كلية الصحة العامة الفلسطينية
Palestinian School of Public Health
القدس- فلسطين
جامعة القدس
وزارة الصحة

PSYCHOSOCIAL PROBLEMS OF SUBSTANCE ABUSERS ATTENDING EL-NASER PSYCHIATRIC HOSPITAL, GAZA.

By:

ZUHAIR MUSTAFA RASSAS

Supervisor:

SALAH A. EL-SUSI (Ph.D.)

Co-supervisor:

Mohamed F. Afifi (M.D.; M.Sc.)

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master in Mental Health at Al-Quds University

August 2001

بسم الله الرحمن الرحيم

Endorsement

Thesis title

PSYCHOSOCIAL PROBLEMS OF SUBSTANCE ABUSERS ATTENDING EL-NASER PSYCHIATRIC HOSPITAL, GAZA.

Supervisor	Title
Dr. Salah A. El-Susi	Ph.D., Assistant Professor

Signature Date 25/8/2001

Co-Supervisor	Title
Dr. Mohamed F. Afifi	Master of Science in Medicine

Signature Date 25/8/2001

External examiner	Title
Dr. Mohamed G. Al-Khateeb	Ph.D., Assistant Professor

Signature Date 25.8.2001

Internal examiner	Title
Dr. Yehia Abed	Ph.D., Associate Professor

Signature Date 25.8.2001

DEDICATION

TO MY FAMILY -----

INTIFADA MARTYRS-----

STATE OF PALESTINE---

ZUHAIR M. RASSAS

ACKNOWLEDGEMENT

I gratefully express my thanks to all that have assisted me in the preparation of this study. My sincere gratitude goes to the Director General of Palestinian National Guidance **Mr. Mazen Aez-Adeen** for his continual encouragement and endless support. Thanks and Appreciation to my uncle **Mahmood Abu-Zalaf** for his financial help and support, **Dr. Marwan Abu-Zalaf**, and **Mr. Ahmad Al- Zebak.**

I would like to express my sincere gratitude to the Dean of Palestinian School of Public of Health **Dr. Yahia Abed,** and **Dr. Abedelaziz Thabet** for their advice, kind help and endless support, and **Dr. Suzanne Shasha'a** for her contribution in this work

Thanks and Appreciation to my supervisors **Dr. Salah El-Susi**, **Dr. Mohamed El- afifi**, and **Dr. Mohamed Gawad Al-khateeb** for their great advice and guidance. Special thanks and appreciates for **Mr. Reyad Afifi** , **Mr. Aa'ed El-Raba'e** and **Miss Neda'a Temraz** for their crucial observations as statisticians.

I gratefully acknowledge every body of the **Staff of the Psychiatric Hospital.**

My thanks extended to those entire not mentioned in person and who contributed in any way during this research.

I would like to express my warmest gratitude to **my family** for the tolerance shown during the years of studying and writing this thesis.

ABSTRACT

The present work is a cross sectional study conducted at EL-Naser Psychiatric Hospital in Gaza Strip - Palestine, in the year 2001.

Overall aim: This study aims to determine the comorbidity of psychosocial problems among substance abusers according to abused substances, and psychological disorders and its prevalence.

The study also determines the common abused substances among outpatients' substance abusers.

This is to provide reliable information that may help both therapists and policy makers to improve the management and control of substance abuse problem in Palestine.

Methods : 85 outpatient substance abusers attending El-Naser Psychiatric Hospital during a two month study period were interviewed separately by the investigator, and a structured questionnaire was used to collect data , The psychological disorder was measured by using GHQ-28 and substance abuse was determined by using DSM-IV criteria. The association between substance abuse and psychological disorders was assessed by using one way ANOVA.

Results : Prevalence of psychological disorders among drug abusers was (**92.9 %**), and patients were categorized as clinical cases according to GHQ scale. On the other hand, anxiety disorder (89.4 %) was the specific measure disorder of highest value, social dysfunction (87.1 %), somatic disorder (78.8 %) and depression (77.6 %) which was the lowest disorder. In the present study, Bango abusers with psychological health disorders mean (mean 12.11), were suffering the lowest psychological disorders on GHQ scale than alcohol abusers (mean 22.75), coke abusers (mean 18.95), and Psychotropic abusers (mean 20.58). The results showed that abused substances which were used compulsively and dependently by the abusers were : Coke (54.1 %), Bango and Hashish (21.2 %), Psychotropic (20 %), and Alcohol (4.7 %). Bango and Hashish (58.8 %) were the first abused substances, and Psychotropic (48.2 %) was the last abused substances.

Conclusions: Psychological disorder prevalence was high (92.9%) among substance abusers due to a long history of substance dependence, and their multiple competing life stressors, such as their ongoing need to satisfy drug dependence and social and economical livelihood as well as their poor mental health. Interventions designed to reduce psychological disorder, continuous social and economical helps and comprehensive treatment – rehabilitation programs in a separate specialized center are important and urgent need to be integrated with mental health services.

KEY WORDS: Gaza Strip, Palestine, Psychosocial disorders, Substance Abusers.

ملخص

الضغوطات النفسية والإجتماعية لدى المرضى المدمنين على المخدرات المراجعين لمستشفى النصر للصحة النفسية بقطاع غزة .

تم إجراء هذة الدراسة المقطعية على المرضى المدمنين المراجعين للعيادة الخارجية لمستشفى النصر للصحة النفسية بقطاع غزة – فلسطين خلال عام 2001 ، وكان **الهدف** منها تحديد مدى العلاقة المرضية بين الإدمان على المخدرات والمشاكل والضغوطات النفسية والإجتماعية التى يعانون منها بسبب التعاطى المستمر لأنواع مختلفة من المخدرات، وتحديد نسبة إنتشار هذة الضغوطات النفسية والإجتماعية بينهم وتحديد أنواع المخدرات المختلفة التى تعاطاها المرضى المدمنين خلال فترة إدمانهم لفترات طويلة ومستمرة، وذلك بهدف توفير معلومات صادقة للمعالجين ومتخذى القرارلتحسين الخدمة الطبية والتأهيلية للمرضى المدمنين فى فلسطين .

الأدوات : ولقد تم إستخدام أسلوب المقابلة الشخصية الفردية مع كل مدمن مريض وتم إستخدام إستبيان خاص لجمع البيانات من 85 مريضا" مدمنا"على المخدرات المختلفة بحسب الملفات والتشخيص الطبى والنفسى. وإستخدم الباحث مقياس الصحة(GHQ-28) لتحديد الإضطرابات النفسية واستخدم مقياس الدليل التشخيصى الرابع للأمراض النفسية(DSM-IV) لتحديد المدمنين والمتعاطين للمواد المخدرة. ولتحديد العلاقة بين الإدمان على المخدرات والإضطرابات النفسية تم استخدام تحليل One way ANOVA .

النتائج : كانت نتائج البيانات المجموعة فى هذة الدراسة كالتالى : أكثر أنواع المخدرات تعاطيا" وإدمانا" بين المدمنين هو الكوك (54.1 %) ، البانجو (21.2 %) ، أدوية نفسية مخدرة (20 %) ، كحول (4.7 %) ، وتبين أن البانجو والحشيش (56.5 %) هو أكثر المخدرات تعاطيا" فى بداية تجربة التعاطى كأول مخدر ، وأن الأدوية النفسية المخدرة (48.2 %) هى أكثر المخدرات تعاطيا" كأخر تجربة للتعاطى الحالى بين المدمنين.

وأظهرت نتائج الدراسة أن حوالى (**92.9 %**) من المدمنين يعانون من إضطرابات نفسية وأعتبروا حالات مرضية بحسب مقياس الصحة المستخدم ، وتبين أن حوالى (89.4 %) يعانون بالدرجة الأولى من القلق والتوترالنفسى وهو الأكثر انتشارا" بينهم، يلية العزلة الأجتماعية (87.1 %)، ثم المعاناة من الإضطرابات الجسدية (78.8 %) وأخيرا" المعاناة من.الإكتئاب (77.6 %). كما لوحظ فى الدراسة أن هناك فروقا" ذات دلالة إحصائية فى متوسط الإضطرابات النفسية بين مدمنى الكحول (متوسط 22.75) أكثر من مدمنى البانجو (متوسط12.11) ، وكذلك وجود فروق ذات دلالة إحصائية فى كل من متوسط الإضطرابات النفسية بين مدمنى الكوك (متوسط 18.95)

و مدمنى الأدوية النفسية (متوسط 20.58) أكثر من مدمنى البانجو (متوسط 12.11) ولم تتضح أى فروق إحصائية بين مدمنى الكوك ومدمنى الأدوية المخدرة النفسية .

الإستنتاجات : الضغوطات النفسية كانت منتشرة بدرجة عالية (92.9%) بين المدمنين فى الدراسة وذلك لطول مدة إدمانهم على المواد المخدرة وما صاحبة من ضغوطات الإنقطاع عن المخدر ومشاكل حياتية سواء إجتماعية أو إقتصادية. وبناءا" على النتائج المذكورة فى الدراسة فلابد من التأكيد على ضرورة التدخل المبكر وإستخدام البرامج الوقائية والتأهيلية لمنع الوقوع فى براثن آفة الإدمان. ويوصى الباحث كذلك بضرورة إستخدام برامج العلاج الشامل ضمن مركز علاجى وتأهيلى متخصص الذى يشمل بالإضافة للعلاج الطبى كلا" من التأهيل المهنى والأسرى والمجتمعى من أجل التخفيف من الضغوطات النفسية والمجتمعية الشديدة التى يعانيها المرضى المدمنين.

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LIST OF ABBREVIATIONS

APA	American Psychiatric Association
CNS	Central Nervous System
DSM	Diagnostic And Statistical Manual of Mental Disorder
ECA	Epidemiological Catchments Area
HIMS	Health Information Management System
GHSRC	Gaza Health Service Research center
GHQ	General Health Questionnaire
LSD	Lysergic Acid Diethylamide
PHC	Primary Health Care
PCBS	Palestinian Central Bureau of Statistics
PA	Palestinian Authority
PADA	Palestinian Anti Drug Administration
PTSD	Post Traumatic Stress Disorder
MOH	Ministry of Health
NIDA	National Institute on Drug Abuse
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NGOs	Non-Governmental Organizations
OTC	Over The Counter
SPSS	Statistical Package for the Social Science
SARC	Substance Abuse Research Center
SAMHSA	Substance Abuse and Mental Health Service Administration
THC	Tetrahydrocannabinol

UNIDCP	United Nation International Drug Control Program
UNRWA	United Nations For Relief and Working Agency
USA	United States of America
WHO	World Health Organization

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CHAPTER (1)

INTRODUCTION

1.1 Overview

Substance abuse has becoming one of the most widespread and public health problem in this century. Involving an increasingly broad spectrum of drugs and alcohol, the epidemic of substance abuse is affecting countries everywhere, both developed and developing. The use, abuse of and dependency on addictive substances include a wide variety of compounds consisting of Tobacco, Alcohol, Illicit drugs, Prescript medications, Inhalants, and Designer drugs. No sex, race, social strata, or culture are immune to the effects of drug abuse (1)

Substance use associated with emotional or behavioral problems, may evidence different developmental history, more severe functional impairment, and poor prognosis if the co occurrence is not taken into consideration, the presence of an unmeasured condition may confound findings concerning etiology, course, treatment, transmission, and classification for either mental illness or substance abuse (Angold et al., 1993).(2)

The WHO collaborative study done by Ustun and Satorius (1995) on psychological problems in general health care pointed that mental disorders are frequent in primary health care PHC in many countries, with three commonest conditions being major depressive episode, generalized anxiety disorder and alcohol and drugs related problems. (3)

Exposure and experimentation with mood altering substances occur in some unfortunate individuals as early as before birth from drug using mothers, but more frequently among youth in their early teens. Peer groups and media are powerful influences for the initiation of drug use and abuse. Physiological, psychological and sociological determinants pave the path to dependence. The negative effects on family, friends, work, health, legal, and social functioning are severe. (1)

Regional, national and international school surveys conducted since 1970 have consistently shown that initiation of substance use rises dramatically during early adolescence (UNIDCP, 1997 ;Desjarlais et al .,1995 ; Kalant et al 1997 (4)

In a survey applied by SAMHSA (1996c), Measures of psychosocial problems were found to be highly associated with substance use. Past month cigarette smoking and binge drinking were associated with high ratings for psychosocial problems in the past six months. For marijuana use, the relationship was more pronounced. While overall substance use is generally higher for adolescent males than for females, females with high ratings for psychosocial problems were as likely as males to smoke cigarettes binge drink, or use of illicit drugs..(5)

The long – term consequences of chronic ingestion of psychoactive substance include, impaired psychological development, physical health problems, as well as interference with important developmental tasks such as academic performance, career choice, peer socialization, and identity formation (Newcomb & Bentler, 1988) (6)

The onset of use of most substances and the initial indications of many psychosocial problems as depression, anxiety and delinquent behavior are first appear during adolescence, and both can occur on a chronic or repeated basis for many years (7).

The prevalence of co occurring emotional and behavioral problems and addictive disorders across the period of adolescence has not been clearly established. Estimates of co-occurring mental disorders and substance use problems among adolescents range from 22 to 82 percent.(7)

In Palestine, the OSLO process has resulted in drastic changes in the context of drugs. The fear of Intifada militants is gone; the network of Israeli and Palestinian dealers has been rebuilt; the Egyptian laws being enforced by the PA in Gaza do not adequately address drug abuse or distribution; the lack of a forensic lab makes investigations for drugs impossible; soaring unemployment, rapidly dying dreams of peace, political oppression, widespread PTSD, continued suffering, anger, frustration, and despair have aggravated the inclusion to reject society, and suffering both emotional and behavioral problems and use drugs. While the strong family and religious structure in Gaza and the stigma of shame, attached to drugs still provide a protection on the rise of drug use. For that, in Palestine it is necessary to clarify the relationship between the emotional and Behavioral problems and substance use among Palestinian substance abusers. Such findings may make it possible for the therapists in the psychiatric health services facilities to improve the care and management of psychosocial problems for substance abusers, and consequently improve efforts to control substance abuse problem in Gaza Strip.

1.2 Overall aim

The study aims to determine the comorbidity of psychosocial problems among substance abusers according to abused substances, and to improve not only the therapists' knowledge but also the decision makers' efforts to manage and control substance abuse problem in Palestine.

1.3 Objectives

1-To determine the prevalence of psychosocial problems among substance abusers.

2-To assess whether specific measures of psychological functioning are associated with substance abuse.

3- To determine the common abused substances.

4- To recognize the differences in psychosocial problems among substance abusers.

5- To recognize the differences in psychosocial problems according to abused drugs.

1.4 Importance of study

1) The result will be theoretically a source of valuable information on comorbidity of psychosocial problems among drug abusers in Gaza Strip.

2) The study will theoretically define the extent of psychosocial problems, which will improve future suitable treatment – rehabilitation programs.

3) Practically this study will facilitate better planning of health education and intervention programs concerning drug abuse problem.

4) The justification of the study that, there is no previous academic studies that were carried out in the field of drug abuse in Palestine in general and especially in Gaza Strip

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CHAPTER (2)

SITUATION ANALYSIS

2.1 DEMOGRAPHIC OVERVIEW

Palestinian National Authority lands consist of nine provinces in the North (West Bank) and five provinces in the south (the Gaza Strip) .The mid year population size of Palestine in 1999 was estimated at 3,097,452 of which 50.5% are males and 49.5% are females. Which forms 35.8% of all Palestine people, which are 8,598,196 as was estimated by the Palestine central bureau of statistic (PCBS) in 1999. (HMIS 2000)(8)

The provinces of the Gaza Strip (North, Gaza, Mid zone, Khan Younis and Rafah) comprise a narrow zone of land, located on the South of Palestine, constituting the coastal zone of the Palestinian territory along the Mediterranean Sea between Israel and Egypt. It is 50 kilometers long and 5-12 kilometers wide with an area of 362 square kilometres and an altitude of 0-120 feet above sea level (GHSRC 1997).(9)

In the Gaza Strip's five districts there are four towns, eight refugee camps and fourteen villages. The population in the Gaza Strip was 1,000,175 inhabitants in 1997. More than 16 percent of the populations reside in the North of Gaza, 52 percent in the central area and 32 percent in the Southern area (GHSRC 1997).

More than 61.5 percent of the population resides in the Northern provinces (West Bank) and 38.5 percent in the Southern provinces (Gaza Strip).

40 percent of that total population was refugees, 64 percent in the Gaza Strip and 27 percent in the West Bank (GHSRC 1997)(9). The rates of unemployment according to recent PCBS publications are unstable. The rate of unemployment has dropped to 14.4% in 1998, compared to the rate of 23.8% in 1996.(8)

2.2 THE HEALTH SYSTEM

The ministry of health (MOH) administers the health sector. The Palestinian National Authority is the main provider of health services, in addition to the contribution of the United Nation for Relief and Working Agency (UNRWA), the Non-governmental Organizations (NGOs) and the private sector. They operate Primary Health Care (PHC) centers, hospitals and specialized clinics. In addition to this, a number of health programs are carried out such as health education, school health, immunization, women's health and child health.

2.3 MENTAL HEALTH SERVICES IN THE GAZA STRIP

Mental Health in Palestine has been evolving as one of the national priorities for health in order to improve the mental health status of a population that was under occupation and oppression for a long time. Thus, mental health services for Palestinians have been, to a great extend, affected by the sociodemographic, political, and cultural factors. The primary victims of such adversities were children and adolescent, whom constitutes about 50% of the total population (9)

A. El Naser Psychiatric Hospital

In Gaza, the Palestinian Health Authority runs a psychiatric hospital in Gaza city (El Naser Psychiatric Hospital). The Psychiatric Hospital comes into operation in 1978. It is a 52- bed of which 11-bed are for the addiction department. The hospital providing secondary mental care to residents in Gaza city and to the whole region of Gaza Strip. The occupancy rate of the psychiatric hospital is 60-70%. The numbers of ex-addicts who come to the hospital for follow- up treatment are 110. The sanitarium of addicts still need to be further upgraded and this requires collaboration effort of all related governmental branches. (9)

B. Community Mental Health Services:

Mental Health Department runs three community mental health centers in the Gaza strip.

1. Sabha Community Mental Health Center.

This center had been established in May 1995 in Gaza city.

2. Khan Younis Community Mental Health Center:

This center was opened in Khan Younis in January 1996. This center covers the mental health services in South of the Gaza strip.

3. Beit Lahhia Community M.H.C

This is a part time clinic in north of Gaza covered by the team working in Gaza.

Beside the three community mental health centers, there is a child psychiatry clinic:

El Remal Child psychiatry Clinic:

This clinic opened on December 1994 in 2 hours weekly base. This clinic receives cases from schools, doctors and other organization for initial assessment and then this cases are seen at one of the community based centers.

2.4 THE PALESTINIAN ANTI-DRUG ADMINISTRATION

The Palestinian Anti-Drug Administration (P-ADA) was established (1994) immediately after the establishment of the Palestinian National Authority. It works in all the 15 governorates. The P-ADA works actively on the field of fighting the drugs dealer as well working hard jointly with other community organization in reducing the demand and raising the awareness among youth.(11)

2.5 SCALE OF THE SUBSTANCE ABUSE PROBLEM

Based on unofficial UNIDCP estimates, the annual global prevalence rate of illicit drugs consumption is in the range of 3-4 present of the world population, which is far below the estimated consumption of the two primary illicit substances, alcohol (50%) and tobacco (20%) .The plant based drug with the most widespread use internationally is cannabis (Hashish, Marijuana, Bango) with an estimated 141.2 million annual users. (4)

Different societies have different attitudes to drugs. In Moslem countries, alcohol (and often tobacco) are frowned upon and sometimes proscribed .In some countries , cannabis (Marihuana), opium and coca derivative have long been used and are socially , even if not legally , condoned . All societies sanction at least some forms of drug use be it purely recreational (for pleasure) or for more formal, ritualized purposes There is a strong human demand for drug – induced change of consciousness .(12)

Drug abuse is a major public health problem in United States. The reduction of this problem continues to be a national priority. National survey data indicate that drug use among American youth is the highest in the industrialized world (Doweiko, 1996) (13)

Extent of the problem in America as to the National Household Survey on Drug Abuse estimates that 12.8 million (1995),or 13 million(1996) or 6.1 % of the population age 12 and older currently use illicit drugs while about 32 million American (15.8 % of population) had engaged in binge on heavy drinking . (13)

The scale of the problem in Arabic countries is increasing continuously, the United Arab Emirates is suffering from the Inhalants, Hashish, Heroin, opium, Khat, and

Narcotic tablets. It's land is used as a transit point from the production to the consumption countries .(14)

Saudi Arabia is a country with no cultivation or production or manufacturing of any narcotics or psychotropic. Saudi Arabia suffers from the abuse of Hashish, Heroin and Kaptagon , Seconal tablets . Since 1987, S. A. has applied the execution plenty on traffickers and dealers of drugs. (14)

Syria and Jordan are also a transit point for drugs , but for Syria , there is a special lab in Halaab for transforming Morphine base to Heroin . Hashish is popular use among businessmen, while heroin is abused among youth . (14)

Farag (1980) said that cannabis resin was the favorite drug of Egyptian addicts and one of the most widely abused, came from Lebanon. Next, were psychotropic substances particularly Methaqualone which usually came from European countries . Later Opium came from Asia , which may be due to its high price .(15)

The report issued by the Egyptian General Department for narcotic control (1987) , in their study at number of cases , accused persons and caught substances in 1985 and 1986 , may reflect changes in the situation of addiction in Egypt . The study showed that there was decrease in the caught substances in 1986 as compared to 1985 . In comparing between 1985 and 1986 , there caught while there was increase in the amount of Heroin caught in that period . (15

2.5.1 Scale of substance abuse problem in Palestine

The substance abuse pattern in Palestine, is highly different from the other countries. Substance abusers who are mainly labors inside Israel, where they can easily obtain all kinds of drugs during and before they return back home in Gaza or West Bank.

Before 1948, Hashish came from Jaffa and Jerusalem, the only two cities in Palestine involved in hashish marketing and addiction. After 1948, substances began to come from Turkey and Lebanon. Families of high status as well as criminals were the main dealer with drugs. Coffee shops in Jerusalem were used by dealers and addicts as meeting places. At that time only elderly people were allowed to take drugs. Young men , children , women were not allowed to deal with these substance (Hanoun, R ; 1998).(16)

After 1967 , when Israel occupied Arabs land, drugs began to be smuggled to Palestine from Lebanon , Egypt, and Israel. Gaza and Jerusalem have become important areas for drug storage and trade . This situation continued until the outbreak of the Palestinian uprising in 1987 which decreased the spread of drug trade for political reasons during the Intifada, there was the feeling that the drug phenomenon is a threat and there were some attempts &efforts to fight it and prevent it (16)

A recent survey in Gaza Strip (UNDCP, 1999)in cooperation with Anti drug administration (in press) conducted on 400 addicts , the result showed that 60.5 % started using beer , 48 % alcoholic drink , 54 % Heroin , 59 % hashish, 58 % Bango, 17 % cough syrup , 35 % narcotic tablet . Onset age of drug use was 19 years old .

