment rates remained very high. A considerable reduction (almost a halving) in psychiatric symptoms was observed, but there was no significant change in mean levels of20social disability.

Shaw et al (2000) found that ninety-two percent of patients reported use of community support services. The mean number of annual service contacts per patient was 36.6 for psychological services, 81 for social services, and 39.7 for daily living services. High users of psychological services were younger and experienced more severe positive psychotic symptoms and depressive symptoms. High users of social services were of higher socioeconomic status, more likely to be female, and had a longer history of psychosis, more

cognitive deficits, and more severe negative psychotic and depressive symptoms. Patients who used daily living services were older, had poorer functional health status and more cognitive deficits, and had more severe negative psychotic and depressive symptoms. A trend was noted for high users of social services to experience relief from depressive symptoms over time.

2.11 Marital status

Gureje et al (2002) found that most of the interviewees were unemployed and had never married. There was widespread impairment in sexual and social relationships and in the performance of activities of daily living. Over half expressed dissatisfaction with life in general. Persons with affective psychoses were often as disabled as those with schizophrenia and diagnostic categorizations were not important in the conferment of risk for disability. Rather, poor pre-morbid work or social adjustment and poor course of illness were potent risk factors for diverse forms of disability in persons with psychosis.

2.12 Diagnosis and outcome

Sing et al (2000) found that on most outcome measures, non-affective psychoses had a worse outcome than affective psychoses. Affective psychoses had better outcome than previously reported. Substance-related psychoses had very poor occupational outcome.

Srinivasa et al (2005) found that a total of 100 cases of untreated schizophrenia were recruited, of whom 28% had never received antipsychotic medication and the remaining 72% had not been on medication for the past 6 months.

Summary scores for psychotic symptoms, disability and family burden were all reduced significantly, with particular improvement observed at the first follow-up assessment. Increases in treatment and community outreach costs over the follow-up period were accompanied by reductions in the costs of informal-care sector visits and family care-giving time and their conclusions that efforts to organize community-based care such as outreach

services for people with schizophrenia living in more remote areas of resource-constrained countries can bring substantial benefits to patients and families alike.

Gureje et al(2002) found that in their study most of the interviewees were unemployed and had never married. There was widespread impairment in sexual and social relationships and in the performance of activities of daily living. Over half expressed dissatisfaction with life in general.

Persons with affective psychoses were often as disabled as those with schizophrenia and diagnostic categorizations were not important in the conferment of risk for disability. Rather, poor pre-morbid work or social adjustment and poor course of illness were potent risk factors for diverse forms of disability in persons with psychosis and their conclusion was a large proportion of persons with experience of psychosis living in the community suffers from significant levels of psychosocial disability. Disablement seems to reflect, in part, a diathesis of poor pre-morbid functioning and less than optimal response to treatment of the disorder.

Choon et al (2000) found that earlier age at illness onset was associated with longer duration of untreated prodromal psychotic symptoms. There were no significant gender differences in duration of untreated initial psychosis, nor were there any significant associations between untreated initial psychosis duration and premorbid functioning. After controlling for the effects of age at onset, the duration of untreated initial psychosis did not significantly impair subsequent quality of life, symptom severity, or remission of positive symptoms and their conclusions that duration of untreated initial psychosis was not prognostic of poor outcome early in the course of schizophrenia. Biological measures of neurotoxicity are needed to examine the "toxic psychosis" hypothesis more directly.

Jon et al (1999) in their study, early-onset psychotic disorders were characterized by recognizable patterns of course and outcome. Bipolar disorder primarily displayed a cyclical course, with bouts of illness separated by periods of remission. In contrast, subjects with schizophrenia tended to be chronically impaired. Subjects with bipolar disorder fared better at both the year 1 and year 2 follow-up assessments than those with schizophrenia. Most subjects with bipolar disorder were in remission at the time of their follow-up assessments, whereas youths with schizophrenia generally displayed some persistent evidence of their illness (primarily negative symptoms).

Hollis (2000) found that the global assessment of functioning symptom scale (GAF) range expressed the variability in levels of symptoms during the follow-up period and was defined as the difference between the highest and lowest global assessment of functioning symptom scale score for each subject. Variables measuring time were expressed as the proportion (percentage) of the individual follow-up period. The definition of employment included any time spent in full-time education or vocational training (or full-time child care).

Independent adult living was defined as living either alone or with friends/partner or with parents and receiving no more support than would be received by the majority of individuals at a similar age.

Boydell et al (2003) in their study (Incidence of schizophrenia in south-east London between 1965 and 1997). There was a continuous and statistically significant increase in the incidence of schizophrenia, which was greatest in people under 35 years of age and was not gender-specific.

McClellan & McCurry (1998) found that the psychosis non otherwise specific "group" is not meant to be a group, but rather a collection of youths who reported either atypical symptoms and/or did not meet full criteria for a defined psychotic illness. The psychotic symptoms

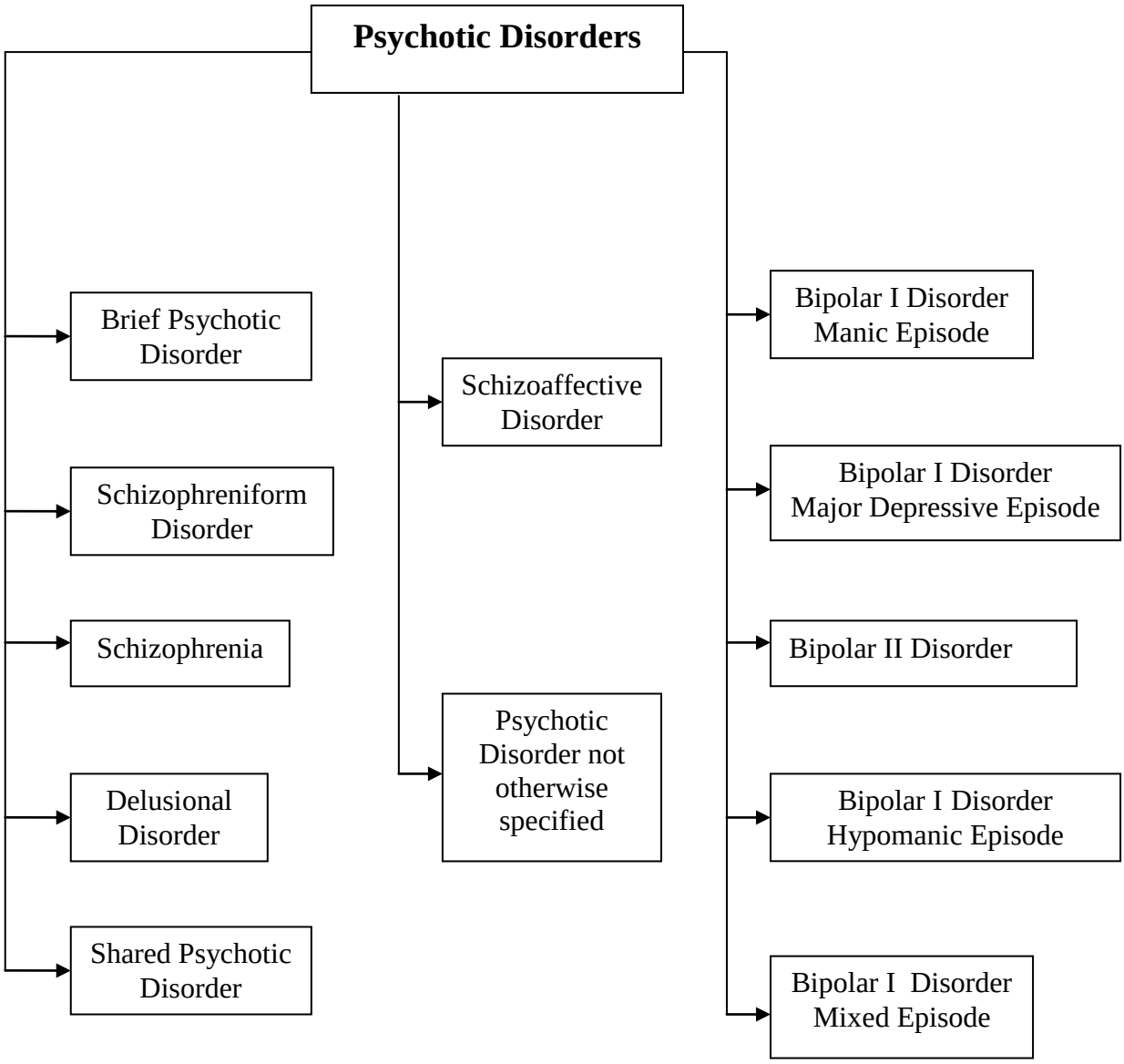
reported by these youths consisted almost entirely of hallucinations and delusions that were questionable in nature. In schizoaffective disorder was associated with chronic impairment and the poorest outcome. The few subjects with this disorder had the most persistent problems with ongoing positive symptoms .

Werry et al (1991) study had a greater range of intellectual functioning in their subjects. Thus, the selection biases inherent to our sample limited the variance associated with IQ, thus limiting its significance as a predictor in the regression models.

Werry & McClellan (1992) found that premorbid functioning and IQ, but not diagnosis, significantly predicted functioning at outcome. Intellectual functioning is also noted to be a prognostic factor in the adult literature. Our sampling biases reduced the likelihood that IQ would be a significant predictor variable. In our subjects, cognitive delays were certainly associated clinically with greater dysfunction.

Chapter 3

Conceptual Framework


Psychotic Disorders
Brief Psychotic Disorder
Schizophreniform Disorder
Schizophrenia
Delusional Disorder
Shared Psychotic Disorder
Schizoaffective Disorder
Psychotic Disorder not otherwise specified
Bipolar I Disorder Manic Episode
Bipolar I Disorder Major Depressive Episode
Bipolar II Disorder
Bipolar I Disorder Hypomanic Episode
Bipolar I Disorder Mixed Episode

Chapter 3

Conceptual Framework

3.1 Psychosis

The term psychosis was introduced by Ernst Feuchtersleben in 1845 to describe mental illness as a complex interaction of the psychic and the physical, and to denote a subclass of the nervous diseases referred to at that time as the neuroses. Confusion soon arose when psychosis, psychoneurosis, and psychopathy all came to mean the same thing. Efforts to clarify the confusion in terminology continued over the remaining half of the nineteenth century. By the beginning of the twentieth century, under the strong influence of Kraepelin, the meanings of neurosis and psychosis had become reversed. Freud proposed a nonorganic etiology for psychoneuroses. Karl Jaspers and Kurt Schneider continued in Kraepelin's tradition in Germany, so that the psychoses came to represent severe constitutional or endogenous psychiatric illness. The neuroses and psychopathies (now called personality disorders) came to represent exogenous reactions or static deviations on a continuum from normal (Michael & Nurnberg 2000).

Perhaps more than any other psychodiagnostic construct, the term psychosis has been repeatedly misused for political ends. In the social-political context of Germany in the late 1930s, this classification served the ends of the Nazi regime by providing a pseudoscientific distinction or dividing line that could be used for the eugenics program that systematically killed institutionalized patients with mental retardation, schizophrenia, and manic-depressive illness (bipolar I disorder). Soviet psychiatry would later also be used to promote political agendas based on psychiatric nosological constructs.

Although the traditional meaning of the term psychosis emphasized loss of reality testing and impairment of mental functioning—manifested by delusions, hallucinations, confusion, and impaired memory—two additional meanings have evolved over the past 100 years. One common use of the term psychosis denotes severe impairment of social and personal functioning characterized by social withdrawal and an inability to perform usual household and occupational roles. The second use of the term specifies the extent of ego regression as a criterion for psychosis. As a consequence of various and multiple meanings, the term has lost its precision in current clinical and research practice. It is possible that the term will fail to appear in future official nosological systems, following the trend set in DSM-III for the class of neuroses. (Michael & Nurnberg 2000).

According to the glossary of the American Psychiatric Association, psychotic means grossly impaired in reality testing. The term may be used to describe the behavior of a person at a given time or a mental disorder in which all persons with the disorder have grossly impaired reality testing at some time during its course. Gross impairment in reality testing is defined as existing when individuals incorrectly evaluate the accuracy of their perceptions and thoughts, and make incorrect inferences about external reality, even in the face of contrary evidence. Psychotic does not apply to minor distortions of reality that involve matters of relative judgment. For example, depressed persons who underestimate their achievements are not described as psychotic, whereas those who incorrectly believe that they have caused actual catastrophes are so described.

Direct evidence of psychotic perceptions, thoughts, and behavior is the presence of delusions or hallucinations not accompanied by insight into their pathological nature. The term psychotic is also appropriate when behavior is so disorganized that it is reasonable to infer that reality testing is grossly disturbed. Examples include markedly incoherent speech without

apparent awareness by the person that the speech is not understandable, and the agitated, inattentive, and disoriented behavior seen in a phencyclidine psychotic disorder.

The psychotic disorders are those that are predominantly characterized by psychosis. In DSM-IV the psychotic disorders include schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance-induced psychotic disorder, and psychotic disorder not otherwise specified. In addition, some severe mood disorders can have psychotic features. A person with a nonpsychotic mental disorder may exhibit transient psychotic thoughts and behaviors. For example, a person with borderline personality disorder may, when under the influence of substantial stress, loss, or substance abuse, come to believe in the reality of hearing voices, of conspiracies, or of government persecution (Michael & Nurnberg 2000).

3.2 Signs and symptoms in psychiatry

Descriptions of signs and symptoms in psychiatry have remained fairly constant over the years; however some terms fall in and out of favor. In the various editions of diagnostic and statistical manual of mental disorders (DSM), for example, some terms have been retained and others omitted, and some terms are not common to DSM and the International Classification of Diseases (ICD) (Juan et al 2000).

The fourth edition of DSM (DSM-IV) eliminated the diagnosis of organic mental disorder in an attempt to indicate that all mental disorders may have a biological basis, or medical cause. The diagnosis of organic mental disorder is called "delirium, dementia ،and amnestic and other cognitive disorders" in DSM-IV. The 10th revision of international statistical classification of diseases and related health broblems (ICD-10), however, retains the diagnostic category of organic mental disorders.

Neurasthenia is omitted from DSM-IV but is retained in ICD-10. Although a significant number of patients diagnosed with neurasthenia can also be classified as having a depressive or anxiety disorder, many patients cannot, and ICD-10 reflects that fact.

DSM-IV eschews the term "psychogenic." Nevertheless, it appears in ICD-10 to refer to the fact that life events or difficulties play an important role in the genesis of many psychiatric disorders. Similarly, DSM-IV has eliminated the term "neurosis," which is used in ICD-10. The author regards both as useful terms that should be retained.

Mathematical approach is reflected in the algorithms and decision trees used in DSM-IV and in the various computer programs that record signs and symptoms to provide a diagnosis .influenced by social traditions, prevalent customs or philosophies, and even unconscious determinants such as the classifier's view of the world. Over 35 years ago, Karl Menninger anticipated the structure of the mathematical device currently in use in DSM-IV. He wrote: "If the patient has, let us say, five symptoms, one can look up each of these symptoms and find which disease is so characterized under all five headings. Then, voila! the diagnosis!" Menninger suggested that the trend toward tabulating disease states was antithetical to understanding the person experiencing the illness and deemphasized the compassionate approach toward the patient that is the hallmark of psychiatry (Juan et al, 2000) .

The concept of "diagnosis," at any point in time, defines the field of medicine in general and psychiatry in particular. It does so by delineating the informational base necessary for clinical care. With various degrees of systematization and explicitness, diagnostic schemas, as consensual notions and formats for describing clinical conditions, have emerged since the dawn of mankind. In every case, these notions have been embedded within their time and culture (Juan et al, 2000).

Building on conceptual contributions over the past two centuries in various parts of the world, and having the 100-year-old international classification of diseases (ICD) as general reference, the emphasis for advancing psychiatric diagnosis during the past several decades has been on more-systematic and clearer formulations of psychopathology and nosology. This has led to gain in interdiagnostician agreement (diagnostic reliability) and universal communicability of diagnostic statements. These developments have been widely regarded as propitious (although not guarantees) for diagnostic validity or usefulness and for the broader advancement of the field.

