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- Declaration of interest after the key words.
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#### **Tables**

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All illustration should be submitted camera-ready; line drawings/diagrams should be approximately twice the size they will appear in print.

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## **Editorial Letter**

Dear Readers,

I am pleased to say that the Arab Journal of Psychiatry is in its thirtieth year of publication. There is now a call for papers to be included in a special issue of the AJP set for publication in November 2019. We thank so many of our regular contributors and welcome new contributors to this much read and well-regarded scientific publication.

The current issue contains a rich variety of papers on issues ranging from smartphone use in university students in Jordan to attitudes toward mental illness among nursing staff in Egypt. As always, your feedback is helpful for making improvements and informing thematic development of the AJP ahead of each new edition.

Remember that research is the energy that raises society to a higher standard of living and with such effort our own countries - represented by the AJP's contributors and readers - can aspire and achieve to the standard of the most advanced nations.

**Walid Sarhan**

**Amman May 2019**

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## Homicide by People with Mental Disorders in the Sudan: A Clinical and Demographic Profile

Abelghani Elshiekh, Abdelmajid Abuzid, Fathalalim Abdelrahim

الملاح السريرية والديموغرافية لمرضى الاضطرابات العقلية الذين ارتكبوا جرائم القتل

عبد الغني الشيخ، عبد الماجد ابوزيد، فتح العليم عبد الرحيم

### Abstract

**B** **ackground:** There are few published studies on mental illness and homicide in developing countries, particularly Arab ones. **Aim:** The current study explored the clinical and demographic characteristics of homicidal patients with mental illness admitted to the forensic psychiatry facility in Khartoum, Sudan. **Method:** Using a retrospective design, 44 people with mental illness who committed homicide and were sentenced to Eledresi Forensic Hospital were assessed. Demographic and clinical information was obtained from patient medical records and comprehensive clinical interviews were conducted with patients and their relatives. **Results:** Participants were men (one woman) aged between 20-30 years. Almost half (48%) had been abusing alcohol and/or cannabis. Thirty six (82%) had a diagnosis of schizophrenia, three had delusional disorder (7%), two had drug-induced psychosis (4%) and only one suffered from postpartum psychotic major depressive disorder (2%). The majority (80%) of them had delusions and/or hallucinations at the time of the crime. **Conclusions:** Homicide offenders with mental illness were more likely to be single men diagnosed with schizophrenia with psychotic features who were illiterate or had minimal education, were 20 to 30 years of age, abusers of alcohol or cannabis, and living with their families; the victims were more likely to be a family member. Compared with other studies, the results reflect cultural differences.

**Key words:** Homicide, Mental illness

**Declaration of interest:** None

### Introduction

Homicide by people with serious mental illness is usually widely publicized by the media, causing stigmatization and fueling societal fears about people with such illness. People with mental illness who commit homicide are defined by legal criteria and include those who are unfit to stand trial; not guilty by reason of insanity; convicted and sentenced to a psychiatric facility; and, convicted of infanticide.

The 1960s and 1970s witnessed an active move away from institutional care of people with mental illness towards community care. The presence of people experiencing mental illness in the community contributed to wide spread concern that their tendency would be toward committing homicide. However, no increase following deinstitutionalization was reported in the international literature.<sup>1, 2, 3</sup>

Australian data found that rising numbers of convictions for violence by people with schizophrenia coincided with rising levels of general societal violence.<sup>4</sup> Coid found that rates of homicide in people with mental illness were relatively uniform between countries - ranging from 0.8 to 2.2 per million annually.<sup>5</sup>

A study in New Zealand provided accurate information about the contribution of mental illness to homicide rates; this constituted 8.7% of all homicides and the annual rate of such homicides was 1.3 per million populations.<sup>6</sup> The percentage of people with mental illness who commit homicide fell from 19.5% in 1970s to 5.0% in 2000 coinciding with deinstitutionalization and the introduction of community care services.<sup>6</sup>

A study by Mateiskuski *et al.* in the United States reported that individuals with severe and untreated psychiatric disorders were responsible for approximately 10% of all recorded homicides.<sup>7</sup>

Taylor and Gunn in UK showed that the rate of homicide committed by people with mental illness decreased between the years 1957-1995 when the move towards community care occurred and concluded that people in treatment for mental illness are no more violent or dangerous than the general population and that a major cause of recidivism is lack of community mental health services.<sup>2</sup> It has been reported that such deaths could be prevented by improved mental health care.<sup>8</sup> Research indicates an association between schizophrenia and homicide and that most perpetrators were not receiving mental health care at the time of the offence.<sup>9</sup>

Paradoxically, it was reported by Hiroeh *et al.* that people with mental disorders, particularly men with schizophrenia and affective psychosis, are at increased risk of death by homicide.<sup>10</sup>

The literature on homicide and mental illness in developing countries, particularly African and Arab countries, is sparse. A Nigerian study found that, of 160 homicide offenders, 51 (31.9%) were suffering from a psychiatric disorder, most commonly schizophrenia.<sup>11</sup> A South African study by Khoele *et al.* gave a detailed account of women charged with the murder or attempted murder of minors.<sup>12</sup> A Kuwaiti study by Fido *et al.* reported that, of the prisoners who committed murder, the majority had a diagnosis of schizophrenia with active symptoms at the time of the offence.<sup>13</sup>

In the Sudan, there is no published report about the relationship between mental illness and homicide. The aim of the current study was to shed light on the clinical and demographic characteristics of homicide perpetrators admitted to a forensic psychiatric facility in Khartoum, Sudan.

## Methods

The current study is a retrospective study conducted in the Eledresi Forensic Hospital in Khartoum, Sudan. The hospital was once known as the Kobar Asylum and was built during the British rule of Sudan. It is the main national forensic facility with capacity of 250 beds and receives referrals from different regions of the country. Various levels of security are implemented, including a high security unit for patients who commit homicide or cause grievous bodily harm.

### *Ethical review*

The research protocol for the current study was approved by the hospital ethics committee. Consent was obtained from participants' relatives.

### *Participants*

The first author clinically evaluated all people with mental illness who had committed or were alleged to have committed homicide and were admitted to the hospital during the period from December 2012 to December 2016. The cohort included both convicted and on remand patients awaiting trial.

### *Data collection*

Information was gathered from the participants' medical records, and by direct clinical interview. This was augmented by collateral information from family

members, and covered demographic characteristics of the participants, information about them at the time of having committed the offence, duration of the mental disorder, substance misuse at the time of the crime, past history of previous violence or homicide, and relationship to victims. The International Classification of Diseases – Tenth Edition (ICD-10) criteria were used for the diagnosis.<sup>14</sup>

### *Statistical analysis*

Data were analyzed via the Statistical Package for Social Science version 20 (SPSS 20) and results were expressed in percentages.

## Results

Forty four people with mental illness who had committed homicide were identified during the study period. Socio-demographic characteristics are shown in Table 1. Almost half of participants (48%) were within the age range 20-30 years and all, apart from one, were men. The majority (82%) were living with their families and 22 (50%) were unemployed. Thirty one (70%) were either illiterate or only had primary education and 30 (68%) were single.

Table 2 shows the diagnostic and clinical characteristics of the cohort. Thirty six participants (81.8%) had schizophrenic disorder, three had delusional disorder, two had drug induced psychosis and one had major depressive disorder with psychotic features. In half of the participants (52%), the duration of the illness was in the range 1-4 years. As shown in Table 2, 13 participants (29.5%) were on regular treatment and outpatient follow-up before the crime, 16 (36.4%) had previous contact with psychiatric services, but not treatment or follow up and 15 (34.1%) had never been in contact with such services. Previous violent behavior was documented in 25 patients (56.8%) and a past forensic history was reported in 12 (27.3%). Past comorbid alcohol and or cannabis misuse was reported in 21 (47.7%) participants. Delusion and/or hallucinations were present in 35 (79.5%) participants.

Table 3 shows the characteristics of the victims. Forty six homicides were committed or alleged to have been committed by the 44 participants interviewed; two participants had committed two homicides each, including a woman suffering from postpartum-onset major depressive disorder with psychotic features who had killed two of her children. Information about the victims and their relationship to the offender could be assigned for all the victims. A parent was a victim on 10 occasions (21.7%), a second-degree relation on 13 occasions (28.3%) whereas nine strangers (19.6%) were victims. Thirty of the victims (65.2%) were

men and 16 (34.8%) were women. Twenty five victims (54.3%) were more than 40 years old (see Table 3).

Forty one (93.2%) used blunt or sharp objects; the remaining three used a firearm, strangulation or drowning.

**Table 1.** Sociodemographic characteristics of the 44 homicide offenders

<b>Characteristic</b>	<b>Frequency (n)</b>	<b>(%)</b>
<b>Age</b>		
<20	2	(4.5)
20-30	21	(47.7)
31-40	10	(22.7)
>40	11	(25)
<b>Gender</b>		
male	43	(97.7)
female	1	(2.3)
<b>Living with</b>		
family	36	(81.8)
alone	3	(6.8)
relatives	4	(9.1)
friends	1	(2.3)
<b>Occupation</b>		
unemployed	22	(50)
laborers	14	(31.8)
students	4	(9.1)
professional	4	(9.1)
<b>Marital status</b>		
single	30	(68.2)
married	10	(22.7)
divorced	3	(6.8)
widow	1	(2.3)
<b>Educational level</b>		
illiterate	13	(29.5)
primary	18	(40.9)
secondary	8	(18.2)
university	5	(11.4)

**Table 2.** Psychiatric diagnoses and clinical characteristics of the 44 homicide offenders

Characteristic	Frequency (n)	(%)
<b>Diagnosis</b>		
Schizophrenia	36	(81.8)
Depression	1	(2.3)
Delusional disorder	3	(6.8)
Schizoaffective disorder	1	(2.3)
Organic psychosis	1	(2.3)
Drug induced psychosis	2	(4.5)
<b>Duration of illness (in years)</b>		
1-4	23	(52.3)
5-9	8	(18.2)
10-14	7	(15.9)
15 or more	6	(13.6)
<b>Substance misuse</b>		
alcohol	5	(11.4)
cannabis	3	(6.8)
alcohol + cannabis	13	(29.5)
<b>Psychotic features</b>		
delusions only	9	(20.5)
hallucinations only	5	(11.4)
delusions + hallucinations	21	(47.7)
<b>Prior contact with psychiatric services</b>		
on treatment and follow up	13	(29.5)
previous contact, no follow up	16	(36.4)
no previous contact	15	(34.1)
<b>Past violent behavior</b>		
yes	25	(56.8)
no	19	(43.2)
<b>Past forensic history</b>		
yes	12	(27.3)
no	32	(72.7)

**Table 3.** Characteristics of the 46 victims

Characteristic	Frequency (n)	(%)
<b>Relationship with participant</b>		
parent	10	(21.7)
sibling	2	(4.3)
child	2	(4.3)
wife	1	(2.1)
relative	13	(28.2)
neighbor	4	(8.6)
stranger	9	(19.5)
friend	5	(10.8)
<b>Gender</b>		
male	30	(65.2)
female	16	(34.8)
<b>Age (in years)</b>		
<20	9	(19.5)
20-30	7	(15.2)
31-40	5	(10.8)
>40	25	(54.3%)

## Discussion

During the study period, 44 people with mental illness who committed homicide were identified.

The marked preponderance of men convicted of homicide (97.7%) in the current study is high compared with existing studies from other countries where the ratio of men to women is about 2:1<sup>6,9,15</sup> and higher than the 88.2% reported by Auba *et al.* in Nigeria.<sup>11</sup> Taylor and Gunn reported that those with serious mental illness who commit murder were likely to be older and women compared with offenders who were mentally well.<sup>2</sup> This difference in gender ratio from Western research can be explained by cultural factors and gender role differences.

The current finding that almost half (47.7%) of the offenders fall in the age range 20-30 years is not in keeping with prior comparative studies where the age tended to be older.<sup>15,16</sup> The mean age of offenders in the Nigerian study was 38.2 years. The high percentage of participants diagnosed with schizophrenia in the present study (81.8%) explains this difference. The 20-30 years age range reflects the age when schizophrenia psychopathology starts to become more apparent.

In the current study, 36 (81.8%) participants were living with their families at the time of the offence. This is also attributed to cultural differences. In Sudan, the burden of care for people with mental illness falls on the family. Half of the participants in the current study were unemployed and cared for by their families. The high percentage (68.2%) who were single is in keeping with past studies on the trend of low marriage rates in people with mental illness, particularly those with schizophrenia.<sup>6</sup> In the current study, 36 (81.8%) participants were suffering from schizophrenia. An increased risk of violence and homicide among patients diagnosed with schizophrenia has been consistently reported in evaluations of criminal records and twin studies.<sup>13,17-20</sup> It has been postulated that there is an increased risk of homicide of around 20 times in individuals with schizophrenia and other psychosis compared with the general population.<sup>21</sup> Eronen *et al.* reported that schizophrenia increases the odds ratio of homicidal violence by a factor of about eight.<sup>18</sup>

Mood disorders and schizophrenia are known to be the two major psychiatric disorders that are likely to predispose homicide; however, men are diagnosed with schizophrenia much more frequently than women,<sup>21</sup> partially explaining the strikingly low representation of mood disorder in the current cohort. There was one woman in the current study who twice committed infanticide by drowning in the context of major depressive

psychosis during two consecutive postpartum episodes. Mood disorder with psychotic features are reported in women who commit child homicide.<sup>2,23</sup>

More than half (52.3%) of the offences in the current study were committed during the first few years of onset of the illness. This finding is consistent with studies indicating that those with first episode psychosis have higher rates of homicide than those with subsequent episodes of psychosis.<sup>19</sup>

Comorbid substance misuse significantly increases the risk of violent behavior and homicide in people experiencing psychosis.<sup>22,24</sup> Gilles' classic study of homicide in Scotland found that 58% of men and 30% of women studied were intoxicated with alcohol at the time of their offences.<sup>25</sup> Similarly, the increasing contribution of illicit drugs to homicide incidents has been highlighted by Peturrson and Gudjonsson, who reported that 20% of murderers had been treated for abusing these drugs.<sup>26</sup> In the present study, nearly half (47.7%) of the participants had a history of alcohol and/or cannabis misuse. The global increase in substance misuse has been postulated to account for a rising trend in rates of homicide by these participants. Swinson *et al.* conducted a national consecutive case series of homicide perpetrators in England and Wales, and reported an increase in homicide by psychiatric patients and attributed that to a concomitant increase in substance misuse.<sup>27</sup> Risk factors reported to increase the possibility of violent behavior in schizophrenia include systematized paranoid delusions with the conviction that enemies must be defended against and instructions are from hallucinatory voices.<sup>20</sup> This is in agreement with the current finding that 35 (79.5%) of the sample harbored delusions and/or hallucinations.

Of the 44 participants in the current study, 13 (29.5%) were on treatment and follow up at the time of the offence, whereas the remainders either had previous contact, but stopped treatment and follow-up, or never had previous contact with psychiatric services. These findings highlight the importance of treatment adherence and the establishment of community psychiatric services, which is sadly absent in the Sudan; both factors have been reported to reduce homicide risk rate among those with mental illness.<sup>3,6,8,9</sup> Cultural and religious beliefs are deeply rooted in this mainly Muslim society where traditional and faith healing methods are widely utilized leading to delays in seeking psychiatric treatment.

A history of violent behavior and past forensic history were reported in 25 (56.8%) and 12 (27.3%) of our group of patients, respectively. This is consistent with several studies that suggest a history of violent behavior and

forensic history increase the risk of subsequent homicide.<sup>13,19</sup>

The current finding that the victims of the studied cohort were predominantly people known to the perpetrators is in keeping with findings from Australia, UK, Denmark, and USA.<sup>1,2,3,6</sup> In the current study, victims were parents or relatives in 21.7% and 28.2% of cases, respectively. This is explained by the fact that, in Sudanese culture, people with mental illness tend to live with and are catered for by both the nuclear and extended family. The victim was a stranger on nine (18.8%) occasions. This finding supports the notion that it is a myth that offenders with mental illness are more likely to kill a stranger than offenders without such illness.<sup>2,27</sup> Homicide as committed by strangers are reported to be more likely related to alcohol or drug misuse in young men.<sup>28</sup>

The finding that more than half of the victims in the studied cohort were older than 40 years is difficult to explain; the relatively high representation of parents among the victims is a contributing factor.