78 % of study sample, their education was below secondary school and 19.5 % of education above secondary school. (17)

Since the entry of Palestinian Authority to our land until December 1999, there were

2966 arresting cases according to the adopted legal principals, and led to control of the following quantity of drugs: Dry Bango 575.245 Kg, Bango plants 44431, Coke (mixed Heroin) 7.041 Kg, Heroin 679.7 gram, Hashish 9.74 Kg, Opium plants 13471, Tablets Narcotic 100265 , Injection Narcotic 135, Khat 1 Kg. (11)

CHAPTER (3)

LITERATURE REVIEW

3.1 TERMS AND DEFINITIONS

3.1.1 Psychosocial problems

Following Achenbach (1991) psychosocial problems were distinguished as externalizing and internalizing, the externalizing scale measures overt behavioral problems, and are the combination of the scores on the aggressive and delinquent behaviors scales, the internalizing scale summarizes emotional problems that may not be overtly evident, and it is the combination of scores on the somatic complaints, withdrawal, and anxious depressed subscales.

The cutoff points have been found to distinguish clinical (adolescence experiencing significant distress) from non clinical (normal) population. (67)

3.1.2 Drug (Substance)

The meaning of the word 'Drug 'often varies with the context in which it is used (18).

Drug, Substance, Drug dependence, Drug abuse and drug addiction are used so often and in many different ways varying across geographical locations, from country to country, and changing over time in response to social and economical pressures, it is often difficult to provide accurate ,up date, definition of the terms.(18)

From a strict scientific viewpoint, (a drug) is any substance other than food which by its chemical nature affects the structure and function of living organism. (18) From a sociological perspective, the concept of drug is a cultural artifact, a social fabrication,

The psychoactive substance abuse category is applied when maladaptive patterns of substance use do not meet criteria for dependence. This category involves substances without marked physiologic dependence characteristics and is applied when use is recent, when there are a limited number of symptoms, and when there is little evidence of taking drugs to relieve withdrawal symptoms (21).

It is useful to differentiate users and abusers (20) . Users are those individuals who have tried or continue to use alcohol or other drugs but who are not dependent or addicted. Abusers are heavily involved in alcohol or drug use , while level of abuse may range from early dependence to life – threading use , treatment is clearly the appropriate intervention . (20)

3.1.4 Substance dependence

When a person takes certain drugs in sufficient quantity over a sufficient long period of time, and stops taking them abruptly, the user will experience a set of physical symptoms known as withdrawal, which are likely include chills , fever, diarrhea , muscular twitching, nausea, vomiting ,cramps , and general body aches and pains, (20)

According to the world health organization, dependence syndrome is "cluster of physiological, behavioral, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value (22). A central descriptive characteristic of the dependence syndrome is the desire [often strong, sometimes overpowering] to take psychoactive drugs [which may or may not have been medically prescribed] including alcohol or tobacco (22).

As described in DSM-III-R, psychoactive substance use disorders are categorized as either dependence or abuse.(23)

Psychoactive substance dependence is characterized in DSM-III-R as a "cluster of cognitive, behavioral, and psychological symptoms that indicate that the person has impaired control of psychoactive substance use and continues use despite adverse consequences" (APA, 1987, p. 166). (23)

3.2 DSM-IV DIAGNOSTIC CRITERIA FOR SUBSTANCE DEPENDENCE

The DSM-IV defines the diagnostic criteria for substance dependence as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following , occurring at any time in the same 12-month period :

1) Tolerance, as defined by either of the following:
   - The need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   - Markedly diminished effect with continued use of the same amount of the substance.
2) Withdrawal, as manifested by either of the following:
   - The characteristic withdrawal syndrome for the substance.
   - The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3) Taking the substance often in larger amounts or over a longer period than was intended.
4) A persistent desire or unsuccessful efforts to cut down or control substance use.

5) Spending a great deal of time in activities necessary to obtain or use the substance or to recover from its effects.
6) Giving up social, occupational, or recreational activities because of substance abuse.
7) Continuing the substance use with the knowledge that it is causing or exacerbating a persistent or recurrent physical or psychological problem (21).

The dependence syndrome my be present for a specific substance (e.g., tobacco, or diazepam), for a class of substances(e.g., opioids drugs) , or for a wider range of different substances (20). Yet, not all drugs even when used over time and in large quantities, produce withdrawal symptoms when the substances is discontinued.

Many substances – legal, illicit, and prescribed have psychoactive properties. Some, such as tea, are so mild that they are rarely abused. Other psychoactive substances, such as those found in some plants, require the user to endure considerable effort or gastrointestinal distress and are therefore abused by few. (20).

3.3 THE CLASSES OF ABUSED SUBSTANCES

DSM-III-R defines 10 classes of substances, of which 9 are associated with both dependency and abuse (23) These classes may be grouped into three clusters, which have similar features: alcohol and sedatives, and substances with similar effects; cocaine, amphetamines, and substances with stimulant properties (including nicotine); and hallucinogens, phencyclidine (PCP), and similarly acting substances. (23)

But the DSM IV (1994) lists 11 classes of pharmacological agents: Alcohol, amphetamines or similar acting agents, caffeine, cannabis, cocaine, hallucinogens,

inhalants, nicotine, opiates, phencyclidine or similar agents, and sedative , hypnotics , and anxiolytic . There is a 12th residual category for everything else including anabolic steroids, nitrous oxide, etc..(21)

3.3.1 Alcohol

Alcohol, like heroin, cocaine, and LSD, is a psychoactive substance. Alcohol is addictive .It generates severe withdrawal symptoms when the heavy, long- term drinker discontinues its use .(24)

Alcohol, tobacco, and caffeine are the only legal psychoactive substances in most western nations, aside from certain misused non prescription medicines (e.g., glue, gasoline).(20)

Alcohol is the most used and abused psychoactive substance in all industrialized countries and in most less developed nations as well. In 1987, per capita consumption in the united states, for all persons aged 14 and older, was 2.54 gallons of pure alcohol (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1990).(25)

In the United States , it is estimated that there are 10 million alcoholics and only half a million heroin addicts (24)

Recent data from the united states indicate that nearly three-fourths of persons 12 and older used alcohol within the past year (National Institute on Drug Abuse [NIDA], 1989) (26), and 15% of adults reported ingestion of five or more drinks on one occasion during the past month (Anda, Waller, Wooten, Mast, Escobedo, & Sanderson, 1990).(26)

Alcoholism (in USA) claims tens of thousands of lives each year , ruins untold numbers of families, and costs $ 117 billion a year in everything from medical bills to lost work days, cirrhosis of liver kills at least 14,000 alcoholics a year . Drunk drivers tend to cause about half of annual driving fatalities (which in 1986 totaled 43,000 deaths) (27) Alcohol was implicated up to 70% of the 4,000 drawing deaths (1986) and in about 30 % of the nearly 30,000 suicides , nearly a third of the nation's 523,000 state prison inmates drank heavily before committing rape , buglers and assaults. As many as 45 % of the country's more than 250,000 homeless are alcoholics . (27)

Young adults tend to drink more and are less likely than older adults to abstain. Women drink less than men and are far less likely to be heavy or binge drinkers, African-Americans tend to begin using alcohol later in life than the members of the majority culture. As with virtually all of the psychoactive substance use disorders, alcohol disorders include dependence and abuse.

The symptoms of alcohol dependence and abuse vary considerably. As early as 1951 the world Health Organization (WHO) held that alcohol misuse was to some extent defined by the individual's culture (WHO, 1952).(28)

Alcoholism and excessive drinking were defined as a level that interfered with an individual's bodily and mental health, interpersonal relationships, and social and economic functioning (WHO, 1952) (28)

Study in California (Maltzman & Schweiger , 1991) conducted on 400 adolescence (280 clients in treatment center and 120 control sample) 13- 17 years . Different scales

used to detect the personal and family effects related to substance abuse in adolescence. The result showed that alcohol consumption 405 ounce compare to 109 ounce in control group . the dependence degree for alcohol was 41 / 47 compare to 26 / 47 control (47 Max degree) and for drugs the dependence degree 19 /20 compare to 10 /20 control .61 % clients and 29 % control said that one or both parents abusing drugs .(29)

3.3.2 Opioids

Heroin and morphine derivatives of the poppy, are the best known of the natural opioids. Synthetic opioids include codeine, methadone, meperidine, and other agents often prescribed for pain or cough suppression. Such as pentazocine and buprenorphine, have similar effects and are thus included in this class. (20) Opioids use typically begins in late adolescence or the early twenties. Heroin is often mixed with cocaine ("speedballs"), and may also be used in combination with many other psychoactive substances.

In Palestine Heroin always mixed with other additives to increase the bulk volume, and thus increase the money benefits. The street name for mixed heroin is (coke), and this name also popular in Israel. In 1999, there were a number of deaths in Gaza due to the toxic injections of mixed heroin.

For many years, estimates of heroin users in New York city ranged from 200,000 to 250, 000; estimates of regular users in the united states generally do not exceed 1 to 2 million. Estimates of lifetime use range between less than 1% and 4% (Day & Leonard; Fishburne, Abelson, & Cisin, 1980).(30)

Use often begins with sniffing ("Snorting") but typically progresses to skin-popping (injection under the skin) and injection into blood vessels ("mainlining")(20)

A 200-300 % excess mortality among heroin addicts has been reported in the USA. The main cause of premature death is overdose (31)

It is clear that many users move from limited to daily use. Once dependence is established, procurement of one or more daily "fixes" becomes a central activity. Many heroin users support their habits through criminal activity. (32)

Unlike stimulants, opioids do not produce a psychotic state when used in its pure form and have the ability to reduce or eliminate psychotic symptoms in mental patients. (20)

3.3.3 Cocaine

Cocaine, derived from the coca leaf, was a popular patent medicine in Europe and the United States in the late 19th century. (20)

It is worth noting that Freud was a regular user of cocaine, which was in the original formulation of coca cola. Reports of the drug's ill effects surfaced in the 19th century, and eventually the drug was outlawed in Canada and the United States in 1911 and 1914, respectively (Erickson, Adlaf, Murray, & Smart, 1987; Rosecan & Spitz, 1987).(33)

A relatively simple process renders the coca base into cocaine hydrochloride, a white water-soluble powder that is typically snorted or placed under the tongue but may also be injected.(20)

Cocaine overdose deaths in USA increased by about 300% over the period 1978-1982 (31)

In the 1970s, users discovered that cocaine has much more immediate and powerful effects if prepared in a smokable "freebase" from. Originally, freebasing required elaborate preparation with ether, but this process is now done with baking soda. "Crack" cocaine is available in many U.S cities for a few dollars, and now accounts for the bulk of cocaine used in the United States.(20)

In 1988, 10.7% and 1.5% of persons 12 and older reported lifetime and past-month use of cocaine. Lifetime and past-month crack use was reported by 1.3% and 0.2% of respondents (NIDA, 1989).(26)

3.3.4 Amphetamine or Amphetamine-like Substances

These chemical agents, often known as speed, have effects and use patterns similar to those of cocaine. Although the subjective experience of intoxication may be virtually indistinguishable from that of cocaine, amphetamines tend to last longer and may have more potent side effects.(20)

A synthetic drug, methamphetamine is related chemically to amphetamine, but produces greater effect on the CNS . It is reported that the euphoric effects are similar to but longer lasting than those of cocaine . Also , the substance is cheaper to obtain than cocaine (34)

Methamphetamine was used by soldiers to help them fight off fatigue during and after World War II (33)Legally manufactured tablets of methamphetamine were used by

college students, truck drivers, and athletes, who usually did not become severely addicted . (34)

A study in Seattle confirmed that methamphetamine use was widespread among the city's homosexual and bisexual populations. Of these groups, members using methamphetamine reported they practice sexual and needle-use behaviors that place them at risk of contracting and transmitting HIV and AIDS (37)

Ecstasy, (similar to methamphetamine and mescaline) a synthetic drug used increasingly among young adults as well as college and high students. According to NIDA' 1996 study , nearly 5 % of 10^{th} and 12^{th} graders and about 2% of 8^{th} graders said they had used ecstasy in the past year . (36)

3.3.5 Sedatives, Hypnotic, and Anxiolytic

This class of drugs is commonly known as ' Downers ' (20) .

Usually taken orally, these substances are often called tranquilizers. Commonly used substances include benzodiazepine (such as Valium), barbiturates, and methaqualone; they are prescribed to reduce anxiety, induce sleep, and relax muscles.(20)

The pharmacological properties of these drugs vary widely, but all share depressant, inhibitory effects similar to those of alcohol. Thus, intoxicated individuals may evidence increased sexual or occasionally aggressive behavior, and poor judgment in social situations and coordination across any of life's domains.

A comparative study in West Bank conducted on 32 educated young male and female Palestinian , the result showed 90 % women use Tranquilizers tablet , 85 % men use Hashish . Average age was 14-24 years . The majority of addicts were from the middle or lower class and poor families. Most of the sample had passed school failure (Hanoun, R 1998).(16)

Tolerance can readily develop to many of these psychoactive substances; withdrawal symptoms are similar to those of alcohol and, in severe cases, can be accompanied by seizures or myoclonic jerks. Even the safest of these agents (e.g., diazepam) can result in death if mixed with alcohol or other substances in this class.(20)

According to a household survey, assumed to be a method that underreports consumption, less than 2% of individuals over 12 reported use of sedatives or tranquilizers over the past month (NIDA, 1989).(26)

3.3.6 LSD

LSD (lysergic acid diethylamid) is one of the major drugs making up the hallucinogen class. LSD was discovered in 1938 and is one of the most potent mood-changing chemicals. It is manufactured from lysergic acid, which is found in ergot, a fungus that grows on rye and other grains.(37)

LSD, commonly referred to as "acid," is sold on the street in tablets, capsules, and, occasionally, liquid form. It is odorless, colorless, and has a slightly bitter taste and is usually taken by mouth. Often LSD is added to absorbent paper, such as blotter paper, and divided into small decorated squares, with each square representing one dose.(37)

The Drug Enforcement Administration reports that the strength of LSD samples obtained currently from illicit sources ranges from 20 to 80 micrograms of LSD per dose. This is considerably less than the levels reported during the 1960s and early 1970s, when the dosage ranged from 100 to 200 micrograms, or higher, per unit.(37)

3.3.7 Cannabis

Cannabis (Marijuana) is a green or gray mixture of dried, shredded flowers and leaves of the hemp plant Cannabis sativa. There are over 200 slang terms for marijuana including "pot," "herb," "weed," "boom," "Mary Jane," "gangster," and "chronic.". It is usually smoked as a cigarette (called a joint or a nail) or in a pipe or bong (37)

In Palestine the popular name is Bango, and it becomes well known soon after the first Palestinian Intifada in 1987, and the disappear of hashish from the region.

The main active chemical in marijuana is THC (delta-9-tetrahydrocannabinol). In 1988, it was discovered that the membranes of certain nerve cells contain protein receptors that bind THC. Once securely in place, THC kicks off a series of cellular reactions that ultimately lead to the high that users experience when they smoke marijuana.(37)

Marijuana, in leaf , hashish , or purified form, has according to some estimates, been tried by over 60 % of American adults (Maxmen, 1986).(38)

Study (Swaif , et al 1985) conducted on 3686 student of technical school in Cairo . The result showed 29.1 % use Cannabis , 7.2 % use Opium , 4.6 % hypnotic , 5.9 % Stimulants , 24.5 % Smoking (Okasha , 1985) (39).

The short term effects of marijuana use include problems with memory and learning; distorted perception; difficulty in thinking and problem-solving; loss of coordination; and increased heart rate, anxiety, and panic attacks.

Scientists have found that whether an individual has positive or negative sensations after smoking marijuana can be influenced by heredity. (37)

A recent study demonstrated that identical male twins were more likely than non identical male twins to report similar responses to marijuana use, indicating a genetic basis for their sensations.(37)

An epidemiological study (Swaif et al 1982) conducted on 5530 male secondary school in Cairo . The result indicated 90.7 % use Cannabis, 7.4 % use Opium, 4.7 % use Hypnotic , 5.3 % use Stimulants , 18 % Smoking .(Okasha, 1985).(39)

Recent research findings also indicate that long-term use of marijuana produces changes in the brain similar to those seen after long-term use of other major drugs of abuse (37)

Recent findings indicate that smoking marijuana while shooting up cocaine has the potential to cause severe increases in heart rate and blood pressure.

A study of college students has shown that critical skills related to attention, memory, and learning are impaired among people who use marijuana heavily, even after discontinuing its use for at least 24 hours.(37)

Longitudinal research on marijuana use among young people below college age indicates those who used have lower achievement than the non-users, more acceptance of deviant behavior, more delinquent behavior and aggression, greater rebelliousness, poorer relationships with parents, and more associations with delinquent and drug-using friends.

Research also shows more anger and more regressive behavior (thumb sucking, temper tantrums) in toddlers whose parents use marijuana than among the toddlers of non-using

parents.(37)

Some studies have found that babies born to mothers who used marijuana during pregnancy were smaller than those born to mothers who did not use the drug. In general, smaller babies are more likely to develop health problems.

A nursing mother who uses marijuana passes some of the THC to the baby in her breast milk.(37)

Research indicates that the use of marijuana by a mother during the first month of breast-feeding can impair the infant's motor development (control of muscle movement).(37)

A drug is addicting if it causes compulsive, often-uncontrollable drug craving, seeking, and use, even in the face of negative health and social consequences. Marijuana meets this criterion.

3.4 SUBSTANCE ABUSE AND ASSOCIATED PSYCHOLOGICAL DISORDERS

All psychoactive drugs cause alterations in normal mood. The severity and manner of these alterations are regulated by preexisting mood states, type and a mount of drug used, chronicity of drug use, route of drug administration, current psychiatric status, and history of mood disorders.(40)

For American adolescents (1994), psychosocial (emotional and behavioral) problems were measured during the past six months-including depression, anxiety, social withdrawal, somatic complaints, social problems, thought problems, attention problems, delinquent behavior, and aggressive behavior- and their co-occurrence with substance

use.(41) Adolescents with high problem scores during the past six months, especially high behavioral problems, were in the past 30 days more likely to use cigarettes or engage in "binge " drinking (five or more drinks on the same occasion) and much more likely to use marijuana, compared to those with lower problem scores. (41)

A psychosocial Study in Qatar (Akabawe et al , 1990) showed that 60 % drug user age 20- 29, 87 % drug user age 20- 39, 55 % were married .40 % use Hashish, 24 % Opium. More than one third sample suffering psychological disorder (depression, anxiety) ,more than one half suffering passive aggression, withdrawal, dependence, hysteria. 81 % sample were complain of health, social, economic, legal problems (42).

3.4.1 Co morbidity status

Researchers have long been aware that many drug abusers also have serious mental disorders, a status referred to as dual diagnosis or comorbidity. Does the psychiatric disorder precede and perhaps con-tribute to the onset of drug abuse? Or, conversely, do drug abuse and addiction develop first, perhaps contributing to the development of the mental disorder? (40)

A self- medication hypothesis has been advanced suggesting that some individuals use drugs because they provide temporary relief from symptoms of depression or anxiety. Depression or anxiety may be the sole etiology or one of several casual factors, including genetic and environmental vulnerabilities in substance abuse. Also depression or anxiety may alter the course of substance abuse . (Khantzian 1985; Quitkin et al 1972) (43)

Symptoms of depression and anxiety are common in-patients with substance use disorders (Meyer 1986; Schuckit 1986) (44)

Theories concerned with the relationship of substance use and mental disorders have emphasized the interaction between the symptoms of the mental disorder and the mood – altering characteristics of specific substances. It has been proposed that substance use is an attempt to self-medicate for difficult feeling status such as depression and anxiety (Khantzian, 1985)..(43)

Data from the Epidemiological Catchment Area (ECA) study (Regier et al 1990) showed that over half (53 %) of individuals who have a life time diagnosis of a drug use disorder also have a life time diagnosis of a mental disorder. Approximately two-thirds of individuals with a cocaine or opiate use disorder have at some point in their lives had a mental disorder. (45)

Other studies have demonstrated that most anxiety disorders among patients in addiction treatment are alcohol and drug induced (Anthenelli and schuckit, 1993) (44) .

Woody et al (1995) discussed the issue of why are psychiatric disorders more common among persons with substance abuse disorders? And does this association mean that drugs of abuse cause additional psychiatric disorder? They finally agreed that although epidemiological data indicate that psychopathology is common among persons with substance abuse disorder, these findings simply point to an association and cannot lead directly to conclusions about etiology .(46)

Among patients with alcohol and other drug problems, there is a significant likelihood for having a coexisting anxiety disorder.

Clinical researchers, Smail P, et al (1984) suggest an association between drug abuse and a broad spectrum of psychiatric disorders (47)

Kessler et al, (1996) stated that, The lifetime co-occurrence of mental disorders with addictive disorders was estimated to be approximately 50 %. (48)

Woody et al (1995) showed that psychoactive substance use may signal an increased risk of developing clinically significant psychiatric disturbances such as panic attacks, suicidal attempts, depressive episodes, and possibly even obsessive compulsive disorder. (46)

Adults with a major depressive episode, generalized anxiety disorder, panic attack, or agoraphobia were about twice as likely to have been dependent on cigarettes and several times more likely to have been dependent on illicit drugs than those with none of these four mental syndromes.(40)

A study conducted by Dr. Kathleen T. Brady and her colleagues (1996) at the Medical University of South Carolina provides insights into these questions. The researchers examined gender differences in psychiatric disorders among 100 treatment-seeking cocaine and alcohol abusers. Among these substance abusers, comorbidity with mental disorders was substantive. Some 48 percent of the men and 70 percent of the women had a comorbid affective or anxiety disorder. The study's preliminary findings suggest that both onset scenarios - drug abuse first or mental disorder first - sometimes may occur. It is possible that the sex of the drug abuser may be a factor in determining which comes first, depending on the comorbid psychiatric disorder involved. In the case of depressive episodes, Dr. Brady's study suggests that for women, depression comes first more often; for men, drug abuse appears to come first more often. (49)

3.4.2 Anxiety disorders

Stockwell et al (1984) found that severe anxiety disorders may well precede substance abuse in many cases, and the use of alcohol or drugs may be utilized primarily for anxiolytic purposes by these patients. However, once addicted, the patient's use of alcohol or drug may have a deleterious effect on mood creating a vicious cycle. (46)

In the general population, mood and anxiety disorders convey increased risk for substance use disorder (Regier, et al 1990) (45)

In America (1994) an estimated 14 million adults, or 7.6 % of all those age 18 or older, had a major depressive episode during the past 12 months. Generalized anxiety disorder, panic attack, and agoraphobia were each estimated to occur in about 2.0 – 2.5 % of adults (4.0 million, 4.6 million, and 3.7 million, respectively) (41)

One study (Ross, et al 1988) noted that more than 60% of patients being treated for alcohol and other drug disorder had a lifetime diagnosis of an anxiety disorder, and a bout 45% experienced an anxiety disorder within the past month (41)

The prevalence of clinically significant anxiety disorder in patients with alcohol abuse and dependence range from 25 % to 45 % for patients with clearly defined anxiety disorder, but may be approach 60 % in other identifiable anxiety disorders(Bowen et al 1984; Chambless et al 1987).(50)

Williamson et al (1997) contacted and interviewed 158 drug users about their use of ecstasy, cocaine powder and amphetamines and the adverse effects of these drugs. Subjects reported a wide range of adverse effects including anxiety problems and panic attacks. (41)

3.4.3 Depression disorders

Alcohol and other drug induced mood disorders, most notably acute depression lasting from hours to days can result from sedative- hypnotic, stimulants, marijuana, and hallucinogenic, intoxication or subacute withdrawal, lasting from weeks to months can cause episodes of depression accompanied by suicidal attempts.