Among recent efforts to update diagnostic validity, clinically and epidemiologically, are developments to enhance existing universalistic diagnostic systems by paying attention to both local realities and the uniqueness of the individual. The first type of these developments involves adaptations of the international classification system to regional or national clinical patterns and needs. The second corresponds to idiographic or personalized formulations (Juan et al, 2000).

3.3 The Stigma

The most immediate impact on the psychotic patient may well be on public opinion. Psychiatrically ill persons have long suffered from the stigma and discrimination that portions of the public impose out of fear and ignorance. Acceptance of major mental illnesses as brain disorders has been slow. The definitive identification of genetic causes may be highly beneficial to public understanding and acceptance.

A somatic idiom of distress may be preferentially invoked in contexts in which mental illness is seen as a stigma or in which mental health care is not readily available. Similarly, in contexts in which emotional distress is not culturally marked, the somatic expression of distress can be understood as a means of engaging the social milieu and mobilizing support

within the local cultural context. Embodied distress may also have a moral context, signaling complaint, resistance, or profound demoralization in a political or social milieu in which direct articulation is an impossibility.

Local beliefs that mental illness is a stigma may discourage individuals or families from seeking professional psychiatric care.

The medicalization or relocation of some illnesses from one social arena to a clinical one may diminish their social stigma and allow mobilization of social resources in more effective ways for the patient.

Effective treatment late in the course of a chronic disease will diminish morbidity, but it will not restore lost experience and opportunity—nor will it overcome stigma. A history of disabling schizophrenia is a serious social and occupational burden regardless of the degree of recovery (Robert & William 2000).

.

The twenty-first century promises to be a time of fundamental discovery regarding the etiology and pathophysiology of what may be the world's most vexing public health problem. These developments have emerged at a time of decreasing stigma, increasing partnership in clinical care and research with citizen advocacy groups, and the initiation of nationwide private fundraising for research on this disease.

A brief individual psychotherapy termed compliance therapy has been designed for acutely psychotic patients with chronic illness who have recently been readmitted for an illness relapse. This intervention consists of 4 to 6 cognitive-behaviorally oriented sessions lasting 20 to 60 minutes twice a week administered prior to hospital discharge. The sessions focus on (1) a review of symptoms and treatment adverse effects, (2) the patient's actions and beliefs regarding treatment, and (3) reducing stigma comparing pharmacotherapy to the need for medicine in other physical illnesses and defining drug treatment as a freely chosen strategy to

enhance quality of life. In a randomized, controlled trial, Anthony David and his colleagues at the Maudsley Hospital reported that inpatients receiving compliance therapy showed greater postdischarge insight and more observer-rated treatment compliance compared with nonspecific counseling. In addition, survival in the community and social functioning were significantly better in the treatment group over an 18-month follow-up period.

because of the negative connotation of schizophrenia and the stigma currently attached to it, a diagnostic system that avoids a false-positive diagnosis of schizophrenia is desirable. A 6-month duration of illness prior to making the diagnosis of schizophrenia will eliminate virtually all false-positive diagnoses.

While the stigma of psychiatric illness remains a strong deterrent, the availability of effective treatments, frequently a combination of somatic and psychological, is a powerful incentive for patients to come forward (Trujillo M.2000).

3.4 The Multiaxial Presentation of DSM IV

Axis I Axis I consists of all mental disorders except those listed under Axis II, and other conditions that may be a focus of clinical attention.

Axis II Axis II consists of personality disorders and mental retardation.

Axis III Axis III lists any physical disorder or general medical condition that is present in addition to the mental disorder.

Axis IV Axis IV is used to code psychosocial and environmental problems that contribute significantly to the development or the exacerbation of the current disorder.

Axis V Axis V is the Global Assessment of Functioning (GAF) scale**.**

3.5 Primary health version

The ICD-10 primary health version is a simple, brief classification arrangement compatible with and translatable into the ICD-10 standard classification of mental disorders . It is linked with management aids prepared for use by primary care practitioners. The short list of categories was selected principally on the basis of importance to public health and the availability of effective and acceptable management. The centerpiece of the package is a set of pocket-sized flip-cards, one for each selected category. One side of the flip card exhibits assessment information, such as presenting complaints, diagnostic features, and differential diagnosis. The other side displays management guidelines, such as essential information for patient and family, specific counseling for the patient and family, medication, and specialist consultation. Additional elements of the package include flow charts, symptom indexes, and a computerized version (Juan et al, 2000).

Addition of culture-specific diagnostic categories both ICD-10 and DSM-IV lack a coded classification of culture-bound syndromes, which are often cited in the argument against an international classification of mental disorders. .

In the Western psychiatric literature, psychosis related to traveling is uncommonly reported and is usually confined to air travel among subjects with a preexisting history of mental disorder. By contrast, the category of traveling psychosis arose from reports of acute psychosis developing among thousands of rural migrants who traveled in severely crammed trains over long distances in search of jobs in the richer regions of China. Its principal manifestations include an acute onset, perplexity, disturbed consciousness, anxiety, persecutory delusions, horrifying illusions or hallucinations, motor excitement, impulsive and suicidal jumping off the train, and injuring others. In most cases, the termination of travel, rest, and renourishment lead to spontaneous recovery within a few hours to a few days.

A personal or family history of mental disorder is rare. Even if traveling psychosis has an organic cause (e.g., hypercapnia, sleep deprivation, fatigue, and dehydration), its origin must be seen in the context of China's rapid market reforms, which result in marked economic regionalism and massive domestic migration. Granting traveling psychosis a special nosological status in CCMD-2-R is expected to promote research into its prevention (e.g., improved conditions for traveling and regulation of migration). It also serves judicial functions, since offenders with this diagnosis may be granted a verdict of diminished responsibility or acquittal.

Deletion of culturally inappropriate categories despite the common belief that Chinese people are prone to somatization, almost the whole block of somatoform disorder in ICD-10 and DSM-IV is excluded in the CCMD-2-R. According to ICD-10, the main features of such conditions are the repeated presentation of physical symptoms and persistent requests for medical investigations despite negative findings and reassurances by doctors that the symptoms have no physical basis. The patient usually resists attempts to discuss the possibility of psychological causation even in the presence of precipitating psychosocial stressors. This definition embodies a radical mind-body epistemology that is exotic to traditional Chinese or Ayurvedic medicine. Several factors have made it difficult for Chinese psychiatrists to apply the category of somatoform disorders. Chinese patients, if given the opportunity, readily communicate dysphoria and relate somatic symptoms to psychosocial stressors. Rather than being mutually exclusive, their somatic and emotional symptoms are highly intercorrelated. Clinically, their somatization may be considered a context-dependent strategy of engaging the concern of physicians who often work at overcrowded clinics. Moreover, the hybrid (half Greek and half Latin) word "somatoform" is a terminological puzzlement to Chinese psychiatrists, who find that neuroses (including neurasthenia) are

clinically more useful categories for engaging patients in treatment (Juan et al 2000).

3.6 Psychotic disorders

Reports that have estimated incidence at a single time also may be inaccurate because diagnosis may change over time, especially in Black patients (Littlewood & Lipsedge, 1981) The incidence of schizophrenia is higher in Black than White populations in the UK (Harrison et al, 1988; King et al, 1994; Bhugra et al, 1997).

There are three disorders in addition to schizophrenia listed in the fourth edition of diagnostic and statistical manual of mental disorders (DSM-IV) in the section "Schizophrenia and Other Psychotic Disorders." The first, schizoaffective disorder, is a complex illness that has changed significantly over time. In its simplest definition, it is presently conceived as an illness with coexisting, but independent, schizophrenic (psychotic) and mood components. Schizoaffective disorder is seen primarily as part of a schizophrenia spectrum rather than an equal hybrid of mood and schizophrenia disorders. Schizophreniform disorder is a diagnosis that assumes another will replace it after 6 months. Most cases of schizophreniform disorder progress to either schizophrenia or schizoaffective disorder, with some cases rediagnosed as a non–schizophrenia spectrum illness (i.e., schizotypal or schizoid personality disorders), while a few resolve completely. Finally, the diagnosis brief psychotic disorder describes an impairment in reality testing that lasts at least 1 day, but less than 1 month. All three disorders have a psychotic component, are often misunderstood, are incorrectly applied, and are not as well studied as schizophrenia, bipolar I disorder, or major depressive disorder (Lauriello et al 2000).

3.6.1.1 Schizophrenia

Historical Background Toward the end of the nineteenth century, Kraepelin differentiated dementia praecox and manic-depressive psychoses. Dementia praecox described patients who showed a global disruption of perceptual and cognitive processes (dementia) and an early onset (praecox). Kraepelin's dementia praecox patients usually had an illness onset in early adulthood and a progressively deteriorating course with no return to premorbid levels of function. These features contrasted with the relatively intact thinking, later onset, and episodic nature of illness in patients with manic-depressive psychoses, whose episodes of psychopathology alternated with periods of normal function (Tsuang, et al, 2000) .

Bleuler's emphasis on theory as a means for determining the diagnostic relevance of signs and symptoms contrasted sharply with Kraepelin's reliance on empirical observations. Bleuler's approach was also notable for three other reasons. First, his reformulation of dementia praecox as "the group of schizophrenias" foreshadowed the contemporary view that schizophrenia is a heterogeneous group of disorders with similar clinical presentations. Second, Bleuler included defects in affect as a core feature of the disorder. Third, his view of schizophrenia allowed for the possibility of recovery (Tsuang, et al, 2000) .

DSM-III contained several innovations, including field tests of diagnostic reliability, specific inclusion and exclusion criteria for diagnoses, multiaxial diagnosis, and a focus on the description of syndromes and course of disorders rather than inferences about their etiology. This latter point made psychiatric diagnosis more explicitly consistent with the diagnosis of other medical disorders of unknown etiology (Tsuang, et al, 2000) .

Schizophrenia the most common psychotic disorder, affecting 1% of the world population, and having a strong familial tendency. Between one third and one half of homeless Americans

have schizophrenia .In one prospective study in south London, outcome at one year was poorer for African-Caribbeans than for Whites or Asians (Bhugra et al, 1997) .

3.6.1.2 Outcome studies of scizophrenia

Outcome of schizophrenia appears to be better in 'developing' than 'developed' countries, possibly because of greater social support and fuller employment (Keh-Ming & Kleinman, 1988; Jablensky et al, 1992).

Few studies address outcome of psychosis in people from ethnic minorities living in 'developed' countries. Most have not recruited their cohort at first contact with services, or have selected patients from hospital records or admissions (Sugarman, 1992; McKenzie et al, 1995; Takei et al, 1998)

Buckley (1998) reports that schizophrenia "accounts for about 2.5% of the total healthcare expenditure in the United States", that it represented "more than 22% of the cost for all mental illness", and that the "direct costs of treatment and support costs accounted for [only] 53% of the total cost of schizophrenia" the rest being the indirect costs born by the schizophrenic and his/her family and community. Drug costs for schizophrenia, until recently, comprised only "approximately 5% of the total direct expenditures;" however, this estimate was based on information "before the advent of newer, more costly antipsychotic medications)." The largest direct costs of this disease are associated with hospital and nursing home care and professional services of mental health care providers.

3.6.2 Mood disorders

It’s a number of terms, these include manic-depression, manic-depressive psychosis, bipolar disorders and mood swings .There are essentially three subgroups of the bipolar disorders .

Firstly, bipolar I, in which the user experiences amanic episode and a depressive episode of duration great than one week .

The second type is referred to as bipolar II, during which the client experiences hypo-mania and depressive episode .

Finally, cyclothymic disorder, which represents multiple hypo-manic and depressive episodes of less severity and duration .

Perry et al (1999) defines the disorder (Manic-depression psychosis) is a common serious mental illness characteristed by two types of relapse, mania(elation with disinhibition, over active behavior) and depression.

Coryell et al (1995) also suggests that in the absence of an empirically designed interview, diagnostic instability will remain. As with all diagnosis, there is debate about the validity of the term. Khan et al (1998) found that clients with bipolar disorders often have to see three or four doctors and wait an average of eight years before they receive the correct diagnosis. Daly (1997) also proposes that there are diagnostic difficulties, especially in the young, when the initial presentation is often confusing, and clients are at the most risk of self-harm. Bipolar disorders have a one per cent incidence, which similar to that of schizophrenia (Sheppard & Hill 1996, Daly 1997, George 1998, Hilty et al.1999, Tohen & Grundy 1999). However, increasing numbers of people are being diagnosed with this disorder (George 1998, Tohen & Grundy 1999). Daly 1997 maintains that bipolar disorders have a higher heritability than other psychiatric disorders (Baker 2001).

According to Albert Bandura (1995) there are lack of belief in their ability to manage their illness and their lives, or low sense of self-efficacy in this regard, that draws attention to an important theory through which clinical and treatment implications can be explored.

Coryell et al (1987) found that A two-years semiannual follow-up of 40 patients with RDC schizo-affective disorder, depressed type revealed poorer outcomes among those who

were subtyped as chronic or mainly schizophrenic patients than among their counterparts with nonchronic or mainly affective schizo-affective depression. Outcomes for these latter groups, in turn, were no worse than those for patients with psychotic major depression. Among a variety of predictors entered into step-wise regression analyses, diagnosis was most important in predicting recovery overall and outcome at 6 months, while demographic variables, particularly sex, predicted outcome at 2 years.

Bipolar disorder has previously been thought to be a well-maintained illness because of the availability of efficacious medications. However, recent studies have indicated otherwise. The cumulative risk of an episode recurrence has been estimated at 50% during the first year of follow-up, approximately 70% by the end of 4 years, and more than 80% by the end of 5 years (Coryell et al., 1993; Tohen et al., 1990).

3.6.2.2Outcome studies of bipolar disorders

Coryell et al. (1995) suggests a need for further separation of the diagnosis between bipolar I and bipolar II due to burring between hypo-mania and mania, which often leads to poor confidence in the diagnostic criteria. Studies of adolescents with bipolar disorder report a cyclical course with variable outcomes (McClellan et al., 1993; McGlashan, 1988; Strober et al., 1995; Werry et al., 1991).

Nawata et al (2006) aimed of their study to determine the factors related to outcome, as measured by the cumulative number of days hospitalized, of a cohort group of inpatients with a diagnosis of schizophrenia followed up for 6 years. Comprehensive data were obtained from 18 psychiatric hospitals from two surveys conducted in 1993 and 1999. Outcome was evaluated by calculating the cumulative number of days between the two surveys that the cohort group was hospitalized. Tree-based models analysis was used to explore the factors related to outcome. Patient characteristics at the time of the first survey that were related to

outcome were the number of days hospitalized, cumulative number of years hospitalized, age, Global Assessment of Functioning score and relationship to the main visitor. The number of beds in each hospital and changes in their number were also related. Increasing staffing levels is not likely to impact on deinstitutionalization since their levels were not related to outcome.

Harvey et al (2006) found that some groups have reported the longitudinal course of elderly poor outcome schizophrenic patients to be characterized by progressive decline in cognitive functions and functional capacity. Although many of these patients experience minimal reduction of psychotic symptoms, there may be beneficial effects of antipsychotic treatments on cognitive functions and functional capacity.

3.7 Delusional disorder and shared psychotic disorder.

Delusional disorder refers to a group of disorders, the chief feature of which is the presence of a nonbizarre delusion. It is the delusion and the relative absence of other psychopathology that unifies these disorders in terms of natural history and impact on functioning. Once called paranoia, this condition as defined in the fourth edition of diagnostic and statistical manual of mental disorders (DSM-IV) and the 10th revision of international statistical classification of diseases and related health problems (ICD-10) is easier to recognize and less subject to misdiagnosis (Manschreck, 2000).

3.8 Sources of diagnostic uncertainty for chronically psychotic cocaine abusers

Drugs can cause a wide range of psychological symptoms and diagnosis of patients with both substance abuse and psychiatric symptoms may be inaccurate or uncertain because abuse of alcohol and syndromes. To make an accurate diagnosis in the presence of substance abuse, one must determine what role abused substances have played in the initiation and maintenance

of psychological symptoms. This determination depends on the answers to four questions: What drugs has the patient used? What symptoms can these drugs cause? In what way can these drugs alter the symptoms of pre-existing psychiatric disorders? When did symptoms occur relative to drug use?

Unfortunately, this information is often missing or inaccurate, for two reasons. First, patients often do not accurately report substance use and, second, little is known about how drugs may mimic or alter psychiatric disorders.