Readily available objects were used by our group, firearms only once. It is the authors' concern that this trend may change in favor of firearms, which may become easily available as a result of the aftermath of armed conflicts in some regions of Sudan.

A sizable proportion of participants in the current study were never assessed by psychiatric facilities or adhered to treatment. Improvement of psychiatric services, including early detection and follow up is recommended to reduce such fatalities.

## Limitations

The small size of the sample and lack of control group of people without mental illness who commit homicide limits generalization of the findings from the current study. The types and contents of delusions and hallucinations experienced by participants are relevant to the subject matter and should have been included in the study.

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## المخلص

اجريت هذه الدراسة الاستطلاعية لمجموعة من المرضى النفسيين الذين ارتكبوا جرائم قتل وادخلوا مستشفى الادريسي للطب النفسي الشرعي خلال الفترة من ديسمبر 2012 الى ديسمبر 2016.

هدفت الدراسة الى استكشاف الصفات السريرية والديموغرافية لهذه الفئة .

اتضح ان كل المرضى ما عدا انثى واحدة كانوا من الذكور تراوحت اعمار نصفهم بين 20 عام و30 عام. اغلبهم يقطنون مع اسرهم وقلة منهم مع الاقارب او الاصدقاء وأكثر من نصفهم غير متزوجين .

الضحية كان من الاقارب من الدرجة الأولى في 34% وأحد الابوين في 23% ومن الغزباء في 20%. غالبية المرضى (93%) استعملوا الة حادة في ارتكاب الجريمة وفي البقية منهم (7%) كان القتل عن طريق الخنق او سلاح ناري او الاغراق .

الغالبية من المرضى (82%) كانوا يعانون من اضطراب الفصام والبقية من اضطراب الوهمية او الذهان الناجم عن المخدرات او ذهان ما بعد الولادة (18%). 48 % من المرضى استخدموا حشيشة القنب او الخمر او الاثنتين معا. وفي اغلبهم (80%) كانت هناك اعراض ذهانية عند ارتكاب الجريمة.

خلصت الدراسة ان هذه الفئة من المرضى كان جلهم من فئة الشباب العزب الذكور ويعانون من اضطراب الفصام وعاطلين عن العمل وتلقوا تعليماً محدوداً وكان لاستعمال المخدرات دور عند ارتكاب الجريمة والغالبية من الضحايا كانوا من الاقارب.

مقارنة بالدراسات الغربية اتضح ان هناك فروقات ثقافية.

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## The Relationship between Mental Health of Palestinian Mothers Due to Siege and Child Attachment

Abdelaziz Mousa Thabet

العلاقة ما بين الضغوط النفسية الناتجة عن الحصار والصحة النفسية للأمهات الفلسطينيات و الرباط مع أطفالهن

عبد العزيز موسى ثابت

### Abstract

**Aim:** The current study investigated the relationship between mothers' stressors due to siege, their mental health and the attachment styles of their children. **Methods:** Participants were recruited from a list of previously studied Palestinian families in the Gaza Strip, which was part of a three-stage prospective study of 184 households. N=140 mothers were recruited to the study. Ages ranged from 18 to 64 years with a mean age of 41.53 years. Participants completed self-report questionnaires, which included a sociodemographic scale, the Gaza Siege Checklist, the Hopkins Symptoms Checklist (HSC-25), and the Parent/Child Reunion Inventory (P/CRI). Data were collected from October to November 2008. **Results:** Mothers reported from 2-20 stressors due to siege (M=10.83, SD=4.07). Those with monthly income of less than \$350 US reported experiencing more stressors than mothers whose families had a monthly income of \$351 US or more. Results identified 16.8% of mothers met the criteria for psychiatric conditions; 19.0% reported anxiety and 15.2% reported depression. Mothers living in cities reported fewer mental health problems compared with those living in villages and camps. Further, insecure attachment of children was positively associated with total stressors and mothers' anxiety, and depression. **Conclusion:** Maternal depression and anxiety was associated with insecure attachment styles in children. Maternal depression and anxiety were also associated with experiences of siege stressors and an insecure attachment style in children. The study highlights potential targets for future intervention.

**Key word:** Attachment, Gaza Strip, Anxiety, Depression, Siege, Stressors, Mothers

**Declaration of interest:** None

### Introduction

Since the Israeli Government enacted the full Gaza blockade in 2007, which has restricted the free movement of goods and people in and out of the Gaza Strip almost completely, the population there has suffered ever-increasing infringements of their economic and social rights. The access-restricted area (the so-called "buffer zone" or no man's land) was imposed by Israel within Gaza territory and covered 35% of key agricultural land; it highlights how fundamentally the right to movement is ignored with 113,000 people unable to access their farms.<sup>1</sup> Siege on the Gaza Strip since 2007 has been a unique situation and there have been very few studies on the impact of siege in the area.

A study of N=386 Palestinian adults in the Gaza Strip showed that people commonly reported the following siege stressors: prices were sharply increased (97.67%), they feel they are in a big prison (92.23%), they cannot find things they need in the market (91.70%), they quit making daily purchases for basic needs (88.30%), and social visits were less frequent than before (85.23%).<sup>2</sup> In another study involving 502 randomly selected

participants from five areas of the Gaza Strip, the most common stressful situations due to siege were: feelings of living in a big prison, being unable to complete construction and repair work in their house due to shortage of cement and building materials, a sharp increase in prices in the last few years. Participants commonly reported traumatic events, such as hearing artillery shelling in the area, hearing the sonic sounds of jetfighters, hearing loud drones, and witnessing mutilated bodies on television. Men and boys experienced more severe traumatic events than women and girls. People living in cities reported more traumatic events than those living in villages or camps. As a reaction to stress and trauma, Palestinians participants reported anxiety symptoms such as nervousness or shakiness inside, feeling tense or keyed up; while depressive symptoms were expressed as feeling sad and physically weak. However, feelings of worthlessness and thoughts of ending life were rarely expressed.<sup>3</sup>

Bowlby's attachment theory is an essential reference for understanding relational aspects, which can impact mental dysfunction. The attachment system is theorized as a set

of instinctive affective, behavioral, cognitive, and motivational mechanisms designed to encourage infants to seek proximity to protective caregivers during times of stress. By viewing caregivers as attachment figures to turn to in times of emotional stress or uncertainty, infants can feel comfortable exploring the world around them, knowing that their caregivers are available if needed.<sup>4,5 6,7</sup>

Attachment in children is defined as a long-lasting emotional bond formed between a child and his/her caregiver. When children feel secure in their relationships with attachment figures, they perceive them as consistently available, sensitive and responsive to their needs. Children form insecure relationships with attachment figures that show deficiencies in sensitivity and responsiveness. Accordingly, by preschool age, the child with secure attachment shows relaxed and enjoyable interactions with the parent, and uses the caregiver as a secure base from which to explore the environment. In comparison with secure children, children with avoidant attachment tend to show greater affective neutrality and physical avoidance. Children with ambivalent attachment show exaggerated emotional expression and immature or angry behavior toward the parent. These children are known to show resistance, conflict or excessive dependence on the caregiver. Children with disorganized attachment show contradictory or incoherent behavior in proximity to the caregiver, such as simultaneous or successive approach and avoidance, disordered, incomplete, or undirected sequencing of movements, and confusion or apprehension. They seem unable to use their caregivers as a secure base for exploration and havens of safety.<sup>8</sup> Moreover, certain attachment patterns are particularly relevant to mental health; namely, the four attachment styles (secure, dismissing, preoccupied, and fearful), which can measure attachment dimensionally in terms of anxiety (the fear of being abandoned or rejected in close relationships) and avoidance (the preference for emotional distance).<sup>9</sup> A growing body of research links attachment insecurity to the whole spectrum of mental health problems in both children and adults.<sup>10</sup> Another study showed that maternal depression and anxiety have been linked to insecure parent-child attachment relationships.<sup>11</sup> Another reported that fearful attachment is more often found in people diagnosed with depressive disorders, while the depression related to bipolar or schizoaffective disorder is often associated with those who experience a more dismissive attachment style.<sup>12</sup> LeCompte *et al.*,<sup>13</sup> examined the psychological, social and cultural risk factors for child insecure attachment in a sample of N=33 South Asian immigrant families experiencing high migration stress in Montreal, Canada. Results suggested that child attachment security scores were associated with maternal depression, although statistically marginal, suggesting that high maternal depression is related to low child attachment security.

The aim of the current study was to investigate the relationship between mothers' stressors due to siege, their mental health and their children's attachment styles.

## **Methodology**

### ***Participants***

The current study recruited N=140 mothers with at least one child aged between 6 to 18 years. Mothers' ages ranged from 26 to 65 years with a mean age of 41.61 (SD=8.79) years.

### ***Instruments***

Data were collected from mother/child pairs by using the following questionnaires:

#### ***Demographic questionnaire***

Demographic information about the participants was obtained using a form developed by the authors. The questionnaire included gender, age, citizenship, education level, place of residence, and number of children in the family.

#### ***Gaza Siege Checklist – mothers' form***<sup>2,3</sup>

The checklist consisted of 21 items covering a wide range of daily life situations affected by the Gaza Siege, including family, health, education, social life, and economic issues. The first checklist was developed after conducting a focus group for 20 professionals working in different sectors of health, education, social services, and economic sectors. In the current study, the split half reliability of the scale was ( $r=.76$ ).

#### ***Hopkins Symptoms Checklist (HSCL-25)***<sup>14</sup>

Hopkins Symptoms Checklist measures the presence and degree of symptoms of anxiety and depression during the past seven days. Each item was scored on a scale from 0 (not at all) to 3 (extremely). Examples of items are 'Nervousness or shakiness inside' and 'Feeling hopeless about the future.' The checklist comprises total anxiety and depression scales, an overall problem scale, as well as clinical cut-offs (set at 1.75). The Arabic translated version has proved reliable and valid in a multicultural context.<sup>15</sup> The internal consistency of the scale was calculated using Cronbach's alpha ( $\alpha=.92$ ).

#### ***Parent/Child Reunion Inventory***<sup>16</sup>

The Parent/Child Reunion Inventory (P/CRI)<sup>16</sup> relies on the child's internal working model of his/her attachment relationship. It is based on direct observations of childhood reunions and it provides parents with hypothetical everyday separation situations. Parents are asked to select behaviors that are shown by their child at

reunion times. To assist with this, parents are asked to remember the last separation they had from their child lasting one hour or more. Parents rate each behavior as 'usually' (2), 'occasionally' (1) or 'never' (0). The P/CRI allows for the calculation of total secure and insecure scores. Six items measure secure attachment (range 0-12), and 14 items measure insecure attachment (range 0-28). The P/CRI is tentatively split into five insecure factors: insecure-avoidant-distancing (items 7, 8), insecure-avoidant (items 9, 10, 11, 12), insecure-anxious (items 13, 16), insecure-controlling (items 14, 15), and insecure-unspecified (items 17, 18, 19, 20). This scale was translated from English by Dr Thabet and was back translated by a professional with a diploma in Translation. There were no major changes identified in the translations.<sup>17</sup> The Cronbach's alpha for the secure and insecure subscales were  $\alpha=0.65$  and  $\alpha=0.77$ , respectively.

### Procedure

Eight mental health professionals (four social workers, four psychologists) received four hours of training during which the aims of the current study were reviewed. All had previous experience in data collection. Participants were recruited from list of previously studied Palestinian families in the Gaza Strip, which was part of a three-stage prospective study of 184 households. One hundred and forty mothers were contacted. A letter outlining the study aims was given to each and written consent to participate was obtained. Sociodemographic information for the study population was collected from mothers at home. Each interview took 30 minutes to complete. Data collection was done between September and November 2008.

### Statistical Analysis

Data entry and analysis were carried out using the Statistical Package for Social Science version 20 (SPSS Inc. Chicago Ill, US). Frequency and percentages were used to express quantitative data of types of stressful situations, mother's mental health disorder, attachment and resilience. For continuous variables, means and standard deviations were reported. For differences between means of two groups independent *t* tests were used. ANOVA tests were used for measuring differences between more than two groups of continuous variables, such as place of residence and stress, mother's mental health and child attachment style. Spearman's correlation coefficient was used to test the association between number of stressors, mother's mental health and child attachment style. Multivariate regression analysis was conducted in which each stressor was entered as the independent variable and the psychological symptoms of mothers (HSCL) entered as the dependent variable.

### Results

#### *Sociodemographic characteristic*

A total of N=140 mothers responded. Their ages ranged from 26 to 65 years with mean age of 41.61 y (SD=8.79). According to place of residence, 26.1% were from North Gaza, 37.5% from Gaza, 14.7% from the middle region of Gaza, 3.8% were from Khan Younis and 17.9% were from Rafah (south of Gaza). According to type of residence, 43.5% lived in cities, 12.5% lived in villages, and 44% lived in camps. In terms of number of children, 13.6% of families had less than 4 children, 61.4% had 5-7 children, and 25% had 8 and more siblings. As for family monthly income, 60.9% earned less than \$350 US per month, 30.4% earned \$351-700 US, and 8.7% earned more than \$701 US.

**Table 1.** Sociodemographic characteristic of the study sample (N=140)

	N	%
<b>Address</b>		
North Gaza	37	26.4
Gaza	53	37.9
Middle area	21	15.0
Khan Younis	6	4.3
Rafah area	23	16.4
<b>Place of residence</b>		
City	58	41.4
Village	16	11.4

Camp	66	47.1
<b>Number of children</b>		
Less than 4	14	10.0
5-7 children	90	64.3
8 and above	36	25.7
<b>Monthly family income</b>		
Less than \$350 US	84	60.0
\$351-700 US	42	30.0
More than \$701 US	14	10.0
<b>Husbands' education</b>		
Uneducated	7	5.0
Secondary school and less	89	63.6
University and above	44	31.4
<b>Husbands' employment status</b>		
Unemployed	70	50.0
Skilled worker	13	9.3
Employee	47	33.6
Others	10	7.1
<b>Mothers' education</b>		
Uneducated	4	2.9
Secondary school and less	131	93.6
University and above	5	3.6
<b>Mothers' employment status</b>		
Housewives	133	95.0
Employee	7	5.0

**Frequency of stressors related to the siege of Gaza in mothers**

Results showed that the most common stressors arising from the siege of Gaza as rated by mothers were: prices have increased sharply (89.3%), I feel I am in a big prison

(87.8%), I was not able to get specific medicine for me or for one of the family members due to shortage of fuel and absence of transportation (75.7%). Mothers reported from 3-18 stressors relating to the siege with mean of 10.16 (SD=3.76).

**Table 2.** Frequency of items of siege of Gaza (N = 140)

<i>Items</i>	<b>N=</b>	<b>%</b>	<b>No.</b>	<b>%</b>
Prices are sharply increased	125	89.3	15	10.7
I feel I am in a big prison	122	87.8	17	12.2
I was not able to get specific medicine for me or for one of the family members due to shortage of fuel and absence of transportation	106	75.7	34	24.3
I stopped sending my children to school due to shortage of money and I let them do other jobs	103	73.6	37	26.4
Social visits are less than before due to shortage of fuel and absence of transportation	93	66.9	46	33.1
I was not able to get specific medicine for me or for one of my family members due to shortage of physicians and nurses	92	65.7	48	34.3
Ability to send children to school due to shortage of money	85	60.7	55	39.3

Social visits are less than before due to shortage of money due to unemployment	84	60.0	56	40.0
I was not able to get specific medicine for me or for one of my family members due to shortage of medicine and equipment	82	58.6	58	41.4
Losing the job due to shortage of cement, and basic construction materials	80	57.1	60	42.2
I started borrowing from banks and people to keep my family demands	80	57.1	60	42.9
I cannot find things I need in the market	78	55.7	62	44.3
I went to Zakat organizations and other organizations to get food	71	50.7	69	49.3
I sold some of my furniture and wife's gold	64	45.7	76	54.3
I thought of immigration	60	42.9	80	57.1
I postponed the marriage ceremony of my sons due to shortage of furniture and building materials	60	42.9	80	57.1
I cannot finish some construction and repair work in my house due to shortage of cement and building materials	60	42.9	80	57.1
I need to travel outside the Gaza Strip and cannot	40	28.6	100	71.4
I started doing the papers for immigration	25	17.9	115	82.1

**Siege stressors in mothers and sociodemographic variables**

A one-way ANOVA test was used to find differences in total siege stressors and other sociodemographic variables, such as number of children, monthly family income, education, place of residence. Post Hoc test using Tukey showed that mothers with low family income (less than \$250 US) ( $F(2/137)=9.6, p=0.001$ ), not educated ( $F(5/134)=6.7, p=0.001$ ), and mothers living in North Gaza ( $F(4/135)=7.94, p=0.001$ ) had reported more stressors.