In a study (Mirin &Weiss et al, 1984) showed almost 29 % of drug abusing patients satisfied DSM- III criteria for a current diagnosis of major affective disorder (major depression) compared to 6 % for male, 15 % for female in general population. (41)
Significant associations between substance use disorders and major depression have been found in general population surveys (Regier et al 1990; Robins et al 1988; Weissman and Mayers 1980) (45)
Study in England, Kent district by (Swadi , 1992)the researcher chose 46 teenagers from 352 who were treated from psychological disorder . A group of specialist applied and studied different behavioral, emotional, and family dynamics . The result showed that 13.1 % of adolescence only abused drugs, 16.3 % male , 9.3 % female , 67 % abuse solvents , 33 % use cannabis , 50 % use both solvent and cannabis together, all sample use alcohol and 83 % experience abuse of alcohol .The depression and school refusal was more among drug abuser . (39)

The co-occurrence of alcohol and drug use disorders, and major depression has frequently been reported in alcoholics, drug abuse and psychiatric patient samples (Allen and Francis 1986; Demilio 1989; El-Guebaly 1990; Rassetal 1988; Raunsaville et al 1982).(51)

3.4.4 Co morbidity treatment

Mood syndromes observed in substance dependent patients often resolve soon after abstinence or the initiation of specific treatment, such as methadone (Weddington, et al 1990) (53)

Interestingly, Mason and Kocsis (1991) recently completed placebo- controlled trial of desipramine in alcoholics who all had depression. Their results suggested that desipramine was useful in treating both depression and drinking. (55)

In recent studies (Nunes, et al 1994) bearing on the hypothesis that depression can be treated in patients with substance abuse disorders and that treatment will improve the outcome of substance abuse. These include studies of several antidepressants and lithium in alcoholics samples, of antidepressants in samples with cocaine abuse as well as samples with opiate dependence. (54)

Increasingly today, experienced practitioners are aware that the relationship between substance abuse and other psychiatric disorders is complex, and that treatment if it is to be successful, must treat both. Not treating the psychiatric disorder increase's the likelihood that the substance abusers will either dropout of treatment or relapse.

3.5 PREDISPOSING RISK FACTORS

Drug use and dependence may be explained as a biomedical, psychological, and /or sociological phenomenon. A social science approach, however, tends to consider factors that fall in to three major theoretical perspectives: 1) society through its policy and decision –making processes (e.g., determining the societal normative order and allocating resources) is a prime force in shaping problems associated with drug use ;2) certain sociological forces shape a person's personality and cause deviant behavior; and

, 3) those who use and abuse drugs have physical and/ or personality characteristics that precipitate involvement with such activity (18).

Additional consideration include : 1) the history of drug abuse patterns and changing populations of users ;2) recognition that specific drug abuse patterns are culturally determined ;3) demographic (and epidemiological)characteristics of abusers depend upon the time period ,nation and local selected for study; 4) the need to delineate the specific drug of abuse , route of administration and length of dependence ;5) the etiology of social context in which the drug abuse begins; 6) the influence of major institutions (e.g., family , community, peer group , schools, and media)upon the onset and continuation of drug dependency ;7) why drug abuse more prevalent in certain populations than others ;and 8) determination of institutional supports that promote successful treatment and rehabilitation, including consideration of how persistent behavior in subcultures can be changed . (18)

3.5.1 Biological and Psychological characteristics

Biological theories are those that postulate innate , constitutional , physical mechanisms in specific individuals that impel them to either experiment with drugs , or to abuse them once they are exposed to them . (24)

Research shows that certain individuals are predisposed toward drug and alcohol use because of their genetic makeup . Non drinking sons , for example , have brain wave similar to their alcoholic fathers .

Studies have showed that sons of alcoholics turned up with drinking problems four to five times as often as sons of non-alcoholics. (24)

And it appear that genetic loading in combination with environmental and personality factors could make for a significantly higher level of drug abuse or alcoholism in certain individuals or groups in the population .(24)

Psychological theories associated with drug use and dependence may be categorized in to two groups – those that emphasize the mechanism of reinforcement, and those that stress personality differences between people who use and are dependent on drugs and those who abstain. (24)

Positive reinforcement occurs when the individual receives a pleasurable sensation and, because of this , is motivated to repeat what caused it .(24)

The pleasure mechanism may give rise to a strong fixation on repetitive behaviors.(56) The euphoria – seeking addict has sacrificed conventional activities and commitments for hedonistic pursuit of pleasure ; and to engage in this pursuit ,a commitment to a deviant and criminal life style is also necessary .(56)

Negative reinforcement occurs when an individual does something to seek relief or to avoid pain ,thereby being rewarded and , hence ,motivated to repeat whatever it was that achieved relief or alleviated the pain .For example (withdrawal symptoms as being due the absence of opiates will generate a burning desire for the drug .(57)

The inadequate personality approach point to the problems of an emotional or psychic nature of certain individuals leading them to the drug use . They use drugs as an escape

from reality ; as a means of avoiding life's problems and retreating into euphoric bliss and drugged out indifference .(24)

There is a tendency to use narcotics and hypnotics in order to manage such emotions as rage, shame, jealously and anxiety ; to use stimulants to alleviate depression and weakness; psychedelics against boredom and disillusionment; and alcohol against guilt , loneliness and anxiety . (58)

This personality type also tend to have low self –esteem and feelings of self degradation brought about by (peer rejection, parental neglect , high expectations for achievement, school failure , physical stigmata , (rejection by peer group) , impaired sex-role identity, ego deficiencies , low coping abilities ,and coping mechanisms that are socially devaluated and / or are otherwise self-defeating.(59)

A psychosocial study in Arab Emirates (Marzoke et al , 1995) showed that 60% drug user age 27 years , 69 % Hashish was first drug , 41 % heroin
more than one third sample suffering psychological disorders. 77 % use drug with friend , 36 % using drugs regularly ,50 % sample have previous criminal file .(60)

3.5.2 Drug Use Initiation

The most prominent conceptualizations of drug use initiation include the theory of problem behavior (Donovan & Jessor, 1985), stage theory (Kandel & logan, 1984), and peer cluster theory (Beauvais & Oetting, 1988; Oetting et al., 1988). Problem behavior theory holds that adolescents who abuse drugs and alcohol exhibit earlier independence, lack of respect for conventional institutions and values, and a critical view of society.

According to stage theory, adolescents tend to begin with certain entry drugs such as cigarettes and liquor, and then move on to marijuana and finally to "harder" drugs. Peer cluster theorists argue that religious, school, and familial adjustment variables are related to drug use through mediated peer variables.(61)

Other theories that extend these causal notions include parental rejection, social competence, self-efficacy, coping style, and aggression (Botvin, Baker, Renick, Filazzala, & Botvin, 1984; Pentz, 1985; Schinke & Gilchrist, 1985). Notwithstanding the overlap between these etiological elements, research as yet offers no parsimonious theory as to how children become chemically dependent as adolescents and young adults (Schilling & Mcalister, 1990). (61)

A survey in Gaza Strip (Al- Hayatt Anti drug Association , 1998) conducted on 220 addicts , the result showed that 67.5 % sample onset age 16-21 years , 61.5 % were labors , 74.5 % start use Hashish and Bango, 6.5 % use white powder (Heroin, coke) , 6.5 % narcotic tablet. 47 % sample start with bad peer , 33 % curiosity , 28 % family problem (62)

3.5.3 Peer correlates

As youth mature through puberty and into adolescence, the influence of their parents becomes less powerful in relation to the influence of their peers (Utech, Hoving 1969). The group of peers with which the youth associates may either encourage or discourage substance abuse (Oetting, Beauvais, 1986).(61)

Study in Saudi Arabia (Sairafi et al 1988) conducted on all prisoners for drug crimes . the result showed 29. 2 % drug traffickers, 29.2 drug abusers , 19.8 drug dealer , 65.8 % not married and age less 30 years , 70 % prisoner fathers used punishment , 55 % prisoner mothers used punishment . 82.2 % bad peer and free time were direct reasons for drug crimes .(63)

3.5.4 Familial determinants

Understanding risk factors can serve at least two purposes, first: risk factors serve as a means of identify youth who have higher probability of engaging in substance abuse, Second: risk factors can provide a focus for intervention efforts.

The interest in familial determinants of alcohol and drug use has become widespread in recent years (Goodwin, 1984; Hesselbrock, 1986). Proponents of familial etiology can find an extensive literature to support their claims (Brown, 1988), but the evidence is mixed (Jacob, Favorini, Meisel, & Anderson, 1978; Russell, Henderson, & Blume, 1984). Advocates of the disease model usually focus on the genetic vulnerability of children of alcoholics, but social learning is at least as plausible in explaining generation effects of problem drinking. The most favored perspectives in the literature on substance abuse in families tend to be rich in theory and poor in empirical foundation. (61)

It is increasingly clear that risk factors exist which, when present, increase the likelihood of substance abuse for young people. When these risk factors are the focus of an intervention effort, positive outcomes from the intervention are more likely.

Poverty and inadequate housing are associated with delinquency and drug use (west, 1982; west, Farrington, 1979). Also, physically deteriorated and densely populated

neighborhoods have higher rates of drug trafficking (Fagan, 1987) conditions in the home and family have also been correlated with substance abuse increased family conflict (raillant, Milofsky 1982), decreased family management (Demaosh of Kumpfer, 1986), decreased family rituals (wolins Bennett, pnoonan 1979), decreased family cohesion (raillante milofsky 1982) and low income (El-Guebaly, offord, 1990).(64)

The role the family is often referred to as a major causal factor in shaping the personality and behavior of children .The family serves as a reference group on personal and normative levels .Members of the family serve as agents of a culture , transmitting norms , attitudes and values to the child ; how long the family remains a reference group for the child may depend on how well it serves his needs. (20)

With industrialization and the growth of a technological and urbanized society, family structures and functions have experienced great change. "The family...may no longer be the major socializing influence. Rather, that responsibility is shared today with other societal institutions and with peer groups(20).

Additionally, research shows that parental divorce, arrest, a lack of closeness between parents and children, parent and sibling drug use, family disorganization, father unemployed, one or both parents missing, a perceived lack of parental support, lack of identification with a positive male figure, family emphasis on independence instead of self-discipline and community responsibility, and mental illness, all correlate with alcohol and drug abuse among young people in the family(20).

Study in west London conducted on 146 pupils of two secondary school in a poor people area , the pupils age 15-16 , and 53 % male , 47 % female . the result showed 29 % use drug once or more time . 28 % male , 30 % female , 71 % non drug user . 18.3 % use speed , 8.3 % LSD , 4 % Heroin 76 % Alcohol (10 % more than one a week) . Most of pupils suffering divorced parents or separation or death of one parents . (Stroker & Swadi , 1990) (65)

The quality of the parent-child relationship; the quality and consistency of family management; family structure; attachment; communication within the family; modeling of substance use; approval and tolerance of substance use; involvement; absence of closeness of parents; low educational aspirations for the children; lack of parental involvement in the child's activities; weak parental control and discipline, death or absence of a parent; and, emotional, physical, or sexual abuse are other factors that have been correlated with drug use(20).

Study in Egypt conducted on 271 universities student , 149 prisoners for drugs , 121 out & inpatients drug abuse . The result showed 63 % use Hashish , 10 % Heroin , 5.5 % Maxton F , 5 % Opium , bad Peer and family nurture are apparent in drug abusers than others . (Marzoke et al 1990 (60)

3.6 GENERAL TREATMENT PRINCIPLES AND ALTERNATIVES

Goals of treatment include reduction in the use and effects of substances or achievement of abstinence, reduction in the frequency and severity of relapse, and improvement in psychological and social functioning.

Psychosocial treatments are essential components of a comprehensive treatment program. Although controlled studies are few in number and many have major design limitations, the available data, along with clinical experience, indicate that the following forms of treatment are effective for selected patients with substance use disorders: cognitive behavioral therapies, behavioral therapies, psychodynamic/interpersonal therapies, group and family therapies, and participation in self-help groups.(7)

The effectiveness of any single treatment is very low; reported one-year abstinence rates are almost invariably below 25% and often below 10 %. Some unknown but probably small proportion of chemically dependent individuals can learn to use in moderation. Despite some evidence to support the self- medication theory of addiction, prescribed medications have thus far yielded minimal results. Exceptions are methadone, which control opiate use, albeit not completely, and disulfiram, for those few alcoholics who will participate in this deterrent form of treatment. Substance abuse treatment is expensive, particularly when success rates are factored into the cost.(65)

The high prevalence of comorbid psychiatric disorders and the diagnostic distinction between substance use symptoms and other disorders should receive particular attention, and specific treatment for comorbid disorders should be provided.

Treatment planning and implementation should reflect consideration of comorbid psychiatric and general medical conditions, gender-related factors, age (e.g., for children, adolescents, and the elderly), social milieu and living environment, cultural factors, and family characteristics.(65)

There is growing recognition that short-term, expensive inpatient treatments usually do not have lasting effects unless meaningful aftercare programs follow them.

Since many substance use disorders are chronic, patients usually require long-term treatment, although the intensity and specific components may vary over time (65). A treatment plan should includes the following components:

- Psychiatric management;
- A strategy for achieving abstinence or reducing the effects or use of illicit substances;
- Efforts to enhance ongoing compliance with the treatment program, prevent relapse, and improve functioning
- Additional treatments necessary for patients with comorbid conditions.


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CHAPTER 4

MATERIALS AND METHODS

4.1 STUDY DESIGN

This is a cross- sectional study of institutional reported substance abusers, conducted from March 15 to May 15, 2001, from patients who attending El -Naser Psychiatric Hospital in Gaza Strip. The selection of this design for the investigator was because it is a simple easy and time saving for the description of the health status and psychological disorders.

4.2 SETTING:

The setting of the study was El-Naser Psychiatric hospital, MOH, Gaza Strip, Palestinian Authority, Palestine.

4.3 STUDY POPULATION

There is no easy way to catch all substance abusers .In this study; the study population was all reported substance abusers attending psychiatric health services in El- Naser Psychiatric Hospital in Gaza Strip.

A total of 85 substance abusers patients were included in this study. All patients were outpatient attenders from Gaza town and surrounded refugee camps (Beach Camp, Jabalia Camp, Buraige Camp, Nusirate Camp, Magazee Camp and Dair- El Balah . Patient's interview and questionnaire answers were collected over a two-months period, From March 15 to May 15, 2001 in which a psychiatrist was referred all substance abusers patients to the investigator after completing the medical examination and obtaining patients agreement in sharing in the study.

The study included 85 outpatient substance abusers who were attending the psychiatric hospital. The overall sex distribution of the patients were one female (age 33 years) and 84 males, mean age was 37.5 years (SD=6.17). The patient's age ranged between 22 and 58 years. Substance abusers were from Gaza town 45 (52.9 %) and from refugee camps 40 (47.1 %) and (87.1 %)of substance abusers were unemployed.

4.4 THE SAMPLE:

A cluster sample of all Substance Abusers who were attending El-Naser Psychiatric Hospital in Gaza, during the two months study period, from March 15 to May 15, 2001. The sample was previously reported, diagnosed and treated in the hospital as substance abusers, and met criteria of (DSM IV) Diagnostic Statistical Manual of Mental Disorders Fourth Edition (American Psychiatric Association, 1994).

4.4.1 PARTICIPANTS CRITERIA

A-Inclusion criteria: All reported substance abusers who were attending the Psychiatric Hospital in Gaza during the period of study.

B-Exclusion criteria: The investigator excluded

1) Patients suffering from drug withdrawal symptoms.

2) All cases whom age is under 16 or above 60 .

3) Patients not meet the DSM IV criteria.

4.4.2 SAMPLE SELECTION

In order to select the sample we had taken the following procedures:

PHASE ONE: the patients (which previously diagnosed, and treated as drug abusers in the hospital) must be first seen by the psychiatrist for medical investigation, diagnosis as abusers and medication prescription.

PHASE TWO: the patients then were referred to the investigator after their approval for participating in the study. The investigator (interviewer) attempt to conduct interviews in a separate suitable place, away from other patients . The interview averages about twenty minutes, and includes a combination of interviewer- administered and self-administered questions. Questions on general health scale (GHQ-28) are interviewer-administered while other sensitive questions (such as those on illicit drug use) are self-administered. The investigator first explained the study aims, procedures, and took the patients approval for participating by their free signatures on patient ethical consensual.

4.5 MATERIALS OF STUDY

- Interview structured questionnaires.
- Review for patients medical files.
- The investigator's Observations.

4.5.1 Questionnaire

- An interview-administered close ended questionnaire for the patients was designed (Annex-1) and translated into Arabic (Annex-2). The questions were dichotomous items and multiple choices. The investigator had interviewed face-to-face all the patients who participated in the study. The questions were direct and brief, it included FIRST: the personal data as age, location, marital status, education, and occupation, SECOND: the drug abuse information as type of drug, frequency, onset age of use, last drug use and different reasons for use drugs.
- The DSM IV criteria used to differentiate between substance dependent and non dependent patients.
- The GHQ-28 scale used to measure psychiatric morbidity among the patients.

4.5.1.1 DSM IV Diagnostic criteria of dependence

The investigator had applied the dependence criteria of Diagnostic Statistical Manual of Mental Disorders DSM IV (American Psychiatric Association, 1994) (21), which defines the person as dependent on a substance if he met three out of seven (the investigator summarized a seven comprehensive items) applied from the DSM IV. Respondents are categorized as substance dependents, if they respond affirmatively to at least three out of the seven items applied, and categorized as substance abusers, if they respond to less than three items.

4.5.1.2 The GHQ- 28 scale

The General Health Questionnaire is a self-administered screening questionnaire designed for use in consulting settings aimed at detecting those with diagnosable psychiatric disorder (Goldberg, 1972) (68).

General Health Questionnaire 28 (GHQ-28) is a popular 28-item screening test that derived from factor analysis of General Health Questionnaire 60. The questionnaire has 4 subscales of Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction and Severe Depression , it has 7 questions in each subscale and a cut-off point of 1/2 for each subscale. The total scores are calculated by using binary (0-0-1-1) score, and threshold score (cut-off point)of 4/5 , scores of 4 or less were categorized as normal and scores of 5 and more were categorized as clinical cases .

The Arabic version of GHQ-28 has been validated in Gaza Strip, and could be used as a screening instrument of psychiatric morbidity in the Arab adult population with the threshold score (cut-off point)of 4/5, The split half reliability of the scale (r=0.88) was high. The internal consistency of the scale calculated using Chronbach's alpha (Alpha =0.93) was also high (Thabt et al 2000). (69).

In our study, the covariance matrix method used for reliability analysis –scale (split half), the reliability of the scale was high (r= 0.84), and by using Spearman-Brown (r= 0.91). Reliability analysis –scale of Chronbach's (Alpha =0.92).

For the internal consistency of the scale, the Pearson Correlations were: somatic (0.835**), anxiety (0.777**), social (0.863**), depression (0.787**).

** means that the correlation is significant at the P level 0.01 (2-tailed).

The investigator had established a psychosocial problems scale from the combination of GHQ scale (4/5 cut-off point) and the behavioral problems scale which contain 6 items (2/3 cut-off point). A total of 69 (81.2 %) patients were positive on the combined psychosocial problem scale.

4.5.2 Reviewing patients medical files

The investigator revised the medical file for each patient, and checked the first registration date, personal information, prescriptions of medicines, compliance of patients, written orders for social and family helps, types and doses of dispensed medicines.

4.5.3 The investigator's Observations

The investigator tried to observe the patients before, during and after the interviews for any deviant behaviors and verbal and non-verbal communications.

4.6 THE STUDY LIMITATIONS

This study investigated the psychosocial Problems of substance abuse among institutional reported addicts only but not investigated the non-institutional addicts.

Accordingly the study will not explored the psychosocial problems of the non- attending health services abusers who could be more serious.

4.7 ETHICAL ISSUE

1) A letter from university was sent to Director General of hospitals administration, who gives a written permission to enter the Psychiatric hospital and conduct the study. (Appendix I). 2) All participants were given an explanation of the study procedures, risks and the benefits by the interviewer. Patients were asked to sign an Informed Consent Form (I.C.F) if they wish to participate, following resolution of any questions. Confidentiality for the collected materials will be maintained via a numbered reference system. Participants name will appear only on a consent form according to patients approvals. (Annex - 3).

4.8 PILOT STUDY

Pilot testing for patient questionnaire was done for twenty-five subjects to check the validity of the questionnaire and evaluate the outcome. The investigator attended each of these interviews when the pilot testing was being done. Some questions were modified for clarification and others were added or deleted, like the questions dealing with income due to sensitivity, personal information like name and identification, also a question was deleted due to sensitivity dealing with given information of any members of the family or relatives were abused substances.

4. 9 DATA ANALYSIS

The variables were coded numerically to enable the investigator to enter the data systematically and efficiently. Data were entered and analyzed on SPSS by using a

CHAPTER (5)

RESULTS

5.1 Characteristics of the patients according to DSM- IV

In this study, out of the 85 patients interviewed only 81 patients **(95.3 %)** met the DSM IV criteria for dependence (American Psychiatric Association, 1994) with a cut-off point (2/3) and categorized as substance dependents, 4 patients only (4.7 %) who were not met the DSM criteria for dependence which they were categorized as substance abusers.