Diagnostic uncertainty is especially problematic among patients who abuse stimulants and have psychotic syndromes resembling schizophrenia. . Even among amphetamine abusers who have never been psychotic, large doses of stimulants can cause acute psychotic symptoms strikingly similar to those of schizophrenia . Finally, chronic stimulant abuse or dependence, particularly involving amphetamine, may produce a chronic psychosis indistinguishable from schizophrenia that persists long after the patient has stopped using stimulan (Shaner et al 1998).

Because stimulants can mimic and alter schizophrenic symptoms, stimulant abuse can lead to diagnostic error—either a false positive or a false negative diagnosis of schizophrenia. Such diagnostic errors could lead to inappropriate treatment. On the one hand, a false positive diagnosis of schizophrenia for a patient who actually has a substance-induced psychosis could lead to inappropriately prolonged use of antipsychotic medication. On the other hand, a false negative diagnosis of schizophrenia could lead to a failure to use antipsychotic medication. Diagnostic uncertainty and inaccuracy can also lead to exclusion from appropriate treatment programs. For example, substance abuse treatment programs often accept patients with transient toxic psychoses but exclude those with schizophrenia or uncertain diagnoses. Although there are many reasons to suspect that comorbid substance abuse and dependence (Shaner et al, 1998).

3.9 Scope of the assessment: conditions addressed and drug class

Psychosis is an often severe, disabling, and incapacitating disease, whether in the form of a chronic and repetitive-episode schizophrenia, a more transient delusional or brief psychotic disorder, or a symptom response to another psychiatric or physical condition or to substance use. The typical symptoms of psychosis can range widely from delusions and hallucinations to blunted affect and perception to cognitive impairment. These manifested symptoms can potentially be treated and relieved by various classes of older and newer anti-psychotic psychotropic drugs, either alone or in combination with other psychotherapeutic modalities, over various phases of pharmacotherapy. The scope of this assessment can be defined in terms of these three considerations: the types of conditions classified as psychotic along with common psychotic symptoms through which these conditions may be manifested (Conditions Addressed), the classes of psychotropic drugs that are generally identified and used as anti-psychotic pharmacotherapy agents (Drug Classes), and the various phases of treatment through which pharmacotherapy treatment may pass (Shaner et al, 1998).

Conditions addressed this assessment evaluates the effectiveness and use of anti-psychotic drugs in the treatment and relief of psychosis and its symptoms. The diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV) identifies psychosis and psychotic disorders as being "all characterized by having psychotic symptoms as the defining feature" (DSM-IV) rather than identifying them in terms of causation or mechanism. For purposes of this assessment, and to guide the panel in its work, psychosis was defined as experiencing and exhibiting psychotic symptoms regardless of the diagnostic category into which a given patient’s disorder may fall (or even if it does not clearly fall into any such category), and regardless of the mechanism of causation. Thus, schizophrenia (and all of its sub-types); schizophreniform, schizoaffective, delusional, brief psychotic, and shared psychotic disorders;

psychotic disorders that are due to a general medical or other psychiatric condition or are substance-induced; and all other displays of psychotic symptoms not otherwise classifiable are all defined as instances of psychosis. What distinguishes them are severity/activity, duration, multiplicity and, to some extent, source of symptoms rather than disease mechanism. The symptoms associated with psychosis may appear as a constellation or syndrome rather than individually, but they need not be – and rarely are – all present at once. Psychotic symptoms are often grouped into positive, negative, cognitive, and affective; these categorizations are not necessarily mutually exclusive and may overlap. In addition, the consequences of these symptoms often include impaired psychosocial adaptation and functioning and/or significant distress or suffering (Shaner et al,1998).

The major symptom-types are positive and negative; positive symptoms appear to reflect an excess or distortion of normal functions, whereas negative symptoms "appear to reflect a diminution or loss of normal functions" (DSM-IV). Positive symptoms include delusions (persecutory, grandiose, religious, sexual, etc), impaired thinking and thought disorder (loosening of associations, irrelevancies, neologisms, incoherent speech, etc), hallucinations (auditory, visual, tactile, olfactory, etc), bizarre behavior, confusion and impaired judgement, emotional instability, and severe agitation and anxiety (Shaner et al 1998).

By contrast, negative symptoms include flat or blunted affect (emotions), blunting of perception (e.g., insensitivity to pain), poverty of thought or speech (few or no thoughts or expressed thoughts and extremely concrete thinking), apathy and lack of motivation, feelings of emptiness and anhedonia (inability to experience joy), psychomotor retardation and inactivity, and social isolation. There is some difficulty in evaluating negative symptoms and whether, in any given case, they are primary symptoms of the disease or secondary reactions to the disease and/or its treatment (especially with anti-psychotic drugs, given many of their

side effects). Nevertheless, regardless of their origin, such symptoms are often present in cases of psychosis and require treatment when they are present (Shaner et al, 1998).

Cognitive symptoms include deficits in attention, perception, judgement and similar executive (problem solving) functions, memory, and learning. Affective symptoms include suicidal ideation; depressed mood, hostility or irritability, and low self-esteem; and manic mood, grandiosity, euphoria, excitement, impulsiveness, and hyperactivity. The totality of the experienced symptoms often lead to or are exacerbated by associated social and functional deficits as well, including socialization deficits, educational and vocational difficulties, difficulty in making and maintaining positive and supportive social relationships (leading to social isolation), and deficits in general social skills (Shaner et al, 1998).

There are many estimates of the prevalence and impact of psychosis and its most prominent form, schizophrenia. Both Marder and Daniel and Whitcomb estimate that schizophrenia will afflict 1% of the American population sometime in their lifetimes. Often, this disease first manifests in late adolescence or early adulthood, and is frequently chronic in nature less than 20 percent of patients recover and return to the lives they knew before. More frequently, patients have repeated episodes, with decrements in base-line functioning accompanying each one; a few never recover from the first episode (Shaner et al, 1998).

Anti-Psychotic Drug Classes This assessment reviews two classes of anti-psychotic agents: (1) the first class of anti-psychotic drugs developed – referred to as typical anti-psychotics – which are largely based on a chlorpromazine model; and (2) a newer generation class of anti-psychotic agents – referred to as atypical anti-psychotics – which largely follow a clozapine model .

Chapter 4

Methodology

Chapter 4

Methodology

4.1 Study design

This is a prospective study for 6 months time for psychotic patients attending the governmental health services, as this study design is considered suitable in describing the variables, and examining differences between the outcomes of the psychotic disorders**.**

In this research longitudinal follow up study for 6 months is considered suitable in describing the effect of treatment through the follow up.

4.2 Sample and sampling

4.2.1 Study population

The population of this study includes 283 adult patients attending the governmental health services (hospital and community mental health) in Gaza Strip.

Voluntary patients experiencing acute or chronic psychosis, schizophrenia ، brief psychotic disorder, schizophreniform disorder, schizoaffective disorder, shared psychotic disorder, delusional disorder, psychotic disorder not otherwise specified, bipolar I disorder major depressive episode , bipolar I mixed episode , bipolar I hypomanic episode ,bipolar I disorder manic episode, bipolar II disorder.

4.2.2 Target population

The target population of this study consist of 4939 psychotic patients attending governmental health services in Gaza Strip from 51203 a total population,12% from this psychotic patients attending hospital (N=34832),and 5% attending community mental health .

4.2.2 Target population

Convenient collected sample of psychotic patients attending the governmental health services (GHS) in Gaza Strip . A total sample (N=283) , 85%(N=241) of the sample is from the hospital and 15% (N=42) is from the community mental health .

4.3 Setting of study

On El Naser psychiatric hospital in tow places in the out clinic in the morning period and in the departments of the admitted patients (inpatients) and community mental health clinics (Rashad Mosmar) in Jabalia and Sorani in Gaza city.

4.4 Data collection

Structured psychiatric interview was conducted by using the fourth edition of Diagnostic and Statistical Manual of Mental Disorders DSM IV criteria and using GAF **(**Axis V is the Global Assessment of Functioning) (GAF) scale**.**

The subjects interviewed twice first interview to put the first diagnosis and GAF1 and second interview to put the second diagnosis and GAF2. The researcher depends DSM IV criteria because it is used in the previous studies and its have high validity and reliability . The criteria was modified based on the experts' assessment and tested for determining its validity and stability as well as its applicability in the Palestinian community. The Structured psychiatric interview was developed mainly with close-ended questions.

4.5 Statistical analysis

The data entered and analyzed by using SPSS for windows version 10 .The Frequency and percents was used. Chi square was used to test differences between categorical variables,

while t tests and analysis of variance (ANOVA) were used for continuous variables. Post hoc pairwise comparisons were made by Duncan test statistic. Chi square test statistic was used to examine Wilcoxon Signed Ranks for pairwise sample to know differences between first and second diagnosis. Chi square was used to know the independent variable diagnosis differences return to age, sex and marital status as dependant variables . But GAF 1 and GAF 2 was independent variables and diagnosis was dependant variable to know the effect of diagnosis and treatment on social and occupational among the follow up of psychotic patients in Gaza Strip.

4.6 Ethical consideration

Because the study haven't any experimentation it's only interview and it the nature of the researcher work and clinical observation .The researcher have the agreement from the patient and the family because the psychotic patient cant judge the matter . Family consent was used to have family agreement . However the researcher have Helsinki approval on January 2006 .

4.7 Timing

The study conducted 6 months from of 1st of Jan to 30th , June 2006. Each interview by using DSM IV criteria and using GAF have 30 minutes . The process of data entry and analysis was done between October and November 2006. The researcher continued to review the literature and writing the report till the end of December 2006.

4.8 Eligibility criteria

4.8.1 Inclusion criteria:

The psychotic patients acute and chronic (attending) in patients and out patients in hospital and community mental health .

4.8. 2 Exclusion criteria

Exclude patients those were organic cause or substance abuse .

Chapter(5)

Results

Chapter(5)

Results

Introduction

This study aimed to find the diagnostic and therapeutic outcome of psychotic patients attending governmental health services six months in the Gaza Strip. In addition the study aims to identify the GAF changes of the psychotic disorders which are associated (283 cases) of the sample.

The data was entered and analyzed by using SPSS for windows. The Frequency statistic was used to test differences for categorical variables while t tests and analysis of variance (ANOVA) were used for continuous variables. Post hoc paired comparisons were made by Duncan test statistic. Chi square test statistic was used to examine Wilcoxon Signed Ranks for paired sample to now differences between first and second diagnosis.

Chi square was used to now the diagnosis differences return to age, sex and marital status .

5.1 Distribution of the sample population by sex

As shown from a total of 159 males which represents 56.18% and 124 females which represents 43.82%. The ratio male: female=3:2 nearly.

Table (1) Distribution of the sample population by sex

Sex	Frequency	Percent
Male	159	56.18
Female	124	43.82
Total	283	100.00

5.2 Distribution of the sample population by age

As shown from a total 188 patients which represent 77% of the psychotic patients less than 40 years of the age, and 95 which represent 33% between 20 to 40 years .

Table (2) : Distribution of the sample population by age

Age	Frequency	Percent
Less than 20 years	23	8.13
From 21 -25 years	36	12.72
From 26 -30 years	41	14.49
From 31 -35 years	31	10.95
From 36 -40 years	57	20.14
From 41 -45 years	37	13.07
more than 46 years	58	20.49
Total	283	100.00

5.3 Distribution of the sample population by marital status

The sample consisted of 283 patients, according to marital status from a total 72 patients which represent 25% were single, 128 were married which represent 45%, 8 were widower which represent 3%, and 75 were divorce which represent 27%.

Table (3) : Distribution of the sample population by marital status

Marital status	Frequency	Percent
Single	72	25.44
Married	128	45.23
Widower	8	2.83
Divorce	75	26.50
Total	283	100.00

5.4 Psychotic disorders among the cases in Gaza strip at the first interview

A total of 283 patients were classified in this study as having psychoses. From a total 119 were diagnosed as schizophrenia (42%), 15 brief psychotic disorder (5.30%), 4 schizophreniform (1.41)%, 20 schizoaffective (7.07%), delusional disorder (7.42%),

psychotic disorder not otherwise (2.12%), bipolar I disorder manic episode (16.25%), bipolar I disorder major depressive episode (8.13%), bipolar I mixed episode (2.47%), bipolar I Hypomanic Episode (7.77%) .

Table (4) Frequencies and percent for diagnosis of psychotic disorders among the sample cases attending governmental services in Gaza Strip at the first interview

First diagnosis	Frequency	Percent
Schizophrenia	119	42.05
Brief Psychotic Disorder	15	5.30
Schizophreniform Disorder	4	1.41
Schizoaffective	20	7.07
Delusional Disorder	21	7.42
Psychotic Disorder not Otherwise	6	2.12
Bipolar I Disorder Manic Episode	46	16.25
Bipolar I Disorder Major Depressive Episode	23	8.13
Bipolar I Mixed Episode	7	2.47
Bipolar I Hypo manic Episode	22	7.77
Total	283	100.00

5.5 Diagnosis of psychotic disorders among the sample cases attending governmental services in Gaza Strip at the second interview

A total of 283 patients were classified in this study as having psychoses 132 were diagnosed as schizophrenia, 14brief psychotic disorder, 4 schizophreniform disorder, 18 schizoaffective, 16 delusional disorder, 6 psychotic disorder not otherwise, 42 bipolar I disorder manic episode, 22 bipolar I disorder major depressive episode, 7 bipolar I mixed episode and 22 bipolar I hypomanic episode.

Table (5) Frequencies and percent for diagnosis of psychotic disorders among cases attending governmental services in Gaza strip at second interview

second diagnosis	Frequency	Percent
Schizophrenia	132	46.64
Brief Psychotic Disorder	14	4.95
schizophreniform Disorder	4	1.41
Schizoaffective	18	6.36
Delusional Disorder	16	5.65
Psychotic Disorder not Otherwise	6	2.12
Bipolar I Disorder Manic Episode	42	14.84
Bipolar I Disorder Major Depressive Episode	22	7.77
Bipolar I Mixed Episode	7	2.47
Bipolar I Hypomanic Episode	22	7.77
Total	283	100.00

5.6 Diagnoses of psychotic patient at the first stage according to sex

The table shows that a total of 283 patients were classified in this study as having psychoses, receiving DSM V diagnoses, and $X^2 = 42.326$, df = 9, and P value = 0.000 that means there were statistical significant differences between males and females in diagnoses .

From a total 124 Female, 38schizophrenia, 10 brief psychotic disorder , 4 schizophreniform disorder, 14 schizoaffective, 7 delusional disorder , 6 psychotic disorder not otherwise, 29 bipolar I disorder manic episode , 9 bipolar I disorder major depressive episode , 3 bipolar I mixed episode and 4 bipolar I hypomanic episode , but table shows that males a total of 283 patients were 159, 81schizophrenia, 5 brief psychotic disorder, 6 schizoaffective , 14 delusional disorder, 17 bipolar I disorder manic episode, 14 bipolar I disorder major depressive episode, 4 bipolar I mixed episode and 18 bipolar I hypomanic episode table (8) .

Table (6) Distribution of diagnoses at first stage according to sex

First diagnoses	male	female	Total	X^2 Value	df	P value	Sig. level
Schizophrenia	81	38	119				
Brief Psychotic Disorder	5	10	15				
Schizophreniform Disorder		4	4				
Schizoaffective	6	14	20				
Delusional Disorder	14	7	21				
Psychotic Disorder not Otherwise		6	6	42.326	9	0.000	sig. at 0.01
Bipolar I Disorder Manic Episode	17	29	46				
Bipolar I Disorder Major Depressive Episode	14	9	23				
Bipolar I Mixed Episode	4	3	7				
Bipolar I Hypomanic Episode	18	4	22				
	159	124	283				

5.7 Second diagnoses and distribution between males and females .

The table shows that a total of 283 patients were classified in this study as having psychoses, receiving DSM V diagnoses of female (N =124), schizophrenia (N=46) brief psychotic disorder (N = 10), schizophreniform disorder(N=4), schizoaffective (N=11), delusional

disorder (N=4), psychotic disorder not otherwise (N=6), bipolar I disorder manic episode (N=27), bipolar I disorder major depressive episode (N=9), bipolar I mixed episode (N=3) and bipolar I hypomanic episode (N=4) , but table shows that males a total of 283 patients were (N =159), schizophrenia (N=86) brief psychotic disorder (N = 4), schizophreniform disorder(N=0), schizoaffective (N=7), delusional disorder (N=12), psychotic disorder not otherwise (N=0), bipolar I disorder manic episode (N=15), bipolar I disorder major depressive episode (N=13), bipolar I mixed episode (N=4) and bipolar I hypomanic episode (N=18)**.**

Table (7) second diagnoses and distribution between males and females .