**Mean and standard deviation of mental health using HSCL**

The results showed the mean HSCL was 1.15 (SD=0.56), mean anxiety subscale score was 1.17 (SD=.64), and mean depression subscale score was 1.14 (SD=0.57). Taking in consideration the cutoff point of <1.76 of HSCL, 16.8% of mothers were rated as having psychiatric conditions, 19.0% reported experiencing anxiety and 15.2% reported symptoms related to depression.

**Table 3.** Mean and standard deviation of mental health using HSCL

	Mean	SD
<b>Mean HSCL</b>	1.15	.56
HSCL - Anxiety subscale	1.17	.64
HSCL - Depression subscale	1.14	.57

**Differences between mental health problems rated by HSCL and other socioeconomic variables (place of residence, number of siblings, and family monthly income)**

In order to find the differences between the places of residence, number of siblings, monthly income and mental health, a one-way ANOVA test was performed. Post hoc Tukey test showed that mothers living in cities reported fewer mental health problems compared with those who lived in villages and camps ( $F(2/137)=15.2, p=0.001$ ). Results also showed that mothers with a monthly income

of less than \$350 US reported more mental health problems than the other two groups. This group were more affected by siege that the other groups ( $F(1/137)=4.5, p=0.01$ ).

**Parent/Child Reunion (attachment style of children)**

The current study showed that mean secure attachment was 8.67 (SD=2.40) and mean insecure attachment was 14.16 (SD=5.10).

**Table 4.** Means and Standard deviations of attachment

Attachment	Mean	SD
<b>Secure attachment</b>	8.67	2.40
<b>Insecure attachment</b>	14.16	5.10

**Differences between attachment and other socioeconomic variables (place of residence, number of siblings, and family monthly income)**

A one-way ANOVA test was performed. Post hoc Tukey test showed that children living in families with monthly incomes of less than \$350 US demonstrated more insecure attachment than the other two groups ( $F(2/137)=3.15, p=0.04$ ).

**The relationships between stressors arising from siege and mental health of mothers and child attachment styles**

In order to find the relationship between stressors due to the siege of Gaza and the mental health of mothers as relates to parent/child reunion, the Pearson correlation coefficient test was conducted. Results indicated that the total stressors were positively associated with maternal mental health ( $r(140)=0.27, p<0.001$ ), anxiety ( $r(140)=0.25, p<0.001$ ), depression ( $r(140)=0.26, p<0.001$ ) and insecure attachment of children.

**Table 5.** Relationships between stressors related to siege as experienced by mothers and attachment of children

	Siege	Mean HSCL	Anxiety	Depression	Secure attachment
Maternal experience of siege stressors					
Mean HSCL	.27**				
Anxiety subscale	.25**	.92**			
Depression subscale	.26**	.95**	.74**		
Secure attachment-child	-.14-	-.13-	-.10-	-.14-	
Insecure attachment-child	.34**	.22*	.16	.24**	.02

**Prediction of child insecurity and maternal stressors due to the siege of Gaza**

Using a multivariate regression model, insecure attachment scores were entered as dependent variables and each siege-related stressor reported by mothers as

independent variables. Total secure attachment: I sold some of my furniture and my gold. ( $\beta= 0.32, t(135), p<0.001$ ). I need to travel outside the Gaza Strip and cannot ( $\beta= 0.18, t(135), p<0.01$ ), and negatively predicted by I thought of immigration ( $\beta=-0.17, t(135) p<0.02$ ),  $R^2=.23, F(1/135)=12.20, p=0.001$ .

**Table 6.** Multivariate regression model predicting child insecure attachment style and maternal stressors arising from the Gaza siege

	Unstandardized Coefficients		Standardized Coefficients	t	p	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	12.42	0.63		19.86	0	11.19	13.66
I sold some of my furniture and my gold	3.3	0.79	0.32	4.2	0	1.75	4.86
I need to travel outside the Gaza Strip and cannot	3.19	0.88	0.28	3.62	0	1.45	4.94
I thought of immigration	-1.79	0.79	-0.17	-2.28	0.02	-3.35	-0.24

**Prediction of child secure attachment style and maternal stressors due to the siege of Gaza**

In a multivariate regression model, secure attachment scores were entered as dependent variables and each stressor of siege experienced by mothers was entered as

an independent variable, secure attachment was negatively predicted by stressor: I went to Zakat organizations and other organizations to get the food ( $\beta=-0.28$ ,  $t(135)$ ,  $p<0.001b$ ,  $R^2=0.06$ ,  $F(1/135)=9.20$ ,  $p=0.001$ )

**Table 7.** Multivariate regression model predicting child secure attachment style and maternal stressors due to siege of Gaza

Secure attachment	Unstandardized Coefficients		Standardized Coefficients	t	P	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	9.3	0.28		33.1		8.75	9.86
I went to Zakat organizations and other organizations to get food	-1.22	0.4	-0.25	-3.05	0.001	-2.01	-0.43

**Discussion**

The current study investigated the impact of siege stressors on the mental health of Palestinian mothers and attachment style of their children. Results showed that the most commonly reported stressors relating to the siege of Gaza as experienced by mothers were: prices have increased sharply (89.3%); I feel I am in a big prison (87.8%); I was not able to get specific medicine for me or for one of the family members due to shortage of fuel and absence of transportation (75.7%). The mean stressors arising from an experience of the siege of Gaza was 10.16. Higher levels of stress were reported by mothers who had low monthly family income (less than \$250 US), were educated, and lived in the North of Gaza. The current study found the mean subscale scores for anxiety and depression were 1.17 and 1.14, respectively. Psychiatric

conditions were identified for 16.8% of mothers, 19.0% reported anxiety and 15.2% reported symptoms related to depression. Mothers living in cities reported fewer mental health problems compared with those who lived in villages and camps. Results also found that mothers with a monthly income of less than \$350 US reported more mental health problems than the other two groups. It appears that this group were more affected by siege than the other groups. Similarly, in a study of university students in the Gaza Strip, Juma and Thabet<sup>18</sup> found that the most commonly reported stressors arising from siege were the sharp increase in prices due to border closures (92%) and an adverse impact on their ability to study due to Gaza’s electricity being cut off and also gas shortages (83.5%). Within the student population studied, the mean number of stressors reported by men was 12.38 and 10.33

for women. For symptoms related to depression, 9.5% of men and 12% women reported severe symptom levels; 10.3% men reported experiencing anxiety compared to 13.8% of women. There was a positive correlation between total stress due to siege and symptoms associated with depression and anxiety among students. Moreover, a study of N=502 Palestinian families in the Gaza Strip found the most common stressful situations arising from the siege were: feelings of living in a big prison, being unable to finish some construction and repair work in their homes due to shortages of cement and building materials, prices increased sharply in the last few years.<sup>3</sup> Further, there was a positive relationship between stressors due to the siege and closure and psychological symptoms. By way of further comparison, studies on mental health following earthquakes in Lushang and Wenchang, China found prevalence rates for anxiety and depression remained high nearly five years later.<sup>19</sup> The current study found that mental health problems among mothers was lower than a study on 114 refugee women-at-risk who had been resettled to Australia, as well as factors contributing to symptoms of trauma, anxiety, depression, and somatization.<sup>20</sup> The level of psychiatric symptomatology is compared to reference groups of women from Sudan and Burma. Participants' psychiatric distress met levels symptomatic for traumatization (41%), PTSD (20%), anxiety (29%), and depression (41%). Forty two percent also reported high levels ( $\geq 1.75$ ) of somatization. Results were not consistent with the secondary analysis on baseline data from N=288 HIV-positive women, enrolled in a parenting intervention in Uganda. Total JHCL-25 mean score was 1.9, mean depression score was 2.0, and mean anxiety score was 1.8.<sup>21</sup> In the Middle East, Karam *et al.*, assessed a nationally representative sample of the Lebanese population (N=2857 adults).

Respondents were interviewed using the fully structured World Health Organization (WHO) Composite International Diagnostic Interview 3.0. Lifetime prevalence of any Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorder was 25.8%. Anxiety (16.7%) and mood (12.6%) were more common than impulse control (4.4%) and substance (2.2%) disorders.<sup>22</sup>

The study showed that mean secure attachment was 8.67 and mean insecure attachment was 14.16. Such findings were inconsistent with previous research using the same scale in a sample of N=13 mothers previously admitted to psychiatric hospital. In the study, the mean secure attachment score was 11.33 and mean insecure attachment score was 5.00.<sup>23</sup> Results suggested that total stressors experienced by mothers during the siege of Gaza were positively associated with their experience of mental health, anxiety, and depression and linked also to having insecurely attached children. The current study results

were consistent with those of Campbell *et al.*<sup>24</sup> who found that mothers who experienced intermittent or chronic symptoms of depression and who evidenced less sensitivity to their children's needs had offspring at greater risk of experiencing insecure attachment. Therefore, while children of depressed mothers are more vulnerable to attachment insecurity, not all will be adversely affected or respond in a similar manner. Similarly, in a longitudinal study of postnatal depression and maternal attachment in middle-class mothers (N=111) and their infants, chronic maternal depression was significantly associated with less secure attachment 12 months after birth.<sup>25</sup>

A similar finding was identified in a population-based study in the Netherlands of N=606 infant-mother dyads. Results showed that infant attachment moderated the effect of parent stress on child emotional and behavioral problems. Parent stress was related to more aggression and attention problem behaviors in insecurely attached children, but not in securely attached children. Moreover, higher levels of stress in parents was associated with more withdrawal problem behaviors in insecurely attached children. This was particularly the case for insecure resistant and disorganized children.<sup>26</sup> The current study showed that children living in families with a monthly income of less than \$350 US appeared to have less secure attachments compared with the other two groups.

The importance of economic stability as a mediating factor for the development of secure attachments was also supported in Fraley *et al.*<sup>27</sup> Their longitudinal research of mother-child dyads examined attachment from one month post-natal until the children reached 18 years of age. Conducted at the National Institute of Child Health and Human Development on the Study of Early Child Care and Youth Development, the study concluded that secure children were more likely than insecure children to have had more supportive parenting over time, to have come from families characterized by stability (e.g., low levels of parental depression, fathers living in the household), and to have had higher-quality friendships in adolescence. A study conducted in the Gaza Strip with N=392 parents ( $n=380$  mothers;  $n=12$  fathers) of preschoolers indicated that 86% of preschoolers were securely attached and 9.7% were insecurely attached to their mothers. Further, the insecure attachment with mothers was among children with low monthly income.<sup>17</sup> Consistent with the current findings, Lecompte *et al.*,<sup>28</sup> found that maternal depressive symptoms were related to lower child attachment security scores. Lower support from friends was related to greater child ambivalent attachment behaviors. A higher sense of belonging to the country of origin was related to greater child disorganized attachment behaviors. These findings suggest that migration stresses, which include maternal depression, lack of social support and the sense of

belonging, are associated with child attachment, and these variables should be considered in the design of appropriate interventions.

## Limitations

The present study has some limitations that are important to consider when interpreting the results: (1) the data were derived from children/adolescents (and mothers) as part of a cohort who were studied when Gaza was experiencing traumatic stressors related to siege and war; and, (2) the study sample may not be representative of the whole Palestinian population suffering from other types of war trauma and stress.

## Conclusion

The current study is the first to explore the impact of siege stressors on the mental health of Palestinian mothers and the attachment style of their children. Data showed that maternal depression and anxiety is associated with insecure attachment children. Maternal depression and anxiety were associated with the siege-related stressors they experienced and how securely their children were attached to them. Findings highlight potential targets of intervention, including identifying and treating mothers affected by stress and trauma in the Gaza Strip and supporting the development of secure mother-infant attachment relationships, particularly in populations at high risk of stress and trauma exposure.

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## المخلص

الهدف من الدراسة هو البحث في العلاقة بين الضغوط الناجمة عن الحصار على غزة والمشاكل النفسية عند الأمهات وبين الرباط مع الأطفال داخل العائلات الفلسطينية.

**المنهجية:** تم اختيار عينة مكونة من 140 أم من أصل 184 أب و أم من قاعدة بيانات الدراسة التتبعية للعائلات الفلسطينية في قطاع غزة - المرحلة الثالثة والتي تم اختيارها من جميع المناطق في غزة . وتراوحت الأعمار للأمهات بين 18 إلى 64 سنة وكن المتوسط الحسابي للعمر =41.53 سنة، و الأطفال من 6-18 سنة، وتم جمع البيانات باستخدام مقياس الخصائص الديمغرافية والاجتماعية ، واستبيان الضغوط الناجمة عن الحصار، واستبيان قائمة جون هوبكنز، و مقياس الانفصال والالتصاق بالأم (الرباط). وتمت عملية جمع البيانات في شهري أكتوبر ونوفمبر من عام 2008.

**النتائج:** أظهرت النتائج أن أكثر أنواع الضغوط النفسية الناتجة عن الحصار على قطاع غزة هي: الارتفاع الحاد للأسعار (90.8%)، وأشعر أني في سجن كبير (88.5%)، لا أستطيع إيجاد ما أحجته من البقالة (91.70%)، ولا أستطيع الحصول على العلاج لي أو لأحد من أفراد عائلتي بسبب نقص في الوقود أو غياب المواصلات (73.4%) ، ولا أستطيع الحصول على الدواء لي أو لأحد أفراد عائلتي بسبب نقص الرعاية الصحية (62.58%). و كان متوسط الضغوط النفسية الناجمة عن الحصار هو 10.83 وأظهرت النتائج أن الأمهات اللواتي يعشن في أسر دخلها الشهري أقل 350 دولار لديها ضغوط نفسية أعلى من الامهات اللواتي يعشن في أسر دخلها الشهري 351 دولار وأعلى .

ومن الاعراض النفسية للأمهات: البكاء سريعاً (21.7%)، وصعوبة في النوم (16.8%)، والقلق المستمر (16.3%)، والصداق (15.2%)، والشعور بالتشنج والتوتر (15.2%). أظهرت النتائج أن 19% من الأمهات لديهن قلق و 15.2% لديهن اكتئاب. وتبين أن الأمهات اللواتي يعشن في المدينة لديهن مشاكل نفسية أقل من اللواتي يعشن في القرى والمخيمات. وأظهرت النتائج أيضاً أن الأمهات اللواتي يقل الدخل الشهري لديهن عن 350 دولار شهرياً يعانين من مشاكل نفسية أكثر من اللواتي لديهن دخل مرتفع . وقد أشارت النتائج أن الرباط غير الآمن مع الأطفال يرتبط مع زيادة الضغوط وقلق واكتئاب الامهات .

**الخلاصة:** هذه الدراسة الاولى التي تكشف أنواع الضغوط الناجمة عن الحصار والمشاكل النفسية لدي الأمهات الفلسطينيات وعلاقة ذلك بالرباط مع الأطفال. وأظهرت النتائج بأن الإكتئاب والقلق يرتبطان بالرباط غير الآمن مع الأطفال. وأيضاً فإن الإكتئاب والقلق يرتبطان بالضغوط النفسية الناتجة عن الحصار . وعليه ننصح بتدخلات نفسية إجتماعية لعلاج الامهات المتأثرات بالضغوط والصدمات في قطاع غزة ودعم تطوير علاقة الرباط بين الامهات والرضع وخاصة عند الأمهات الأكثر عرضة لخطر الضغوط النفسية والصدمات النفسية.