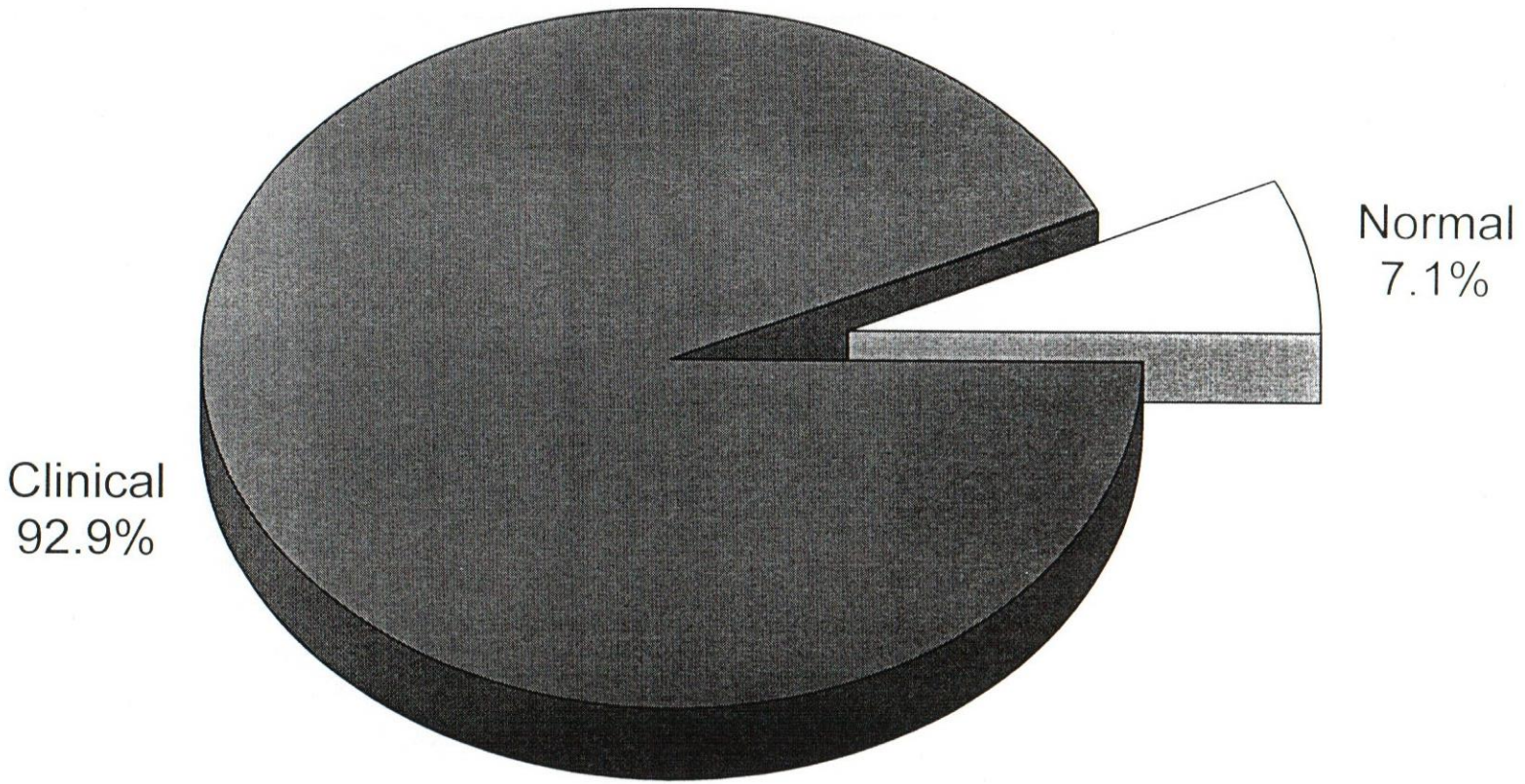
5.2 Characteristics of the patients according to GHQ-28

Out of the 85 patients interviewed, only 79 **(92.9 %)** were scored above cut off point of GHQ-28 (using 4/5 as a cut- off point) and were categorized as clinical cases compared to only 6 (7.1 %) were scored below cut off point of GHQ and were categorized as normal cases (Table 1).

Table-1: Distribution of General Health Scale among study population.

PATIENTS CATEGORIZATION	FREQUENCY	PERCENT	VALID PERCENT	CUMULATIVE PERCENT
NORMAL	6	7.1	7.1	7.1
CLINICAL	79	92.9	**92.9**	100.0
Total	85	100.0	100.0	

Distribution of all patients according to **GHQ-28 scale**



5.3 Socio-Demographic Characteristics

The general education levels of all patients were as follows: (52.9 %) primary and lowest, (35.3 %) preparatory, (11.8 %) secondary.

The occupation of patients was classified as original occupation and current occupation, for the current occupation, the majority 74 (87.1 %) were unemployed, and 11 patients (12.9 %) were employed and specified as (4.7 %) unskilled work, (8.2 %) skilled work.

Out of total number of patients only 18 (21.1 %) depending on their work as the source of income, while the majority of patients 67 (78.8 %) depending on either family support 30 (35.2 %) or depending on social aids and other helps 37 (43.5 %).

Substance abusers from Gaza town were 45 (52.9 %) and from refugee camps were 40 (47.1 %).

For the marital status of the study population, a total number of 76 (89.4 %) were married, 5 (5.9 %) were single and 4 (4.7 %) were divorced (Table 2).

5.3.1 Age distribution

The age of the patients ranged between 22 years to 58 years old. Most of studied cases 43 (50.6 %) were between the age 30 – 39 years old, and 33 patients (38.8 %) were at the age of 40 years and more. All patients at age 20 – 29 years 9 (10.6 %) were clinical cases on the GHQ scale, mean age was 37.55 years (Table 2).

Table-2 Socio-Demographic characteristics among study population.

Age group	**20-29**	**30-39**	**40++**	**TOTAL**	
Number	9	43	33	85	
Percentage	10.6	50.6	38.8	100	
RESIDENCE					
Town	6	22	17	45	52.9
Camp	3	21	16	40	47.1
EDUCATION					
Lower Primary	4	18	23	45	52.9
Preparatory	3	21	6	30	35.3
Secondary	2	4	4	10	11.8
MARITAL STATUS					
Married	7	39	30	76	89.4
Single	2	2	1	5	5.9
Divorced	0	2	2	4	4.7
ORIGINAL OCCUPATION*					
Unemployed	0	0	1	1	1.2
Unskilled	3	30	22	55	64.7
Skilled	6	13	10	29	34.1
CURRENT OCCUPATION					
Unemployed	6	37	31	74	87.1
Unskilled	0	4	0	4	4.7
Skilled	3	2	2	7	8.2

* Original occupation before started using substances

5.4 Distribution of four psychological health disorders

The four psychological health disorders were studied : somatic, anxiety & insomnia, social dysfunction, and depression. The results showed that psychological disorders distribution among the study population were as follow : anxiety and insomnia was the highest distinguished disorder (89.4 %), social dysfunction (87.1 %), somatic disorder (78.8 %) and depression (77.6 %) (Table 3).

Table 3-: Distribution of four psychological health disorders.

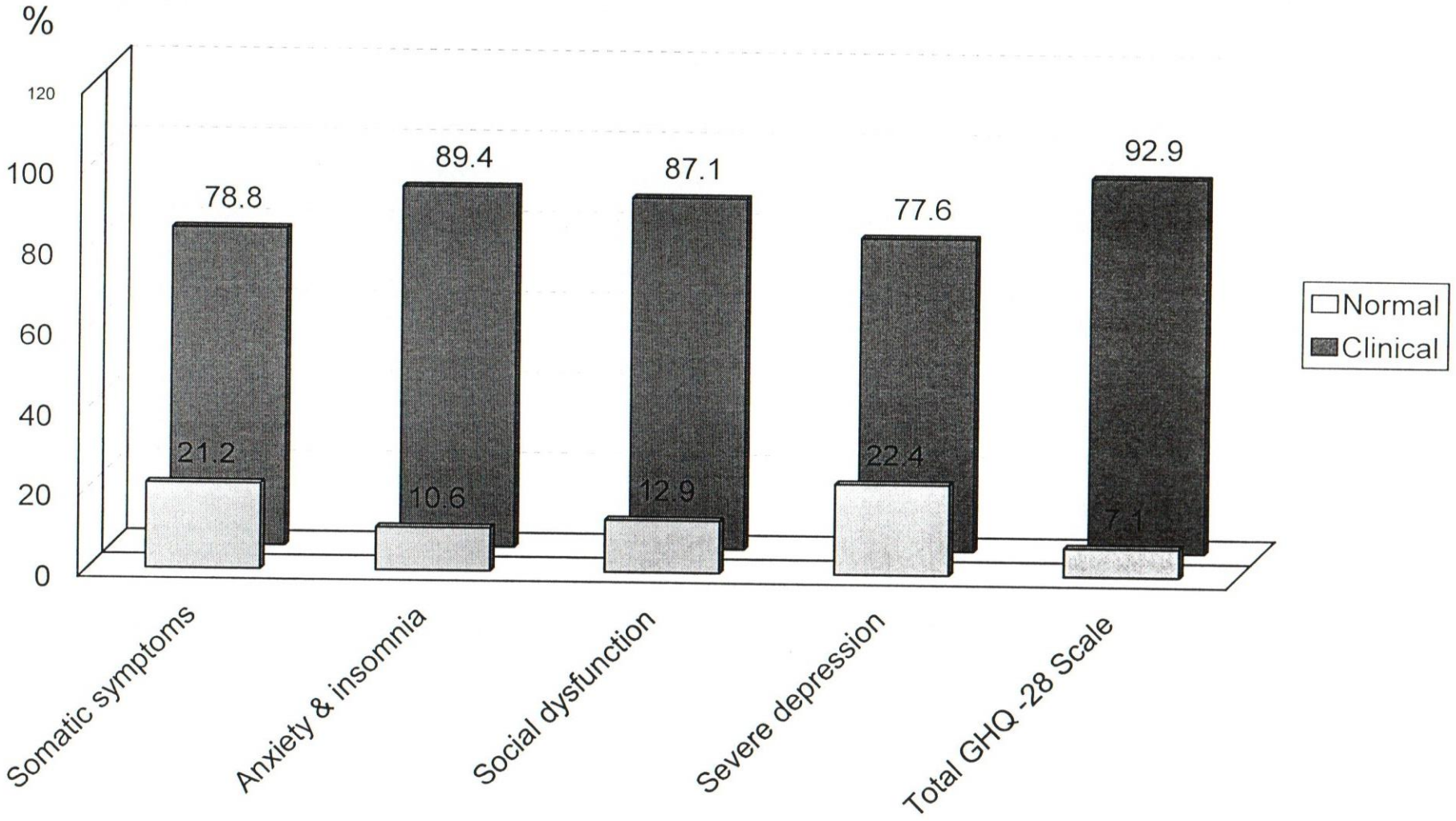
HEALTH DISORDERS	PATIENTS NO.	SUM	MEAN*	SD	%	GRADE
SUM ALL	85	1531	18.01	7.61	92.9	
SOMATIC	85	368	4.33	2.62	78.8	3
ANXIETY	85	404	4.75	2.06	89.4	1
SOCIAL	85	389	4.58	2.20	87.1	2
DEPRESSION	85	370	4.35	2.51	77.6	4

* Mean of psychological disorders equal to sum of all positive responses / 85

5.5 Distribution of psychological health disorders among patients by age

The study showed that there were three cluster groups 20^{th}, 30^{th}, 40^{th} and more of age among the study population. The age of the patients ranged between 22 years and 58 years old. Most of clinical cases 39 (45.9 %) were between the age 30 – 39 , and 31 patients (36.5 %) were in the age of 40 and more and 9 patients (10.6 %) were in the age 22 – 29 years . A total of 92.9 % of different age were categorized as clinical cases on the GHQ scale Table (4) .

Distribution of all patients according to the four psychological health disorders in **GHQ-28 scale**



Table(4): Distribution of psychological health disorders by patients age.

Age Group	GHQ-28 (used 4/5 as a cut- off point). for Somatic , Anxiety , Social & Depression (used 1 / 2 as a cut – off point)										
	GHQ TOTAL			SOMATIC		ANXIETY		SOCIAL		DEPRESSION	
	Normal	Clinical	Clin%	Normal	Clinical	Normal	Clinical	Normal	Clinical	Normal	Clinical
20-29	0 0	9 100 %	**10.6**	3 33.3 %	6 66.7 %	1 11.1 %	8 88.9 %	0 0	9 100 %	1 11.1 %	8 88.9 %
30-39	4 9.3 %	39 90.7 %	**45.9**	12 27.9 %	31 72.1 %	5 11.6 %	38 88.4 %	7 16.3 %	36 83.7 %	10 23.3 %	33 76.7 %
40++	2 6.1 %	31 93.9 %	**36.5**	3 9.1 %	30 90.9 %	3 9.1 %	30 90.9 %	4 12.1 %	29 87.9 %	8 24.2 %	25 75.8 %
Total	6 7.1 %	79 92.9 %	**92.9**	18 21.2 %	67 78.8 %	9 10.6 %	76 89.4 %	11 12.9 %	74 87.1 %	19 22.4 %	66 77.6 %

- *Mean (Total) 37.55 years*
- *Standard Deviation 6.17*
- *Statistical Significance not appear at $P \leq 0.05$ level*

5.6 Distribution of all patients by type of abused substances

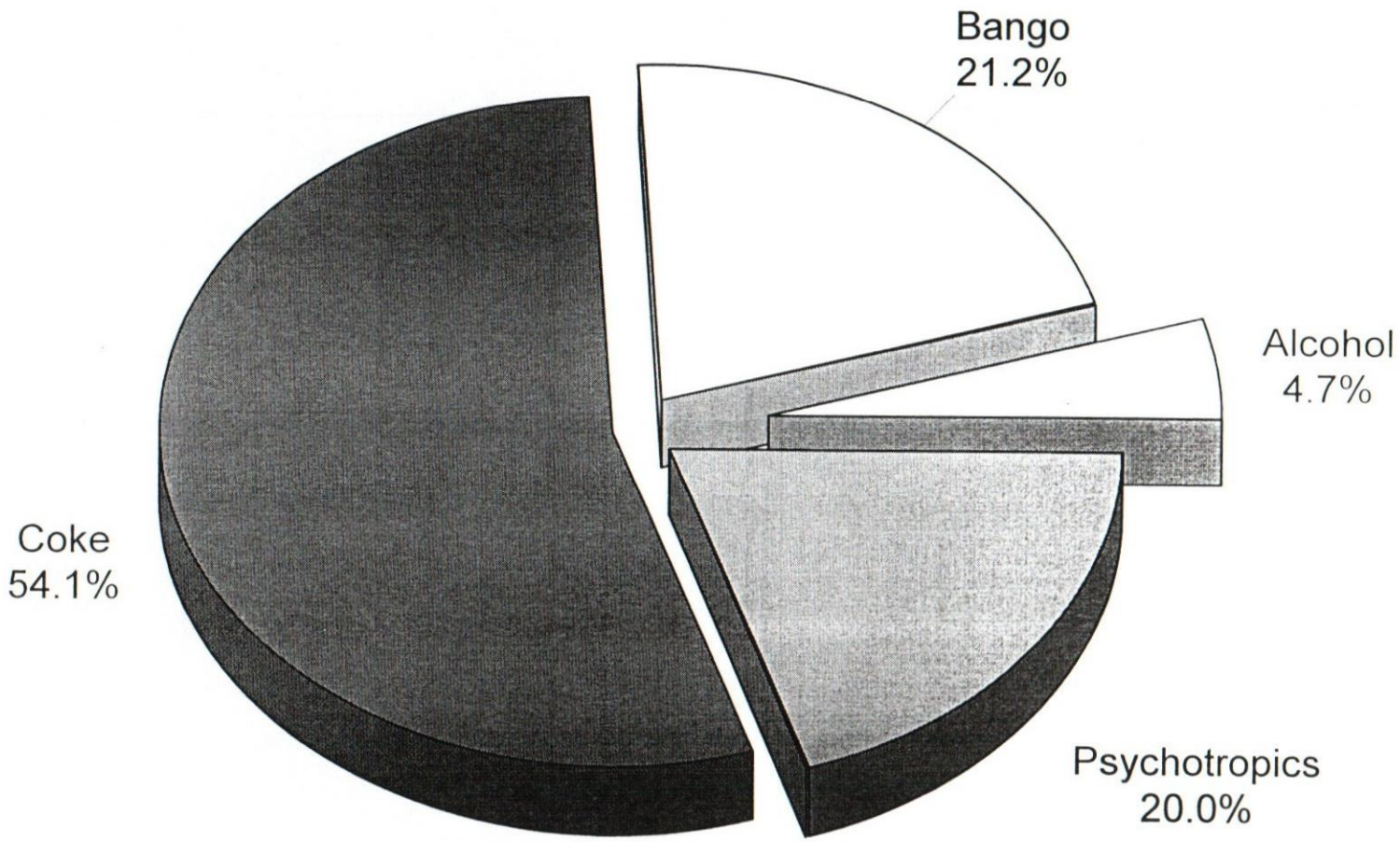
The highest number of substance abusers 46 (54.1 %) were dependent on coke, while 18 (21.2 %) dependent on Bango , 17 (20 %) were dependent on Psycho tropics drugs, and only 4 (4.7 %) were dependent on Alcohol (Table 5) .

The substance abusers with psychological disorders on GHQ-28 scale were respectively as follow: 44 (55.7 %) were coke abusers, 15 (19.0%) were Bango abusers, 16 (20.3 %) were Psycho tropics abusers, and 4 (5.1 %) were Alcohol abusers.

Table-5: Distribution of dependent substances among study population.

DEPENDENT SUBSTANCE	TOTAL		NORMAL (GHQ)		CLINICAL (GHQ)	
	No	%	No	%	No	%
Alcohol	4	4.7	0	0	4	100 %
Bango	18	21.2	3	16.7 %	15	83.3 %
coke	46	**54.1**	2	4.3 %	44	95.7 %
psychotropic	17	20.0	1	5.9 %	16	94.1 %
Total	85	100.0	6	7.1 %	79	92.9 %

Distribution of all patients according to the **dependent substances**



5.7 Distribution of different types of substances by period of use

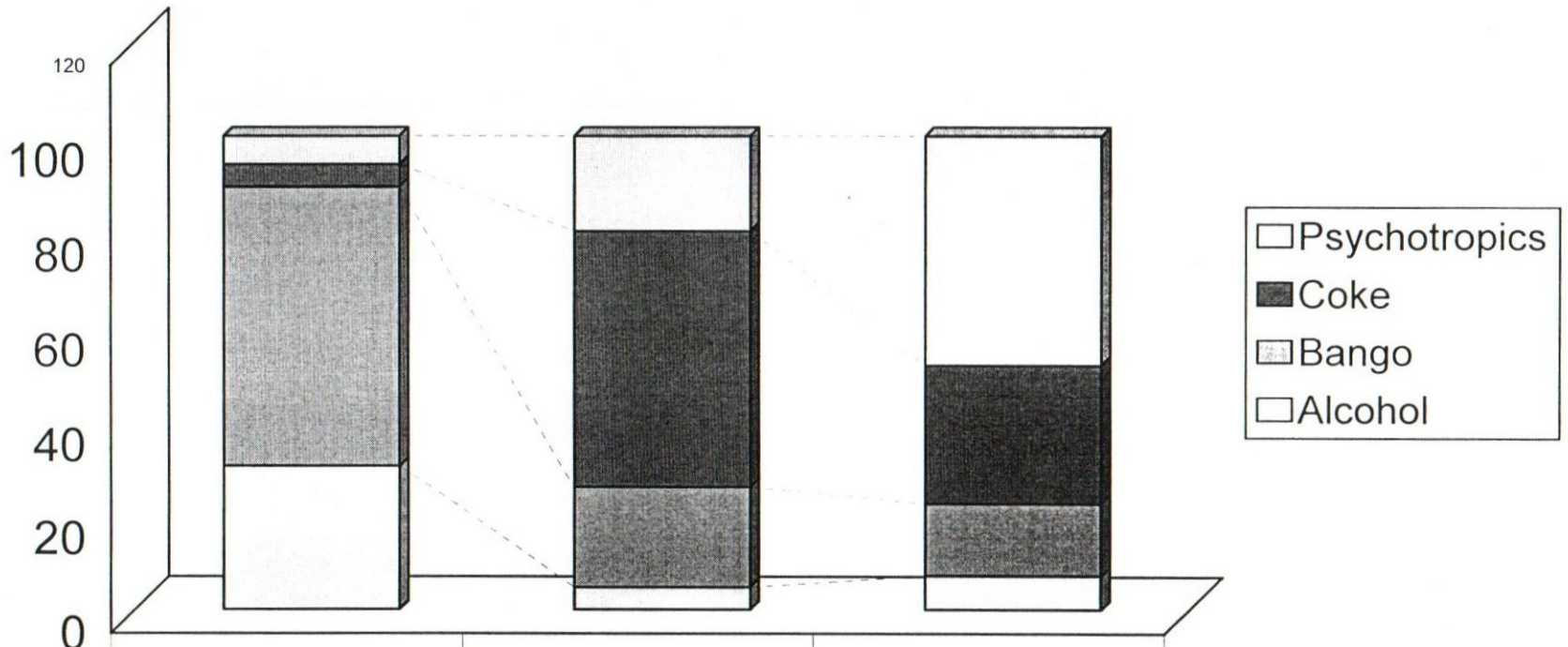
Bango and Hashish were the highest 48 (56.4 %) substances which first used among the substance abusers, but Coke (Mixed Heroin) was the highest 46 (54.1 %) substance which used continuously and dependently during dependence period, and Psychotropic substance was the highest 41 (48.3 %) which last used among patients (Table 5).

Table-6:. Distribution of different types of substances by period of use

Types of substance	FIRST USE		DEPENDENT		LAST USE	
	FREQ	%	FREQ	%	FREQ	%
ALCOHOL	26	30.6	4	4.7	6	7.1
BANGO & HASH	48	**58.8**	18	21.2	13	15.3
HEROIN(COKE)	6	4.7	46	**54.1**	25	29.4
PSYCHOTROPIC	5	5.9	17	20	41	**48.2**

Substances first used, dependence used and last used

(Total Sample)



	First	Dependence	last
Psychotropics	5.9	20	48.2
Coke	4.7	54.1	29.4
Bango	58.8	21.2	15.3
Alcohol	30.6	4.7	7.1

5.8 Relationship between abused substances and psychological health disorders

The investigator used the one way ANOVA which showed that there were significant differences at P level ≤ 0.05 between different abused substances groups and psychological health disorders, and the investigator used Tukey Post Hoc Tests HSD, for explaining the pairs significant differences of abused substances and either somatic, social, behavior, GHQ, and psychosocial health disorders (Table 7).

Table-7: Relationship between abused substances and psychological health disorders.

DISORDERS		SUM OF SQUARES	DF	MEAN SQUARE	F	P-Value
SOMATIC	Between groups	92.792	3	30.931	5.155	0.01*
	Within groups	485.984	81	6.000		
	Total	578.776	84			
ANXIETY	Between groups	33.313	3	11.104	2.772	0.52#
	Within groups	324.499	81	4.006		
	Total	357.812	84			
SOCIAL	Between groups	69.210	3	23.070	5.536	0.01*
	Within groups	337.542	81	4.167		
	Total	406.753	84			
DEPRESSION	Between groups	45.963	3	15.321	2.578	0.07#
	Within groups	481.448	81	5.944		
	Total	527.412	84			
G.H.Q	Between groups	870.430	3	290.143	5.889	0.01*
	Within groups	3990.558	81	49.266		
	Total	4860.988	84			
BEHAVIOR	Between groups	21.403	3	7.134	3.038	.0.05*
	Within groups	190.244	81	2.349		
	Total	211.647	84			
PSYCHOSOCIAL	Between groups	681.662	3	227.221	5.926	0.01*
	Within groups	3105.561	81	38.340		
	Total	3787.224	84			

* Significant at P level ≤ 0.05

Not significant

For explaining the significant differences at P level 0.01 in the psychosocial problems, the results showed that alcohol abusers (M=30.0) were suffering more psychosocial disorder than Bango abusers(M=20.67). There were no significant differences between alcohol abusers and both coke abusers and Psychotropic abusers. Also the result showed that Coke abusers(M= 26.28) and Psychotropic abusers(M=28.53) were suffering more Psychosocial disorders than Bango abusers (M=20.67). There were no significant associations between Coke and Psychotropic abusers (Table 6.1).

Table: 7.1 Description of Tuky HSD of abused substances by psychosocial problems.