Second diagnoses	male	female	Total	X2 Value	df	P value	Sig. level
schizophrenia	86	46	132	39.058	9	0.000	sig. at 0.01
Brief Psychotic Disorder	4	10	14				
schizophreniform Disorder		4	4				
Schizoaffective	7	11	18				
Delusional Disorder	12	4	16				
Psychotic Disorder not Otherwise		6	6				
Bipolar I Disorder Manic Episode	15	27	42				
Bipolar I Disorder Major Depressive Episode	13	9	22				
Bipolar I Mixed Episode	4	3	7				
Bipolar I Hypomanic Episode	18	4	22				
	159	124	283				

5.8 Differences in diagnosis between the two interviews

There are little differences between the two interviews of diagnosis. Most shifted of the diagnosis was from the other to schizophrenia . That could be due to changes of symptoms over 6 months or any other reasons.

The table(8S) shows that a total of 283 patients were classified in this study as having psychoses,

receiving DSM V diagnoses among the first and the second Z = -3.285, and P value = 0.001

that means there are statistical significant differences between the first and second diagnoses.

.

Table (8) Differences between the two interviews of diagnosis.

first diagnosis	first diagnosis	second diagnosis	Z	P value	Sig. level
Schizophrenia	119	132	-3.285	0.001	sig. at 0.01
Brief Psychotic Disorder	15	14			
Schizophreniform Disorder	4	4			
Schizoaffective	20	18			
Delusional Disorder	21	16			
Psychotic Disorder not Otherwise	6	6			
Bipolar I Disorder Manic Episode	46	42			
Bipolar I Disorder Major Depressive Episode	23	22			
Bipolar I Mixed Episode	7	7			
Bipolar I Hypomanic Episode	22	22			
Total	283	283			

Table (9) Wilcoxon Signed Ranks for paired sample to now differences between first and second diagnoses including Z value, and sig. level .

second diagnosis - first diagnoses	N	Mean Rank	Sum of Ranks	Z	P value	Sig. level
Negative Ranks	14	9.357	131.000	-3.285	0.001	sig. at 0.01
Positive Ranks	2	2.500	5.000			
Ties	267					
Total	283					

5.9 Global assessment of function

The subjects interviewed twice first interview to put the first diagnosis and GAF1 and second interview to put the second diagnosis and GAF2.

The researcher found that there were impairment associated with the cases of psychotic disorders, that is clear from the table (10) 90% of the GAF values between 10 to 70 .

Table (10) the GAF among the cases in Gaza strip first interview

(GAF1) Global Assessment of Function at First interview	Frequency	Percent
10	2	0.71
20	1	0.35
21	2	0.71
30	9	3.18
40	17	6.01
50	42	14.84
60	69	24.38
61	1	0.35
65	3	1.06
70	104	36.75
71	1	0.35
80	27	9.54
90	5	1.77
Total	283	100.00

There were response to treatment and the impairment associated with the cases of psychotic disorders is better than first interview , that is clear from the table (13) 85% of the GAF values above 70(Table 11) .

Table (11) the GAF among the cases in Gaza strip second interview

(GAF2) Global Assessment of Function at Second interview	Frequency	Percent	Cumulative Percent
30	2	0.71	0.71
50	5	1.77	2.47
60	27	9.54	12.37
70	72	25.44	37.81
80	109	38.52	76.33
90	51	18.02	94.35
100	16	5.65	100.00
Total	283	100.00	

5.10 Differences of the GAF

The Table (12) shows the differences of the GAF among the cases in Gaza strip at Second interview and shows the response to treatment.

Table (12) differences of the GAF among the cases in Gaza strip at Second interview

(GAF) Global Assessment of Function at Second interview	GAF1	%	GAF2	%
10	2	0.71	0	0
20	1	0.35	0	0
21	2	0.71	0	0
30	9	3.18	2	0.71
40	17	6.01	0	0
50	42	14.84	5	1.77
51	0	0	1	0.35
60	69	24.38	27	9.54
61	1	0.35	0	0
65	3	1.06	0	0
70	104	36.75	72	25.44
71	1	0.35	0	0
80	27	9.54	109	38.52
90	5	1.77	51	18.02
100	0	0	16	5.65
Total	283	100.00	283	100.00

To found the statistical significant differences between the different diagnoses in (GAF1) the researcher used One Way ANOVA.

Table (13) differences of the GAF among the cases in Gaza strip at Second interview

ANOVA	Sum of Squares	df	Mean Square	F	Sig.	Sig. level
Between Groups	5987.362	9	665.262	3.805	0.000	sig at 0.01
Within Groups	47736.16	273	174.858			
Total	53723.52	282				

Post Hoc Tests

The researcher used Duncan Post Hoc Tests to determined the GAF1 means between the subjects and he found there three groups.

Means for groups in homogeneous subsets are displayed.

a Uses Harmonic Mean Sample Size = 11.477.

b The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed. The disorders divided to 3 groups

The first group severe social and relationships impairment (GAF1 from 50 to 60)

1. Schizophreniform disorder
2. Psychotic disorder not therwise
3. Brief psychotic disorder
4. Bipolar I disorder manic episode
5. Schizophrenia
6. Bipolar I disorder major depressive episode

The second group moderate social and relationships impairment (GAF1 from 58 to 69)

1. Brief psychotic disorder
2. Bipolar I disorder manic episode
3. Schizophrenia
4. Bipolar I disorder major depressive episode
5. Schizoaffective
6. Bipolar I mixed episode
7. Delusional disorder

The third group mild social and relationships impairment (GAF1 from 64 to 73)

1. Schizoaffective
2. Bipolar I mixed episode
3. Delusional disorder
4. Bipolar I hypomanic episode

As shown from the Table (14) there are loss of social function among the psychotic patients attending governmental health services in Gaza Strip.

Table (14) (GAF1) Global assessment of function at first interview

Duncan

final diagnosis	N	1	2	3
Schiznophreniform Disorder	4	50.5000		
Psychotic Disorder not Otherwise	6	51.6667		
Brief Psychotic Disorder	14	58.5714	58.5714	
Bipolar I Disorder Manic Episode	42	60.0000	60.0000	
schizophrenia	132	60.2727	60.2727	
Bipolar I Disorder Major Depressive Episode	22	60.5000	60.5000	
Schizoaffective	18		64.4444	64.4444
Bipolar I Mixed Episode	7		65.7143	65.7143
Delusional Disorder	16		69.3750	69.3750
Bipolar I Hypomanic Episode	22			73.6364
Sig.		.116	.093	.131

As shown from the figure (1) , there are loss of social function among the psychotic patients attending governmental health services in Gaza Strip.

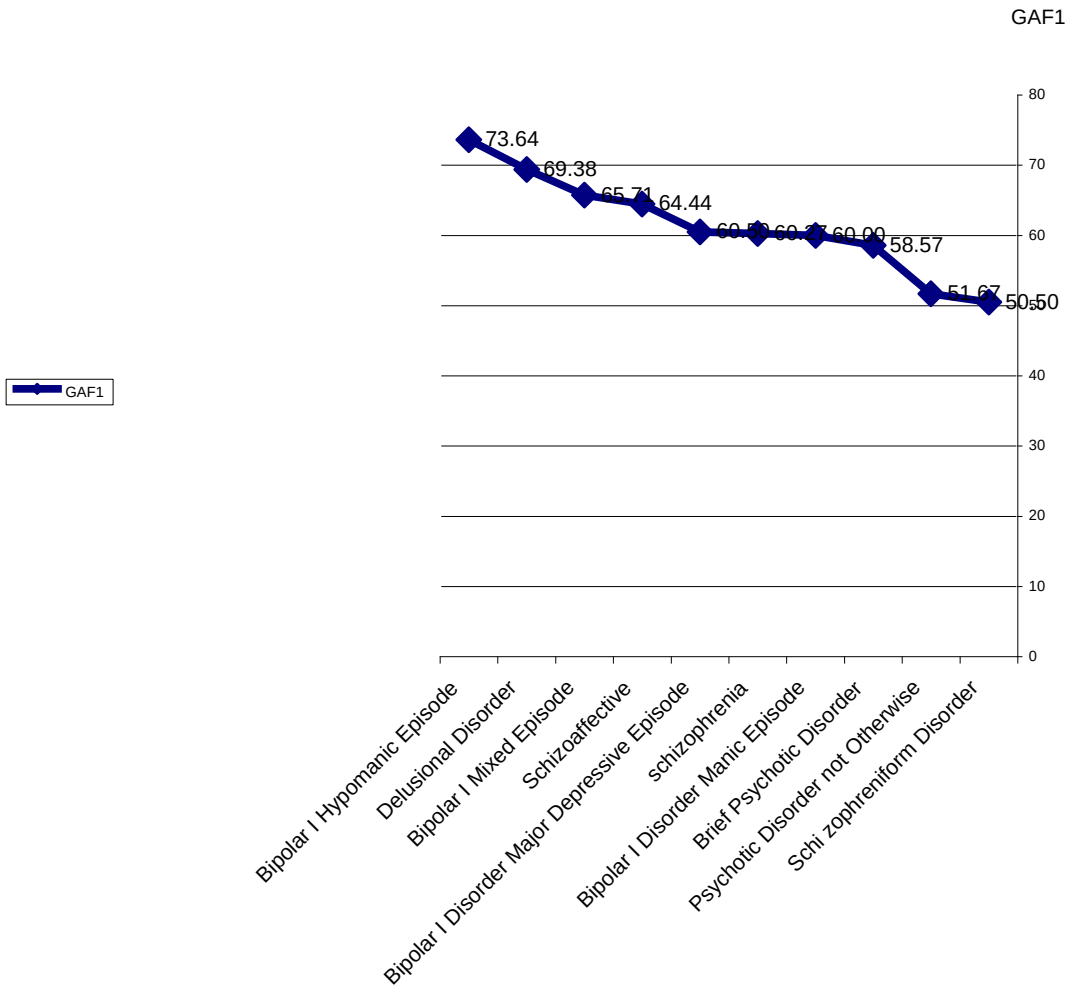


Figure:(1) explain(GAF1)

To found the statistical significant differences between the different diagnoses in (GAF2) the researcher used One Way ANOVA.

Table (15) differences between the different diagnoses in (GAF2)

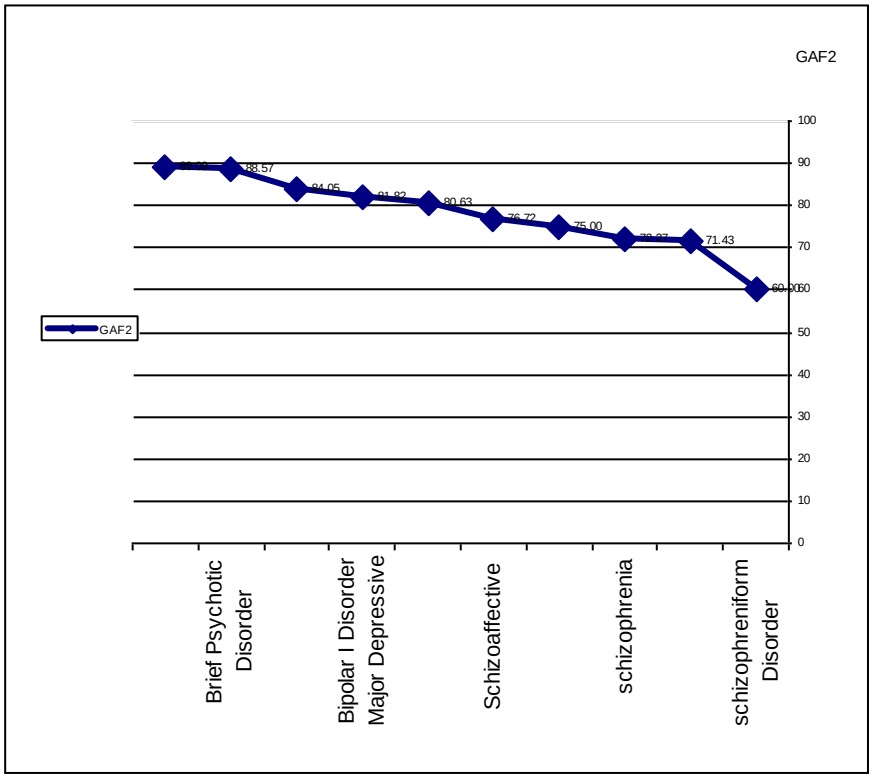
ANOVA	Sum of Squares	df	Mean Square	F	Sig.	Sig. level
Between Groups	12177.06	9	1353.007	14.268	0.000	sig at 0.01
Within Groups	25887.68	273	94.827			
Total	38064.74	282				

Table (16) (GAF2) Global assismant of function at second interview

Duncan

final diagnosis	N	1	2	3	4	5	6
Schizophreniform Disorder	4	60.0000					
Bipolar I Mixed Episode	7		71.4286				
schizophrenia	132		72.2727	72.2727			
Psychotic Disorder not Otherwise	6		75.0000	75.0000	75.0000		
Schizoaffective	18		76.7222	76.7222	76.7222	76.7222	
Delusional Disorder	16			80.6250	80.6250	80.6250	80.6250
Bipolar I Disorder Major Depressive Episode	22				81.8182	81.8182	81.8182
Bipolar I Disorder Manic Episode	42					84.0476	84.0476
Brief Psychotic Disorder	14						88.5714
Bipolar I Hypomanic Episode	22						89.0909
Sig.		1.000	.241	.061	.128	.101	.063

There are response to treatment and the impairment associated with the cases of psychotic disorders is better than first interview , that is clear from the figure (2) explain (GAF 2)



GAF (2)

Figure (2) : Explain GAF (2)

As shown of the figure 3 , there are differences in function between the first interview and second interview, which reveled that there is response to the treatment especially affective disorders

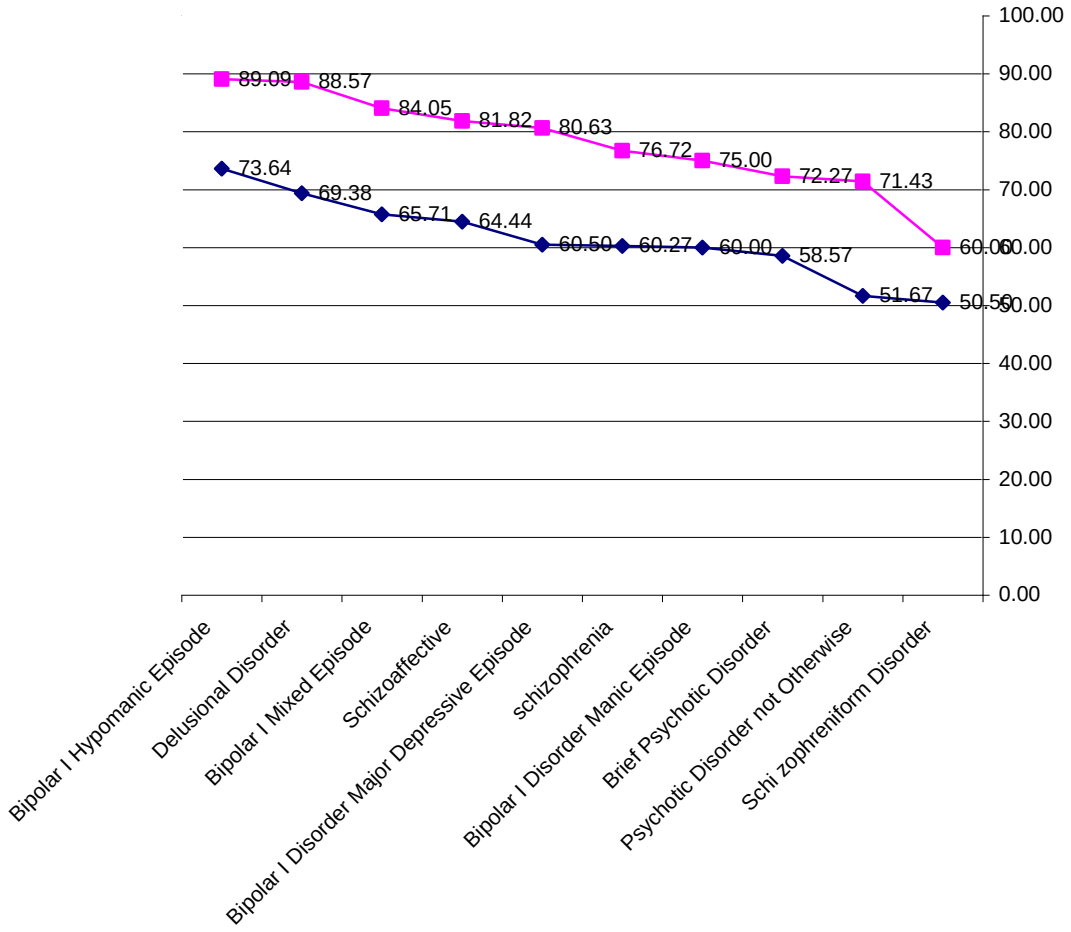


Figure 3 Differences in GAF1 and GAF2

5.11 Psychosocial disability

A large proportion of persons with experience of psychosis suffers from significant levels of psychosocial disability. The table shows that treatment affect outcome in psychosis and GAF was better especially in Bipolar disorders and brief psychotic disorder .