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## Psychosocial Aspects of Patients with Substance Misuse Problems Attending a Psychiatric Hospital in Erbil/Iraq

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المظاهر الاجتماعية والنفسية للمرضى المدمنين في مستشفى الطب النفسي في مدينة اربيل/العراق

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### Abstract

**B**ackground: Substance use that results in addiction can lead to chronic disease that is often associated with other psychiatric disorders. Anxiety, depression and stress are among the more common psychiatric disorders experienced by people with addictions. **Aim:** The current study compared socio-demographic characteristics, severity of stress, anxiety, depression and social relationship levels in patients who reported experiences of addiction and those who did not. Participants were admitted to Hawler Psychiatric Hospital, in Erbil, which is situated in the Kurdistan Region of Iraq. **Method:** Using a descriptive design, the study assessed participants from 2 July 2017 to 26 September 2018. N=100 patients were selected from the hospital's inpatient and outpatient clinics. Data were collected via a three-part questionnaire that assessed socio-demographic information, social and academic background and psychological symptoms. The Depression, Anxiety and Stress Scale (DASS) was used to measure psychological symptoms. **Results:** Of the 100 participants, 42% reported moderate symptom levels for depression; 17% reported severe symptom levels; and, 14% described extremely severe symptom levels for depression. In terms of relationships, 68% reported having poor social relationships; 30% described having good social relationships and 2% reported having experienced bad social relationship. There was highly significant association with depression, anxiety, and stress while there was no significant association between level of education and social relationship. A significant association was found between economic status and psychological aspects, and no significant association between economic status and social relationship for patients who reporting dependency on drugs.

**Key words:** Addiction, Substance misuse, Psychosocial, Depression, Stress, Social relationships

**Declaration of interest:** None

### Introduction

Substance misuse leading to drug dependency and addiction remains a critical problem for most countries. It is associated with numerous social and economic consequences. The societal consequences of substance misuse include a dramatic loss of resources, both human and material, increased morbidity and mortality; and reduced or lost productivity. Some of these societal effects include increased rate of accidents, crime, domestic violence, child abuse, suicide, prostitution, diseases, work place consequences and community deterioration. Adolescents and young adults are at increased risk for developing drug dependency that could lead to addiction and the highest risk is in early adolescence, reaching a peak between the ages of 15 and 25 years.<sup>1</sup> Substance misuse is often associated with mental health difficulties - anxiety, depression and stress being among the more common. Studies have shown that over 70% of people with substance misuse problems tend to present with mental health problems, such as

substance dependent personality disorder, sexual disorder, anxiety and depression. People prone to addiction often become dependent on substances in order to block out annoying or unpleasant states such as pain, anxiety or depression. The results of several studies indicated that the physical and mental consequences of addiction can lead to a decreased quality of life and satisfaction and a drop in social interactions and mental health. Researchers have also shown that substance misuse is frequently co-morbid with anxiety and depression (Flavio 2005; Harrell & Karim 2008). It seems that apart from depression, stress may play a role in patients' substance abuse problems. Numerous factors, including types of social stress, economic, and psychological factors influence a person's path toward addiction. The physiological aspect of stress is manifest through anxiety. Depressive symptoms are common in people suffering from substance misuse or dependency on drugs.<sup>2</sup>

Stress may affect health by producing changes in behavior and there is evidence that under high levels of stress, health-enhancing behavior declines and health-threatening behavior such as consumption of nicotine, alcohol, and drugs may increase so people are more likely to engage in behaviors that increase the risk of illness and injury. Research on the mechanisms underlying substance misuse disorders has shown that stress is one of the strongest predictors of drug use and coping mechanisms can be an important factor in mediating the effects of stress on substance use. Stress refers to the problems or strains that people encounter throughout life, and coping refers to the behavioral or cognitive responses that people use to manage stress. Many studies have consistently demonstrated an association between stress and substance misuse.<sup>3</sup>

## Methods

Using a cross-sectional design, the current study was conducted between 2 July 2017 and 26 September 2018 with N=100 patients with substance misuse problems attending Hawler Psychiatric Hospital in Erbil, Iraq. A non-probability purposive sample was selected.

The following inclusion criteria were used:

- in and outpatients at Hawler Psychiatric Hospital;
- substance use must be more than one year;
- past and present psychiatric and psychological profile must be negative;
- all participant who gave consent to take part in the study.

Exclusion criteria were:

- other co-morbid psychiatric disorders;
- those who declined to participate.

Data were gathered by the researcher who offered each participant a 30-minute interview. The questionnaire was comprised of three parts: Part one included a socio-demographic questionnaire to determine characteristics concerning age, gender, level of education, marital status, economic status and residence. Part two involved the use of the Depression Anxiety and Stress Scale (DASS). The DASS is a self-report measure that assesses depression, anxiety, and stress levels.<sup>4</sup> Part three explored social experiences of participants via a social scale comprised of 14 questions with three response options: never, sometimes, and always. Ethical approval was obtained from the College of Nursing ethics committee of Hawler Medical University. Data were analyzed using the Statistical Package of Social Sciences (SPSS, Version 23), which took a descriptive statistical data analysis approach to include frequencies and percentages, and chi-square tests. All statistical procedures were tested on a probability of  $p$  value and divided as follows:

$\leq 0.01$  highly significant

$\leq 0.05$  significant

$> 0.05$  non-significant.<sup>4</sup>

## Results

Table 1 shows that 49% of participants were between 26-35 year of age. The mean age  $\pm$  SD was  $27.25 \pm 6.58$ . Concerning the gender, 98% were men; 44% of participants were married while 30% had been widowed. In terms of education and employment, 47% had graduated from secondary school and 67% were unemployed with 46% stating their income was insufficient. Nearly all lived in an urban area. Regarding the type of substances being misused, 78% of participants reported being dependent on tramadol.

**Table 1.** Socio-demographic characteristics of participants (N=100)

<b>Socio-demographic</b>		<b>No.</b>	<b>%</b>
<b>Age</b>	<b>16-25</b>	<b>44</b>	<b>44</b>
	<b>26-35</b>	<b>49</b>	<b>49</b>
	<b>36-45</b>	<b>7</b>	<b>7</b>
<b>Gender</b>	<b>Male</b>	<b>98</b>	<b>98</b>
	<b>Female</b>	<b>2</b>	<b>2</b>
<b>Marital state</b>	<b>Single</b>	<b>26</b>	<b>26</b>
	<b>Married</b>	<b>44</b>	<b>44</b>
	<b>Widower</b>	<b>30</b>	<b>30</b>
<b>Education level</b>	<b>Illiterate</b>	<b>5</b>	<b>5</b>
	<b>Able to read and write</b>	<b>20</b>	<b>20</b>
	<b>Primary school</b>	<b>20</b>	<b>20</b>
	<b>Secondary School</b>	<b>47</b>	<b>47</b>
	<b>High school</b>	<b>2</b>	<b>2</b>
	<b>College and institute</b>	<b>6</b>	<b>6</b>
<b>Occupation</b>	<b>Employed</b>	<b>21</b>	<b>21</b>
	<b>Unpaid work</b>	<b>67</b>	<b>67</b>
	<b>Student</b>	<b>8</b>	<b>8</b>
	<b>Unemployed</b>	<b>4</b>	<b>4</b>
<b>Economic status</b>	<b>Sufficient</b>	<b>23</b>	<b>23</b>
	<b>Fair</b>	<b>31</b>	<b>31</b>
	<b>Insufficient</b>	<b>46</b>	<b>46</b>
<b>Residency</b>	<b>Urban</b>	<b>59</b>	<b>59</b>
	<b>Rural</b>	<b>41</b>	<b>41</b>
<b>Types of drug abuse</b>	<b>Tramadol</b>	<b>78</b>	<b>78</b>
	<b>Amphetamine</b>	<b>14</b>	<b>14</b>
	<b>Trihexyphenidyl</b>	<b>5</b>	<b>5</b>
	<b>Heroin</b>	<b>3</b>	<b>3</b>
<b>Duration of taking</b>	<b>1-2 year</b>	<b>51</b>	<b>51</b>
	<b>More than two year</b>	<b>49</b>	<b>49</b>

Table 2. Shows the occurrence of severity levels of depression among patients who reported being drug dependent. Of the 100 participants, 42% reported moderate symptom levels for depression; 17% reported severe symptom levels and 14% described extremely severe symptom levels for depression. In terms of anxiety, 32% reported extremely severe levels of anxiety; 24% described moderate anxiety levels and 14%

reported their anxiety levels as being severe. In terms of their experience of stress, 32% of participants reported normal levels of stress; 28% reported moderate stress 15% reported severe stress levels.

**Table 2.** Levels of depression, anxiety and stress among participants

Psychological Symptom Levels	Normal		Mild		Moderate		Severe		Extreme		Total
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	(%)	No.	100 %
<b>Depression</b>	3	(3)	24	(24)	42	(42)	17	(17)	14	(14)	100
<b>Anxiety</b>	24	(24)	6	(6)	24	(24)	14	(14)	32	(32)	100
<b>Stress</b>	32	(32)	22	(22)	28	(28)	15	(15)	3	(3)	100

Table 3 shows the levels of impairment of social relationships among patients who reported being drug dependent. Of the 100 participants, 68% reported having

poor social relationships; 30% described having good social relationships and 2% reported having experienced bad social relationship.

**Table 3.** Levels of impairment of social relationships among participants

Levels of Impairment of Social Relationships	No.	%
Good social relationships	30	30
Poor social relationships	68	68
Bad social relationships	2	2
<b>Total</b>	<b>100</b>	<b>100.0</b>

Table 4 demonstrates that there was a significant association between marital status and depression, anxiety, and stress while there was no significant association between marital status and social relationship. In addition, it shows that significant association between the economic status of participants and Anxiety, depression, and stress, while there was no significant association between economic and social

relations. On the other hand in age group, educational level and a job of addictive patients there was highly significant statistically with depression, anxiety, and stress while there was no significant association between level of education and social relationship. However, shows that there were very high statistically significant differences between social relationships and age group and job of participants.

**Table 4.** Association between participants’ socio-demographic characteristics and levels of depression, anxiety stress and social relationships

Biographic Characteristics		Levels of	Depression	Anxiety	Stress	Social relationship
			Chi-square	Chi-square	Chi-square	Chi-square
Age group	16-25	0.481	0.000	0.001	0.000	
	26-35					
	36-45					
Gender	Male	0.167	0.167	0.124	0.619	
	Female					
Marital Status	Single	0.035	0.054	0.006	0.259	
	Married					
	Widower					
Economic Status	Sufficient	0.031	0.02	0.002	0.320	
	Fair					
	Insufficient					
Educational Level	Illiterate	0.000	0.006	0.001	0.787	
	Literate					
	Primary					
	Secondary					
	High School					
	Institute and College					
Jobs	Employed	0.002	0.003	0.137	0.000	
	Voluntary					
	Student					
	Unemployed					
Residency area	Urban	0.331	0.065	0.061	0.271	

## Discussion

The present study assessed the severity of stress, anxiety, depression and social relationship levels together with socio-demographic data in patients with a history of substance misuse resulting in drug dependency and/or addiction. Findings indicated that most participants in the current study reported experiencing stress, anxiety, depression and poor social relationships. This finding is supported by research carried out in a drug rehabilitation unit in Iran, which identified all patients who reported being drug dependent also suffered from depression, anxiety and stress.<sup>2</sup> Findings from the current study were also consistent with a study in India.<sup>6</sup> Further, a significant relationship between stress, depression and anxiety was found in a study with participants who were from the same age group and gender as participants in the current study.<sup>7</sup> The mean age of current study was similar to that of a study done by Sudrabaa.<sup>5</sup> Participants were aged from 17 to 67, mean age 38.24 ±10.28. The severe stress level reported by participants in the current

study was similar levels reported by Hassanbeigi *et al.* (2012), which supports the view that many people drug dependency problems also experienced severe stress. Findings in the current study were also aligned with research conducted in Egypt in that participants had a mean age =25.41± 7.24 years, low educational level and low social level.<sup>1</sup> It appears that people with substance misuse problems may be prone to experiencing a vicious cycle whereby they may believe that using drugs can alleviate their negative emotions or heal their mental health conditions, which then leads to further drug use. In addition, people with depression who misuse substances may believe that their experience of lethargy, low mood and fatigue can be improved with drugs and this outlook would also lead to further drug use. The consequence, however, is that the pattern risks positively reinforcing the substance misuse behavior in a perpetual cycle of psychological symptoms leading to drug use and drug use leading to psychological symptoms. Results showed a significant association between psychological outlook and social relationships in participants with

severe depression, stress and anxiety who also complained of having had bad relationships. This is an important point when considering a World Health Organization survey conducted in Iraq and in the Kurdistan region over a 12-month period which reported high prevalence rates for stress, depression and anxiety disorder.<sup>8</sup>

## Conclusion

The current study found that the majority of participants who were dependent on or addicted to substances also reported high levels of anxiety, moderate depression and poor social relationships. There was a significant association between participant age group, economic status and educational level although this was not the case with social relationship and depression. Further, there was a statistically significant association between drug dependency and depression, anxiety and poor social relationships.

## Recommendation

Psychoeducation about the impact of substance misuse on mental health, social relationships and overall well-being is recommended for people who have become dependent on drugs and for those who support them, including family and the wider community. An information campaign using mass media, pamphlets or posters would be helpful. Early detection of substance misuse problems and appropriate psychosocial and pharmacological interventions would likely benefit those affected and reduce community burden. Conducting similar studies at a national level on larger samples of patients who are dependent on substances may provide further insights for the management of substance misuse.

## Limitations

The current study identified four limitations: (1) the DASS has not been validated in Iraq; (2) many patients were hesitant to participate for fear that they might be incriminated for their substance misuse; (3) many reported finding it difficult to attend hospital due to the stigma and associated feelings of shame; and, (4) there

are fewer people with drug dependency problems in Iraq compared with other countries.

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**الخلفية والهدف:** إدمان المخدرات هو مرض مزمن يرتبط غالباً باضطرابات نفسية أخرى. القلق والاكتئاب والتوتر هي من بين الاضطرابات النفسية الأكثر شيوعاً في مدمني المخدرات هناك. كانت أهداف هذه الدراسة لتقييم شدة مستويات التوتر والقلق والاكتئاب والعلاقة الاجتماعية والربط بين البيانات الاجتماعية والديموغرافية مع شدة مستويات التوتر والقلق والاكتئاب والعلاقة الاجتماعية بين مرضى المدمنين في مستشفى هولير للطب النفسي / مدينة أربيل- كردستان - العراق. **الطريقة:** كان تصميم الدراسة وصفية، أجريت الدراسة في مستشفى الطب النفسي والعيادة الخارجية في مدينة أربيل. بدأت الدراسة في 2017/7/2 حتى 2018/9/26؛ كان حجم العينة 100 مريض مدمن أدخلوا إلى مستشفى هولير للطب النفسي أو العيادة الخارجية. يتكون الاستبيان المستخدم لجمع البيانات من ثلاثة أجزاء (الجزء الأول، البيانات الاجتماعية-الديموغرافية، الجزء الثاني، البنود المتعلقة بالجوانب الاجتماعية والجزء 3 حول الجانب النفسي. يستخدم الإكثتاب والقلق ومقياس الضغط) لقياس الإكثتاب والقلق والإجهاد. تم استخدام الطريقة الإحصائية لبرنامج SPSS لتحليل البيانات. **النتائج:** كانت هناك أربعة مستويات للجوانب النفسية والاجتماعية (الإجهاد، القلق، الإكثتاب والمجال الاجتماعي) على أنها (معتدلة، معتدلة، شديدة ومتطرفة)، وثلاثة مستويات للعلاقات الاجتماعية (30% جيد، سبب 2% وضعيف 68%) في المستوى التعليمي، كان هناك ارتباط كبير مع الإكثتاب والقلق والتوتر، بينما لم يكن هناك ارتباط معنوي بين مستوى التعليم والعلاقة الاجتماعية. الحالة والجوانب النفسية، وعدم وجود ارتباط كبير بين الوضع الاقتصادي والعلاقة الاجتماعية للمدمنين.