PSYCHOSOCIAL	ALCOHOL M = 30.00	BANGO M =20.67	COKE M = 26.28	PSYCHOTROPIC M =28.53
Alcohol M = 30.00	-	9.33*	3.71	1.47
Bango M =20.67	-	-	5.61*	7.86*
Coke M = 26.28	-	-	-	2.24
Psychotropic M =28.53	-	-	-	-

* The mean difference (M) is significant at the P level.$\leq$ 0.05

For explaining the significant differences at P level 0.01 in the somatic problems , the results showed that Coke abusers (M=4.43) were suffering more somatic disorder than Bango abuser(M=2.56) . There were no significant differences between alcohol abusers and either coke abusers , Psychotropic abusers and Bango abusers. Also the results showed that Psychotropic abusers (M=5.53) were suffering more somatic disorders than Bango abusers (M=2.56). There were no significant associations between Coke and Psychotropic abusers (Table 7.2).

Table: 7.2 Description of Tuky HSD of somatic disorder by abused substances.

SOMATIC	ALCOHOL M = 6.00	BANGO M =2.65	COKE M = 4.43	PSYCHOTROPIC M =5.53
Alcohol M = 6.00	-	3.44	1.56	.47
Bango M =2.65	-	-	-1.87*	-2.97*
Coke M = 4.43	-	-	-	-1.09
Psychotropic M =5.53	-	-	-	-

* The mean difference (M) is significant at the P level ≤ 0.05

For explaining the significant differences at P level 0.01 in the social problems, the results showed that Alcohol abusers (M=6.00) were suffering more social disorder than Bango abusers (M=2.89). There were no significant differences between alcohol abusers and both coke abusers and Psychotropic abusers. Also the results showed that Psychotropic abusers (M=4.88) and Coke abusers (M= 5.00)were suffering more social disorders than Bango abusers(M=2.89). There were no significant associations between Coke and Psychotropic abusers (Table 7.3).

Table: 7.3 Description of Tuky HSD of social dysfunction by abused substances.

SOCIAL	ALCOHOL M = 6.00	BANGO M =2.89	COKE M =5.00	PSYCHOTROPIC M =4.88
Alcohol M = 6.00	-	3.11*	1.00	1.11
Bango M =2.89	-	-	-2.11*	-1.99*
Coke M = 5.00	-	-	-	.11
Psychotropic M =4.88	-	-	-	-

* The mean difference (M) is significant at the P level ≤ 0.05

For explaining the significant differences at P level 0.05 in the behavior problems , the results showed that Bango abusers (M=8.56), were suffering more behavior disorder than Coke abusers (M=7.33). There were no significant differences between alcohol abusers and either coke abusers , Psychotropic abusers and Bango abusers. . There were no significant associations between Coke and Psychotropic abusers (Table 7.4).

Table: 7.4 Description of Tuky HSD for behavior problems by abused substances

BEHAVIOR	ALCOHOL M = 7.25	BANGO M =8.56	COKE M = 7.33	PSYCHOTROPIC M =7.94
Alcohol M = 7.25	-	-1.30	-7.60	-.69
Bango M =8.56	-	-	1.22*	.61
Coke M = 7.33	-	-	-	-.61
Psychotropic M =7.94	-	-	-	-

* The mean difference (M) is significant at the P level ≤ 0.05

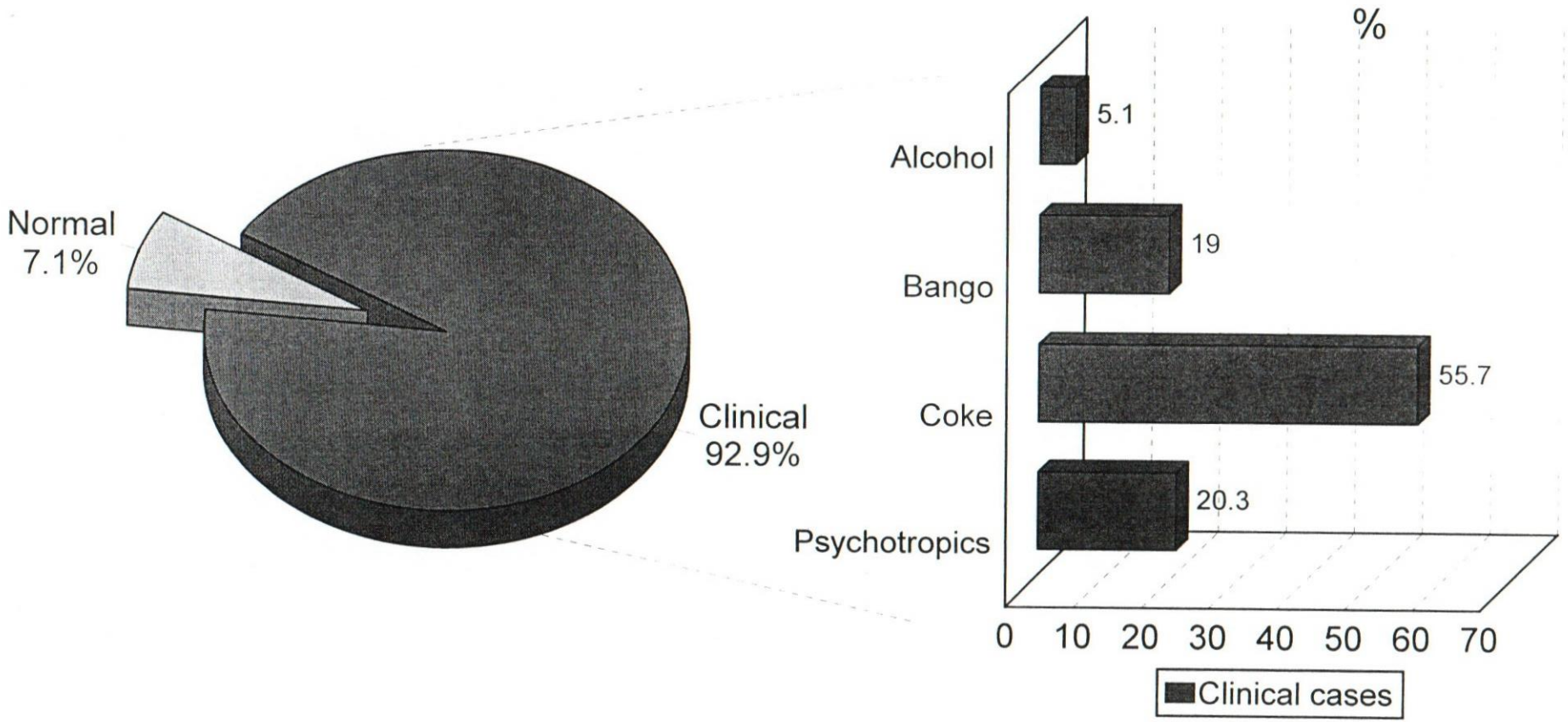
For explaining the significant differences at P level 0.01 in the general health problems (GHQ),the results showed that Alcohol abusers (M=22.75) were suffering more general health disorder than Bango abusers (M=12.11). There were no significant differences between alcohol abusers and both coke abusers and Psychotropic abusers. Also the results showed that Psychotropic abusers (M=20.59) and Coke abusers (18.96)were suffering more general health disorders than Bango abusers (M=12.11). There were not found significant associations between Coke and Psychotropic abusers (Table 7.5).

Table: 7.5 Description of Tuky HSD of general health status by abused substances.

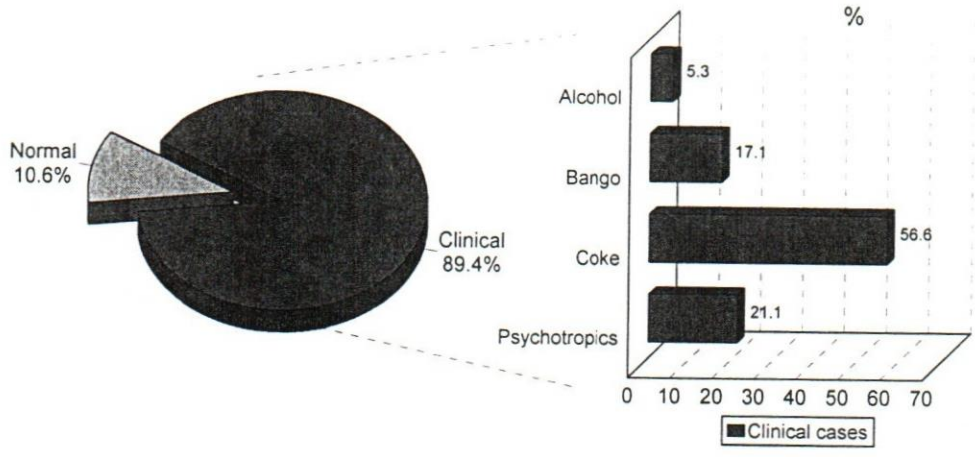
GHQ	ALCOHOL M = 22.75	BANGO M =12.11	COKE M =18.96	PSYCHOTROPIC M =20.59
Alcohol M = 22.75	-	10.63*	3.79	2.16
Bango M =12.11	-	-	-6.84*	-8.47*
Coke M = 18.96	-	-	-	-1.63
Psychotropic M =20.59	-	-	-	-

* The mean difference (M) is significant at the P level ≤ 0.05.

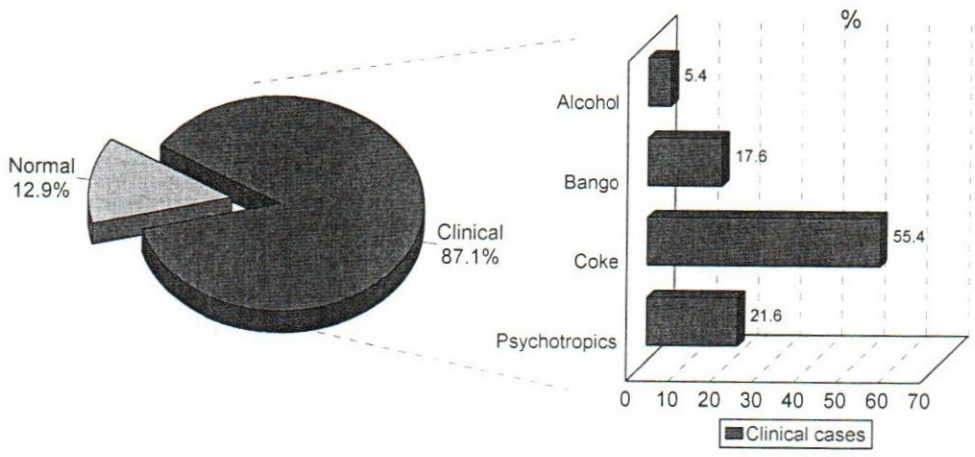
Distribution of all patients according to **GHQ -28** and type of dependent substances



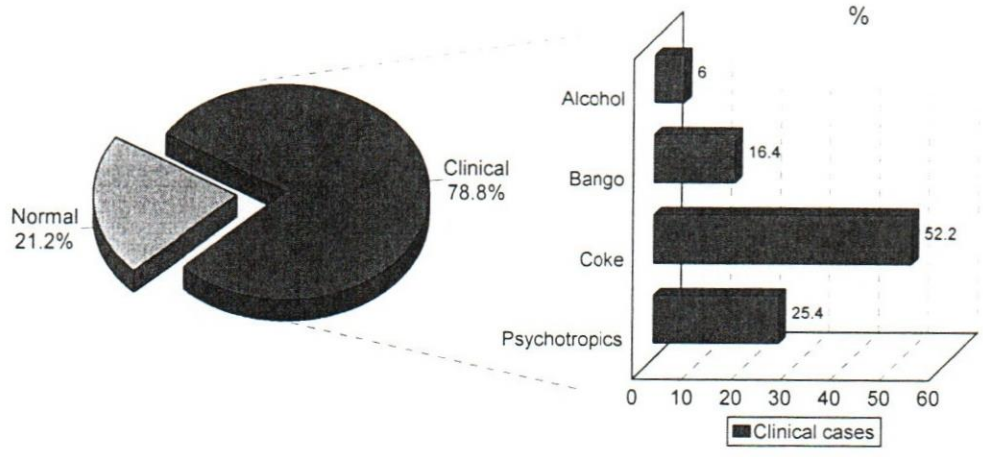
Distribution of all patients according to **Anxiety & Insomnia** and type of dependent substances



Distribution of all patients according to **Social dysfunction** and type of dependent substances



Distribution of all patients according to **Somatic Symptoms** and type of dependent substances



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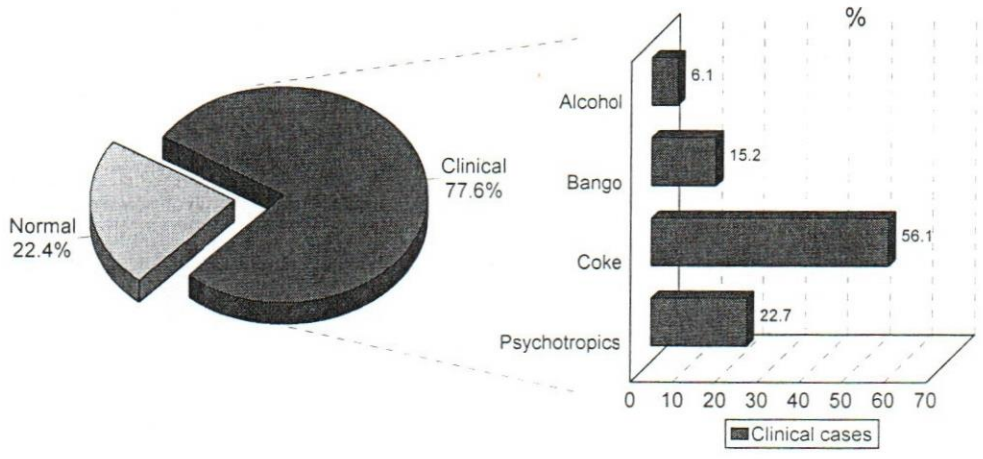
Graphic (8)

Distribution of all patients according to **Severe depression** and type of dependent substances



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Graphic (9)

5.9 The relationship between education level and psychological health disorders

The investigator used one way ANOVA which showed that there were no significant differences at P level ≤ 0.05 between substance abusers psychological health disorders and educational level (Table 8).

Table-8: Relationship between education level and psychological health disorders.

Disorder	Source Of Variance	Sum Of Squares	df	Mean Square	F	P-Value
SOMATIC	Between groups	9.499	2	4.749	.684	0.61#
	Within groups	569.278	82	6.942		
	Total	578.776	84			
ANXIETY	Between groups	6.967	2	3.484	.814	0.98#
	Within groups	350.844	82	4.279		
	Total	357.812	84			
SOCIAL	Between groups	6.975	2	3.488	.715	0.39#
	Within groups	399.778	82	4.875		
	Total	406.753	84			
DEPRESSION	Between groups	8.245	2	4.123	.651	0.65#.
	Within groups	519.167	82	6.331		
	Total	527.412	84			
G.H.Q	Between groups	96.544	2	48.272	.831	0.99#.
	Within groups	4764.444	82	58.103		
	Total	4860.988	84			
BEHAVIOR	Between groups	10.369	2	5.185	2.112	0.09#.
	Within groups	201.278	82	2.455		
	Total	211.647	84			
PSYCHOSOCIAL	Between groups	48.079	2	24.040	.527	0.11#
	Within groups	3739.144	82	45.599		
	Total	3787.224	84			

* Significant at P level < 0.05

Not significant

5.10 Relationship between original occupation and psychological health disorders

There were no significant differences between the Psychological health disorders and the current occupation of substance abusers patients (Table 9).

Table-9: Relationship between original occupation and psychological health disorders.

Disorder	Source Of Variance	Sum Of Squares	df	Mean Square	F	P-Value
SOMATIC	Between groups	7.815	2	3.907	.561	0.06#
	Within groups	570.962	82	6.963		
	Total	578.776	84			
ANXIETY	Between groups	5.308	2	2.654	.617	0.11#
	Within groups	352.504	82	4.299		
	Total	357.812	84			
SOCIAL	Between groups	7.915	2	3.958	.814	0.84#
	Within groups	398.838	82	4.864		
	Total	406.753	84			
DEPRESSION	Between groups	13.096	2	6.548	1.044	0.75#
	Within groups	514.316	82	6.272		
	Total	527.412	84			
G.H.Q	Between groups	126.691	2	63.346	1.097	0.99#
	Within groups	4734.297	82	57.735		
	Total	4860.988	84			
BEHAVIOR	Between groups	3.004	2	1.502	.590	0.39#
	Within groups	208.643	82	2.544		
	Total	211.647	84			
PSYCHOSOCIAL	Between groups	92.745	2	46.372	1.029	0.09#
	Within groups	3694.479	82	45.055		
	Total	3787.224	84			

* Significant at P level ≤ 0.05

Not significant

5.11 Relationship between current occupation and psychological health disorders

The results showed that there were significant differences at P level ≤ 0.05 between the Psychological health disorders and the current occupation of substance abusers patients, and the investigator used Tukey HSD, for explaining the pairs significant differences of current occupation and either anxiety and GHQ (Table 10.1).

Table-10.1: Relationship between current occupation and psychological health disorders.

Disorder	Source Of Variance	Sum Of Squares	df	Mean Square	F	P-Value
SOMATIC	Between groups	45.939	2	22.969	3.535	0.05*
	Within groups	532.838	82	6.498		
	Total	578.776	84			
ANXIETY	Between groups	40.397	2	20.198	5.218	0.01*
	Within groups	317.415	82	3.871		
	Total	357.812	84			
SOCIAL	Between groups	17.774	2	8.887	1.873	0.39#
	Within groups	388.979	82	4.744		
	Total	406.753	84			
DEPRESSION	Between groups	37.271	2	18.635	3.118	0.09#
	Within groups	490.141	82	5.977		
	Total	527.412	84			
G.H.Q	Between groups	533.650	2	266.825	5.056	0.01*
	Within groups	4327.338	82	52.772		
	Total	4860.988	84			
BEHAVIOR	Between groups	21.833	2	10.917	4.716	0.05*
	Within groups	189.814	82	2.315		
	Total	211.647	84			
PSYCHOSOCI -AL	Between groups	384.558	2	192.279	4.634	0.05*
	Within groups	3402.665	82	41.496		
	Total	3787.224	84			

* Significant at P level ≤ 0.05

Not significant

For explaining the significant differences at P level 0.05 in anxiety disorder , the results showed that unemployed patients (M=5.01) were suffering more anxiety disorders than the employed skilled patients (M=2.71). But no significant differences were found between unemployed and unskilled patients, and also between skilled and unskilled patients (Table 10 .2).

Table-10.2: Description of Tuky HSD of anxiety problems by current occupation.

ANXIETY	Unemployed M=5.01	Unskilled M=3.50	Skilled M=2.71
Unemployed M=5.01	-	1.51	2.29*
Unskilled M=3.50	-	-	0.78
Skilled M=2.71	-	-	-

*The mean difference (M) is significant at the P level $\leq$ 0.05 level.

For explaining the significant differences at P level 0.05 in general health status ,the results showed that unemployed patients (M=18.90) were suffering more general health disorders than the employed skilled patients(M=10.0). But no significant differences were found between unemployed and unskilled patients, and also between skilled and unskilled patients (Table 10.3).

Table-10.3 : Description of Tuky HSD of general health problems by current occupation.

GHQ	Unemployed M=18.90	Unskilled M=15.50	Skilled M=10.0
Unemployed M= 18.90	-	3.40	8.90*
Unskilled M= 15.50	-	-	5.50
Skilled M= 10.0	-	-	-

* The mean difference (M) is significant at the P level $\leq$ 0.05 level.

For explaining the significant differences at P level 0.05 in psychosocial problems , the results showed that unemployed patients (M=26.51) were suffering more psychological disorders than the employed skilled patients (M=19.28). But no significant differences

were found between unemployed and unskilled patients, and also between skilled and unskilled patients (Table 10 .4).

Table-10.4: Description of Tuky HSD for current occupation by psychosocial problems.

Psychosocial	Unemployed M=26.51	Unskilled M=22.25	Skilled M=19.28
Unemployed M=26.51	-	4.26	7.22*
Unskilled M=22.25	-	-	2.96
Skilled M=19.28	-	-	-

* The mean difference (M) is significant at the P level $\leq$ 0.05 level.

For explaining the significant differences at P level 0.05 in somatic disorder , the results showed that unemployed patients (M=4.59) were suffering more somatic disorders than the employed skilled patients(M=2.00). But no significant differences were found between unemployed and unskilled patients, and also between skilled and unskilled patients (Table 10.5).

Table-10.5: Description of Tuky HSD for current occupation by somatic problems.

SOMATIC	Unemployed M=4.59	Unskilled M=3.50	Skilled M=2.00
Unemployed M=4.59	-	1.09	2.59*
Unskilled M=3.50	-	-	1.50
Skilled M=2.00	-	-	-

* The mean difference (M) is significant at the P level $\leq$ 0.05 level.

For explaining the significant differences at P level 0.05 in behavior , the results showed that unemployed patients (M=7.60) were suffering more behavioral disorders

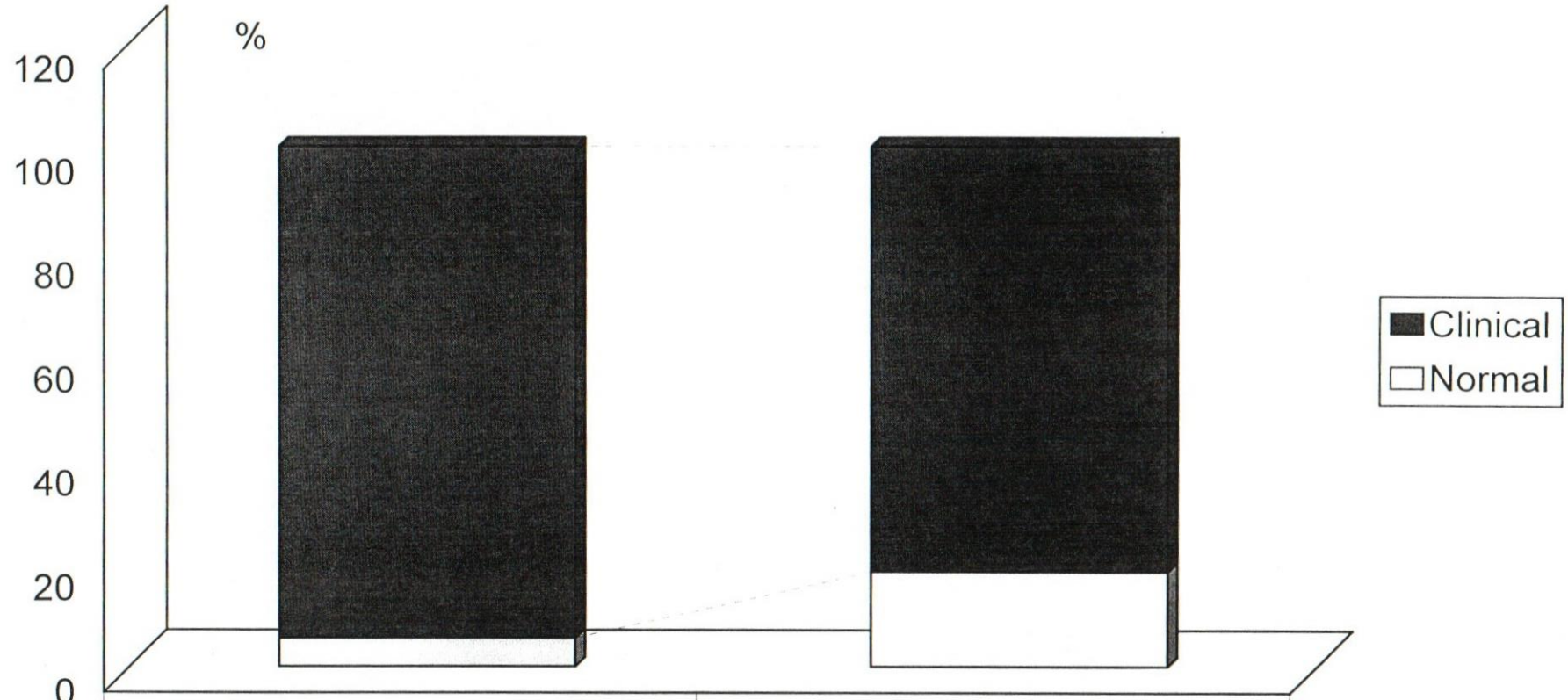
than the employed skilled patients(M= -1.67). Also there were significant difference in behavior between employed unskilled (M= 6.75) and employed skilled (M= 9.28) patients, indicating that skilled were suffering more behavioral disorders that unskilled patients. No significant differences were found between unemployed and unskilled patients (Table 10.6).