Table (17) GAF in the first interview and second interview after treatment of pattients

diagnoses	GAF	N	Mean	Std. Deviation	t	df	Sig. (2-tailed)	Sig. level
schizophrenia	(GAF1)	132	60.273	14.642	10.394	131	0.000	Sig. at 0.01
	(GAF2)	132	72.273	9.045				
Brief Psychotic Disorder	(GAF1)	14	58.571	9.493	9.050	13	0.000	Sig. at 0.01
	(GAF2)	14	88.571	13.506				
schizophreniform Disorder	(GAF1)	4	50.500	34.064	32.909	3	0.000	Sig. at 0.01
	(GAF2)	4	60.000	34.641				
Schizoaffective	(GAF1)	18	64.444	12.472	4.917	17	0.000	Sig. at 0.01
	(GAF2)	18	76.722	10.704				
Delusional Disorder	(GAF1)	16	69.375	11.236	3.308	15	0.005	Sig. at 0.01
	(GAF2)	16	80.625	6.801				
Psychotic Disorder non Otherwise	(GAF1)	6	51.667	13.292	3.500	5	0.017	Sig. at 0.01
	(GAF2)	6	75.000	8.367				
Bipolar I Disorder Manic Episode	(GAF1)	42	60.000	11.262	10.397	41	0.000	Sig. at 0.01
	(GAF2)	42	84.048	9.642				
Bipolar I Disorder Major Depressive Episode	(GAF1)	22	60.500	11.329	8.847	21	0.000	Sig. at 0.01
	(GAF2)	22	81.818	5.885				
Bipolar I Mixed Episode	(GAF1)	7	65.714	5.345	2.828	6	0.030	Sig. at 0.01
	(GAF2)	7	71.429	8.997				
Bipolar I Hypomanic Episode	(GAF1)	22	73.636	8.477	7.951	21	0.000	Sig. at 0.01
	(GAF2)	22	89.091	7.502				
sTotal disorders	(GAF1)	283	61.799	13.802	18.925	282	0.000	Sig. at 0.01
	(GAF2)	283	77.495	11.618				

5.12 Differences in diagnoses return to age

From total (N=283) cases (N=132)schizophrenia (N=111) cases les than 26 years, brief psychotic disorder (N=14) 50%(N=7) les than 20 years, three cases les than 26 years from schizoaffective (N=18) and most cases more than 30 years of the age, but delusional disorder most cases above 40 years of the age .Bipolar disorders allocated distribution .

Table (18) differences in diagnoses return to age

diagnoses	less than 20 years	from 21 - 25 years	from 26 - 30 years	from 31 - 35 years	from 36 - 40 years	from 41 - 45 years	more than 46 years	total	X^2 Value	df	Asymp. Sig. (2-sided)	Sig. level
schizophrenia	4	17	23	11	20	19	38	132	167.041	54.0	0.000	sig. at 0.01
Brief Psychotic Disorder	7	2	2	0	3	0	0	14				
schizophreniform Disorder	0	0	0	0	4	0	0	4				
Schizoaffective	1	2	2	2	5	5	1	18				
Delusional Disorder	0	0	0	0	1	8	7	16				
Psychotic Disorder not Otherwise	1	1	0	0	4	0	0	6				
Bipolar I Disorder Manic Episode	6	7	7	5	6	0	11	42				
Bipolar I Disorder Major Depressive Episode	0	0	4	8	8	1	1	22				
Bipolar I Mixed Episode	0	0	2	1	3	1	0	7				
Bipolar I Hypomanic Episode	4	7	1	4	3	3	0	22				
	23	36	41	31	57	37	58	283				

5.13 The diagnoses return to sex

the table(21) shows that a total of 283 patients were classified in this study as having psychoses, receiving DSM V diagnoses of female (N =124), schizophrenia (N=46) brief psychotic disorder (N = 10), schizophreniform disorder(N=4), schizoaffective (N=11), delusional disorder (N=4), psychotic disorder not otherwise (N=6), bipolar I disorder manic episode (N=27), bipolar I disorder major depressive episode (N=9), bipolar I mixed episode (N=3) and bipolar I hypomanic episode (N=4) , but table shows that males a total of 283 patients were (N =159), schizophrenia (N=86) brief psychotic disorder (N = 4), schizophreniform disorder(N=0), schizoaffective (N=7), delusional disorder (N=12), psychotic disorder not otherwise (N=0), bipolar I disorder manic episode (N=15), bipolar I disorder major depressive episode (N=13), bipolar I mixed episode (N=4) and bipolar I hypomanic episode (N=18)

5.14 Diagnoses return to marital status

Most of the interviewees were unemployed and had never married (N=155} There was widespread impairment in social relationships and in the performance of activities of daily living(Table (19).

Table (19) diagnoses return to marital status

Second diagnoses	single	married	widower	divorce	Total	X^2 Value	df	Asymp. Sig. (2-sided)	Sig. level
schizophrenia	30	63	5	34	132	42.474	27	0.030	Sig. at 0.05
Brief Psychotic Disorder	9	2	0	3	14				
schizophreniform Disorder	0	2	0	2	4				
Schizoaffective	3	6	0	9	18				
Delusional Disorder	1	10	0	5	16				
Psychotic Disorder not Otherwise	2	4	0	0	6				
Bipolar I Disorder Manic Episode	13	16	2	11	42				
Bipolar I Disorder Major Depressive Episode	2	12	1	7	22				
Bipolar I Mixed Episode	1	3	0	3	7				
Bipolar I Hypomanic Episode	11	10	0	1	22				
	72	128	8	75	283				

Chapter 6

Conclusion and recommendations

Chapter 6

Conclusion and recommendations

This chapter introduced the main results that achieved in chapter five and its discussion on the light of the previous studies.

Furthermore, its important here to clarify the results and its relation with other studies .This chapter include main results, discussion and recommendation .

6.1 Main results

A total of 283 patients were schizophrenia 42.05% (N =119), brief psychotic disorder 5.30% (N = 15), schizophreniform disorder 1.41% (N=4), schizoaffective 7.07% (N=20), delusional disorder 7.42% (N=21), psychotic disorder not Otherwise 2.12% (N=6), bipolar I disorder manic episode 16.25% (N=46), bipolar I disorder major depressive episode 8.13% (N=23), bipolar I mixed episode 2.47% (N=7) and bipolar I hypomanic episode 7.77% (N=22).This findings mean that affective psychosis forms 30% and non-affective psychosis 70% this findings is very important because the nature of bad prognosis and impairment is higher in non-affective psychosis was associated with chronic impairment and the poorest outcome.

In schizophrenia and schizoaffective disorder was associated with chronic impairment and the poorest outcome. The few subjects with this disorder had the most persistent problems with ongoing positive symptoms .

Female (N =124), schizophrenia (N=38) Brief Psychotic Disorder (N = 10), schizophreniform disorder(N=4), schizoaffective (N=14), delusional disorder (N=7), psychotic disorder not otherwise (N=6), bipolar I disorder manic episode (N=29), bipolar I disorder major depressive episode (N=9), bipolar I mixed episode (N=3) and bipolar I hypomanic episode (N=4) , but table shows that males a total of 283 patients were (N =159), schizophrenia (N=81) brief

psychotic disorder (N = 5), schizophreniform disorder(N=0), schizoaffective (N=6), delusional disorder (N=14), psychotic disorder not otherwise (N=0), bipolar I disorder manic episode (N=17), bipolar I disorder major depressive episode (N=14), bipolar I mixed episode (N=4) and bipolar I hypomanic episode (N=18).

Psychosis were higher in males in general and that due to elevation of the rate of schizophrenia disorder , delusional disorder and bipolar I hypomanic episode in the males but, the other disorders higher in females especially psychotic disorder not otherwise.

There were little differences between the two interviews of diagnosis. Most shifted of the diagnosis was from the other to schizophrenia .

There were impairment associated with the cases of psychotic disorders, 90% of the GAF values between 10 to 70.

Treatment affect outcome in psychosis and GAF was better especially in Bipolar disorders and Brief Psychotic Disorder .

There were differences in diagnosis acording to age.

Most of the interviewees were unemployed and had never married (N=155) There was widespread impairment in social relationships and in the performance of activities of daily living. This results explain the sever effect of the nature of psychotic disorders on the future of these cases on youths because its chronic disorders and need to follow up all there life and affect there social relationships.

6.2 Discussion

The present study has assessed six months longitudinal outcomes of patients psychoses within a geographically defined catchments area. Patients were not homogeneous for time since first contact with mental health services. Structure clinical interview research instrument used of information were and data were collected .The strengths of the study was the completeness and comprehensive tracing of the subjects, a high proportion of face-to-face interviews, use of DSM IV operational criteria for diagnosis and the use of standardized instrument with high interrater reliability. Previous studies used this method as (Jairam et al. 2004). The study phenotype required DSM-IV criteria of mania with elation and or grandiosity and use the young's mania rating scale (YMRS) and the children's global assessment (CGAS) and another study as McClellan et al. (1999) use in their study all subjects received an extensive diagnostic assessment upon entry into the study and at years 1 and 2. They report data only from those measures pertinent to this report. diagnostic assignment was made by using sections of the structured clinical interview for DSM-IV (SCID).

Carrie L. & Joseph F.(2003) studied group consisted of 56 patients with bipolar disorder type I (n = 46), II (n=7) or not otherwise specified (NOS; n = 3). Diagnoses of bipolar disorder, as well as of comorbid substance abuse or dependence, were made using the Structured Clinical Interview for the DSM-IV.

A total of 283 patients were classified in this study as having psychoses, receiving DSM- V diagnoses of Schizophrenia 42.05% (N =119), Brief Psychotic Disorder 5.30% (N = 15), Schizophreniform Disorder 1.41% (N=4), Schizoaffective 7.07% (N=20), Delusional Disorder 7.42% (N=21), Psychotic Disorder not Otherwise 2.12% (N=6), Bipolar I Disorder Manic Episode 16.25% (N=46), Bipolar I Disorder Major Depressive Episode 8.13% (N=23), Bipolar I Mixed Episode 2.47% (N=7) and Bipolar I Hypomanic Episode 7.77% (N=22).This

findings mean that affective psychosis forms 30% and non-affective psychosis 70% this findings is very important because the nature of bad prognosis and impairment is higher in non-affective psychosis was associated with chronic impairment and the poorest outcome. This results on line with other studies as:

On most outcome measures, non-affective psychoses had a worse outcome than affective psychoses .Affective psychoses had better outcome than previously reported (Sing et al 2000). Bipolar disorder primarily displayed a cyclical course, with bouts of illness separated by periods of remission. In contrast, subjects with schizophrenia tended to be chronically impaired (Jon et al 1999). Boydell, J. et al (2003) in their study (Incidence of schizophrenia in south-east London between 1965 and 1997). There was a continuous and statistically significant increase in the incidence of schizophrenia, which was greatest in people under 35 years of age and was not gender-specific. McClellan & McCurry (1998) found that the psychosis Non Otherwise Specific "group" is not meant to be a group, but rather a collection of youths who reported either atypical symptoms and/or did not meet full criteria for a defined psychotic illness. Sing et al (2000) found that on most outcome measures, non-affective psychoses had a worse outcome than affective psychoses. Affective psychoses had better outcome than previously reported. Substance-related psychoses had very poor occupational outcome.

In schizophrenia and schizoaffective disorder was associated with chronic impairment and the poorest outcome. The few subjects with this disorder had the most persistent problems with ongoing positive symptoms .

Carlson et al (2000) in their study found that , the mean ages at onset of bipolar disorder and the index manic episode were significantly different for the two groups . Six (26.1%) of the early-onset and five (16.6%) of the adult-onset subjects had a prior depressive episode.

But not on line with Swaran P.; & et al .(2000) non – affective and effective psychoses did not differ significantly in the rates of compulsory detention and treatment, number of hospital admissions or the overall length of stay . Significantly more than patients with non – affective than affective psychoses had a chronic, unremitting course. On the McGlashan outcome categories, patients with affective psychoses were two to three times as likely to have good symptomatic , occupational, social and global outcome as compared to those with non-affective psychoses. There was a statistically non- significant trend towards patients with affective psychoses being more satisfied with the services than patients with non-affective psychoses.

To find the differences of the first diagnoses and distribution between males and females that a total of 283 patients were classified in this study as having psychoses receiving DSM V diagnoses of female (N =124), schizophrenia (N=38) Brief Psychotic Disorder (N = 10), schizophreniform disorder(N=4), schizoaffective (N=14), delusional disorder (N=7), psychotic disorder not otherwise (N=6), bipolar I disorder manic episode (N=29), bipolar I disorder major depressive episode (N=9), bipolar I mixed episode (N=3) and bipolar I hypomanic episode (N=4) , but table shows that males a total of 283 patients were (N =159), schizophrenia (N=81) brief psychotic disorder (N = 5), schizophreniform disorder(N=0), schizoaffective (N=6), delusional disorder (N=14), psychotic disorder not otherwise (N=0), bipolar I disorder manic episode (N=17), bipolar I disorder major depressive episode (N=14), bipolar I mixed episode (N=4) and bipolar I hypomanic episode (N=18).

The researcher found that psychosis was higher among males in general and that returns to elevation of the rate of schizophrenia disorder , delusional disorder and bipolar I hypomanic episode in the males but, the other disorders was higher among females especially psychotic disorder not otherwise because all cases of this disorder return to post partum psychosis .

There are little differences between the two interviews of diagnosis. Most shifted of the diagnosis was from the other to schizophrenia .This differences return to nature of psychotic disorders as the time of length of the symptoms one of the criteria especially between brief reactive psychosis and schizophrenia ,that add to some times the symptoms not clear or not complete especially on newly cases.

There are impairment associated psychotic disorders, that is clear from the table (5.10) 90% of the GAF values between 10 to 70 between 30 and 40% of the total subjects had good outcome in all (N=283). These results are broadly comparable with previous outcome studies. There are response to treatment and the impairment associated with the cases of psychotic disorders is better than first interview , that is clear from the table (13) 85% of the GAF values above 70 .

A large proportion of persons with experience of psychosis suffers from significant levels of psychosocial disability. The table shows that treatment affect outcome in psychosis and GAF was better especially in Bipolar disorders and Brief Psychotic Disorder .This results on line other studies as ,on most outcome measures, non-affective psychoses had a worse outcome than affective psychoses .Affective psychoses had better outcome than previously reported. (Sing et al 2000) . Bipolar disorder primarily displayed a cyclical course, with bouts of illness separated by periods of remission. Subjects with schizophrenia tended to be chronically impaired (Jon et al 1999). Boydell, J. et al (2003) in their study (Incidence of schizophrenia in south-east London between 1965 and 1997).