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## Teaching Recovery Techniques to Adolescents Exposed to Multiple Trauma Following War and Ongoing Violence in Baghdad

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تعليم اساليب التعافي لطلبة مراهقين في بغداد

نعمان سرحان علي و ثراء وضاح الجودي وتوري سنيل

### Abstract

**B**ackground: Adolescents in Baghdad have had repeated experiences of war and community violence during their lifetime. The majority will have maintained good mental health although some will struggle with social, emotional and behavioral difficulties often associated with posttraumatic stress reactions (PTSD). Psychosocial interventions that enhance coping and resilience can improve mental health. Few have been evaluated in communities affected by such conflict. The current study was conducted in 2015 when an upsurge in violence across Iraq triggered a rise in car bombs, aerial bombardment, armed conflict and internal displacement. **Method:** Four classrooms from three randomly chosen, single-sex secondary schools in Baghdad were selected. Of the 116 students recruited, 102 (48 boys, 54 girls) agreed to participate; ages ranged from 13-18 years. Trauma history, anxiety and PTSD-related symptoms were assessed using age appropriate, reliable and valid self-report measures. Teaching Recovery Techniques (TRT) involved a five session, group-based intervention for PTSD-related symptoms with one psychoeducational session for parents and post-assessment at two weeks. **Results:** Exposure to seven or more traumatic events were reported in 44% of students. Those with more severe PTSD-related symptoms (44%) demonstrated statistically significant improvement. Overall results showed no statistically significant difference for anxiety or PTSD-related symptoms. Parent engagement was low although feedback from teachers and participants was positive. **Conclusion:** Multiple trauma exposure and moderate-to-severe PTSD-related symptoms reported by most participants suggests the need for targeted interventions, such as TRT. Further evaluation using an active control possibly in a community-based setting may improve outcomes and increase parent engagement. Delivery and implementation should be localized with costs kept to a minimum to ensure sustainability.

**Key Words:** Teaching Recovery Techniques, Adolescents, Baghdad, Posttraumatic Stress, Multiple Trauma Exposure, War

**Declaration of interest:** None.

### Introduction

A generation of young people growing up in Baghdad have been exposed to war and community violence. Aerial bombardment, car explosions, abductions, and seeing dead bodies have characterized daily life alongside more typical childhood experiences. The majority have learned to cope and function normally; however, in our clinical experience we encounter those in Baghdad who report difficulties that have persisted over many years, including chronic poor sleep, disturbing memories, behavior problems, concentration difficulties and social withdrawal, all of which can lead to mental health problems and compromise academic performance if left unaddressed. This is supported in studies of school age children and adolescents living in Baghdad and other cities in Iraq.<sup>1-6</sup> Traumatic stress reactions leading to posttraumatic stress disorder (PTSD) diagnosis has been reported in youth from many cultures following exposure to war.<sup>7,8</sup>

Psychosocial interventions for dealing with traumatic stress and PTSD are less common in Iraq than traditional methods of care, such as psychiatry and faith healing. In Baghdad and other major cities in the country where there still are very few NGOs on the ground, it is up to local practitioners to establish and maintain training networks and there is growing capacity to achieve this. Group-based psychosocial approaches offer one way of helping the affected population regardless of individual differences in war related exposures or traumatic stress reactions. Promotion of resilience and personal coping through normalizing activities is the basis for improved wellbeing.<sup>9</sup>

An increasing number of researchers in conflict-affected communities, such as Palestine, Afghanistan, Lebanon, Uganda and the Sudan are evaluating group psychosocial interventions designed to reduce the risk of developing mental health difficulties in children and adolescents following mass violence.<sup>10,11,12</sup> Such evaluation can ultimately lead to the evidence-base for what remains a

largely under-researched field of study. The growing implementation of non-evidenced based psychosocial interventions in low to middle-income countries affected by war and open conflict is reason enough to persevere.<sup>12</sup>

Schools are a practical setting for group-based interventions designed for large numbers of children with shared experiences of car explosions, shelling, kidnapping and interpersonal violence. School environments have the potential to provide support for children since teachers may better understand their psychological, social and academic challenges. Researchers nevertheless must concern themselves with the feasibility and acceptability of the intervention being delivered if its sustainability is to be assured. This point goes beyond the fundamental expectation that the intervention should be culturally adaptable. Schools are busy places of learning. In Western culture, it is not unusual for mental health topics to form part of the school curriculum and good mental health is more commonly recognized as integral to successful academic performance. This is less so for war-torn societies, particularly those where the focus may still be on a return to normalcy, such as through the improvement of national literacy rates, which may have declined due to years of education lost to a country.

A meta-analysis of studies on interventions for trauma exposed children and adolescents has identified programs varying in duration from five sessions to 18 sessions.<sup>12</sup> It can be argued that brief, but effective interventions may offer a balance against such competing demands. Among the earliest and briefest is Teaching Recovery Techniques (TRT), which was developed in 1999; has since undergone several revisions – most recently in 2016; and, in 2018, was recognized as an effective group-based intervention in the UK's National Institute for Health and Care Excellence (NICE) Guideline for children and adolescents with PTSD.<sup>13,14</sup>

### **Teaching Recovery Techniques (TRT)**

TRT is a group-based, psychosocial intervention informed by Cognitive Behavior Therapy (CBT) approaches targeting posttraumatic stress reactions in adolescents aged between 12 to 18 years. Its main purpose is to educate children about the symptoms associated with PTSD and teach appropriate coping strategies for dealing with core symptoms of intrusions, arousal and avoidance. Parent/caregiver involvement is key to supporting young participants to practice the skills they learn during the sessions.

A variety of techniques are taught, including normalization of stress reactions, psychoeducation, symbolic and dream work, relaxation techniques and exposure. TRT is a practical choice for secondary

prevention when working in complex and difficult environments, where child mental health care professionals may be in short supply, so it is intended for use by teachers, youth workers, pedagogues, psychologists, counselors, or community leaders, after some preliminary training.

The first two sessions involve normalizing and educating about posttraumatic stress reactions, dealing with intrusive memories (using imagery techniques designed to master the visual, auditory and olfactory memories), dual attention tasks (alternative tapping on the knees which is a technique used in EMDR), and dream work (by using the same imagery techniques mentioned above to master the recalled frightening dreams). The third session deals with hyper-arousal through teaching relaxation techniques, birth control, and sleep hygiene.

The fourth and fifth sessions deal with avoidance and exposure by encouraging adolescents to engage with traumatic reminders using a fear hierarchy, graded exposure while also encouraging them to express their thoughts and emotions through writing, drawing and talking.

A session for parents/caregivers is run in parallel to these sessions with the aim of normalizing children's reactions; improving the recovery environment of the child; and, providing advice to parents on self-help strategies.

TRT has resulted in significant reductions in PTS and depression in Palestinian adolescents living through ongoing community violence<sup>15,16,17</sup> and with those displaced by war to the UK and Sweden.<sup>18,19</sup> It has also had favorable results with adolescents following natural disaster.<sup>20</sup>

The current study is the first to use TRT in Iraq for adolescents affected by war and ongoing community violence. It had two aims: (1) to assess trauma exposure, PTS and anxiety levels in secondary school students living in Baghdad; and, (2) to apply TRT to help them learn coping and resilience-building skills.

### **Methods**

#### ***Setting and participants***

Three single-sex secondary schools were randomly selected from a list 1368 students in 20 schools. The boys' school was an intermediate and high school situated in the same building; there were two girls' schools – one for intermediate and one for high. The list was provided by the Directorates of Education in the district Al-Karkh in Baghdad. The city is divided into two sides by the Tigris - Karkh and Resafa. Both sides of the river experienced

ongoing violence until 2014 followed by an upsurge in violence at the time of the current study.

From the three schools, four out of 24 classrooms were randomly selected. This resulted in the girls' school yielding  $n=54$  girls and  $n=48$  boys from the other two schools, which took groups somewhat over the recommended 15 student per group limit for TRT. Five weekly, consecutive group sessions were delivered in their respective classrooms. Participants' ages ranged from 13 to 18 years.

### ***Intervention and training***

The 2012 version of the TRT manual was translated by the first author (NA) using a translation, back-translation procedure supported by the third author (TS). The first author who also delivered the TRT training at Baghdad Teaching Hospital to a team of psychiatrists, psychologists and social workers over two-days, supported online by the third author, then produced final versions. Total training costs to deliver and implement TRT were under £300 UK pounds sterling due to training responsibilities being managed at the local level.

A half-day educational meeting with teachers and staff of the selected schools was held during which the symptomatology of PTSD and purpose of the intervention was explained.

From 23 February 2015 to 31 March 2015, the intervention was delivered simultaneously to the four groups of students with two leaders for each group. It involved weekly sessions of two hours each for five consecutive weeks. Parents/caregivers were invited to attend a psychoeducational session in parallel with the first TRT session to the students and later groups were encouraged, but there was very little take up despite meetings held to explain the intervention. Parents expressed some ambivalence stating that they felt the intervention was not linked to education, which was a greater priority for them.

### ***Measures***

Assessment was conducted at baseline and two weeks posttest for posttraumatic stress reactions and anxiety. Sociodemographic factors, including trauma history was via the Baghdad Trauma Checklist.<sup>21</sup> Arabic versions of the assessment tools followed the same translation procedure as for the intervention. Those measuring psychological distress were chosen for their reliability and validity and have previously been used in the Arab world.

#### **Children's Revised Impact of Events Scale**

**(CRIES-8)**<sup>22</sup>

The CRIES has been used in most TRT studies. It is brief self-report measure for screening children and adolescents at risk for PTSD. The eight statements make up two subscales: avoidance and intrusion. The total score, from 0 to 40 with a cut-off of 17 or above, has shown good internal consistency and has successfully categorized over 75% of children with and without a PTSD diagnosis.<sup>23</sup>

#### **Spence Children's Anxiety Scale (SCAS)**<sup>24</sup>

The SCAS is a 45-item child self-report questionnaire devised to evaluate symptoms relating to separation anxiety, social phobia, obsessive-compulsive disorder, panic agoraphobia, generalized anxiety and fears of physical injury. It has strong psychometric properties.<sup>24</sup>

### ***Ethics***

Ethical review was via the Ethics Committee of the Scientific Council of Psychiatry - Arab Board. Permission to conduct the current research was obtained from the Department of Education of Al-Karkh and from the schools' administrations. All parents/caregivers received a letter explaining the purpose of the study, which assured confidentiality and their child's right to withdraw from the study at any time without consequence to their education. Written consent was obtained from all parent/caregivers and oral assent from all participating students who were also reminded of their right to withdraw from the study without consequence.

### **Data analysis**

The Statistical Package for Social Science version 20 (SPSS 20) was used for both data entry and analysis. Continuous variables were presented as mean  $\pm$  SD and discrete variables presented as number (%). Pair sample  $t$  test used to test the significance of association for difference variable and Chi-square test for discrete variable. P-value of  $< 0.05$  was considered significant.

### **Results**

#### ***Attrition***

Out of the total 116 students recruited to the current study, 10 did not start the intervention; and, four who had started, did not complete pre-post measures were not included in the analysis.

#### ***Descriptive statistics***

Of the remaining 102 participants, 48 were boys (47.1%) and 54 were girls (52.9%); all in secondary school. Fifty-five students (53.9%) were in the second year, 26 (25.5%) are in the fourth year and 21 (20.6%) were in the fifth year. Their ages ranged between 13 to 18 years ( $M=15.40$ ,

SD=1.437). Ninety-three students attended all five TRT sessions. The attendance rate for the parent/caregiver session was low with only 20 joining across all four-classroom settings.

**Significant stressors and traumatic events**

The fathers of five students (4.9%) and the mothers two (2%) had died as result of the violence. Eleven students (10.8%) stated their families did not have enough money for daily living. Thirty-five students (34.3%) were living in a house not owned by their families. Twelve students (11.8%) reported that both parents were unemployed. Ten

students (9.8%) reported at least one of their parents was not in good health. Four students (3.9%) were not in good physical health.

Table 1 (below) provides a comprehensive impression of the type the traumatic stressors on the Baghdad Trauma Checklist and percentage of students who experienced them. The highest percentage was for students who had seen dead bodies 46 (45.5%), 43 (42.6%) who had witnessed car bombing, 41 (40.6%) who had witnessed aerial bombardment and the lowest was 19 (18.8%) whose homes were destroyed or damaged by shelling.

**Table 1.** Traumatic events reported by N=102 students on the Baghdad Trauma Checklist

Type of Traumatic Event	n	%
Witnessed aerial bombardment	41	40.6%
Witnessed destruction of buildings	38	37.6%
Witnessed car bombing	43	42.6%
Witnessed armed combat	35	34.7%
Witnessed someone being injured or killed	35	34.7%
Seen dead bodies	46	45.5%
Touched or carried injured person	25	24.8%
Family home destroyed or exploded	19	18.8%
Family home looted	25	24.8%
Family forced by violence to leave home	24	23.8%
Family member injured, kidnapped or imprisoned	27	26.0%
Father or mother killed	7	6.7%

**PTSD-related symptoms**

Table 2 (below) shows the prevalence rate for likely diagnosis of PTSD in the 102 students was 44.5% (n=45). Of the 45 students scoring above the CRIES-8 cut-off for possible diagnosis, 64.4% (n=29) reported having been exposed to >7 traumatic events, including aerial bombardment, car explosions, witnessing armed combat, seeing someone injured, having their homes looted or their family displaced due to the violence. The experience of multiple trauma exposure was much lower

in those reporting fewer PTSD-related symptoms. The prevalence rate for likely PTSD diagnosis in the current study finding was significantly higher than two studies in Baghdad<sup>1,5</sup> and one in Mosul,<sup>3</sup> which reported PTSD rates of 19%, 18% and 10.5%, respectively. However, these rates and those in the current study were lower than a study with secondary school students in Baghdad which reported 61% students (N=403) met the criteria for PTSD.<sup>2</sup>

**Table 2.** Number of traumatic events for N=102 students reporting PTSD-related symptoms

		n= below or above CRIES-8 cut-off		Total	p-value
		<17	>17		
Number of traumatic events	0	1	0	1	0.002
		1.8%	.0%	1.0%	
	1-2	15	3	18	
		26.3%	6.7%	17.6%	
	3-4	13	9	22	
		22.8%	20.0%	21.6%	
	5-6	12	4	16	
21.1%		8.9%	15.7%		
>7	16	29	45		
	28.1%	64.4%	44.1%		
<b>Total</b>		57	45	102	
		100.0%	100.0%	100.0%	

**Anxiety symptoms**

Table 3 (below) shows the rate of co-occurring anxiety disorders (SCAS cut-off score >60) was 17.6% (n=18). Five times as many girls reported anxiety levels above the Spence cut-off of >60 than did boys.

The rate of comorbid anxiety disorders (Spence cutoff value >60) among adolescent school students was 18 out of 102(17.6%). A higher rate of anxiety disorders was found in Baghdad among students who were exposed to traumatic events (32.66%).<sup>5</sup>

**Table 3.** Relationship between the frequency of traumatic events and scores on SCAS

		SCAS cut-off (anxiety)		Total	p-value
		<60	>60		
Number of traumatic of events for those above and below SCAS cut-off	0	1	0	1	0.125
		1.2%	.0%	1.0%	
	1-2	17	1	18	
		20.2%	5.6%	17.6%	
	3-4	19	3	22	
		22.6%	16.7%	21.6%	
	5-6	15	1	16	
17.9%		5.6%	15.7%		
>7	32	13	45		
	38.1%	72.2%	44.1%		
<b>Total</b>		100.0%	100.0%	100.0%	

Table 4 (below) shows the mean scores of both CRIES-8 and SCAS pre and post intervention for all 102 participants, but no statistically significant

difference in change scores overall for either PTSD-related symptoms or anxiety at post intervention.

**Table 4.** Total CRIES-8 and SCAS scores for N=102 students pre and post intervention

Variables		Mean	SD	p-value
CRIES-8 total score	Pre intervention	15.08	12.120	0.346
	Post intervention	13.65	9.372	
SCAS total score	Pre intervention	42.51	20.231	0.080
	Post intervention	37.78	18.175	

Table 5 (below) shows pre and post scores for PTSD-related symptoms and anxiety. The baseline CRIES-8 score for those above the >17 threshold was M=27.09 (SD 5.923). Post-intervention, the score decreased to M=22.71 (SD 5.279)  $p=0.0001$ , which was statistically significant.

There was no statistically significant difference between pre and post intervention scores for anxiety levels reported above the SCAS cut-off point.