Table-10.6: Description of Tuky HSD for current occupation by behavior problems.

BEHAVIOR	Unemployed M=7.60	Unskilled M=6.75	Skilled M=9.28
Unemployed M=7.60	-	0.85	-1.67*
Unskilled M=6.75	-	-	-2.53*
Skilled M=9.28	-	-	-

* The mean difference (M) is significant at the P level ≤ 0.05 level.

Distribution of all patients according to GHQ -28 Scales and Current occupation (the effect of jobless)



	Unemployed	employed
Clinical	94.6	81.8
Normal	5.4	18.2

5.12 Relationship of marital status and psychological health disorders

There were no significant differences at P level ≤ 0.05 among the substance abusers in the psychological health disorders due to marital status (Table 11).

Table-11 Relationship between marital status and psychological health disorders.

Disorder	Source Of Variance	Sum Of Squares	df	Mean Square	F	Sig.
SOMATIC	Between groups	3.240	2	1.620	.231	0.09#
	Within groups	575.537	82	7.019		
	Total	578.776	84			
ANXIETY	Between groups	1.064	2	.532	.122	0.39#
	Within groups	356.747	82	4.351		
	Total	357.812	84			
SOCIAL	Between groups	15.163	2	7.582	1.588	0.78#.
	Within groups	391.589	82	4.775		
	Total	406.753	84			
DEPRESSION	Between groups	3.830	2	1.915	.300	0.65#
	Within groups	523.582	82	6.385		
	Total	527.412	84			
G.H.Q	Between groups	41.591	2	20.795	.354	0.99#
	Within groups	4819.397	82	58.773		
	Total	4860.988	84			
BEHAVIOR	Between groups	1.265	2	.633	.247	0.98#
	Within groups	210.382	82	2.566		
	Total	211.647	84			
PSYCHOSOCIAL	Between groups	44.287	2	22.143	.485	0.08#
	Within groups	3742.937	82	45.646		
	Total	3787.224	84			

* Significant at P level ≤ 0.05

\# Not significant

5.13 Relationship of age of start smoking and psychological health disorders

There were no significant differences at P level < 0.05 among the substance abusers in the psychological health disorders due to age of start smoking (Table 12).

Table-12: Relationship between age of start smoking and psychological health disorders.

Disorder	Source Of Variance	Sum Of Squares	df	Mean Square	F	Sig.
SOMATIC	Between groups	3.682	2	1.841	.263	0.75#
	Within groups	575.094	82	7.013		
	Total	578.776	84			
ANXIETY	Between groups	22.093	2	11.046	2.698	0.84#
	Within groups	335.719	82	4.094		
	Total	357.812	84			
SOCIAL	Between groups	1.877	2	.938	.190	0.65#
	Within groups	404.876	82	4.938		
	Total	406.753	84			
DEPRESSION	Between groups	17.107	2	8.554	1.374	0.09#
	Within groups	510.305	82	6.223		
	Total	527.412	84			
G.H.Q	Between groups	133.751	2	66.876	1.160	0.97#
	Within groups	4727.237	82	57.649		
	Total	4860.988	84			
BEHAVIOR	Between groups	11.843	2	5.922	2.430	0.57#
	Within groups	199.804	82	2.437		
	Total	211.647	84			
PSYCHOSOCIAL	Between groups	66.933	2	33.467	.738	0.72#
	Within groups	3720.290	82	45.369		
	Total	3787.224	84			

* Significant at P level ≤ 0.05

Not significant

5.14 Relationship between age of first substance use and psychological health disorders

The results showed that there were significant differences at P level ≤ 0.05 between age of first substance use and both depression and behavior disorders, and the investigator used Tukey Post Hoc Tests HSD, for explaining the pairs significant differences of age of first drug use and both depression and behavior health disorders Table (13.1).

Table-13.1: Relationship between age of first substance use and psychological health disorders.

Disorder	Source Of Variance	Sum Of Squares	df	Mean Square	F	Sig.
SOMATIC	Between groups	6.501	2	3.251	.466	0.09#
	Within groups	572.275	82	6.979		
	Total	578.776	84			
ANXIETY	Between groups	.937	2	.468	.108	0.78#
	Within groups	356.875	82	4.352		
	Total	357.812	84			
SOCIAL	Between groups	23.511	2	11.756	2.515	0.88#
	Within groups	383.242	82	4.674		
	Total	406.753	84			
DEPRESSION	Between groups	43.170	2	21.585	3.655	0.05*
	Within groups	484.242	82	5.905		
	Total	527.412	84			
G.H.Q	Between groups	212.188	2	106.094	1.871	0.63#.
	Within groups	4648.800	82	56.693		
	Total	4860.988	84			
BEHAVIOR	Between groups	18.014	2	9.007	3.814	0.05*
	Within groups	193.633	82	2.361		
	Total	211.647	84			
PSYCHOSOCIAL	Between groups	106.790	2	53.395	1.190	0.89#
	Within groups	3680.433	82	44.883		
	Total	3787.224	84			

* Significant at P level ≤ 0.05

\# Not significant

For explaining the significant differences at P level 0.05 in depression , the results showed that substance abusers stating use drugs at age 14 years old and lower (M= 5.80) were suffering more depression than substance abusers starting at age 19 years old and higher (M= 3.73). No significant differences were found between other patients (Table-13.2).

Table-13.2: Description of Tukey HSD for depression. by age of first substance use

DEPRESSION	LOWER THRU 14 M= 5.80	15-18 M = 4.27	HIGHER THRU 19 M= 3.73
LOWER THRU 14 M= 5.80	-	1.52	2.06*
15-18 M = 4.27	-	-	0.54
HIGHER THRU 19 M= 3.73	-	-	-

* The mean difference (M) is significant at the P level ≤ 0.05 .

For explaining the significant differences at P level 0.05 in behavior , the results showed that substance abusers starting drug use at age 19 years old and higher (8.20) were showing more behavioral problems than substance abusers starting drug use at age 14 years old and lower (M=6.86). No significant differences were found between other substance abusers (Table 13.3).

Table-13.3: Description of Tukey HSD for behavior by age of start substance use.

BEHAVIOR	LOWER THRU 14 M=6.86	15-18 M=7.65	HIGHER THRU 19 M=8.20
LOWER THRU 14 M=6.86	-	-0 .78	- 1.33*
15-18 M=7.65	-	-	- 0.55
HIGHER THRU 19 M=8.20	-	-	-

* The mean difference is significant at the P level ≤ 0.05 level.

5.15 Distribution of patients psychological disorders by dependence periods

A total 78 (91.7 %) patients were having a period history of dependence for four and more years, comparing to 4 (4.7 %) patients having a period of two to three years, and 3 (3.5 %) patients having a period dependence of only one year (Table 14) .

Table-14: Distribution of patients psychological health disorders by dependence period

Dependence period by years	GHQ-28 (used 4/5 as a cut- off point). for Somatic , Anxiety , Social & Depression (used 1 / 2 as a cut – off point)										
	GHQ TOTAL			SOMATIC		ANXIETY		SOCIAL		DEPRESSION	
	Normal	Clinical	Clin%	Normal	Clinical	Normal	Clinical	Normal	Clinical	Normal	Clinical
One year	0	3	3.5	1	2	1	2	0	3	1	2
2-3	1	3	3.5	2	2	1	3	2	2	3	1
4++	5	73	85.9	15	63	7	71	9	69	15	63
Total	6	79	92.9	18	67	9	76	11	74	19	66

- *Mean (Total)* : *11.72 years*
- *Standard Deviation* :*6.77 years*
- *Statistical Significance* : *not appear at 0.05 level , but it was appear for severe depression (p = 0.030)*

5.16 Distribution of patients psychological disorders by last time of using substance

The highest number of patients 42 (49.4 %) used substances for last time in the previous week, 13 (15.3 %) used substances during previous month, and only 30 (35.3 %) used substances in a period more than one month ago (Table 15).

Table-15: Distribution of all patients psychological disorders by Last time of using substances

Last time of using substance by days	GHQ-28 (used 4/5 as a cut- off point). for Somatic , Anxiety , Social & Depression (used 1 / 2 as a cut – off point)										
	GHQ TOTAL			SOMATIC		ANXIETY		SOCIAL		DEPRESSION	
	Normal	Clinical	Clin%	Normal	Clinical	Normal	Clinical	Normal	Clinical	Normal	Clinical
1-7 days	2	40	47.1	3	39	3	39	4	38	8	34
8-30 days	0	13	15.3	2	11	0	13	2	11	1	12
31++days	4	26	30.6	13	17	6	24	5	25	10	20
Total	6	79	92.9	18	67	9	76	11	74	19	66

- *Sample size : 85*
- *Statistical Significance : not appear at 0.05 level. but it was appear for somatic (p=0.001)*

5.17 Distribution of substance abusers by main reasons for starting substance use

The total number of patients had agreed on the friend sharing (24.1%) as the first and highest reason for starting use of substances, followed by curious and experiment (21.4 %), family problems (18.8 %) and Israeli problems (15.7 %). The lowest reason for starting drug use was school problems (0.6 %) (Table 16).

Table-16: Distribution of substance abusers by main reasons for starting substance use.

	REASONS	RELATIVE FREQUENCY	GRADE
1	**Curious & experiment**	21.4	**2**
2	**Friend sharing**	24.1	**1**
3	**Health problems**	3.5	7
4	**School problems**	0.6	**12**
5	**Family problems**	18.8	**3**
6	**Israeli problems**	15.7	**4**
7	**Jobless**	4.5	5
8	**Treatment**	4.3	6
9	**Invitation**	2.4	9
10	**Joy & happy**	1	11
11	**Like others**	2.5	8
12	**Others**	1.2	10
	Total	100	

5.18 Distribution of patients satisfaction on psychiatric hospital medical services

The results indicated that the highest satisfaction 58 (68.2 %) was on the nursing services, 52 (61.2 %) was on doctors services, 46 (54.1 %) was on hospital services, and lowest satisfaction was on the way of treatment services of the hospital (Table 17).

Table-17: Distribution of patients satisfaction of services in hospital .

SATISFACTION	YES		NO	
	Count	%	Count	%
Hospital service	46	54.1%	39	45.9%
Doctors service	52	61.2%	33	38.8%
Nursing service	58	68.2%	27	31.8%
Treatment service	28	32.9%	57	67.1%

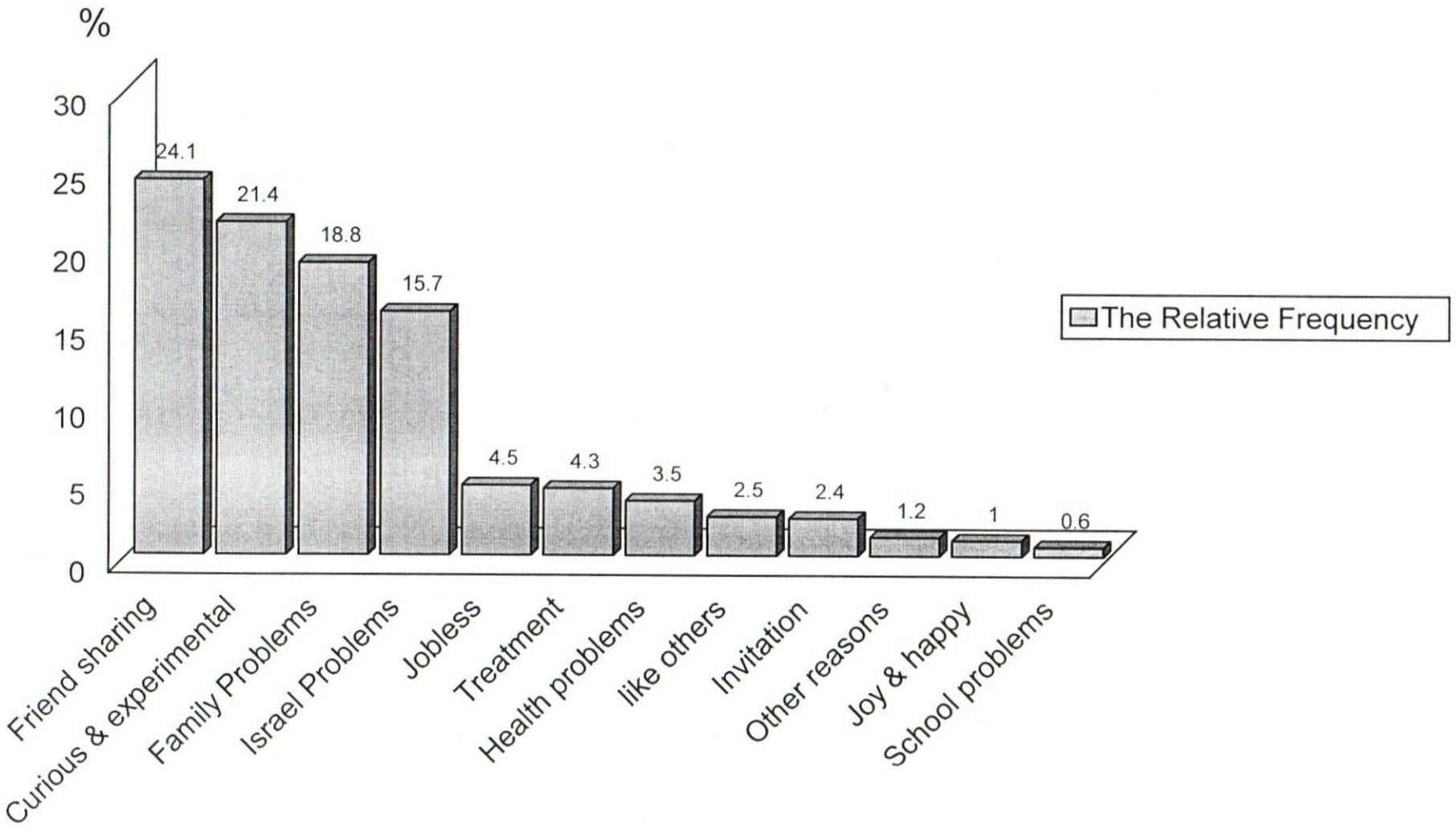
5.19 The association between psychological disorders and type of services needed by patients

There were different requirements among the patients about the type of services needed to improve their suffering from substance abuse. The majority of patients 56 (65.9 %) were approved collectively on the need to be treated in a comprehensive treatment and rehabilitation center and that group of patients were scoring high psychological disorders on GHQ scale, which were (54.4 %) somatic disorder , (64.5 %) anxiety, (63.2 %) social dysfunction and (58.2 %) depression. only 24 (28.2 %) expressed their need to awareness programs, and 5 (5.9 %) agreed to continuation of their present treatment in the psychiatric hospital (Table 18) .

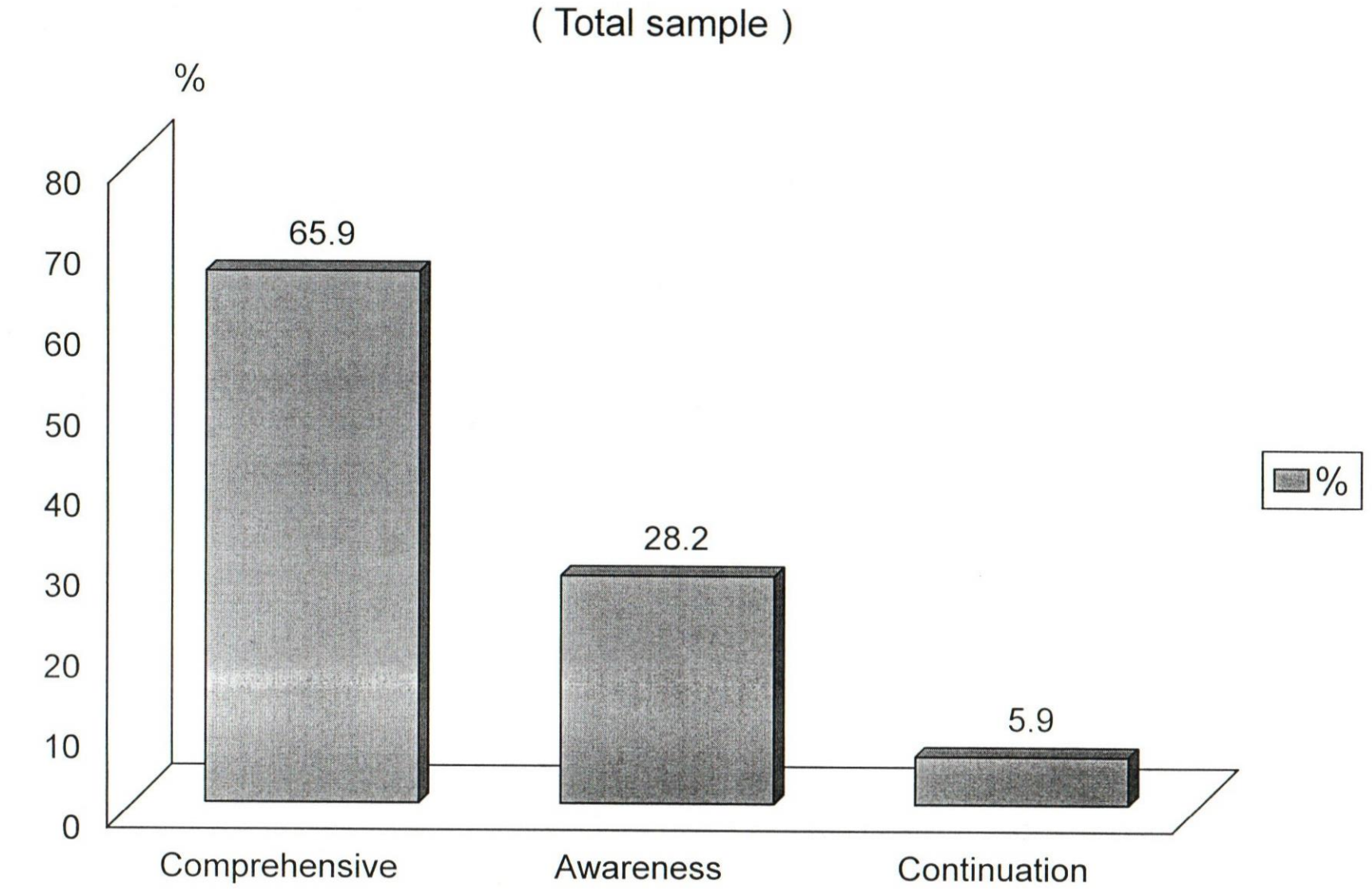
Table-18: Distribution of psychological health problems by type of needed services

Type of services needed by patients	GHQ-28 (used 4/5 as a cut- off point). for Somatic , Anxiety , Social & Depression (used 1 / 2 as a cut – off point)										
	GHQ TOTAL			SOMATIC		ANXIETY		SOCIAL		DEPRESSION	
	Normal	Clinical	Tot.%	Normal	Clinical	Normal	Clinical	Normal	Clinical	Normal	Clinical
Continuation	0	5	**5.9**	0	5	0	5	0	5	2	3
Awareness	4	20	**28.2**	5	19	4	20	5	19	7	17
Comprehensive	2	54	**65.9**	13	43	5	51	6	50	10	46
Total	6	79		18	67	9	76	11	74	19	66
Percent	7.1 %	92.9 %	**100**	21.2 %	78.8 %	10.6 %	89.4 %	12.9 %	87.1 %	22.4 %	77.6 %

Reasons of using substance at first time



Patients' needs to treat their substances dependence



5.20 Results of observations and revised patients files data

The investigator observed directly all the patients who participating in this study, from the moment the patient waiting to enter to the psychiatrist room, during the medical investigation and during the participation in answering the questionnaires. For the purpose of this study the investigator put these important points:

1. Medical files for the substance abuse patients were only some white papers put randomly for written of medicines, no any clear information or previous history in a regular standardized data document, according to medical procedures and regulations.
2. Communication between the psychiatrists and the substance abuse patients were very short , very tuff ,unfair and routinely medicines prescriptions.
3. Substance abusers asking the psychiatrists to prescribe for them special type of medicines and asking for doses and quantity of drugs previously dispensed for them and the psychiatrist easily agree for their demands.
4. Some of patients were very aggressive and tuff with all the medical stuff, withdrawal symptoms were obvious and they were asking for their medicines strongly and dependently. Their answers to me that they were continuously using these dispensed drugs for years and they could not stop administering or taking alternatives medicines.
5. Most of the dispensed drugs for the substance abusers were **Diazepam** tablets, dispensed continuously for many years, and it was obvious the patients dependence on these types of drugs.
6. Unemployment, poverty, personal and family suffering, searching for social helps and aids, all these common characteristics of the study population which where observed by the investigator.

7. All of the participating substance abusers were very cooperative and answering honestly on questionnaires, and their hopes and demands to the investigator that this study will improve their medical and life situations.

CHAPTER (6)

DISCUSSION

The present cross-sectional study determines the comorbidity of psychological problems among outpatient substance abusers, who were attending El-Naser Psychiatric hospital in Gaza Strip. The study also used to determine the prevalence of specific patterns of emotional and behavioral problems and substance abuse among substance abusers adults of different ages clusters at 20^{th}, 30^{th}, 40^{th} and more years. It assesses rates of emotional and behavioral problems in an institutionalized adult population and determines whether specific measures of psychological functioning were associated with substance use.

The results of the study have answered the questions of research. The following discussion is intended to shed lights on the most important results that are relevant directly to the objectives of the study, and in the view of literatures that could be obtained.

Regarding to the **sex** distribution of the patients in the present study, participants were 84 male (98.8%) who were attending the hospital, and only one female sharing in our study. The investigator explains that low number of females who attending the psychiatric hospital for many reasons, first is the high stigma of substance dependence in the Palestinian society especially for female, second is the lower percentage of substance abuse between female due to the religion, habits and customs in the Palestinian society.