There were differences in diagnoses return to age from total (N=283) cases (N=132)schizophrenia (N=111) cases les than 26 years, brief psychotic disorder (N=14) 50%(N=7) les than 20 years, three cases les than 26 years from schizoaffective (N=18) and most cases more than 30 years of the age, but delusional disorder most cases above 40 years of the age .Bipolar disorders allocated distribution . (Table 17) this results on line of the previous studies

as (Shaner et al 1998) patients have repeated episodes, with decrements in base-line functioning accompanying each one; a few never recover from the first episode . Studies of adolescents with bipolar disorder report a cyclical course with variable outcomes (McClellan et al., 1993; McGlashan, 1988; Strober et al., 1995; Werry et al., 1991). Choon et al(2000) found that earlier age at illness onset was associated with longer duration of untreated prodromal psychotic symptoms. Jon et al (1999) in their study, early-onset psychotic disorders were characterized by recognizable patterns of course and outcome. Bipolar disorder primarily displayed a cyclical course, with bouts of illness separated by periods of remission.

Definitive diagnosis of a psychotic disorder such as schizophrenia often requires that a patient be followed over time Ross, N. G.& Ashok M. (2002)**.**

Miller, S.M. (1987) at the 6-month research consensus diagnosis conference, however, 100% of the adult-onset subjects but only 81.8% of the early-onset group were identified as having bipolar disorder . Mixed episodes were much more likely to be experienced by the early-onset subjects (26.1% versus3.3%) and had been the most difficult to diagnose, being initially diagnosed as psychosis not otherwise specified, drug-induced psychosis, or schizoaffective disorder.

This results explain the sever effect of the nature of psychotic disorders on the future of these cases on youths because its chronic disorders and need to follow up all there life and affect there social relationships. Most of the interviewees were unemployed and had never married (N=155} There was widespread impairment in social relationships and in the performance of activities of daily living. Holliss (2000) found that the global assessment of functioning symptom scale (GAF) range expressed the variability in levels of symptoms during the follow-up period and was defined as the difference between the highest and lowest global assessment of functioning symptom scale score for each subject.

Gureje et al (2002) found that most of the interviewees were unemployed and had never married. There was widespread impairment in sexual and social relationships and in the performance of activities of daily living.

6.3 Recommendations

1. There are need to developing protocols of diagnostic operation and criteria for diagnosis DSM IV is good for this purpose.

2.The critical importance to implement early intervention strategies for recurrent affective disorders.

3. Provide psychosocial support for psychotic patient.

4.Developing specific early intervention strategies.

5.Servieces should be easily accessible to reduce by developing community mental health centers .

6.4 Future research recommendations:

1.Future research should therefore aim at defining these risk factors more accurately, and at evaluating their relative impact and their degree of interdependence, in order to allow for the development of specific and targeted therapeutic strategies.

2.Future studies will require both qualitative and quantitative methods to explore the characteristics of environment that promote recovery.

3. Future research is therefore needed to define prodromal symptoms of psychosis, to be able to select a population at high risk of developing the illness and to develop primary preventative strategies.

4.There are need to a large-scale community study of the impact of psychoses on those experiencing the disorders as that in Australia and British survey

References

Alaqra, R.(2004). *Presentation concerning the development of the community mental health services* in the psychiatric hospital ministry of health / W.H.O , February 28th; Gaza .

Allen, F. , & First, M. (1995) .Harold DSM –IV Guidebook , *JAMA*, 27, 1812-1816.

Anne L. , Michael S., Kamran R., Gitry H., John G., & Lynn E.(2000) . Lack of association between duration of untreated illness and severity of cognitive and structural brain deficits at the first episode of schizophrenia . *Am J Psychiatry* ,157,11 -18.

Becker, A ., & Klenman, A .(2000). Anthropology and Psychiatry. *Diagnosis.Kaplan & Sadoke's Comprehensive Textbook of psychiatry (7th) Edition.* USA: Lipponcott Williams& Wilkins.

Bandura, A. (1995). Exercise of personal and collective efficacy in changing societies. In A Bandura (Ed), *Self-Efficacy in Changing Societies*. New York.

Baumeister, F., Lovell, D., DeLashmutt, S., Dunda , E., Matter, H., Zamora, J., & Harris, D.(1999). Health Resources Plan **.** *Oregon Health Resources Commission.*

Bhugra, D., Leff, J. & Mallet, R. (1997). Incidence and outcome of schizophrenia in Whites, African-Caribbeans and Asians in London. *Psychological Medicine*, 27:,791-798.

Bottlender, R .& Moller, H .(2003) .The impact of the duration of untreated psychosis on short- and long-term outcome in schizophrenia .*Current Opinion in Psychiatry*,16,39-43.

BoydellOY, J., Van, M., Lambri, D., Castle, J., Allardyce,J., & Murray, R. (2003). Incidence of schizophrenia in south-east London between 1965 and 1997. *The British Journal of Psychiatry* ,182, 45-49.

Carlson ,G., Bromet ,E., ., & Sievers ,S.(2000) Phenomenology and Outcome of Subjects With Early- and Adult-Onset Psychotic Mania. *Am J Psychiatry* , 157,213–219.

Carrie L. & Joseph F.(2003) Clinical features related to age at onset in bipolar disorder. *Journal of Affective Disorders*.82, 21-27.

Choon , B . , Andreasen, N ., Flaum, M ., Nopoulos, P., & Miller, D . (2000). Untreated Initial Psychosis: Its Relation to Quality of Life and Symptom Remission in First-Episode Schizophrenia . *Am J Psychiatry* 157,808-815 .

Conus, P., & McGorry P. (2002).First-episode mania: a neglected priority for early intervention. *Australian and New Zealand Journal of Psychiatry*; 36,158–172.

Conway, A., Melzer, D., & Hale, S. (1994) . The outcome of targeting community mental health services: evidence from the West Lambeth schizophrenia cohort **.** *BMJ* . 308,627-630 .

Davey,G. Tallis, F. & Hodgson, S. (1993). The relationship between information-seeking and information-avoiding coping styles and the reporting of psychological and physical symptoms. *Journal of Psychosomatic Research*, 37, 333-344.

Fenton, W., Mosher, L., Herrell, J., & Blyler, C. (1998) . Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness . *Am J Psychiatry* 155,516-522 .

Gaza Community Mental Health Program. *Annual report (2005).*Gaza.

Graham, T.& Diana, R. (2005). Mental health in Europe. *British Medical Journal*, 330, 613-614.

Gurej, O.; Herrman, H.; Harvey, C.; Morgan, V.; & Jablensk , A. (2002). The Australian national survey of psychotic disorders: profile of psychosocial disability and its risk factors. *Psychological Medicine* ,32, 639-647.

Harrison, G., Hopper, K.; craig, T., Laska, E., Siegel, C., & Wanderling , J. (2001).Recovery from psychotic illness : a 15 – and 25 year international follow – up study . *British Journal of Psychiatry*,1996, 506-517.

Harrison, G., Owens, D. & Holton, A. (1988). A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychological Medicine*, 18, 643-657.

Harrison, G.; Glazebrook, C.; Brewin, J.; Cantwell, R.; Dalkin, T.; Fox, R.; Jones, P.; & Medley, I.(1997). Increased Incidence of Psychotic Disorders in Migrants from the Caribbean to the United Kingdom. *Psychological Medicine*, 27(4), 799-806.

Harvey, P., Parrella, M., Mihaila, E., Bowie, C. & Davis,K. (2006). Long-term outcomes in chronically hospitalized geriatric patients with schizophrenia: Retrospective comparison of first generation and second generation antipsychotics. www. *Sin direct*.com .schizophrenia research Available online 22 August 2006

Hollis**,** C. (2000). Adult Outcomes of Child- and Adolescent-Onset Schizophrenia: Diagnostic Stability and Predictive Validity **.** *Am J Psychiatry* ,157,1652-1659**.**

Jablensky, A., Sartorius, N. & Ernberg, G. (1992). Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study. *Psychological Medicine, Monograph Supplement*, 20, 1-97.

Jairam, R., Srinath S., Girimaji C. & Seshadri S. (2004). A prospective 4–5 year follow-up of juvenile onset bipolar disorder. *Bipolar Disorders*, 6, 386–394.

Jon , M., , Chrism, M., Snell , J., & Anthony , D. (1999). Early-Onset Psychotic Disorders: Course and Outcome Over a 2-Year Period . *Psychiatric Services.* 49,684-690 .

Jon M.; Chris M., Jennie S., & DuBose, A. (1999). Early-Onset Psychotic Disorders: Course and Outcome Over a 2-Year Period. *American Academy of Child and Adolescent Psychiatry* 38(11) ,1380-1388.

Joshua , B ., Kenneth , K ., Sergio , G ., & Ronald , K . (2005) . Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States . *Psychological Medicine*,35 ,317–327.

Juan, E. , Angel, A. ., & Sing, L.(2000). International Psychiatric *Diagnosis.Kaplan & Sadoke's Comprehensive Textbook of psychiatry (7th) Edition.* USA: Lipponcott Williams& Wilkins.

Keh-Ming, L. & Kleinman, A. (1988). Psychopathology and clinical course of schizophrenia: a cross cultural perspective. *Schizophrenia Bulletin*, 14, 555-567.

Keller, M., Coryell, W., Scheftner, W., Endicott, J., Maser J. & Klerman G. (1993) .The enduring psychosocial consequences of mania and depression. *Am J Psychiatry*, 150,720–727.

Keller, M., Lavori, P., Kane, J., Gelenberg, A., Rosenbaum, J., Walzer, E. & Baker, L. (1992). Subsyndromal symptoms in bipolar disorder: A comparison of standard and low serum levels of lithium. *Arch Gen Psychiatry*, 49,371–376.

King, M., Coker, E. & Leavey, G. (1994) Incidence of psychotic illness in London: comparison of ethnic groups. *British Medical Journal*, 309, 1115-1119.

Lauriello, J., Erickson, B., & Keith, S. (2000). Schizoaffective Disorder, Schizophreniform Disorder, and Brief Psychotic Disorder. *Kaplan & Sadock's Comprehensive TextBook of Psychiatry (7th) Edition*, USA: Lipponcott Williams& Wilkins.

Littlewood, R. & Lipsedge, M. (1981). Some social and phenomenological characteristics of psychotic immigrants. *Psychological Medicine*, 11, 289-302.

Manley, M. (2000). Psychiatric Interview, History, & Mental Status Examination. *Kaplan & Sadock's Comprehensive TextBook of Psychiatry (7th) Edition*, USA: Lipponcott Williams& Wilkins.

Maziade, M., Bouchard, S. & Gingras, N. (1996). Long-term stability of diagnosis and symptom dimensions in a systematic sample of patients with onset of schizophrenia in childhood and early adolescence, II: positive/negative distinction and childhood predictors of adult outcome. *Br J Psychiatry*,169,371-378 .

McClellan, J., & McCurry, C. (1998). Neurodevelopmental pathways in schizophrenia. *Semin Clin Neuropsychiatry* ,3:320-332.

McClellan, J., Werry, J. & Ham, M. (1993). A follow-up study of early onset psychosis: comparison between outcome diagnoses of schizophrenia, mood disorders, and personality disorders. *J Autism Dev Disorder* ,23,243-262.

McKenzie, K., Van Os, J. & Fahy, T. (1995). Psychosis with good prognosis in Afro-Caribbean people now living in the United Kingdom. *British Medical Journal*, 31, 1325-1328.

Miller, S.M (1987). Monitoring and blunting :Validation of a questionnaire to assess styles of information- information seeking under threat. seeking *Journal of Personality and Social Psychology*, 52, 345-353.

Michael, P., & Nurnberg, G. (2000). Classification of mental disorders *Diagnosis.Kaplan & Sadoke's Comprehensive Textbook of psychiatry (7th) Edition.* USA: Lipponcott Williams& Wilkins.

Murthy, R.; Kumar, K.; Chisholm, D.' Thomas, T.; Sekar, K.' & Chandrashekar, C. (2005). Community outreach for untreated schizophrenia in rural India: a follow-up study of symptoms, disability, family burden and costs. *Psychological Medicine*, 35(3),341–351.

Nawata, S., , Yamauchi, K ., & Ikegami, N. (2006). Do staffing levels determine outcome in psychiatric inpatient care? – Factors related to the ratio of period hospitalized in Japan. *Psychiatry and Clinical Neurosciences*.

Nicky; G., Michael; K., Eleanor; C., Gerard; L., Sabine, J., Eric; B., & Hoar, R. (1999) .Ethnicity and outcome of psychosis. *The British Journal of Psychiatry*,175,34-42.

Olfson , M. **,** J. (2000). Mental Health Services Research. *Kaplan & Sadock's Comprehensive TextBook of Psychiatry (7th) Edition*, USA: Lipponcott Williams& Wilkins.

Oxford Advanced Learner's Dictionary of current English, London, 2004.

PCBS (Palestinian Central Bureau of Statistics). Ramallah_Palestine National.

Ramin , M. (2003) . Esra, S., & , Eveelyn, B. clinical characteristics , 4-year course, and DSM-IV classification of patients with non affective Acute Remitting psychosis . *Journal of Psychiatry* , 160, 201-211.

Ross, N. & Ashok M .(2002). Examining Adherence to Medication and Substance Use as Possible Confounds of Duration of Untreated Psychosis. The *Journal of Nervous and Mental Disease*. 190(5) ,331-334.

Robert, W. & William, T. (2000). schizophrenia : introduction and overview. *Diagnosis.Kaplan & Sadoke's Comprehensive Textbook of psychiatry (7th) Edition.* USA: Lipponcott Williams& Wilkins.

Shaner, A., Roberts, L., Eckman, T., Racenstein, M., Tsuang, T., & Mintz J**. (**1998).Sources of diagnostic uncertainty for chronically psychotic cocaine abusers. *Psychiatric Services*, 49,684-690 .

Shaw, W ., Patterson, T., Semple, S ., Halpain, M., Koch, W., Harris, J., Grant, I., & Jeste, D. (2000) . Use of Community Support Services by Middle-Aged and Older Patients With Psychotic Disorders . *Psychiatr Serv* 51,506-512 .

Singh , S ., Croudace , T ., Amin , S ., Kwiecinski , R ., Medley, I ., & Peter , A . (2000) Three-year outcome of first-episode psychoses in an established community psychiatric service **.** *The British Journal of Psychiatry,* 176, 210-216.

Skeate , A., Jackson, C., BirchwoodI ,M., & Jones ,C. (2002). Duration of untreated psychosis and pathways to care in first-episode psychosis . Investigation of help-seeking behaviour in primary care. *British Journal of Psychiatry*,1 81,73-77.

Silva, J. (2000). World aspects of psychiatry. *Diagnosis.Kaplan & Sadoke's Comprehensive Textbook of psychiatry (7th) Edition.* USA: Lipponcott Williams& Wilkins.

Sood, M . (2001) **.** A study on outcome of nonaffective psychoses in armed forces**.** *Indian Journal of Psychiatry,* 43 (2).

SPSS (1999). SPSS for Windows. SPSS Inc.: Chicago, IL.

Srinivasa , M ., Kishore , K ., Sekar , K ., & Thomas, T. (2005). Community outreach for untreated schizophrenia in rural India: a follow-up study of symptoms, disability, family burden and costs . *Psychological Medicine ,* 35 ,317–327.

Strakowski S., Williams J., Fleck D., & DelBello M. (2000). Eight-month functional outcome from mania following a first psychiatric hospitalisation. *Journal of Psychiatric Research*; 34,193–200.

Strober, M,. Schmidt-Lackner, S,. Freeman, R., Bower, S., Lampert, C. & DeAntonio, M. (1995). Recovery and relapse in adolescents with bipolar affective illness: a five-year naturalistic, prospective follow-up. *J Am Acad Child Adolesc Psychiatry* ,34,724-731.

Sugarman, P. (1992) Outcome of schizophrenia in the Afro-Caribbean Community. *Social Psychiatry and Psychiatric Epidemiology*, 27, 102-105.

Swaran, P., Burns, T., Amin, S., Jones, P. & Harrison, G. (2004). Acute and transient psychotic disorders: precursors, epidemiology, course and outcome. *The British Journal of Psychiatry,* 185, 452-459.

Swaranp , S, Tim, C., Shazad, A., Rosemary , K., Ian , M., peter, J. & Gynn, H. (2000) .Three- year outcome of first – episode psychoses in an established community psychiatric service. *British Journal of Psychiatry* , 176, 210-216.