**Table 5.** Total CRIES-8 and SCAS scores for scores above cut-off point

Variables		n=	Mean	SD	p-value
CRIES-8 total score	Pre	45	27.09	5.923	0.0001
	Post	42	22.71	5.279	
SCAS total score	Pre	18	72.78	11.181	0.337
	Post	12	69.42	7.994	

## Discussion

The current study coincided with an upsurge of violence in the northern part of Iraq, which also affected Baghdad. All but one of the 102 adolescents who completed the study reported that they had been exposed to at least one significant stressor associated with war and community violence although time since the most recent trauma was not specified during assessment. At the material time, aerial bombardment in the region had resumed for the first time in many years leading to large-scale internal displacement and a rise in the number of car bombings across Baghdad. This may explain the high rate of PTSD-related symptoms reported. Variances in psychological symptom prevalence rates are important to place in context, particularly considering that violence in long-affected communities can resurface at any time. A study in occupied Palestine found 41% of children reported moderate-to-severe PTSD during a time of heightened levels of violence.<sup>25</sup> Another with secondary students in Uganda reported PTSD prevalence rates of 31.36% in those who had witnessed seven or more traumatic events associated with war.<sup>11</sup> This is supported in a randomized control trial of TRT in rural occupied Palestine using the

CRIES-8, which found 46.1% with clinically significant levels of PTSD following multiple trauma exposure.<sup>15</sup>

As relates to the current study, 23.8% of participants were forced to leave their homes having been displaced from the northern part of Iraq and their experiences may have influenced the overall demographic and psychological profile for participants. However, research methodologies will also differ; for example, a study with secondary students in Baghdad that reported a much lower PTSD prevalence rate used a psychological screen for multiple trauma exposure<sup>26</sup> that has been validated and used in the Middle East with adults.<sup>27,28</sup> Conversely, the TRT evaluation in rural Palestine found a similar level of PTSD symptom severity as the current study; both used the CRIES-8.<sup>15</sup> Nevertheless, studies of war-exposed children in Iraq have consistently highlighted the impact of multiple trauma exposure on the mental health of children living in the country<sup>1-5</sup> and the need for evidence-based psychosocial interventions that can provide relief is stark. An evaluation of TRT in Nablus found significant improvements for adolescents with depression, grief and PTSD-related symptoms and concluded that the intervention had potential to ameliorate children's traumatic stress reactions during a period of ongoing violence.<sup>25</sup>

For the current study, TRT led to significant reduction of PTSD-related symptoms in trauma exposed adolescents who reported levels above the clinical cut-off for likely PTSD diagnosis although overall the result was non-significant. Qualitatively, most students reported that they enjoyed the TRT sessions and felt helped by them. In practical terms, the schools' noisy environments were not entirely conducive to learning relaxation and imagery techniques, which highlights the challenges of evaluating school-based interventions sufficiently to ensure their suitability and adaptability within schools in settings where the aftermath of war and the effects of ongoing violence are still felt. The use of community-based settings for intervention delivery in future may produce better outcomes for children as well as parents/caregivers. A study of TRT in Sweden with unaccompanied minors resulted in good outcomes for the 49 who completed the study in a community-based setting.<sup>19</sup>

Although schools randomized to the current study had good links with the students' parents/caregivers and staff supported the research by encouraging their attendance at an information session organized before the psychoeducation part of TRT, parents/caregiver participation was low. Feedback from parents was that they did not see a link between the intervention and their children's educational needs. Materials produced in the version of the manual used for the current study with trainers and for parents did not provide emphasis on how symptoms associated with PTSD can adversely impact academic performance and, conversely, how enhancing a child's coping and resilience is potentially linked to better academic performance. Such information may well have drawn in more parents and caregivers.

Logistically, TRT training and implementation was possible to achieve locally because the lead trainer had been trained in use of the manual by the Children and War Foundation. Fidelity to the protocol was partly evaluated however there was drift from the original guidelines, e.g. teaching the group of trainers in a circle rather than lecture hall format, although this was not mirrored in the actual delivery of the intervention. TRT is designed for its ease of delivery and potential to be cost-effective. In the current study, training and implementation costs were relatively low, which is in keeping with findings from an evaluation of the intervention conducted in occupied Palestine.<sup>17</sup>

### Strengths and limitations

Obvious limitations were the absence of fidelity checks during training, the small sample size and the lack of active control group. Posttest measure at two-weeks limited evaluation as to long-term effects of the intervention. There were difficulties arranging posttests at

three and six months because these coincided with final exams and school summer holiday. Further, more robust data analysis was needed. The study also would have benefitted from an assessment of depressive symptoms and daily functioning to better understand the impact of these symptom on children. Parent information and TRT psychoeducation sessions were not well attended, which may have limited the effectiveness of the intervention.

In terms of strengths, the current study was the first to use TRT in Iraq and was successfully delivered by volunteers in a school setting despite many logistical challenges. Additionally, assessment of children in Baghdad was followed by an appropriately targeted psychosocial intervention with groups of adolescents, which does not reflect the current trend for studies on the mental health and trauma experiences of children and adolescents in the country, which tends to involve needs analysis and survey methods only.

### Conclusion

Multiple trauma exposure and moderate-to-severe PTSD-related symptoms reported by most participants suggests the need for targeted interventions, such as TRT. While the overall results were non-significant, participants with more severe PTSD-related symptom levels appeared to benefit and the subjective feedback from many participants and their teachers bore this point out. Further evaluation using an active control possibly in a community-based setting may improve outcomes and increase parent engagement. When possible, delivery and implementation of psychosocial interventions within Iraq should be localized with costs kept to a minimum to ensure sustainability.

### Recommendations

Research on the mental health and trauma histories of children and adolescents living in Iraq tends to focus on needs analysis, but often without remedy. There are a growing number of psychosocial interventions being developed for children and adolescents affected by war and community violence. The risk is that these will remain unevaluated despite being implemented. It would be important for researchers to consider broadening needs analysis and prevalence rate studies to include evaluation because it is important to understand what works. Studies evaluating TRT are increasing and starting to demonstrate its effectiveness for adolescents exposed to war and community violence.<sup>15-19</sup> Ensuring more localized training of interventions, such as TRT, through partnerships with regional health and education directorates and established NGOs may help and also lead to reduced costs associated with training and implementation. Collaboration on study

design, analysis and the ultimate dissemination of findings, including good local and regional journals as well as those with high impact factors and broad international outreach is needed and would be beneficial if establishing an evidence-base for interventions in war-torn settings is the shared aim.

## Acknowledgements

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## الملخص

**المقدمة:** تعرض الاطفال والمراهقين في العراق إلى صدمات ذات علاقة بالحرب والعنف المجتمعي خلال حياتهم بشكل مستمر. وأن الاغلبية منهم بصحة نفسية جيدة الا ان بعضهم يعاني من صعوبات اجتماعية وعاطفية وسلوكية ويصاحبها غالباً انفجالات كرب ما بعد الشدة. ان تخفيف هذه الصعوبات ممكن بتطبيق التداخلات النفسية الاجتماعية والتي تعجل التكيف والمرونة وفي نفس الوقت تؤدي لتحسن الصحة النفسية. أن عدد قليل من هذه التداخلات قد تم تقييمه في المجتمعات التي تعاني من الازمات.

في وقت اعداد هذا البحث في عام 2015 كانت احداث العنف قد زادت في العراق بكثرة انفجارات العجلات المفخخة والمواجهات المسلحة مما ادى إلى موجات من النزوح من بعض المناطق.

**طريقة البحث:** تم اختيار أربع صفوف من ثلاث مدارس اختيرت عشوائياً من بين مجموعة مدارس متوسطة واعدادية غير مختلطة في بغداد. وقد وافق 102 طالب وطالبة (48 ولد و54 بنت) على المشاركة بالبحث من أصل 116 كان قد تم اختيارهم. اعمار الطلبة تتراوح بين 13-18 عاماً. تم بعد ذلك اجراء مسح لاعراض اضطراب الكرب ما بعد الشدة والقلق بالاضافة الى تاريخ التعرض للصدمات النفسية.

تم تطبيق برنامج تعليم اساليب التعافي على خمس جلسات بمعدل جلسة واحدة اسبوعياً لمدة خمسة اسابيع متتالية وتبعتها جلسة مخصصة لذوي الطلبة. تم اجراء تقييم ما بعد التداخل بعد مرور اسبوعين من الانتهاء منه.

**النتائج:** كانت نسبة من تعرضوا إلى سبعة أو أكثر من الاحداث الصادمة هو 44% من الطلبة. وقد تحسن اولئك الطلبة الذين لديهم اعراض شديدة بشكل مهم احصائياً، بينما لم يظهر تحسن ذو اهمية احصائية في اعراض القلق أو اعراض ما بعد الشدة على باقي الطلبة.

كان تفاعل اولياء الامور ومشاركتهم قليلة الا ان ردود الافعال من المعلمين والطلبة كانت ايجابية.

**الاستنتاج:** ان التعرض لاحداث صادمة كثيرة ووجود اعراض ما بعد الصدمة بدرجات متوسطة إلى شديدة ما بين الطلبة الذين شاركوا بالبحث يؤدي بنا إلى اقتراح الحاجة لتدخلات محددة مثال تعليم اساليب التعافي. نحتاج إلى تقييم هذا التداخل لاحقاً باستخدام عينة ضابطة وفي المجتمع مما قد يؤدي إلى نتائج أفضل ويزيد من المشاركة الفاعلة من الاباء. ويجب ان يقدم التداخل محلياً مع ضرورة خفض التكاليف لضمان استمراريته.

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## Comparison of Victimized Versus Non-Victimized Egyptian Patients with Major Depressive Disorder

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دراسة مقارنة بين مرضى الاكتئاب المصريين المعرضين و غير المعرضين للايذاء

أحمد عادل المسيري، غادة الخولي، مايسة عيد، مروة المسيري، دينا ابراهيم، احمد عادل عبد الجواد

### Abstract

**B** **ackground:** Victimization of patients with major depressive disorder is a serious problem that is underestimated. **Objectives:** The current study identified and compared clinical and socio-demographic characteristics of victimized and non-victimized Egyptian patients with major depressive disorder. **Methods:** Using a cross-sectional design, N=100 participants were recruited from the Institute of Psychiatry, Ain Shams University and administered the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Axis I (DSM-IV; SCID), Hamilton Rating Scale for Depression (HAM-D), Global Assessment of Functioning (GAF), Clinical Global Impression (CGI), Victimization Questionnaire (VQ) and a questionnaire for demographic data. Patients were classified into victimized ( $n=52$ ) and non-victimized ( $n=48$ ) groups. **Results:** Fifty two percent of patients with depression reported being victimized. The majority were married women with low socio-economic status and experiences of abuse in childhood compared with the non-victimized group. Most victimized patients were diagnosed with recurrent MDD followed by MDD with psychotic features. The HAM-D indicated severe depression in 92.3% of the victimized group and the CGI indicated marked illness compared with the non-victimized group. All patients in the victimized group experienced emotional abuse; 58.3% were subjected to physical abuse and 30.8% were subjected to miscellaneous types of abuse. Emotional abuse was mainly by spouses. The majority did not report such incidents. **Conclusion:** The rate of physical and emotional abuse of patients with depression is high. Women were more likely to be victimized than men. Routine psychiatric interviews should include questions about patient abuse history. Further research is needed in order to inform mental health policies and procedures within Egyptian society.

**Keywords:** Victimization, Depression, Perpetrators, Violence

**Declaration of interest:** None

### Introduction

Depression is a common mental illness. An estimated 350 million people of all ages experience the symptoms of depression worldwide, according to a World Health Organization (WHO) report.<sup>1</sup> Victimization of patients with mental illness is a pressing global health problem affecting recovery and community integration.<sup>2</sup>

Depression also contributes significantly to disability.<sup>3</sup> Previous studies showed that depression was the second leading cause of global disability.<sup>4</sup> Evidence also points to the fact that patients with mental illness are more likely to report a history of physical and emotional abuse than the general population.<sup>5</sup> Many reasons for this have been identified. The illness can impair their ability to manage conflict situations; increase the expression of negative feelings; and, puts more demands on others.<sup>6</sup> In addition to this, there is impaired reality testing, disorganized

thought processes, impulsivity, poor planning and problem solving, which can compromise an individual's ability to perceive risk and protect himself/herself.<sup>7</sup> A Chinese study revealed high levels of depression in abused women.<sup>8</sup>

The risk of victimization varies according to demographic and psychosocial characteristics. Among the putative risk factors, the most important appear to be gender, race, employment status, social environment, economic status, poor physical health, criminal history and history of past victimization.<sup>9</sup>

People with psychiatric disabilities are far more likely to be victims than perpetrators of violent crime.<sup>10</sup> Conversely, in a study conducted in Sweden, it was found that the risk of violent crime was increased in depressed patients.<sup>11</sup>

A study by Arboleda-Florez<sup>12</sup> reported that mental illness may be a risk factor for violence; the reverse may also be true, and that violence may be a causative factor for mental illness. On the other hand, stigmatization of mental illness plays a role in increasing rates of victimization in this population and leads to their reluctance to report the event. Indeed, violent victimization of persons with major mental illness has long-term adverse consequences on the course of their illness, exacerbation of existing symptoms, increases the likelihood of service utilization and substantially impairs the quality of life of patients and their families.<sup>13,14,2</sup>

The current study is part of a research series that evaluated victimization among Egyptian patients with schizophrenia<sup>15</sup> and bipolar disorder.<sup>16</sup> It was primarily driven by the paucity of studies concerning victimization of patients with depression in Egypt. Using a cross-sectional, case-control design, the study compared patients with major depression who were victimized with non-victimized patients and aimed to define the profile of the incidents of victimization.

## **Subjects and Methods**

### *Site and design*

The current study was conducted at the Institute of Psychiatry, Ain Shams University in Eastern Cairo. The university serves a catchment area of about a third of greater Cairo, including urban and rural areas. The study was designed as a case control, cross-sectional observational study. The sample size and the selected tools were developed on the basis of a past pilot and studies on patients with schizophrenia and bipolar disorder who reported histories of abuse.<sup>15,16</sup>

### *Participants*

One hundred participants were recruited from the inpatient and outpatient departments of the Institute of Psychiatry. All fulfilled the inclusion criteria; namely, both genders, 18 years or older, with a primary diagnosis of major depressive disorder according to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), with more than one-year duration of illness. Patients with other Axis I disorders, substance misuse problems or comorbid medical disorders were excluded.

### *Approvals and Consent*

The current study was conducted in accordance with the Helsinki Declaration (1975) and in accordance with the guidelines of the Research and Ethics Committee of the Institute. The research protocol was reviewed by the

Research and Ethics Committee of Ain Shams University. All participants signed an informed consent to participate in the study after the aim and procedures were explained to them. Confidentiality was assured and all were informed their participation was voluntary and that they had the right to withdraw from the study at any time.

### *Tools*

The following tools were used:

1. Structured Clinical Interview for DSM-IV Axis I diagnosis (DSM-IV;SCID-I)<sup>17</sup> which is a semi-structured diagnostic interview administered by an experienced trained bilingual researcher. The Arabic version was translated by El-Missiry. SCID-I was validated and used in previous Egyptian studies.<sup>18,19,20</sup>
2. The Hamilton Rating Scale for Depression (HAM-D) was used to measure the severity of depressive symptoms in patients with major depression. It is a 19-item checklist ranked along a likert scale of 0-4 or 0-2. A score of >23 denotes very severe symptom levels whereas 19-22 is severe, 14-18 is moderate, 8-13 is mild and a score of <7 is normal.<sup>21</sup>
3. Global Assessment of Functioning (GAF) is a numeric scale (0-100) to subjectively rate the social, occupational, and psychological functioning of adults in life.<sup>22</sup>
4. Clinical Global Impression (CGI)<sup>23</sup> is a 7-point scale requiring the clinician to rate the severity of the patient's illness at the time of assessment, relative to the clinician's past experience with patients with the same diagnosis. Considering total clinical experience, a patient is assessed on severity of mental illness at the time of rating.
5. A questionnaire designed to elicit information about demographic data, family circumstances and illness details.
6. Fahmi and El Sherbini Scale for social class determination in Egyptian communities.<sup>24</sup>
7. The Victimization Questionnaire (VQ), developed and Standardized by El-Missiry *et al.*,<sup>15</sup> includes questions about crimes, such as personal theft, robbery, burglary, vandalism, assault with or without a weapon, attempted assault, biased physical and verbal assault, kidnapping, threatening, blackmailing, verbal or physical abuse, sexual harassment, emotional abuse, financial abuse, or different types of emotional victimization. It was adapted from the Criminal Victimization Questionnaire 2009<sup>25</sup> and the Juvenile Victimization Questionnaire.<sup>26</sup>

The questionnaire was modified and standardized for the Egyptian culture. The research team was trained in the use of the tools prior to the study.