According to the **age** of the study population, mean age was 37.5 years, (89.4 %) of substance abusers were at age 30 and more, which point to serious implications of this cluster sample in the society, the individuals of this age are mostly head of families and have a large responsibilities for their children and their work. Only (10.6 %) of substance abusers were at age 22-29 years old, which indicate the lower number of substance abusers adults or adolescence who attending the psychiatric health centers for treatment of reasons unclear, this is which the investigator will recommend it for future research and investigation in the Palestinian society .

The **education level** of substance abusers patients were (52.9 %) primary and lower level, and (95.3 %) were below secondary level, which give implication of lower education, and consequently the connection with early life suffering and hard work make them early bound for substance abuse experimentation, when money and drugs were available.

For the **types of abused substances**, the study showed that the first abused substances were Hashish and Bango (56.5 %), Alcohol (30.6 %), Coke and Opium (7.1 %), Psychotropic (5.9 %), while the types of substances which were used continuously and dependently for many years, the study showed that Alcohol (4.7 %), Hashish and Bango (21.2 %), Coke (54.1 %) and Psychotropic (18.9 %). The results of the last substances which were used during the previous three months, the study showed: Alcohol (7.1 %), Hashish and Bango (15.3 %), Coke (29.4 %) and Psychotropic (48.3 %).

These findings are similar to other studies which showed that Students often report that they began to use inhalants and alcohol before other drugs . Marijuana use begins later, followed by prescription drug abuse and cocaine (Kandel, 1986) (5)

In Arab Emirates, a psychosocial study (Marzoke et al , 1995) showed that (60%) substance user age was 27 years old , (69 %) Hashish was first substances, (41 %) was dependent on heroin ; more than one third sample suffering psychological disorders, (77 %) use drug with friends , (36 %) using drugs regularly , (50 %) of sample have previous criminal records .(60)

In Gaza Strip, in the recent survey of the UNDCP (1999) on a random sample of substance abusers from different region in Gaza Strip, the mean age was 35 years, and male participation was (96.8 %) and female participation was only (3.3 %).for the type of abused drugs, Alcohol use (48 %), Hashish and Bango (58 %), coke (54 %) and Psychotropic (35 %).

Bango was the drug which connects with a significant relationship in psychological disorders more than the other abused substances, the study indicates that Bango abusers (21.2 %) were significantly the lowest in psychological disorders than either alcohol , coke, and psychotropic abusers. Bango was also lower significantly in somatic disorders and social dysfunction than coke and psychotropic among the patients, but Bango abusers were significantly only suffering more behavioral problems than Coke abusers. In general either Alcohol, Coke, Psychotropic abusers were suffering more in the psychological health disorders than Bango abusers.

Both mental disorders and substance use frequently have their onset in adolescence, therefore, examination of a cluster sample of different developmental periods may shed lights on the comorbidity between mental disorders and substance use.

The **four psychological health disorders** were studied: somatic, anxiety & insomnia, social dysfunction, and depression. The results showed that psychological disorders distribution among the study population were as follow : anxiety and insomnia was the highest distinguished disorder (89.4 %), social dysfunction (87.1 %), somatic disorder (78.8 %) and depression (77.6 %)

The investigator explains this high level of psychological disorders to many reasons, which this study had explored, the age of most patients was mostly in category of 30-39 years old, during which many life responsibilities are needed for their families; unemployment also contributing to many emotional and behavioral problems due to depending on external helps and aids which always not sufficient ; the number of years of dependence for the majority (91.7 %) were more than four years which gave an impression of the long suffering period and consequences of psychological disorders.

The prevalence of clinically significant anxiety disorder in patients who abuse alcohol range from 25 % to 45 % for patients with clearly defined anxiety disorder, but may approach 60 % in other identifiable anxiety disorders (Bowen et al 1984; Chambless et al 1987).(50)

Weiss and Rosenberg (1990) found that 40% of patients presenting for treatment of alcohol abuse and / or dependence were also suffering from some form of affective disorder. Conversely, 30 % to 40 % of patients presenting for treatment of affective disorders have abused alcohol or other depressant drug. Furthermore, individual's who abuse alcohol and other CNS depressants appear to have relatively higher rates of anxiety disorders than opiate or cocaine abusers.

From the study , it was clear that (87.1 %) of the patients were unemployed , and only (12.9 %) were employed . That high number of **unemployment** made the majority of the patients (81.74 %) depending on their daily life expenses on either family support or social aids helps, which indicated a hard life situation , affected the patients in their emotional and behavioral health status. The relationship was significant in somatic, anxiety, behavior and psychosocial disorders between the unemployment who were suffering more psychological health disorders and the skilled patients.

The rates of unemployment according to recent PCBS publications are unstable and with constant fluctuation. This is due to the unstable economic situation resulting from the political situation, and the occupation practices of territories closure, Palestinian labor in Israel, constrains imposed on commerce movements and passage between west bank and Gaza strip, and the imposed constraints on trade activities with the outside world. The rate of unemployment has dropped to 14.4% in 1998, compared to the rate of 23.8% in 1996 (10).

The results showed that substance abusers start using substances at **age 14 years old** and lower (Mean= 5.80) were suffering more depression than substance abusers starting at age 19 years old and higher (Mean= 3.73) but substance abusers starting drug use at age 19 years old and higher (Mean=8.20) were showing more behavioral problems than substance abusers start using substance at age 14 years old and lower (M=6.86).

The total number of patients had agreed on the factor of **friend sharing** (24.1%) as the first and highest reason for start using of substances, followed by curious and

experiment (21.4 %), family problems (18.8 %) and Israeli occupation problems (15.7 %). The lowest reason for start using substance was school problems (0.6 %).

In Gaza Strip, a survey applied by Al- Hayatt Anti drug Association (1998) conducted on 220 addicts, the result showed that (67.5 %) of substance abusers onset age was 16-21 years , (61.5 %) were labors , (74.5 %) start used Hashish and Bango, (6.5 %) used white powder (Heroin, coke), (6.5 %) used narcotic tablet, (47 %) of the sample started using substances with bad peer , (33 %) due to curiosity , (28 %) due to family problem (62)

The results indicated that the highest **satisfaction** 58 (68.2 %) was on the nursing services, 52 (61.2 %) was on doctors services, 46 (54.1 %) was on hospital services, and lowest satisfaction was on the way of treatment services of the hospital.

There were different requirements among the patients about **the type of services needed** to improve their suffering from substance abuse. The majority of patients 56 (65.9 %) were approved collectively on the need to be treated in a comprehensive treatment and rehabilitation center and that group of patients were scoring high psychological disorders on GHQ scale, which were (54.4 %) somatic disorder , (64.5 %) anxiety, (63.2 %) social dysfunction and (58.2 %) depression. only 24 (28.2 %) expressed their need to awareness programs, and 5 (5.9 %) agreed to continuation of their present treatment in the psychiatric hospital .

The results showed that 48 (56.5 %) of substance abusers patients in our sample connected by direct **relation at the Israeli occupation role** to their problem of substance abuse , but only 37 (43.5%) were not connected to Israeli occupation role.

For the frequency of **regular drug use** during the day, (57.6 %) used drugs for one to three times daily, but (61.2 %) used drugs for more than three times daily.

A total of 78 (91.7 %) patients were having **a period history of dependence** for four and more years, comparing to 4 (4.7 %) patients having a period of two to three years, and 3 (3.5 %) patients having a period dependence of only one year.

In summary, the evidence to date suggests an intricate and not entirely uniform set of relationship between various patterns of drug abuse and concurrent presence of other psychiatric disorders. The challenge for the future is to develop reliable methods for defining the precise temporal and etiologic relationships between drug use and other forms of psychology and then devise treatment programs.

The high rate of substance use disorders among persons with severe mental illness has important clinical implications, because their substance abuse is associated with an array of negative outcomes. Common negative consequences include increased vulnerability to relapses and rehospitalizations, greater depression and suicidal, violence, housing instability and homelessness, noncompliance with medications and other treatments, increased vulnerability to HIV infection, increased family burden, and higher service utilization and costs. (Bartels et al 1993; Clark 1994; Darke et al 1989).(70)

In Gaza Strip, a study conducted recently (Thabet et al 1997) on mentally ill patients in three different psychiatric health clinics, the results showed that, Ninety three (87.7%) of the referred cases were scoring above cut off point of GHQ (using 4/5 as a cut-off point compared to only 13 (12.3%) of the controls. Using DSM-IV diagnosis criteria (American Psychiatric Association, 1994) as a diagnostic tool, 36.8% of the referred patients were diagnosed as follows: major depression (25.5%), schizophrenia (12 %), anxiety disorder (5.7%), conversion disorder (10.4%), mania (2.8%), post traumatic stress disorder (2.8%) drug addiction (2.8%), and 3.8% epilepsy .

The investigator pointed to the high percent of **psychological disorders prevalence** in this study which was (92.9 %) among the substance abusers comparing to the previous Gaza study which was (87.7 %) among the mentally ill patients and by using the same GHQ scale, that evidence assuring the medical fact that substance abusers suffering more psychologically and physically than the mentally ill patients.

Data showed that psychoactive substance use may signal an increased risk of developing clinically significant psychiatric disturbances such as panic attacks, suicidal attempts, depressive episodes and possibly even obsessive compulsive disorder(Woody et al 1995) (46).

Increasingly today, experienced practitioners are aware that the relationship between substance abuse and other psychiatric disorders is complex, and that treatment, if it is to be successful, must treat both.

Mental health counselors are recognizing that alcohol and drug problems complicate management of psychiatric disorders. It is not enough to provide counseling and medication without first understanding the role a patient's drug, alcohol use may play in aggravating psychological symptoms. Also, alcohol, drug counselors are recognizing that many of their patients have problems that make it difficult for these patients to maintain sobriety . Despite active involvement and drug, alcohol treatment and follow-up care, such patients continue to experience depression and other psychological problems that make them vulnerable to drug and alcohol relapse.

The opinion of the investigator to combat the substance abuse problem in Palestine, we need to do the following: 1) Identify the actual situation in the community and the affected age group, the only data we have now are from police records and hospitals;
2) Establish specialized units for dealing with detected cases, instead of placing them in a psychiatric hospital, we need people to work socially, psychologically and medically with them ; and 3) provide public awareness programs in which all governmental and non- governmental institutions are sharing effectively.

CHAPTER (7)

CONCLUSIONS AND RECOMMENDATIONS

7.1 CONCLUDING REMARKS

Although this study included only the substance abusers patients attending the outpatient psychiatric hospital in Gaza Strip, generalization of the results could not honestly considered because of the heterogeneity of substance abusers who are attending and not attending the psychiatric health services in Gaza Strip.

The investigator put a realistic objectives complies with the nature of this study, and he applied a theoretical framework complies with achieving of these objectives. The objective number (4) showed in page number (15), and the objective number (5) showed in page number (16). The results of the study answered on these objectives as it is obvious in pages number pp. 59-63.

We can also conclude from our study that objective number (3) on abused substances which were used compulsively and dependently were: Coke (54.1 %), Bango and Hashish (21.2 %), Psychotropic (20 %), and Alcohol (4.7 %). Bango and Hashish (58.8 %) was the first abused substance , and Psychotropic (48.2 %) was the last abused substance.

Our results indicated that objective number (1) on prevalence of psychological problems was (92.9 %), and patients were categorized as clinical cases according to GHQ scale, on the other hand, objective number (2) on the specific measures of psychological disorders among substance abusers, anxiety disorder (89.4 %) was the

specific measure disorder of highest value, social dysfunction (87.1 %), somatic disorder (78.8 %) and depression (77.6 %) which was the lowest disorder.

Additionally, we found that, Bango abusers (mean 12.11), were suffering the lowest psychological disorders on GHQ scale than alcohol abusers (mean 22.75), coke abusers (mean 18.95), and Psychotropic abusers (mean 20.58).

The majority of patients 56 (65.9 %) were approved collectively on the need to be treated in a comprehensive treatment and rehabilitation center and that group of patients were scoring high percentage psychological disorders on GHQ scale, which were (54.4 %) somatic disorder , (64.5 %) anxiety, (63.2 %) social dysfunction and (58.2 %) depression. only 24 (28.2 %) expressed their need to awareness programs, and 5 (5.9 %) agreed on continuation of their present treatment in the psychiatric hospital .

The above mentioned results emphasize the urgent Palestinian necessity for the establishment of specialized, internationally standard, comprehensive treatment and rehabilitation center in Palestine, at least one in Gaza Strip and another one in the West Bank.

RECOMMENDATIONS

- We must recommend increasing the medical investigation and an active participation of primary health care providers towards early exploring and caring for the emotional and behavioral disorders among substance abusers.
- Effective Detoxification of substance abusers from coke (Mixed Heroin) is an important medical step towards lowering the high dependence percentage of coke abuser patients in Gaza Strip.
- Necessity to establish independent, comprehensive, treatment and rehabilitation centers in Palestine for substance abusers in accordance with international standards and Palestinian culture.
- Unemployment was a major factor of psychosocial problems, thus it is important to conduct cooperative national programs for suitable employment for substance abusers.
- To dispense very carefully, a low or no addictive proprieties medicines, to carefully monitor the psychotropic medicines dosage, using the gradual decreasing dosage scale, and using aversion therapy medicines for treatment of outpatient substance abusers.
- To concentrate subjectively in the treatment programs on psychotherapy and other psychiatric services therapeutics such as: behavioral, familial, occupational, and recreational therapies.
- Supporting the Palestinian families on both psychological and social levels, to enable them to support effectively their relative's substance abusers and

encouraging outreach programs to reach the patient at home and gives him services in his community.

- Formulating an integral awareness media plain on the harmful consequences of early smoking connected to early abuse substances among adolescents and transmitting through the several mass media, schools, sport youth clubs, and summer youth camps.
- Preventing through raising religious awareness, since religious has a great impact in eliminating anxiety, depression, frustration, strengthen the will, and accepting treatment, and protection against future relapses.
- To prepare teams of social workers, psychologists, clinical psychologists, teachers, former addicts, and employees in education rehabilitation and qualifying them to work with addicts and their families.
- Training cadres from Ministry of Health to specialize in the fields of treatment and rehabilitation of substance abusers in accordance with international standards and World Health Organization requirements.
- Conducting a study about all the applied treatment methods for substance abusers in Palestine, and review these methods and adopting them to treatment methods ratified by the World Health Organization.
- Benefiting from universities, research centers, Ministry of Health and Anti-Drug Police Administration in Palestine to implement substance abuse research and classification statistics for the purpose of providing data bases and information banks.

SUGGESTIONS FOR FURTHER WORK

- We would like to emphasize that similar studies should be conducted throughout Palestine in order to determine the psychological health problems among the non-institutional substance abusers, who are not attending the psychiatric health services, and who could be suffering severe psychosocial problems.
- Longitudinal research is necessary to clarify the temporal relationship between emotional and behavioral problems and initial substance use and escalation to more serious patterns of use.
- Studies are needed to explicate the risk relation between mental health problems and substance use in adolescence. Such finding makes it possible to identify high risk adolescents and to develop early effective intervention programs.

GLOSSARY

Abuse (psychoactive substance abuse)

A maladaptive pattern of use indicated by continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use. The term harmful use is preferred by WHO.

Addict/addiction Repeated use of a psychoactive substance or substances to the extent that the user is periodically intoxicated, shows a compulsion to take the preferred substance(s), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted. While the term is widely used by professionals and the general public, the term dependence is preferred by WHO.

Abstinence Refraining from drug use or from drinking alcoholic beverages, whether as a matter of principle or for other reasons.

Anxiolytic An anti-anxiety drug

Brief intervention A treatment strategy in which structured therapy of short duration (typically 5 – 30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of a psychoactive substance or deal with other life issues. They are also termed minimal interventions, and very useful for practitioners of PHC.

Bango Popular name used by substance abusers in Palestine for Cannabis plant.

Coke Popular name used by substance abusers in Palestine for mixed heroin.

Demand reduction A general term used to describe policies or programs directed at reducing the consumer demand for psychoactive drugs.

Dependence A need for repeated doses of a drug to feel good or to avoid feeling bad. A cluster of cognitive, behavioral and physiologic symptoms that indicate a person has

impaired control of psychoactive substance use and continues use of the substance despite adverse consequences.

Detoxification The process by which an individual is withdrawn from the effects of a psychoactive substance. Detoxification may or may not involve medical care and the administration of medication.

Diazepam A benzodiazepine used as an anxiolytic, sedative/hypnotic and muscle relaxant.

Drug A term of varied usage, it refers to any licit or illicit substance with the potential to prevent or cure disease or enhance physical or mental welfare.

Dual diagnosis The presence of both an alcohol and other drug abuse problem and a psychiatric disorder.

Harmful use A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis) or mental (e.g. a depressive episode secondary to use). Harmful use commonly, but not invariable, has adverse social consequences.

Illicit drug A psychoactive substance, the production, sale, or use of which is prohibited.

Occupation refers to the kind of work done during the reference period by the person employed.

Outpatient The patient who take his treatment outside the hospital

Psychosocial Problems It is the sum of responses to the applied scale to all emotional and behavioral disorders, which are: depression, anxiety, somatic, social, and behavioral disorders

Primary education Include those finished 1-6 years of education.

Preparatory education Include those finished 6-9 years of education.

Prevalence The number of old and new cases in a defined population at a specified point in time. Prevalence may be recorded at a stated moment or during a given period of time.

Substance refers to those substances having psychoactive properties that influence the mental functioning of humans, and consequently a physical effect on body as well. They may take solid, liquid, or gaseous forms and often are modified so that they are more readily available to the body.

Secondary education Include those finished 9-12 years of education.

Skilled worker Occupations consist primarily of blue workers such as electricians, mechanists, farmers, tailors, drivers, and miscellaneous laborers.

Unemployed Those with no monthly income including housewives.

REFERENCES

1- World Health Forum. (1992) Substance Abuse: the global situation. An International Journal of heath development. Vol. **13,** No. 2/3.

2- Angold, A. & Costello E. J. (1993). Depressive comorbidity in children and adolescents: Empirical, theoretical, and methodological issues. American Journal of Psychiatry, 150:1779-1791.

3- Ustun, T. B. & Sartorius, N. (1995). Mental illness in general health care . An International Study. John Wiley & Sons, England.pp.105-110.

4--Babor, T. (1998). WHO: Project on Identification and Management of Psychoactive Substance Problems in Primary Care Settings, Phase one.pp. 23-26.

5- Substance Abuse and Mental health Services Administration (1996c). Mental health Estimates from the !994 National Household Survey on Drug Abuse Rockville, MD. Advance Report Number 15.

6- Newcomb, M. D. and Bentler, P. M.(1988) Consequences of Adolescent Drug Use. Newbury Park: Sage Publications, 97:64-75.

7- Lewinsohn, Rohde & Seeley (1995). The relationship between mental health and substance abuse among adolescents. Office of applied studies, U.S. Department of health and human services, 36: 699-705.

8- Health Management Information System (HMIS 2000) The Status of Health in Palestine., Ministry of health, Palestinian National Authority. Annual Report.

9- Gaza Health Research Service center (GHSRC 1997 Ministry of Health, Palestinian National Authority, Annual Report,.

10- Palestine Central Bureau of Statistics(1997). The demographic survey in the West Bank and Gaza Strip. Annual Report.

11- Palestinian Anti Drug Administration (PADA 2001). Annual Report .

12--Martin, A. (1989) The epidemiology of alcohol and illicit drug use. Medicine International Journal, 62, 660-666.

13-Substance Abuse and Mental Health Service Administration (1997). A Guide to Substance Abuse Services for Primary Care Clinicians. DHHS Publication No.(SMA) 24-3068.

14-Aeed, M. F. (1992) Drugs, Reasons, and Humans. Anti crimes Research Center in Ministry of Affairs. Riyadh, pp.62-69.

15-Farag, S.N., (1980) The role of the general administration in drug abuse control in Egypt . Bulletin on Narcotics 13 : 27-30.

16-Hanoun, R. (1998) Palestinian, social, cultural, and religious factors affecting substance abuse and treatment. Paper presented on workshop, Al-Quds University. Jerusalem

17- United Nation International Drug Control Program (1999) Survey of Substance Abusers Among Youth in Gaza Strip. Cooperation with Palestinian Anti Drug Administration.

18- Ball,J., Nurco, D., Clyton, R., Lerner, Hagan, T., and Groves, G. (1995). Etiology , epidemiology and natural history of heroin addiction : asocial science approach, In L. Harris (ed.), Problem of drug dependence, 1994; proceeding of the 56th annual meeting , The college on Problems of Drug Dependence , Inc.,Vol. 1, pp. 74 -78.

19- Abelson, H.,R. Cohen, D. Schrayer and Rappaport, M (1973) Drug experience, attitudes, and related behavior among adolescence and adults, Part I . Princeton, N J: Response Analysis. P. 44.

20- -R. Jsrafowitz, D. Telias. (1989). Understanding Substance Use and Abuse, The problem and treatment. Praeger Puplisher, pp. 1-16.

21-American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC : Author, pp. 176 -178.

22-World Health Organization (1992) The ICD-10 Classification of Mental and Behavioral Disorders: Clinical descriptions and diagnostic guidelines, Geneva, pp. 72-77.

23-American Psychiatric Association (1987) Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. (revised). Washington DC : Author, p.182.

24-Goode, E. (1989) Drugs in American Society Third Edition. New York : Mc Graw- Hill, p. 23.

25- National Institute on Alcohol Abuse and Alcoholism. (1990) Alcohol and Health. Rockville, MD: Department of Health and Human Services DHHS Publication No. ADM 87-1519.

26-National Institute on Drug Abuse.(1989) National household survey on drug abuse : Population estimates 1988. Rockville, MD : National Institute of Drug Abuse. DHHS publication No. ADM 89-1636.

27-Desmond, E. (1987) Out in the open : Changing attitudes and new research give fresh hope to alcoholics. Time Magazine, November 30, p. 29.

28-World Health Organization (1952) Expert Committee on mental health , Alcoholism subcommittee. Second Report , World Health Organization , Technical Report Series No. 48.

29- Maltzman. I. & Schweiger, A. (1991) Individual and Family Characteristics of middle Class Adolescences Hospitalized for Alcohol and Other Drug Abuse. British Journal of Addiction. Vol. 86, 1435-1447.

30-Fishburne, P., Abelson, H. & Cisin, I. (1980) National survey on drug abuse : Main findings : 1979 Rockville, MD : National Institute on Drug Abuse. DHHS publication No.ADM 80-976 .

31-Gossop, M & Grant M, (1990) Presenting and Controlling Drug Abuse. WHO, Geneva. 3: 357-367.

32-Day, N. & Leonard, K. (1985) Alcohol, drug use , and psychopathology in the general population New York : Plenum Press. pp. 15-44.

33-Erickson, P.G. et al (1987) The steel drug : Cocaine in perspective. Lexington, MA : Lexington Books.pp. 500-504.

34-National Institute of Drug Abuse (1996) Facts About methamphetamine, NIDA, Notes, November / December.

35-National Institute of Drug Abuse (1997) NIDA Capsules,(C-89-06), October.

36-National Institute of Drug Abuse (1997) Study takes a closer look at Ecstasy use. NIDA Notes, March / April.