Swartz, H. , Pilkonis, P., Frank, E., Proietti, J., & Scott J. (2005). Acute treatment outcomes in patients with bipolar I disorder and co-morbid borderline personality disorder receiving medication and psychotherapy. *Bipolar Disorder* 7, 192–197.

Takei, N., Persaud, R. & Woodruff, P. (1998). First episodes of psychosis in Afro-Caribbean and White people. An 18-year follow-up population-based study. British Journal of Psychiatry, 172, 147-153.

Tohen, M., Waternaux C., & Tsuang, M. (1990). Outcome in mania: A 4-year prospective follow-up of 75 patients utilizing survival analysis. *Arch Gen Psychiatry*. 47,1106–1111.

Trujilo, M., (2000). Cultural Psychiatry. *Kaplan & Sadock's Comprehensive TextBook of Psychiatry (7th) Edition*, USA: Lipponcott Williams& Wilkins.

Tsuang, M., Faraone, S., & Stone W. (2000). Toward Reformulating the Diagnosis of Schizophrenia *Am J Psychiatry*. 157,1041-1050.

Werry, J., & McClellan, J. (1992). Predic. ting outcome in child and adolescent (early-onset) schizophrenia and bipolar disorder. *J Am Acad Child Adolesc Psychiatry* ,31,147-150.

Werry, J., McClellan, J. & Chard, L, (1991). Early-onset schizophrenia, bipolar and schizoaffective disorders: a clinical follow-up study. *J Am Acad Child Adolesc Psychiatry* ,30,457-465.

ANNEXES

Annex 1

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

Date: 29/1/2006

التاريخ: 2006/1/29

Mr./ Addel Oda

السيد:عادل عودة

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Diagnostic outcomes of psychotic patients attending governmental mental health services.

In its meeting on January 2006 and decided the Following:-
To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر يناير 2006
و قد قررت ما يلي:-
الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Ministry of Health
Helsinki Committee

Conditions:-
- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Gaza Etwam – Telefax 972-7-2878166

Annex 2
مقابلة نفسية حسب المعايير التشخيصية DSM IV للأمراض الذهانية

عزيزي المعالج الرجاء تطبيق مجموعة الأعراض التالية على المريض الخاص بك حيث تتضمن القائمة الأعراض الذهانية موزعة حسب التصنيف الأمريكي للأمراض النفسية ولذلك يمكن أن تلاحظ بعض الأسئلة موجهة للمريض أو لأهله أو تكون نتيجة لملاحظتك أثناء المقابلة وبعد الانتهاء من المقابلة قم بوضع التشخيص المناسب ثم حدد القدرة الوظيفية حسب (GAF) المرفق مع المقابلة ودونهم في الجدول التالي:

	العمر	الجنس	الحالة الاجتماعية	التشخيص	GAF
1				**فصام عقلي Schizophrenia**	
2				**Brief PsychoticDisorder الاضطراب الذهاني الوجيز**	
3				**اضطراب شبه الفصامي Schizophreniform Disorder**	
4				**اضطراب الفصام الوجداني Schizoaffective Disorder**	
5				**الاضطراب الذهاني المشترك. Shared psychotic Disorder**	
6				**اضطراب الضلالاتDelusional Disorder**	
7				**اضطرابات ذهانية لَيستْ محدّدةَ عادةً Psychotic Disorder not otherwise**	
8				**الاضطراب ثنائي القطبين (I) النوبة الهوسية Bipolar I Disorder Manic Episode**	
9				**الاضطراب ثنائي القطبين (I) نوبة الاكتئاب. Bipolar I Disorder Major Depressive Episode**	
10				**الاضطراب ثنائي القطبين (I) النوبة المختلطة Bipolar I Mixed Episode**	
11				**الاضطراب ثنائي القطبين (II)**	
12				**الاضطراب ثنائي القطبين (I) نوبة الهوس الخفيف. Bipolar I Hypomanic Episode**	

اضطراب الفصام العقلي

أ)	هل يشكو المريض من اثنان (أو أكثر) من التالي ؟	نعم	لا
	(1) هل يشكو المريض من ضلالات؟	نعم	لا
	(2) هل يشكو المريض من هلوسة؟	نعم	لا
	(3) هل يشكو المريض من عدم ترابط في الكلام (مثال على ذلك: – انحراف أو عدم ترابط) ؟	نعم	لا
	(4) هل يشكو المريض من اضطراب في السلوك أو تخشب؟	نعم	لا
	(5) هل يشكو المريض من أعراض سلبية مثل :عدم الاهتمام بالذات أو الانطواء؟	نعم	لا
ب)	هل يوجد عجز اجتماعي/ مهني:ذو دلالة منذ بدايةِ الاضطراب، واحد أو أكثر من النواحي الرئيسيةً مِنْ الوظائف ؟	نعم	لا
	1– هل يوجد عجز في الأداء الاجتماعي؟	نعم	لا
	1 –هل يوجد عجز في العملِ؟	نعم	لا
	2–هل يوجد عجز في العلاقات الشخصية؟	نعم	لا
	3–هل يوجد عجز في العناية الذاتية؟	نعم	لا
ج)	هل الأعراض مستمرة منذ 6 شهور أو أكثر؟	نعم	لا
د)	هل تم استبعاد اضطراب الفصام الوجداني والاضطرابات المزاجية الأخرى أثناء فترة المرض ؟	نعم	لا
هـ)	هل تم استبعاد التأثيرات الفسيولوجية المباشرة الناتجة عن تعاطي المخدرات؟	نعم	لا
	هل تم استبعاد التأثيرات الفسيولوجية المباشرة الناتجة عن مرض عضوي؟	نعم	لا
ز)	هل هناك تاريخ مرضي لاضطراب التوحد أو اضطراب تطوري شامل آخر ؟	نعم	لا

المعايير التشخيصية للاضطراب الذهاني الوجيز

أ)	هل يوجد واحد أو أكثر من الأعراض التالية؟s	نعم	لا
1	هل يوجد ضلالات أو اعتقادات خاطئة؟	نعم	لا
2	هل يوجد هلاوس سمعية أو بصرية أو غيرها؟	نعم	لا
3	هل يوجد حديث غير منتظم(مثال: الانحراف المتكرر عن المسار أو عدم الترابط)؟	نعم	لا
4	هل يوجد سلوكيات مشوشة أو تخشبية او غير منظمة بدرجة كبيرة؟	نعم	لا
ب)	هل تستمر النوبة من يوم–شهر؟	نعم	لا
ج)	1–هل تم نفي أن الأعراض بسبب اضطراب المزاج المصحوب بسمات ذهانية؟	نعم	لا
	2–هل تم نفي أن الأعراض بسبب اضطراب الفصام الوجداني؟	نعم	لا
	3–هل تم نفي أن الأعراض بسبب الفصام العقلي؟	نعم	لا
	4–هل تم نفي أن الأعراض بسبب تأثيرات فسيولوجية مباشرة لبعض العقاقير (مثال: العقا قير التي يساء استخدامها أو الأدوية) أو مرض عضوي؟	نعم	لا

المعايير التشخيصية للاضطراب الذهاني المشترك.

أ)	هل يوجد اعتقاد خاطئ يُطوّرُ عند المريض ضمن سياق علاقة وثيقة مَع شخصٍ آخر لديه نفس الاعتقاد الخاطئِ؟	**نعم**	**لا**
ب)	هل الاعتقاد الخاطئِ مماثلُ في المحتوى مع ذلك الشخصِ الذي لَهُ نفس الاعتقاد الخاطئِ الأصلي ؟	**نعم**	**لا**
ج)	هل تم التحقق من أن الاضطراب لَيس ناتج بسبب الاضطرابات الذهانيةِ الأخرى؟	**نعم**	**لا**
د)	1–هل تم التحقق من أن الاضطراب لَيس ناتج بسبب التأثيراتَ الفسيولوجيةَ المباشرةَ لمادة (مثل –يتعاطى مخدر،أو دواء)؟	**نعم**	**لا**
	2–هل تم التحقق من أن الاضطراب لَيس ناتج بسبب مرض عضوي ؟	**نعم**	**لا**

Delusional Delusional Disorder اضطراب الضلالات

أ	هل يوجد اعتقادات خاطئة غير خارجه عن المنطق(بمعنى أنها تشمل الأحوال التي تحدث في الحياة الحقيقية مثل تلك التي تتبع من اعتقاد بالتسمم و الحب عن بعد أو الخيانة الزوجية أو الاعتقاد بالإصابة بمرض ما).	نعم	لا
ب	–هل المعيار الخاص بالفصام العقلي غير متطابق معه؟	نعم	لا
ت	2–هل يوجد هلاوس اللمس والشم؟	نعم	لا
ث	هل ينتج عن هذه الضلالات أي عجز في الوظائف أو سلوك شاذ؟	نعم	لا
ج	هل صاحب الاعتقادات الخاطئة نوبات مزاجية طويلة ؟	نعم	لا
ح	1–هل تم استبعاد التأثيرات الفسيولوجية المباشرة الناتجة عن تعاطي المخدرات؟	نعم	لا
خ	2–هل تم استبعاد التأثيرات الفسيولوجية المباشرة الناتجة عن مرض عضوي؟	نعم	لا

اضطرابات ذهانية لَيستْ محدّدةَ عادةً

هل هناك معلومات لا تكفي لوضع تشخيص معيّن أَو أَن هناك معلومات متناقضة، أَو اِضطرابات بالأعراضِ الذهانيةِ التي لا تُقابلُ المعاييرَ لأيّ إضرابات ذهانية معيّنة؟ الأمثلة تَتضمّنُ:	نعم	لا
1.هل هناك اختلال بعد الولادةِ العقلي post partum psychosis الذي لا يُقابلُ المعاييرَ التشخيصية لاضطرابات المزاجِ بالسمات الذهانيةِ، ، بسبب مرض عضوي ، أَو حالة ذهانية بسبب العقاقير أو المخدرات؟	نعم	لا
2.هل الأعراض الذهانية دامتْ لأقل مِنْ شهرِ 1 لكن لا تتطابق مع المعاير التشخيصية للاضطراب الذهاني الوجيز ؟	نعم	لا
3.هل هناك هلواس سمعية دائمة في غيابِ أيّ سمات أخرى؟	نعم	لا
4.هل هناك اعتقادات خاطئة غير غريبة دائمة تتَدَاخُل بفتراتِ نوبات مزاجِية مع اضطراب الضلالات بحيث توجد لفترة كجزء أساسي من اضطراب الضلالات ؟	نعم	لا
5.هناك مواقف يستنتج فيها المعالج وجود اضطراب ذهاني ، ولاكن لا يكون قادرا على تحديد إن كان أوليا أو بسبب تأثير مرض عضوي أو بسبب عقاقير ؟	نعم	لا

اضطراب الفصام الوجداني

أ)	هل فترة المرض مستمرة ويوجد أثنائها أما نوبة اكتئاب رئيسية أو هوسية أو مختلطة ؟	نعم	لا
	هل الأعراض تقابل المعيار (أ) في الفصام العقلي؟	نعم	لا
ب)	هل هناك أثناء نفس فترة المرض ضلالات أو هلاوس لمدة أسبوعين على الأقل في غياب أعراض المزاج البارزة؟	نعم	لا
ج)	هل الأعراض تقابل المعايير لنوبة المزاج الموجودة أساسية من مدة المرض ؟	نعم	لا
د)	1-هل تم التحقق من أن الاضطراب ليس بسبب التأثيرات الفسيولوجية المباشرة لسوء استخدام دواء او مادة مخدرة ؟	نعم	لا
	2-هل تم التحقق من أن الاضطراب ليس بسبب التأثيرات الفسيولوجية المباشرة لمرض عضوي؟	نعم	لا

الاضطراب ثنائي القطبين (I) نوبة الاكتئاب الرئيسي

أ.	هل يوجد خمسة (أو أكثر) من الأعراض التالية على مدى أسبوعين متواصلين وتمثل تغيراً في الأداء الوظيفي السابق؛ على أن يكون على الأقل أحد الأعراض إما (1) مزاج مكتئب أو (2) فقدان الاهتمام أو الابتهاج؟	نعم	لا
	1)هل المزاج مكتئب أغلب اليوم كُلّ يوم تقريباً، كما يشار إليه من خلال إمّا الشخص نفسه (مثال: الشعور بالحزن أَو بأنه فارغ) أَو من خلال ملاحظات الآخرين (مثال: يَبْدو باكياً)؟	نعم	لا
	2)هل هناك انخفاض في الاهتمام أَو الرغبة في الاستمتاع والابتهاج لدرجة ملحوظة، في كل، أو غالبية الأنشطة معظم اليوم (كما يشار إليه من خلال إمّا الشخص نفسه أَو من خلال الملاحظات التي يبديها الآخرون)؟	نعم	لا
	3)هل يوجد فقدان الوزن بشكل ملحوظ لَيسَ بالحمية أو زيادة الوزن (مثال: حدوث تغير أكبر من 5% مِنْ وزنِ الجسمِ في الشّهر)، أَو نقصان أو زيادة الشهية تقريباً كُلّ يوم؟	نعم	لا
	4)هل هناك أرق أو زيادة النوم تقريباً كُلّ يوم؟	نعم	لا
	5)هل يوجد تهيج أوتقهقر حركي نفسي تقريباً كُلّ يوم (من خلال ملاحظات الآخرين، وليس مجرد أحاسيس ذاتية بعدم الارتياح أو بالخمول؟	نعم	لا
	6)هل يوجد تعب أو فقدان الطاقة تقريباً كُلّ يوم؟	نعم	لا
	7)هل يوجد شعور بعدم الأهمية أو بالذنب المبلغ فيه أو الغير ملائم؟	نعم	لا
	8)هل يوجد نقص في القدرة على التفكير أو التركيز، أو عدم القدرة على اتخاذ القرارات، تقريباً كُلّ يوم (سواء بالشكوى الذاتية أو من خلال ملاحظات الآخرين)؟	نعم	لا
	9)هل توجد أفكار متكررة عن الموت (ليس مجرد الخوف من الوفاة)، فكرة متكررة بالانتحار بدون وجود خطة معينة، أو محاولة انتحار أو وجود خطة معينة لتنفيذ الانتحار؟	نعم	لا
ب.	هل الأعراض لا تنطبق على المعايير التشخيصية للنوبة المختلطة؟(اكتئاب +هوس)	نعم	لا
ج.	هل الأعراض الوجدانية تسبب تقييداً هاماً، أو عجزاً في الأداء الاجتماعي، المهني، أو في نواحي وظيفية أخرى هامة؟	نعم	لا
د.	هل الأعراض ليست بسبب تأثيرات فسيولوجية مباشرة لمادة ما؟(مثال:الإدمان على المخدرات أو التسمم بأدوية)	نعم	لا
	هل الأعراض ليست بسبب مرض عضوي؟(مثال: النقص الوظيفي في الغدة الدرقية)؟	نعم	لا