### **Statistical analysis**

Data analysis was carried out using the Statistical Package for Social Science - Version 15 (SPSS 15).<sup>27</sup> Student's *t*-test was used for comparison between the means of the different groups. The Pearson's chi-squared test was used for comparison between qualitative variables. The *p*-value was used to indicate the level of significance, where *p* to 0.05 is considered significant.

## **Results**

The current study involved N=100 patients (*n*=20 men, *n*=80 women) fulfilling the diagnostic criteria for Major Depressive Disorder (MDD) according to DSM-IV. The Structured Clinical Interview for DSM-IV Axis I Disorders (DSM-IV; SCID I) was used to ascertain the diagnosis and determine comorbidity. All were assessed using the Victimization Questionnaire (VQ). Results found that 52% of patients had been previously victimized and 48% were never subjected to victimization (see Figure 1). Subsequently, the study sample was classified into a non-victimized group (mean age 40.75±11.721) and victimized group (mean age 38.92±10.586) years.

### **Socio-demographic characteristics**

In the current study, more women reported being subjected to victimization than men (*p*=0.001). The majority in the victimized group were married (92.30%, *p*=0.001), lived in urban areas (*p*=0.23) and had low socioeconomic status (53.80%, *p*=0.346) (Table 1).

Regarding employment status, the non-victimized patients were mostly more stable at work whereas the victimized were commonly not working or were housewives or students. There were no statistically significant differences between either group with respect to age, social class, place of living, years of education, or history of having been bullied at school. The victimized group reported greater exposure to parental domestic violence (*p*=0.000) and childhood abuse (*p*=0.044). A statistically significant difference was found when comparing the two groups in terms of family history of psychiatric illness and family history of drugs and alcohol abuse (see Table 1).

### **Clinical characteristics**

The clinical characteristics of the studied sample are shown in Table 2. Most of the victimized patients were harmed during their first episode (61.6%), additionally the majority were diagnosed with major depression (first or recurrent episode) followed by major depression with psychotic features then major depression with melancholic features. Victimized patients have significantly earlier age of onset of illness (28.69±12.88) than non-victimized patients (36.8±13.49) (*p*=0.003), with significantly longer duration of illness (8.09±9.50) in terms of years. There was no significant difference between the two groups in terms of the prescribed medications and scores for the Global Assessment of Function (GAF). The Clinical Global Impression (CGI) revealed a highly significant degree of illness severity in the victimized group, who reported being markedly ill or extremely ill compared to the non-victimized group (*p*=0.000) - see Table 2.

On comparing the clinical severity of depression via the HAM-D, the current study found that most of the victimized patients were severely depressed (92.3%) compared with 66.7% of the non-victimized group (*p*=0.002).

### **Profile of victimization**

All participants in the current study who reported having been victimized disclosed that they were exposed to emotional abuse, including being locked indoors, called bad names, emotionally threatened and devalued. Physical abuse was encountered in 58.3% in the form of hitting, kicking, slapping while 30.8% were exposed to miscellaneous victimization, including verbal assault, personal theft, sexual harassment and unwanted sexual activity (see Figure. 2, Table 3).

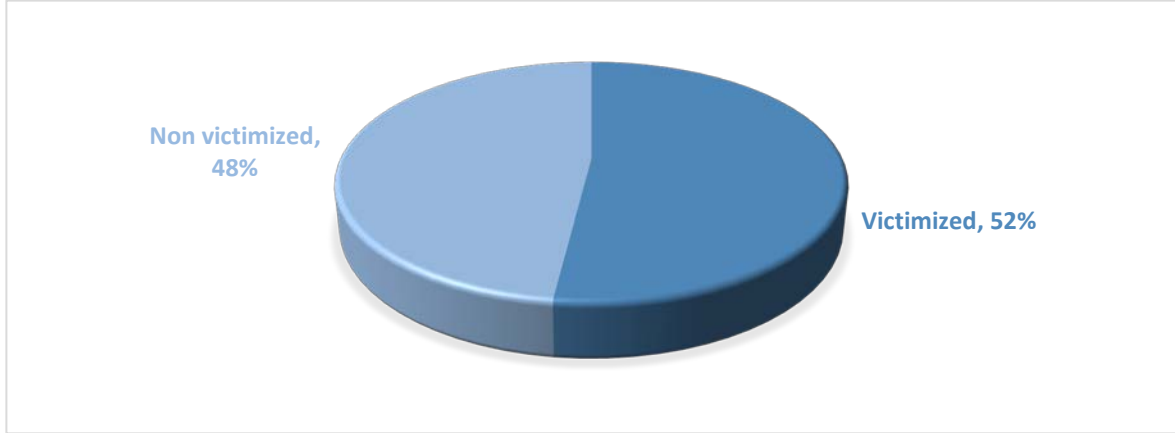
When studying participants' relationships with perpetrators, the results compiled in Table 3 show that emotional abuse was mainly inflicted by spouses in 57.7% of respondents followed by siblings (23%) and lastly by both parents and strangers (7.7%). As regards physical abuse, this was inflicted by acquaintances against 42.8% of respondents, strangers in the case of 28.6% and by either spouses or siblings for 14.3%. Finally, miscellaneous victimization was inflicted by acquaintances as reported by 75% of respondents with the remaining 25% experiencing such abuse by strangers.

The mean frequency of exposure to victimization during the past year was 9.76±3.58 for emotional abuse followed by physical abuse (5.23±5.56) with the least reported being miscellaneous abuse 1.53±3.18. Most participants who reported having been victimized did not report the occurrence of the abusive acts to anyone - whether friends,

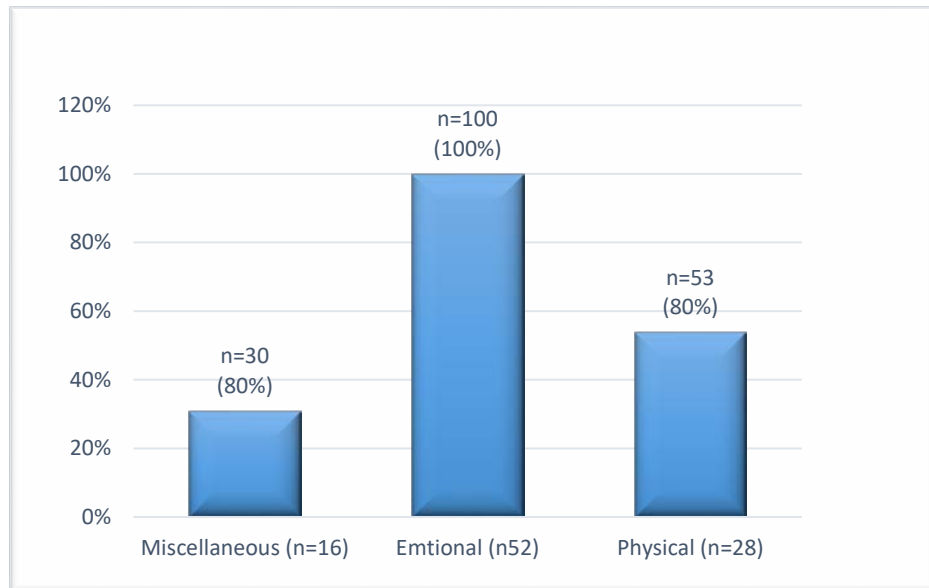
police or family members. The reasons for non-reporting varied. Some considered it a personal matter while others

felt it was not important or felt worried about repercussions from the offender.

**Figure 1.** Prevalence of victimization among patients with depression



**Figure 2.** Type of victimization among patients with depression



**Table 1.** Socio-demographic and family characteristics: victimized versus non-victimized patients

		Non-victimized (n=48)		Victimized (n=52)		Test	p-value	95% confidence interval	
		Mean±SD		Mean±SD				Lower	Upper
Age		40.75±11.72		38.92±10.58		t= 0.819	0.415	-2.60	6.254
Years of education		11.75±5.055		11.85±6.347		t=0.83	0.933	-2.386	2.193
		N	%	N	%				
Gender	Male	16	(33.30%)	4	(7.70%)	X <sup>2</sup> = 10.256	0.001		
	Female	32	(66.70%)	48	(92.30%)				
Marital Status	Single	12	(25%)	0	(0%)	X <sup>2</sup> =15.064	0.001		
	Married	32	(66.70%)	48	(92.30%)				
	Widowed	4	(8.30%)	4	(7.70%)				
Place of living	Rural	12	(25%)	8	(15.40%)	X <sup>2</sup> = 1.442	0.230		
	Urban	36	(75%)	44	(84.60%)				
Bullying at School	Negative	16	(33.30%)	16	(30.80%)	X <sup>2</sup> = .075	0.784		
	Positive	32	(66.70%)	36	(69.20%)				
Stability at work	Not working*	12	(25%)	36	(69.20%)	X <sup>2</sup> =22.988	0.000		
	Stable	28	(58.30%)	8	(15.40%)				
	Unstable	8	(16.70%)	8	(15.40%)				
Social class	High	4	(8.30%)	8	(15.40%)	X <sup>2</sup> =3.312	0.346		
	Middle	4	(8.30%)	8	(15.40%)				
	Low middle	12	(25%)	8	(15.40%)				
	Low	28	(58.30%)	28	(53.80%)				
Childhood abuse	Negative	32	(66.70%)	28	(53.80%)	X <sup>2</sup> = 8.120	0.044		
	Emotional	8	(16.70%)	4	(7.70%)				
	Physical	8	(16.7%)	16	(30.00%)				
	Sexual	0	(0%)	4	(7.70%)				
Domestic parental violence	Yes	4	(16.7%)	20	(38.5%)	X <sup>2</sup> = 12.421	0.000		
	No								
Family history of psychiatric illness	Negative	40	(83.30%)	36	(69.20%)	X <sup>2</sup> = 8.063	0.018		
	1 <sup>st</sup> degree relatives	8	(16.70%)	8	(15.40%)				
	2 <sup>nd</sup> degree relatives	0	(0%)	8	(15.40%)				
Family history of drug /alcohol abuse	Negative	48	(100%)	40	(76.90%)	X <sup>2</sup> =12.587	0.002		
	Abuse	0	(0%)	8	(15.40%)				
	Dependence	0	(0%)	4	(7.7%)				

\* Including students and housewives

**Table 2.** Clinical characteristics of victimized versus non-victimized patients

	Non-victimized n=48		Victimized n= 52		Test	p value	95% confidence interval	
	Mean±SD		Mean±SD				Lower	Upper
<b>Age of Onset</b>	36.8±13.49		28.69±12.88		t 3.08	0.003	2.7	13.37
<b>Duration of illness</b>	4.5±6.35		8.09±9.50		t -2.200	0.03	-6.825	-0.352
<b>GAF</b>	55.33±10.5		54.08±11.53		t 0.628	0.569	-3.106	5.619
<b>Number of episodes</b>	No	%	No	%	X <sup>2</sup> =28.152	0.000		
First	28	58.3	32	61.5				
Second	12	25	4	7.7				
Third	0	0	8	15.4				
Fourth	0	0	8	15.4				
More	8	16.7	0	0				
<b>Current Diagnosis</b>					X <sup>2</sup> =17.66	0.001		
MDD single or recurrent episode	36	75	28	53.8				
MDD with psychotic features	8	16.7	12	23.1				
MDD without psychotic features	4	8.3	0	0				
MDD with melancholic features	0	0	12	23.1				
<b>Medications Prescribed</b>					X <sup>2</sup> =0.641	0.463		
Antipsychotics with antidepressant	8	16.7	12	23.1				
Antidepressants	40	83.3	40	76.9				
<b>CGI impression</b>	No	%	No	%	X <sup>2</sup> = 35.668	0.000		
Moderately ill	16	33.3	4	7.7				
Markedly ill	20	41.7	36	69.2				
Severely ill	12	25	0	0				
Extremely ill	0	0	12	23.1				
<b>HAM-D</b>	No	%	No	%	X <sup>2</sup> =12.393	0.002		
Moderate	8	16.7	0	0				
Severe	8	16.7	4	7.7				
Very severe	32	66.7	48	92.3				

MDD: Major Depressive Disorder, GAF: Global Assessment of Functioning, CGI: Clinical Global Impression, HAM-D: Hamilton Depression Scale

**Table 3.** Profile of victimization

	Physical victimization n=28		Miscellaneous victimization n=16		Emotional victimization n=52	
	Mean±SD		Mean±SD		Mean±SD	
<b>Frequency of victimization</b>	5.23±5.56		1.53±3.18		9.76±3.58	
<b>Perpetrator</b>	No	%	No	%	No	%
Stranger	8	28.6	4	25	4	7.7
Spouse	4	14.3	0	0	30	57.7
Siblings	4	14.3	0	0	12	23
Parents	0	0	0	0	4	7.7
Acquaintance	12	42.8	12	75	2	3.8
<b>Reporting</b>	No	%	No	%	No	%
Yes	2	7	1	6	6	12
No	26	93	15	94	46	88
<b>Reasons for non-reporting</b>	No	%	No	%	No	%
Personal matter	14	50	4	25	22	42.3
Not important	0	0	0	0	6	11.5
Fear of offender	4	14.3	8	50	10	19.2
Dealt with another way	6	21.4	0	0	4	7.7
Offender prevent them	0	0	0	0	4	7.7
Others	4	14.3	4	25	6	11.6

## Discussion

The high rates of victimization among patients with mental illness compared to the general population have been documented by many researchers.<sup>28,29</sup> Prevalence rates of victimization ranged from 4.3% to 59%.<sup>7</sup> Earlier studies estimated victimization prevalence to vary from 16% to 92%.<sup>30</sup> Recently, de Vries *et al.*,<sup>31</sup> recorded victimization rates in patients with mental illness four to six times higher than in the general population.

The current study found that 52% of participants with major depression had been victimized in the previous 12 months. The variation of these rates could be explained by differences in methodology, study design, research population and operational definitions of victimization; moreover, the specific crime-victimization cannot easily be compared across studies. The current findings compared the demographic and clinical characteristics of patients who were victimized<sup>52</sup> with patients who reported no experience of victimization.<sup>48</sup>

### *Psychodemographic data*

In the present study, 53.8% participants identified as having low socio-economic status. This finding supports Passos *et al.*,<sup>7</sup> who posit a theoretical model whereby social disorganization and poverty increase a person's vulnerability to victimization.