37-NIDA Home Page (1999) Substance abuse. http : //www. Nida. nih.gov.

38-Maxmem, S.S. (1986) Essential Psychopathology . New York : Norton, pp. 201-233.

39- Okasha, A. (1985) Young People and the Struggle Against Drug Abuse in the Arab Countries. U. N. Bulletin on Narcotics. 37(243), 67-73.

40- Richard, R (1995) Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and other Drug Abuse. DHHS Publication No. 9

41- Substance Abuse and Mental Health Administration (1996) Mental Health Estimates From The 1994 National Household Survey on Drug Abuse. Report No. 15.

42- Akabawe et al (1990). Drug abuse problem among youth in Qatar. University of Qatar . Part I, p. 65

43-Khantzian, E.J. (1985) The self- medication hypothesis of addictive disorders: focus on heroin and cocaine dependence, AM. J. Psychiatry. 142: 1259-1264.

44-Schuckit, M.A. (1986) Genetic and clinical implication of alcoholism and affective disorder. AM. J. Psychiatry 143 : 140-147.

45-Regier et al (1990) co morbidity of mental disorders with alcohol and other drug abuse .Journal of the American Medical Association, 264: 2511-2518.

46- Woody, et al (1995) . Research on psychopathology and addiction : Treatment implication. 25:121-123.

47-Smail,P. et al (1984) Alcohol dependence and phobic anxiety status: I . A prevalence study . Br. J . Psychiatry 144: 53-57.

48- Kessler, et al (1996) The epidemiology of co-occurring addictive and mental disorders in the National Co morbidity Survey. American Journal of Orthopsychiatry : 66: 17-31 .

49-Brady, K.T.; Grice, D.E.; Dustan, L.; and Randall, C. Gender differences in substance use disorders. American Journal of Psychiatry 150(11):1707-11, 1993.

50-Chambless et al (1987) Anxiety Disorders and Alcoholism : A study with inpatient alcoholics . J. Anxiety Disorder 1 : 29- 40 .

51-Allen, M.H., francis, R. j. (1986) Varieties of psychopathology found in patients with affective disorders. In Meyer, R. E. , ed. Psychopathology and Addictive Disorder. New York. Guilford Press, pp. 17-38.

52- Grant, B. F., and Hasin, D. S. (1992) The Alcohol Use Disorders and Associated Disabilities Interview. Schedule. Rockville, M D : National Institute on Alcohol Abuse and Alcoholism, Publication No. ADM 88-0002.

53-Weddington et al (1990) Changes in mood, craving, and sleep during short-term abstinence reported by male cocaine addicts. Arch Gen. Psychiatry 47: 861-868.

54- Nunes, et al (1994) Antidepressant traetment in methadone maintenance patients. J. Addict Disease 13 : 13-24.

55- Mason.B., and Kocsis, H; (1991) Desipramine treatment of alcoholism. Psychopharmacologic. Bull. 27: 155-161.

56-Bejerot, N. (1980) . Addiction to pleasure : A biological and social-psychological theory of addiction . In D . Lettieri et al. (eds),op.cit.,p.253.

57-Sutter, A. (1966). The world of the righteous dope fiend. Issues in Criminology. 2(fall): p. 195.

58-Wurmser, L. (1980). Drug use as a protective system. In D. Lettieri, M. Sayers, and H. Pearson,(eds).Theories on Drug Abuse: Selected contemporary Perspectives Rockville, M.D.: NIDA.

59-Kaplan, H. (1980). Self- esteem and self-derogation theory of drug abuse. In D .Lettieri et al., (eds), 0p.cit., p. 129.

60- Marzoke, et al (1995) Drug abuse among youth in United Arab Emirates: A comparative study . p. 45.

61- El-Bassel, N., Schilling, R., Schinke, S.; (1994) Substance Abuse. Columbia University School of Social Work . Vol. 15, pp. 276-282.

62- Al- Hayatt Anti drug Association (1998) Drugs, reasons, dangerous, prevention. Ranttesse publisher, Gaza. pp. 50-53.

63- Sairafi, et al (1988). Drug Abuse among youth in Saudi Arabia. A comparative study. p 76.

64-El-Guebaly, N. (1990) Substance abuse and mental disorders. The dual diagnosis concept . Can . J . Psychiatry , 35: 261- 267.

65- Stoker, A. & Swadi, H. Perceived Family Relationships in Drug Abusing Adolescents. Drug and Alcoholic Dependence, 1990, 25, 253-256.

66- Onken, L. et al. (1997) Treatment of Drug- Dependent Individuals With Co morbid Mental Disorders. NIDA. Research Monograph 172.

67- Achenbach, T. M. (1991) Manual for the youth self- report and 1991 profile. Burlington, V T : University of Vermont. Department of Psychiatry.

68- Goldberg, D. P. (1972). The Detection of Psychiatric illness by Questionnaire. Oxford University Press : London

69- Thabet et al, (1997). The Feasibility of Arabic 28- item GHQ on Psychiatric Patients in Gaza Strip. Al-Quds University, Gaza.

70- Bartels, S. J.; Drake, R.E.; and Wallach, M.A.(1995). Long- term course of substance disorders among persons with severe mental disorder. Psychiatric Serv. 46:248-251.

ANNEX (1)

Psychosocial problems of substance abusers attending El-Naser Psychiatric Hospital, Gaza.

A questionnaire for the participating substance abusers patients

SERIAL NO. DATE SEX: MALE FEMALE

1) **AGE** (**years**)
2) **CURRENT RESIDENCE** ----------
3) **EDUCATION COMPLETED**----------
4) **USUAL OCCUPATION** ----------
5) **CURRENT OCCUPATION** ----------
6) **MAIN SOURCE OF INCOME:** 1-work 2- family support 3-social affair support 4- others
7) **MONTHLY INCOME** ----------
8) **MARITAL STATUS:** 1-married 2- single 3-divorced 4- others
9) **IF MARRIED, NO. OF CHILDREN** ----------
10) **DID YOUR PARENTS STAY WITH YOU:** 1- YES 2- NO
11) **NO. OF ROOMS IN YOUR HOUSE** ----------
12) **DID YOU EVER SMOKING CIGARETTES:** 1-never 2- in previous 3- yes 4- too much
13) **WHAT WAS THE FIRST SUBSTANCE HAVE YOU EVER FIRST USED ?**
    1) Beer 2) Alcohol 3) Hashish 4) Bango 5) Opium 6) Heroin 7) Coke
    8) Cough medicine 9) Narcotic tablets 10) Narcotic injection 11) Inhalants 12) Others
14) **WHAT WAS YOUR AGE AT FIRST SUBSTANCE USE ?** ----------**years old.**
15) **WHO DID INTRODUCE THE SUBSTANCE FOR YOU AT FIRST TIME ?**
    1) Friend 2) Family member 3) Drug dealer 4) Others
16) **WHERE WAS THE PLACE OF FIRST SUBSTANCE USE ?**
    1) School 2) Work 3) Club 4) Street 5) Friend house 6) Others
17) **WHAT WERE THE MAIN REASONS FOR FIRST SUBSTANCE USE ?**
    1) CURIOUS & EXPERIMENTAL 2) FRIEND SHARING
    3) HEALTH PROBLEMS 4) SCHOOL PROBLEMS 5) FAMILY PROBLEMS
    6) ISRAELI PROBLEMS 7) JOBLESS 8) TREATMENT 9) INVITATION
    10) JOY & HAPPY 11) LIKE OTHERS 12) OTHERS
    MAIN REASONS WERE: 1) 2) 3)
18) **WHAT WAS THE SUBSTANCE YOU HAVE USED DEPENDENTLY ?**
    1) Beer 2) Alcohol 3) Hashish 4) Bango 5) Opium 6) Heroin 7) Coke
    8) Cough medicine 9) Narcotic tablets 10) Narcotic injection 11) Inhalants 12) Others
19) **DETERMINE THE DEPENDENCE PERIOD ?** ----------YEARS

20) WHAT WAS THE FREQUENCY OF REGULAR SUBSTANCE USE DURING LAST YEAR

1)ONCE DAILY 2) TWICE 3) THREE TIMES 4) FOUR TIMES 5) MANY TIMES

21) WHAT WAS THE USUAL WAY OF ADMINISTER THE SUBSTANCE?

1)EATING OR DRINKING 2) SMOKING 3) SNIFFING

4) INJECTION 5) OTHERS

22) FROM WHERE YOU HAD OBTAIN THE SUBSTANCE?

1) DISTRIBUTORS 2) DEALERS 3) PHARMACIES 4) DOCTORS

6) FRIENDS

23) WHAT WAS THE LAST SUBSTANCE YOU HAD USED ?

24) WHEN WAS THE LAST TIME OF YOUR SUBSTANCE USE?

25) DID THE ISRAELI OCCUPATION HAD ANY RELATION WITH YOUR SUBSTANCE DEPENDENCE?

YES NO

26) IF YES , WHAT WAS THE TYPE OF RELATION ?

1) WORK 2) PRISON 3) KICKING 4) OTHERS

27) DID THE SUBSTANCE DEPENDENCE CAUSE PROBLEMS AS :

1) HEALTH PROBLEMS	YES	NO
2) PSYCHOLOGICAL PROBLEMS	YES	NO
3) FAMILY PROBLEMS	YES	NO
4) FINANCIAL PROBLEMS	YES	NO
5) POLICE PROBLEMS	YES	NO
6) ISRAELI PROBLEMS	YES	NO
7) OTHER PROBLEMS		

28) If you have abuse or dependent on narcotic substances previously or now, or at any time in the same 12- month period. Please answer all questions on the following DSM IV criteria :

	Yes	No
1) Have you Continuing the substance use with the knowledge that it is causing physical or psychological problem		
2) Have you taking the substance in larger amounts or over a longer period		
3)Giving up social, occupational or recreational activities because of substance abuse		
4)Spending a great deal of time to obtain the substance or to recover from its effects.		
5) Have you a persistent desire to cut down or control substance abuse.		
6) Have you suffer withdrawal syndrome ; the substance is taken to relieve from withdrawal symptoms.		
7) Tolerance occurred ; you need continuously increased amount to achieve desired effect, or diminished effect with continuous use.		

GENERAL HEALTH QUESTIONNAIRE

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general **over the past few weeks.** Please answer all questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not just those that you had in the past.

HAVE YOU RECENTLY:

A1	**Been feeling perfectly well and in good health?**	**Better than usual**	**Same as usual**	**Worse than usual**	**Much worse than usual**
A2	**Been feeling the need of a good tonic?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
A3	**Been feeling run down and out of sorts?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
A4	**Felt that you are ill?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
A5	**Been getting any pains in your head?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
A6	**Been getting a feeling of tightness or pressure in your head?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
A7	**Been having hot or cold spells?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
B1	**Lost much sleep over worry?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
B2	**Had difficulty staying asleep once you are off?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
B3	**Felt constantly under strain?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
B4	**Been getting edgy and bad-tempered?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
B5	**Been getting scared or panicky for no good reason?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
B6	**Found everything getting on top of you?**	**Not at all**	**No more than usual**	**Rather more than usual**	**Much more usual**
B7	**Been feeling nervous**	**Not at all**	**No more**	**Rather**	**Much more**

	and strung-up all the time?		than usual	more than usual	usual
C1	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2	Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3	Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4	Been satisfied with the way you've carried out your tasks?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than useful
D1	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4	Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6	Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7	Found the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A B C D Total

ANNEX (2)

الضغوطات النفسية- الإجتماعية
للمرضى المدمنين على المخدرات والمراجعين
لمستشفى النصر للأمراض النفسية بقطاع غزة .

استبيان للمرضى المشاركين فى الدراسة

1-العمر: ( )

2-مكان السكن الحالى: 1-مدينة ---- 2- معسكر----- 3- قرية --- 4- أخرى-

3-عدد سنوات التعليم الرسمي: ( )

4-المهنة فى السابق: ( )

5-العمل الحالى : ( )

6- المصدر الرئيسي للدخل: 1-العمل 2- مساعدة الأهل 3- مساعدة الشئون 4- أخرى

7- الدخل الشهري (تقريبا)

8-الحالة الإجتماعية: 1- متزوج 2- أعزب 3- مطلق 4- أرمل 5- أخرى

9-إذا كنت متزوجا" : -كم عدد أولادك: ( )

10-هل تقيم إقامة دائمة مع عائلتك (الأب والأم والأخوة): نعم لا

11 - كم عدد الغرف فى البيت : ( )

12- **ما هو موقفك من التدخين:** 1- لا أدخن 2- كنت أدخن. 3- أدخن. 4- أدخن بشراهة

13 -**اذا كنت مدخنا" حاليا :1- كم سيجارة تدخن فى اليوم :** ----------
2-كم كان عمرك عندما بدأت التدخين --------

(اذا كنت تعاطيت أو أدمنت على المخدرات حاليا" أو سابقا" ، أو خلال أى 12 شهرا" ماضية تعاطيت أو أدمنت المخدرات أرجو الإجابة على الأسئلة التالية بنعم أو لا :

	DSM-IV DEPENDENCE	نعم	لا
1	تعاطيت المخدرات باستمرار رغم آثارها الجسمانية أو النفسية عليك		
2	فقدت السيطرة ولم تستطيع التوقف عن تعاطى المخدرات		
3	حدث تقصير فى نشاطك العملي أو الوظيفي أو الاجتماعي نتيجة تعاطيك المخدرات		
4	قضيت وقت طويل إما فى البحث عن المخدرات أو فى تناول المخدرات أو الشفاء منها		
5	عندك رغبة قوية فى وقف تعاطى المخدرات ومحاولاتك فى التوقف فشلت		
6	تناولت جرعات أكبر من المخدرات إما للشعور بآثارها القوية السابقة أو لتعويض نقص الاستمتاع بالمخدر		
7	عانيت من حالة اللهفة والجوع للمخدرات عند التوقف عن تعاطيها		

التعاطى الإدمانى (الذى أدمنت علية) :

14-ما هو نوع المخدر الذى تعاطيتة أول مرة فى حياتك :---------- .

15-كم كان عمرك عند التعاطى لأول مرة فى حياتك ؟ -------- سنة .

16- ما هو نوع المخدر الذى تعودت تتعاطاة بشكل دورى وإدمانى:

1- بيرة - خمرة **3**- حشيش **4**- باتجو **5**- أفيون **6**- هيروين **7**-كوك **8**- أدوية الكحة **9** -حبوب مخدرة كالفاليوم **10**- حقن مخدرة **11**- مستنشقات(الأسيتون،الغراء، الدهان) **12**- أخرى أذكر

17- حدد المدة الزمنية للتعاطى الإدمانى : ----------سنة .

18- تعاطى المخدر يتم بصورة شبة منتظمة خلال السنة الماضية :

1 -مرة يوميا **2** -مرة أسبوعيا" **3**-مرة كل أسبوعين

4 - مرة كل شهر **5**-أخرى أذكر

19- ما هو المخدر(عدا العلاج) الذي تعاطيته أخر مرة .....

20- متى حدث آخر تعاطى (حدد المدة بالأيام).....

21- هل أنت راضى عن الخدمة العلاجية المقدمة هنا

1) المستشفى: نعم لا 2) الأطباء: نعم لا 3) التمريض: نعم لا 4) العلاج: نعم لا

22 -ما الذى تحتاجه حاليا" لعلاجك من الإدمان حسب رأيك ؟

1- أريد الاستمرار بتناول الأدوية العلاجية المصروفة لى من الطبيب فقط .

2- أحتاج جلسات إرشاد وتوعية نفسية واجتماعية .

3 - أريد علاج أخر شامل فى مستشفى متخصص.

4 - أخرى أذكر

23- هل حدثت مشاكل لك بسبب تعاطيك للمخدرات

نوع المشكلة	نعم	لا
1-مشاكل صحية		
2-مشاكل نفسية		
3-مشاكل عائلية		
4-مشاكل مالية		
5-مشاكل مع الشرطة		
6-مشاكل مع الاحتلال		
7- أخرى أذكر		

استبيان الصحة

الأخ الكريم : من فضلك أجب على كل الأسئلة التالية حول صحتك فى الأسابيع القليلة الماضية . ضع علامة × على مربع الإجابة التى تنطبق عليك.

الرقم	البيان	0	0	1	1
1	هل تشعر بأنك معافى وبصحة جيدة ؟	أحسن من المعتاد	كالعادة	أسوأ من المعتاد	أسوأ كثير من المعتاد
2	هل تشعر بأنك فى حاجة إلى مقويات جيدة ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
3	هل تشعر بأنك تعبان ومرهق ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
4	هل تشعر بأنك مريض ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
5	هل تشعر بصداع ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
6	هل تشعر بشد وضغط على رأسك ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
7	هل تشعر بنوبات من الحرارة والبرودة فى جسمك ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
8	هل تنام قليلاً لأنك قلقان ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
9	هل تشعر بصعوبة للعودة للنوم عندما تصحوا فى الليل ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
10	هل تشعر بأنك واقع تحت ضغط نفسى ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
11	هل تتترفز بسرعة ومزاجك متعكر ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
12	هل تشعر بأنك خائف ومرعوب بدون سبب ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
13	هل تشعر بأنك تحمل هموم الدنيا على أكتافك ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
14	هل تشعر بأنك قلقان ومتوتر طول الوقت ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
15	هل تشعر بأنك قادر على إلهاء نفسك بأشياء معينة ؟	أكثر من العادة	مثل العادة	أقل من العادة	أقل كثيراً من العادة
16	هل تشعر بأنك تأخذ وقت طويل لتنفيذ أشياء تعملها ؟	أسرع من العادة	مثل العادة	أقل من العادة	أقل كثيراً من العادة
17	هل تشعر بالرضا عن أفعالك وأعمالك ؟	راضى كثيراً	مثل العادة	أقل من العادة	أقل كثيراً من العادة
18	هل تشعر بأنك تقوم بدور فعال فى العمل ؟	أكثر من العادة	مثل العادة	أقل من العادة	أقل كثيراً من العادة
19	هل تشعر بأنك تلعب دور مفيد فى الأشياء التى تقوم بها؟	أكثر من العادة	مثل العادة	أقل من العادة	أقل كثيراً من العادة
20	هل أنت قادر على إتخاذ قرارات ؟	أكثر من العادة	مثل العادة	أقل من العادة	أقل كثيراً من العادة
21	هل تشعر بأنك قادر على الاستمتاع بنشاطاتك اليومية ؟	أكثر من العادة	مثل العادة	أقل من العادة	أقل كثيراً من العادة
22	هل تنتابك أفكار بأنك لا فائدة منك ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
23	هل تشعر بأن الحياة لا تساوى شيئاً وبدون أمل ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
24	هل تشعر بأن الدنيا لا تساوى العيش فيها ؟	لا	لا أعتقد ذلك	أكثر من العادة	أكثر كثيراً من العادة
25	هل تنتابك أفكار أنك تستطيع الاختلاء بنفسك ؟	مطلقاً لا	لا أعتقد ذلك	أعتقد ذلك	أعتقد ذلك بالتأكيد
26	هل تجد أوقات لا تستطيع فعل شئ لأن أعصابك متوترة؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
27	هل تتمنى أن تكون ميتاً وبعيداً عن كل شيء ؟	لا	أقل من العادة	أكثر من العادة	أكثر كثيراً من العادة
28	هل لك أفكار انتحارية للتخلص من حياتك ؟	مطلقاً لا	لا أعتقد ذلك	أكثر من العادة	أكثر كثيراً من العادة

ANNEX (3)

إشعار موافقة

الأخ/ ت ----------

تهدف هذة الدراسة للتعرف على الضغوطات النفسية- الإجتماعية للمرضى المدمنين على المخدرات وتحديد مدى علاقة هذة الضغوطات بإدمان المواد المخدرة المختلفة، وذلك بهدف زيادة معرفة المعالجين ومحاولة إيجاد الحلول الطبية المناسبة. ومشاركتكم فى هذة الدراسة تتطلب فقط الإجابة بأمانة وصدق على بعض الأسئلة الموجودة فى الإستبيان.

من حقكم المشاركة بالدرجة التى تريدونها ولكم الحق فى الإمتناع عن إجابة أى سؤال فى أى وقت . وستظل المعلومات المتلقاة فى إطار السرية التامة. فنحن لا ننشر أى أسماء أو عناوين خاصة فى مجال دراستنا، وستكون آراءكم الخاصة موضع تقدير وإحترام ، وسيتم نشر نتائج هذة الدراسة من خلال صورة جماعية وليست فردية .

نتمنى مشاركتكم الفعالة والصادقة لكى تساعدونا بمعلوماتكم الصادقة فى تقييم الوضع النفسى- الإجتماعى بشكل صحيح والإستفادة من ذلك فى تحسين الخدمة الطبية والتأهيلية للمرضى المدمنين فى فلسطين.

شكرا" لكم على المشاركة واذا رغبتم الإستفسار عن أى معلومة إضافية بخصوص هذة الدراسة ، الرجاء الإتصال على د/ زهير مصطفى رصاص ، تليفون : **2878166** كلية الصحة العامة – ماجستير الصحة النفسية ، جامعة القدس. غزة

توقيع المشارك **الباحث**

د/ زهير مصطفى رصاص

كلية الصحة العامة-فلسطين
School of Public Health
فلسطين-القدس

وزارة الصحة

جامعة القدس

2001/03/12

حضرة السيد الدكتور فيصل أبو شهلا المحترم
مدير عام المستشفيات حفظه الله
تحية طيبه وبعد...

الموضوع: الطالب زهير أبو رصاص

نرجو من سيادتكم التكرم بالإيعاز لمن يلزم نحو السماح للطالب زهير أبو رصاص الطالب بكلية الصحة العامة برنامج ماجستير الصحة النفسية المجتمعية بالدخول إلى المستشفيات في إطار دارسته و التي هي بعنوان Psychosocial problems among substance abusers attending El-Nasser Psychiatric Hospital

شاكرين لكم حسن تعاونكم
واقبلوا التحية ..

عميد كلية الصحة العامة

د. يحيى عابد

بسم الله الرحمن الرحيم

السلطة الوطنيه الفلسطينيه

المديرية العامه الشرطة

الادارة العامة لمكافحة المخدرات

الرقـــم :

التاريـــخ :٢٠٠١/٠٣/٢٥

المرفقات :

إجمالى القضايافي دولة فلسطين

منذ دخول السلطه حتى نهاية عام ٢٠٠٠

بلغ عدد القضايا ٢٦٩٣

- اسفرت عن ضبط:-

النوع	الكميه		
	جرام	كيلو	
مارجوانا	٣٣١,٦	٥١٧	
كوك **	٥٣١.٥	٦	
حشيش	٦٣,٦	٩	
هيروين	١٧٧٫١		
اقراص مخدره	٩٨٣١١		ثمان وتسعون الف وثلاثمائه واحدى عشر قرص
اشتال مارجوانا	٤٢٢٦١		اثنان واربعون الف ومأتى وواحد وستون شتله
اشتال افيون	١٣١٩٧		ثلاث عشر الف ومائه وسبع وتسعون شتله
بذور مارجوانا	١٢٧٥٨		اثنا عشر الـــف وســـبعمائه وثمـــان وخمسون بذره

**كوكتيل (هيروين +مواد تخليقيه مضافه للخليط)