أ.	هل يوجد فترة من اضطراب المزاجِ العالي، الهتوتر أو المتسع بشكل غير اعتيادي ودائم، لمدة أسبوع على الأقل (أو أيّ مدة إذا كان دخول المستشفى ضروري)؟	نعم	لا
ب.	هل أثناء فترةِ الاضطرابِ توجد ثلاثة (أو أكثر) من الأعراضِ التاليةِ باستمرار (أربعة إذا كان المزاج متوترا" فقط) وكَانت متواجدة بدرجة ملحوظة؟	نعم	لا
	1. الإحساس بالعظمة أو التقدير العالي للذات	نعم	لا
	2. نقص الحاجة للنوم (مثال: الشعور بالارتياح بعد ثلاث ساعات من النوم فقط)	نعم	لا
	3. كثرة الكلام أكثر من العادة أو الرغبة الملحة في التواصل بالكلام	نعم	لا
	4. تطاير الأفكار أو الخبرة الذاتية بأن الأفكار تتسابق	نعم	لا
	5. تشتيت الانتباه (ويعني أن الانتباه ينجذب بسهولة بالغة بواسطة مثير خارجي غير هام أو ليس له صلة بالموضوع)		
	6. ازدياد النشاط الموجه نحو هدف محدد (إما اجتماعياً، في العمل أو المدرسة، أو جنسياً) أو التهيج الحركي النفسي	نعم	لا
	7. الانغماس المبالغ فيه في الأنشطة الاستمتاعية والتي تحمل في طياتها احتمالية عالية للتبعات المؤلمة (مثال: الانشغال في متعة الشراء بدون كوابح، الممارسات الجنسية الغير حذرة بلا مبالاة، أو الاستثمارات الحمقاء في المشاريع)	نعم	لا
ج.	هل الأعراض لا تنطبق على المعايير التشخيصية للنوبة المختلطة؟(الاكتئاب+الهوس)	نعم	لا
د.	1-هل الأعراض الوجدانية شديدة بدرجة كافية لأن تسبب عجزاً ملحوظاً في الأداء المهني أو في النشاطات الاجتماعية الاعتيادية أو العلاقات مع الآخرين؟	نعم	لا
	2-هل الأعراض تستدعي دخول المستشفى للوقاية من إيذاء الذات أو الآخرين؟	نعم	لا
	3-هل يصاحب الأعراض سمات ذهانية؟	نعم	لا
هـ.	1-هل الأعراض ليست بسبب تأثيرات فسيولوجية مباشرة لمادة ما (مثال:الإدمان على المخدرات)؟	نعم	لا
	2-هل الأعراض ليست بسبب حالة مرض عضوي (مثال: الإفراط الوظيفي في الغدة الدرقية)؟	نعم	لا
هـ	هل لا تعزى الأعراض إلى الحزن؟ (وهو ما يحدث بعد فقدان شخص محبوب)	نعم	لا

الاضطراب ثنائي القطبين (I) النوبة الهوسية

أ)	هل المعايير تتطابق مع كل من نوبة الهوس ونوبة الاكتئاب الرئيسي (ما عدا المدة الزمنية) تقريبا كل يوم خلال مدة لا تقل عن أسبوع ؟	نعم	لا
ب)	1–هل اضطراب المزاج يسبب عجزا ملحوظا في النوحي الوظيفية المهنية الاعتيادية والنشاطات الاجتماعية والعلاقات مع الآخرين؟	نعم	لا
	2–هل يحتاج المريض لدخول المستشفى للوقاية من إيذاء نفسه أو الآخرين؟	نعم	لا
	3–هل هناك أعراض ذهانية؟	نعم	لا
ج)	1–هل الأعراض ليست بسبب تأثيرات فسيولوجية مباشرة لمادة ما (مثال:الإدمان على المخدرات)؟	نعم	لا
	2–هل الأعراض ليست بسبب مرض عضوي (مثال: الإفراط الوظيفي في الغدة الدرقية؟	نعم	لا

الاضطراب الثنائي القطبين (I) النوبة المختلطة

أ)	هل معايير أ، د، وهـ مِنْ داءِ الفصام موجودة ؟	نعم	لا
ب)	هل الإعراض استمرت لفترة على الأقل لمدة شهرَ 1 لكن أقل مِنْ 6 شهورِ؟	نعم	لا
ج)	هل يوجد عرضان (أَو أكثر) من الأعراض التاليةِ؟	نعم	لا
	(1) بداية الأعراضِ الذهانيةِ البارزةِ خلال 4 أسابيعِ للتغييرِ الملحوظِ الأولِ في السلوكِ أَو الوظائف.	نعم	لا
	(2) تشويش أَو حيرة في ذروة النوبة الذهانية	نعم	لا
	(3) عجز مهني اجتماعي.	نعم	لا
	(4) غياب المزاج المنبسط.	نعم	لا

اضطراب شبه الفصامي

أ)	هل يوجد نوبة اكتئاب رئيسي أو أكثر حاليا أو في الماضي؟	نعم	لا
ب)	هل يوجد نوبة هوس خفيف أو أكثر حاليا أو في الماضي؟	نعم	لا
ج)	هل تم التأكد من عدم وجود أي نوبة هوس أو مختلطة؟	نعم	لا
د)	هل النوبة لَمْ تكن بسبب وجود مرض آخر مثل الفصام الوجداني، اضطراب الفصام، الاضطراب فصامي الشكل، اضطراب الضلالات، الاضطراب الذهاني غير المحدّد ؟	نعم	لا
هـ)	هل الأعراض تسبب تقييداً هاماً، أو عجزاً في الأداء الاجتماعي، المهني، أو في نواحي وظيفية أخرى هامة؟	نعم	لا

المعايير التشخيصية الاضطراب ثنائي القطبين (II)

أ.	هل يوجد فترة من اضطراب المزاجِ العالي، الهتوتر أو المتسع بشكل غير اعتيادي ودائم، لمدة أسبوع على الأقل (أو أيّ مدة إذا كان دخول المستشفى ضروري)؟	نعم	لا
ب.	هل أثناء فترةِ الاضطرابِ توجد ثلاثة (أو أكثر) من الأعراضِ التاليةِ باستمرار (أربعة إذا كان المزاج متوترا" فقط) وكَانت متواجدة بدرجة ملحوظة؟	نعم	لا
	1. الإحساس بالعظمة أو التقدير العالي للذات	نعم	لا
	2. نقص الحاجة للنوم (مثال: الشعور بالارتياح بعد ثلاث ساعات من النوم فقط)	نعم	لا
	3. كثرة الكلام أكثر من العادة أو الرغبة الملحة في التواصل بالكلام	نعم	لا
	4. تطاير الأفكار أو الخبرة الذاتية بأن الأفكار تتسابق	نعم	لا
	5. تشتيت الانتباه (ويعني أن الانتباه ينجذب بسهولة بالغة بواسطة مثير خارجي غير هام أو ليس له صلة بالموضوع)	نعم	لا
	6. ازدياد النشاط الموجه نحو هدف محدد (إما اجتماعياً، في العمل أو المدرسة، أو جنسياً) أو التهيج الحركي النفسي	نعم	لا
	7. الانغماس المبالغ فيه في الأنشطة الاستمتاعية والتي تحمل في طياتها احتمالية عالية للتبعات المؤلمة (مثال: الانشغال في متعة الشراء بدون كوابح، الممارسات الجنسية الغير حذرة بلا مبالاة، أو الاستثمارات الحمقاء في المشاريع)	نعم	لا
ج.	هل الأعراض لا تنطبق على المعايير التشخيصية للنوبة المختلطة؟(الاكتئاب+الهوس)	نعم	لا
د.	1-هل الأعراض الوجدانية شديدة بدرجة كافية لأن تسبب عجزاً ملحوظاً في الأداء المهني أو في النشاطات الاجتماعية الاعتيادية أو العلاقات مع الآخرين؟	نعم	لا
	2-هل الأعراض تستدعي دخول المستشفى للوقاية من إيذاء الذات أو الآخرين؟	نعم	لا
	3-هل يصاحب الأعراض سمات ذهانية؟	نعم	لا
هـ.	1-هل الأعراض ليست بسبب تأثيرات فسيولوجية مباشرة لمادة ما (مثال:الإدمان على المخدرات)؟	نعم	لا
	2-هل الأعراض ليست بسبب حالة مرض عضوي (مثال: الإفراط الوظيفي في الغدة الدرقية)؟	نعم	لا

الاضطراب ثنائي القطبين (I) النوبة الهوسية

(GAF) مقياس التقييم العالمي للقدرات

100-91	النشاطاتِ اليومية موجودة بشكل جيد ، لا تَبْدو هناك مشاكل في الحياةِ و لا يبدو هناك خُرُوجا عن السيطرة. لا أعراضَ.
90-81	أعراض غائبة أو أقل ما يمكن (ومثال على ذلك: -، قلق خفيف قبل امتحان)،الوظائف جيدة في اغلب المجالاتِ ، الانخراط في مدى واسع من النشاطات الاجتماعية و راضي عن الحياةِ، لا أكثر مِنْ مشاكل أَو مخاوف يومية (ومثال على ذلك: -، مشاكل عرضية مَع أفرادِ العائلة).
80-71	إذا كانت الأعراضِ موجودة تكون تفاعلات عابرة و متوقعة نتيجة رضوض نفسية اجتماعية مثل: صعوبةِ تَركيزِ ،ضعف طفيف في النواحي المهنيةِ أو الاجتماعيةَ و المدرسيةِ (ومثال على ذلك: -، يَتأخّرُ عن عمل الواجبات المدرسية بشكل مؤقت).
70-61	بَعْض الأعراضِ المعتدلةِ (ومثال على ذلك: - مزاج مكتئب وأرقَ خفيف) أو بَعْض الصعوبةِ في نواحي (مهنيةِ اجتماعية)، أَو الوظائف المدرسيةِ أَو تغيّب عرضي عن المدرسة لكن الوظائف بشكل عام جيدة ، سرقة، و لَهُ بَعْض العِلاقاتِ الشخصيةِ ذات المغزى.
60-51	أعراض معتدلة (ومثال على ذلك: هجمات رعبِ عرضيةِ) أو صعوبةً متوسطة في الوظائف المهنية أو الاجتماعية،أو المدرسية (ومثال على ذلك: -، قلة الأصدقاءِ وصراعات مع زملاءِ العمل).
50-41	أعراض جدية مثل أفكار انتحارية، أو طقوس وسواسية شديدة و السرقة المتكررة أو أيّ ضعف جدّي في الناحية المهنيةِ أوِ الاجتماعية، أَو المدرسيةِ (ومثال على ذلك: -، عدم وجود أصدقاءَ أو الاحتفاظ بمهنة)
40-31	بعض الخلل في الواقعية (ومثال على ذلك: -، حديث غير منطقيُ أحياناً أو ليس ذو علاقة) أو ضعف رئيسي في عِدّة نواحي، مثل العملِ أَو المدرسةِ، العلاقات العائلية ،خلل في الحكم علي الأمور، التَفْكير، أَو المزاج .
30-21	سلوك يُتأثّرُ بالاعتقادات الخاطئة أو الهلاوسِ إلى حد كبير أو ضعف جدي في الاتصال أو الحكم على الأمور(و مثال على ذلك :متفكك أحيانا يتصرف بشكل غير ملائم أفكار انتحارية) أو عدم قابلية للعمل عجز تقريبا فيً كُلّ النواحي، في العمل، البيت، أَو الأصدقاء ويقضي معظم وقته في السرير.
20-11	بَعْض الخطر منِ إيذاء النفسِ أو الآخرين .محاولات انتحار بدون توقّعِ واضحِ مِنْ الموتِ، حماس هوسي عَنيف كثيراً) أَو يُخفقونَ في إبْقاء النظافةِ الشخصيةِ علي الأقل من حينٍ لآخر (ومثال على ذلك: -، يُلطّخُ غائطاً) أَو ضعف إجمالي في التفكير،أو أن التفكير متفكّك أَو صامت بشكل كبير.
10-1	خطر دائم بشدَّة إيذاء نفسِ أَو آخرين (ومثال على ذلك: -، عنف متكرّر) أَو عدم قابلية دائمة لإبْقاء النظافةِ الشخصيةِ ما يمكنِ أَو الفعلِ الانتحاري الجدّي بالتوقّعِ الواضحِ مِنْ الموت.
0	معلوماتِ ناقصةِ

Annex 3

DSM-IV Diagnostic Criteria for Psychotic disorders

DSM-IV Diagnostic Criteria for Schizophrenia

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions
(2) hallucinations
(3) disorganized speech (eg, frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior
(5) negative symptoms, i.e, affective flattening, alogia, or avolition

Note: Only one criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet criterion A (ie, active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in criterion A present in an attenuated form (eg, odd beliefs, unusual perceptual experiences).

D. Schizoaffective and mood disorder exclusion: Schizoaffective disorder and mood disorder with psychotic features have been ruled out because either: (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition.

F. Relationship to a pervasive developmental disorder: If there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):

Episodic with interepisode residual symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); ***also specify if***: with prominent negative symptoms

Episodic with no interepisode residual symptoms

Continuous (prominent psychotic symptoms are present throughout the period of observation); also specify if: with prominent negative symptoms

Single episode in partial remission; ***also specify if:*** with prominent negative symptoms

Single episode in full remission

Other or unspecified pattern

DSM-IV Diagnostic Criteria for Brief Psychotic Disorder

A. Presence of one (or more) of the following symptoms:
(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior

Note: Do not include a symptom if it is a culturally sanctioned response pattern.

B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

C. The disturbance is not better accounted for by a mood disorder with psychotic features, schizoaffective disorder, or schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With marked stressor(s) (brief reactive psychosis): if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture

Without marked stressor(s): if psychotic symptoms do not occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture

With postpartum onset: if onset within 4 weeks postpartum

DSM-IV Diagnostic Criteria for Schizophreniform Disorder

A. Criteria A, D, and E of schizophrenia are met.

B. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months. (When the diagnosis must be made without waiting for recovery, it should be qualified as "provisional.")

Specify if:

Without good prognostic features

With good prognostic features as evidenced by two (or more) of the following:
(1) onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning
(2) confusion or perplexity at the height of the psychotic episode
(3) good premorbid social and occupational functioning
(4) absence of blunted or flat affect

DSM-IV Diagnostic Criteria for Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a major depressive episode, a manic episode, or a mixed episode concurrent with symptoms that meet criterion A for schizophrenia.

Note: The major depressive episode must include criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

DSM-IV Diagnostic Criteria for Shared Psychotic Disorder

A. A delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion.
B. The delusion is similar in content to that of the person who already has the established delusion.
C. The disturbance is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

DSM-IV Diagnostic Criteria for Delusional Disorder

A. Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration.
B. Criterion A for schizophrenia has never been met. Note: Tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional theme.
C. Apart from the impact of the delusion(s), or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.
D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
Specify type (the following types are assigned based on the predominant delusional theme):
Erotomanic type: delusions that another person, usually of higher status, is in love with the individual
Grandiose type: delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person
Jealous type: delusions that the individual's sexual partner is unfaithful
Persecutory type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way
Somatic type: delusions that the person has some physical defect or general medical condition
Mixed type: delusions characteristic of more than one of the above types but no one theme predominates
Unspecified type

Psychotic Disorder NOS: this category is used for patients who have psychotic symptoms but who do not meet the diagnostic criteria for other specifically defined psychotic disorders. DSM-IV has listed some examples of the diagnosis to help guide clinicians.
induced

DSM-IV Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a mixed episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

DSM-IV Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a mixed episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.

DSM-IV Criteria for Mixed Episode

A. The criteria are met both for a manic episode and for a major depressive episode (except for duration) nearly every day during at least a 1-week period.

B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.

DSM-IV Diagnostic Criteria for Bipolar II Disorder

A. Presence (or history) of one or more major depressive episodes.

B. Presence (or history) of at least one hypomanic episode.

C. There has never been a manic episode.

D. The mood symptoms in criteria A and B are not better accounted for by schizoaffective disorder, and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-IV Criteria for Hypomanic Episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly precipitated by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar II disorder.

Annex 4

Informed consent

نموذج موافقة لإجراء بحث

كلية الصحة العامة–فلسطين

School of Public Health

فلسطين–القدس

وزارة الصحة

جامعة القدس

ولي أمر المريض الفاضل/ .....المحترم أو المحترمة

أقوم بدراسة بحثية كمتطلب للحصول على درجة الماجستير في الصحة النفسية المجتمعية من جامعة القدس _ فلسطين وذلك حول النتائج التشخيصية للأمراض الذهانية في قطاع غزة و من ثم الخروج بنتائج وتوصيات تفيد المجتمع .

أتطلع لمشاركتكم في إتمام هذه الدراسة حيث أنها ليست مموله من أي جهة ولن يترتب على مشاركتكم فيها أي

ضرر أو التزامات أكثر من الوقت ألازم لإتمام المقابلة وإجابة الاستبيان .

سيتم جمع البيانات المطلوبة منكم خلال المقابلة وذلك لمرتين فقط وسيكون ذلك في الفترة الصباحية في مكان الدراسة ولكم الحق في رفض الإجابة أو عدم ذكر الأسماء لأن اهتماماتنا بحثية وليست شخصية وفي حالة الموافقة ستكون الإجابات موضع العناية والسرية التامة ولكم خالص الشكر والامتنان على حسن تعاونكم.

التاريخ 2005/12/7م

الباحث

عادل عودة

Annex 5

Location Map of the Palestine's