Significant interactions between gender and victimization in patients with depression were reported by many researchers.<sup>32,33</sup> Women with mental illness were 1.7 to 3 times more likely to be victimized.<sup>14,34</sup> Women with a diagnosis of depression were more likely than men to report being subjected to physical or sexual assault.<sup>35</sup>

In the current study, 92.3% of victimized patients were women, which is consistent with Teplin *et al.*,<sup>36</sup> who collected separate data for men and women with mental illness who were victimized. The annual prevalence for men was 3% and for women 9.8%. The relative risk was significantly higher for women than men. Other studies have found that girls and women were more vulnerable to sexual victimization, whereas, boys and men were at a higher risk of physical victimization.<sup>37,38,39</sup>

Contrary to the above findings, a Swedish study reported that 3.7% of men and 0.5% of women with depression experienced violence.<sup>11</sup> Moreover, other studies suggested that men were more likely to be victimized than women.<sup>40,41</sup> The differences may be related to cultural issues. In Arab societies, women are the main victims of domestic violence.<sup>42,43</sup>

In the current research, 92% of victimized patients were married compared to 66.7% of the non-victimized patients. A previous study on patients with chronic depression found that approximately 17% of men and 12% of women reported exposure to physical abuse from their partners. The causal explanation for this finding is beyond the aim of the current study yet the authors with the hypothesis put forward by past researchers who attributed such findings to the fact that depressive symptoms predicted marital dissatisfaction, which in turn, predicted psychological and physical victimization.<sup>44</sup>

In the current study, the victimized group was significantly exposed to parental domestic violence and childhood abuse (as defined by the WHO, 1999)<sup>45</sup> which referred to all forms of emotional, physical and sexual abuse and neglect. A previous study showed that abuse experienced in childhood is associated with an increased likelihood of MDD in childhood or witnessing parental violence are frequent precursors of mental illness and vulnerability to victimization in adulthood.<sup>46,47,48,49,50</sup>

### *Clinical data*

Victimization of patients with depression was linked to the severity of depressive symptoms. The current study has documented how victimized patients were more likely to experience more severe symptoms of depression compared to the non-victimized group. This is consistent with the findings from a study of Dutch outpatients.<sup>34</sup>

The current study supports previous studies, which found that the severity of clinical symptoms (as measured by the CGI) was associated with a higher probability of being victimized.<sup>7,29</sup> Clinical explanations of vulnerability to victimization include poor social and occupational functioning, limited social network, comorbid personality disorder, poor problem solving and impaired cognitive functions.<sup>36,41</sup>

Victimization of patients with MDD is a serious problem that is underestimated and often goes unnoticed by clinicians. Indeed, it is rarely documented in the clinical record and seldom influences the treatment decision.<sup>29</sup>

### *Profile of victimization*

It was found that all victimized patients were subjected to emotional abuse, which was operationally defined as being locked indoors, being called bad names, receiving emotional threats and being devalued. The majority of the victimized group reported having been abused mainly by their partners or family members; 58.3% were exposed to physical victimization, which included hitting, kicking, slapping and being burned. Violent incidents were described as having been inflicted by acquaintances,

strangers and family members. Additionally, 30.8% were exposed to miscellaneous abuse, which included verbal assault, personal theft, sexual harassment, and unwanted sexual activity. The offenders were mainly acquaintances and strangers. In accordance with the current findings, numerous researchers have documented that perpetrators were mainly partners, family members or relatives.<sup>51,52</sup>

Some surveys in psychiatric settings in Egypt, Palestine and Tunisia have shown that between 30% to 50% of women were victimized by their husbands or another family member.<sup>53</sup> The reported experiences of emotional abuse in the current Egyptian sample is higher than that of physical abuse, which is not supported in Western studies. This may be explained by differences in emotional expression within Egyptian families, which includes excessive blame and harsh criticism.<sup>54</sup>

It can be suggested that people who are victimized might not report their experiences<sup>55</sup> or speak out about their experiences of abuse; moreover, there is still a common misconception that people with mental illness are unreliable informants about their life experiences. This misconception risks obscuring legitimate concerns about their experiences.<sup>51,56</sup> The current findings support studies that highlight this view; indeed, most participants in the current study did not report their experiences of abuse to anyone.

Non-reporting may be a phenomenon related to Arab culture as patients are often reluctant to report the crime to family members or police and can tend to deny or minimize the incidents even in clinical settings. Patients sometimes believe that disclosure of the incidents may be ineffective because they would likely be advised “to cope” in order to maintain their marital life and protect their children.<sup>43</sup> Patients with mental illness in Western communities are also less likely to report the victimization acts to police than other members of the community. This is supported in studies that suggest official prevalence rates of abuse are underestimated because many victims do not report these experiences to the police.<sup>37,57,58</sup>

Victimized patients were more likely to report psychosocial problems following an experience of abuse,<sup>2</sup> which may lead to serious consequences and re-victimization. From such findings, it is recommended that the management of victims should start with assertive engagement in health care.

## **Conclusion**

Despite the recorded high rate of victimization among patients with major depression the issue of abuse has received limited attention in Egypt.

Routine psychiatric interviews tend not to include questions about patient experiences of current or past abuse. And yet, most participants with mental illness in the current study reported having experienced abuse. Moving forward, prevention and intervention programs must be implemented to reduce victimization rates and measures taken to reduce the exposure and the likelihood of re-victimization. The current study highlights the importance of addressing such neglected issues especially in high-risk groups, such as married women with severe depression and low socio-economic status, in order to create support networks for timely intervention and more effective management to better support them.

## **Strength and Limitations**

To our knowledge, the current study is the first in Egypt to assess the abuse histories of patients with MDD and to understand their socio-demographic and clinical characteristics against a comparator group. It is understood to be the first study to explore types of abuse and to classify perpetrators. The findings highlight a vulnerable group within Egyptian society who would benefit from having greater support and protection.

Limitations of the current study include insufficient statistical power and a non-randomized methodology. The small sample size, single recruitment site and observational design limit the generalizability of the findings and the establishment of causality. The subjective reporting by patients might have introduced a recall bias. Nevertheless, preliminary findings strongly warrant a larger multisite study for better generalization of the findings.

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## المخلص

ان تعرض المرضى المصابين بالاكتئاب للايذاء مشكله خطيرة وغالباً ما يقلل من شأنها. هذا البحث يهدف إلى دراسة المتغيرات الاجتماعية والديموجرافية والخصائص الإكلينيكية المرتبطة بايذاء مرضى الاكتئاب مقارنة مع نظرائهم من غير الضحايا. اشترك في البحث مئة من المرضى المترددين على مركز الطب النفسي-جامعة عين شمس. وقد تم عمل المقابلة النفسية والتشخيص باستخدام دليل المقابلة الإكلينيكية المبنية على الدليل الأمريكي.

كما تم تقييم اعراض الاكتئاب باستخدام مقياس هاملتون وتقييم شامل للأداء والانطباع الإكلينيكي الشامل هذا إلى جانب تصميم استبيان للحصول على البيانات الديموجرافية وآخر تم تصميمه للكشف على الايذاء البدني والمعنوي واللفظي .

وجد ان 52% من المرضى تعرضوا للإيذاء وكانت الاغلبية من الاناث المتزوجات ولهن تاريخ للتعرض للعنف المنزلي واساءة المعاملة في الطفولة قد سجل المرضى اعلى درجات في مقياس هاملتون ووضحت الدراسة ان الاغلبية تعرضت للايذاء العاطفي يليه الايذاء البدني. **الخلاصة:** اثبتت هذه الدراسة مدى تعرض المرضى المصابين بالاكتئاب للايذاء بشكل كبير وبالتالي يجب ان يشتمل تقييم المرضى عما إذا كنتوا تعرضوا للايذاء من قبل او لا، ويوصي هذا البحث بضرورة وضع استراتيجيات مستقبلية لتوفير الحماية اللازمة للمرضى.

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## Depression, Medication Adherence and Quality of Life for Patients with Schizophrenia in Nigeria

Oladejo Teslim Alabi, Saka Saheed Abiola, Alao Irete Folasade

الاكتئاب والالتزام الطبي ونوعية حياة مرضى الفصام في المركز الطبي الاتحادي لوكوكا.

أولاديجو تسلم العبي، ساكا ، سعيد أبيولا، ألو ايريتي

### Abstract

**O**bjective: The current study assessed the influence of depression and medication adherence on the quality of life of people living with schizophrenia who attended the Federal Medical Center in Lokoja, Nigeria. **Method:** From 832 registered patients in the hospital, 287 were selected using a convenience sampling technique whereby potential respondents were approached individually on their clinic days. Three standardized psychological instruments were used: Morisky Medication Adherence Scale (MMAS-8), Calgary Depression Scale (CDSS), and the World Health Organization Quality of Life-Brief Scale (WHOQOL-BREF). **Results:** Data were analysed using simple linear regression. Results showed that 65.5% of participants had a moderate quality of life; 12.4% reported having a low quality of life; and, 21% reported having a high quality of life. Results also showed that depression had a significant influence on the quality of life of people living with schizophrenia ( $R^2=0.66$ ,  $F(1,285)=560.5$ ,  $p<.05$ ). Medication adherence had a significant influence on the quality of life of people living with schizophrenia ( $R^2=0.66$ ,  $F(1,285)=560.5$ ,  $p<.05$ ). **Conclusion:** Depression and medication adherence can have a direct influence on the quality of life and well-being of people living with schizophrenia, which is an important consideration when supporting patients to be compliant with their prescribed treatment regime.

**Keywords:** Quality of life, Depression, Schizophrenia, Medication adherence

**Declaration of interest:** None

### Introduction

All aspects of life for a patient with schizophrenia can be affected by this severe illness; this may include work, self-care and capacity to establish interpersonal relationships.<sup>1</sup> Though schizophrenia is a mental illness that affects about 1% of the world's total population, Adegbaaju reported that about 50% of people with the diagnosis do not have access to treatment and 30% live in developing countries like Nigeria.<sup>2</sup> It is therefore pertinent and important to investigate depression in patients with schizophrenia and their adherence to medication with a view to understanding the extent to which depression and medication adherence could contribute to the quality of life of patients with schizophrenia in Nigeria.

#### *Schizophrenia as a disorder*

Schizophrenia is a psychiatric disorder characterized by positive symptoms (delusions and hallucinations), negative symptoms (apathy, withdrawal, paucity of thought and restriction of affect), disorganization symptoms (disorganized thoughts and actions),<sup>3</sup> and cognitive impairment (memory, attention, working memory, problem solving, processing speed and social

cognition). It is a devastating psychiatric disorder that afflicts approximately 1% of the worldwide population. The condition affects women and men equally and spans all socioeconomic groups.<sup>4</sup> Like any other disability/disorder that affects normal human life, schizophrenia has its attendant emotional/affective breakdown and side effects too, such as low self-concept, depression, social withdrawal, etc. All of these can take their toll on the patient's life and therefore schizophrenia is managed medically to enable patients to live a normal life. In developing countries like Nigeria it is often the case that people with schizophrenia do not have access to treatment. It is also important to know the extent to which adherence to medication is affecting those that have access to treatment in developing country like Nigeria. The quality of life of patients with schizophrenia is said to have an influence on their emotional state, personality type, adaptation and treatment outcome.<sup>5</sup>

#### *Patients with schizophrenia and medication adherence*

Medication adherence is essential for people with schizophrenia. Pharmacotherapy is the mainstay for managing this chronic and often disabling condition. Nevertheless, non-adherence to antipsychotic medication

is common in clinical practice and affects approximately 50% of outpatients with schizophrenia.<sup>6</sup> Many disease-related, patient-related, treatment-related and environmental factors may influence adherence in schizophrenia.<sup>7,8</sup>

Among the variables most consistently found to predict adherence to antipsychotic medication are illness insight,<sup>7,8</sup> the severity of psychopathology,<sup>7</sup> cognitive impairments,<sup>9</sup> attitudes toward medication,<sup>7</sup> substance misuse,<sup>10</sup> antipsychotic side-effects,<sup>11</sup> and the quality of the therapeutic relationship.<sup>12</sup>

Despite the view that medication adherence in schizophrenia is high after hospital discharge, the transition to home-based treatment may be complicated, especially for those individuals who lack family or social support.<sup>13</sup>

Shuler examined the prevalence of schizophrenia and the social factor of the disease.<sup>14</sup> Afolayan *et al.* found a significant improvement in medication adherence in the pharmacological studied group; however, quality of life and symptoms did not improve.<sup>15</sup> The study suggested that non-adherence to medication might affect the patients' quality of life indirectly via symptom severity and medication side effects.<sup>16</sup> The study also revealed that treatment strategies involving patients can improve medication adherence, symptoms and quality of life for people with schizophrenia. Further, nursing interventions that contain supervised self-care, behavioral activation, social skill training, relaxation training, and psycho-educative intervention might minimize the associated disability although this needs to be validated.<sup>17</sup>

Recently, research conducted on the effectiveness of psychiatric nursing interventions pertaining to medication adherence and quality of life in patients with schizophrenia found no significant correlation between quality of life and medication adherence.<sup>18</sup> Findings also demonstrated that after one month post discharge from the hospital, 32.5% of patients showed high treatment adherence; however, six months after discharge adherence rates dropped to 16.7%.<sup>19,20</sup> Research showed that treatment adherence in the first month was very low, but application of telemedicine monitoring systems improved the compliance in patients with the worst compliance records. Empirical studies reported that the level of medication adherence for antipsychotic treatment ranged from 20.0% to 70.0%.<sup>21,22</sup>

### **Schizophrenia and depression**

Schizophrenia and depression have historically been regarded as separate disorders. It is well recognized that depressive symptoms are common in schizophrenia

during the development of the illness.<sup>23,24</sup> These symptoms may occur during the pre-psychotic or prodromal phase; during initial episodes of schizophrenia in chronically ill patients and even in patients who have been stabilized on treatment.<sup>25,26,27,28</sup>

In a substantial number of patients, these symptoms are severe enough to qualify for diagnosis of depression as per standard diagnostic criteria.<sup>29</sup> Depression is one of the psychopathological factors that is assumed to affect a person's quality of life. A common and serious medical illness negatively effects how the patient feels, thinks and acts. Globally, the total number of people with depression is estimated to be 4.4% of a given population and it was estimated to exceed 300 million worldwide in 2015. It is more common among women than men and is the major contributor to suicide deaths, which number close to 800,000 per year.<sup>30</sup> Therefore, depression was investigated in the current study because diagnosis and treatment is seen to be important when considering the well-being of people with schizophrenia not least because symptoms likely affect their quality of life impairing functional capacity and resulting in physical and emotional limitations.

Previous finding showed that negative symptoms were found to positively correlate with depression in stable patients with chronic schizophrenia.<sup>31,32</sup> As the duration of the illness increases, anxiety and depression increase, leading to decreased quality of life.<sup>33</sup> Studies reported that major depressive disorder is associated with lower scores on the aspects of overall quality of life and health satisfaction. Further, untreated depression and anxiety can produce negative effects on a patient's control of symptoms, his/her ability to make treatment decisions, compliance with treatment, social interaction, and quality of life.<sup>34</sup>

### **Study aims**

The current study assessed the quality of life of people living with schizophrenia. The specific objective was to examine the influence of depression and medication adherence on the quality of life of people living with schizophrenia and the relationship between depression, medication adherence.

### **Hypotheses**

- There will be no significant influence of depression on quality of life of patients with schizophrenia.

- There will be no significant influence of medication adherence on the quality of life of patients with schizophrenia.
- There will be no significant relationship between depression, medication adherence and quality of life among people living with schizophrenia.

## Design

A cross-sectional survey design was used to examine the above hypotheses. Out of a population of N=832 people with schizophrenia who were registered outpatients and attended the psychiatry clinic of the Federal Medical Centre in Lokoja,  $n=287$  participants were selected for the study following the Yamane formula for determining sample size. Participants in the outpatients' department were screened by Consultant Psychiatrists using the International Classification of Diseases – Tenth Edition (ICD-10) for the diagnosis of schizophrenia. After identifying eligible individuals through interview and reviews of previous notes, the instruments were administered individually to respondents by the researchers on their clinic days.

Ethical approval was obtained from the Research Committee of the Federal Medical Center Lokoja in the Kogi State of Nigeria.

### *Inclusion criteria*

- All patients in the age group 20 to 65 years who with a diagnosis of schizophrenia, according to ICD-10 criteria;
- clinically stable;
- provided consent to participate in the current study.

### *Exclusion criteria*

- Patients with significant medical or neurological illness;
- With schizoaffective disorder and pharmacological or otherwise ant-depressive treatment;
- had mental disability;
- met criteria for drug dependence and addiction;
- had a history of inpatient admission six months prior to assessment;
- had duration of illness of less than two years.

## Instruments

The Morisky Medication Adherence Scale (MMAS-8): developed by Morisky. This screened for non-adherence in patients with several chronic conditions. It consisted of

eight items, of which seven were to be answered negatively and the eighth positively, with the last question being answered according to a scale of five options: never, almost never, sometimes often and always. Response choices are “yes” or “no” for items 1 through 7 and item 8 has a five-point Likert response. Each “no” response scored 1 point and each “yes” response scored 0 except for item 5, which ensured that each “yes” response was rated as 1 and each “no” response rated as 0. For item 8, the code (0-4) was standardized by dividing the result by 4 to calculate a summated score.

### *Calgary Depression Scale (CDSS)*

The CDSS was designed to measure depression in patients with schizophrenia. It initially consisted of eleven items, but was reduced to nine items in response to validity studies.<sup>35</sup> The nine assessment items are (1) depression, (2) hopelessness, (3) self-depreciation, (4) guilty ideas of reference, (5) pathological guilt, (6) morning depression, (7) early wakening, (8) suicide, and (9) observed depression.

### *World Health Organization Quality of Life-BREF Scale (WHOQOL-BREF)*

Developed by World Health Organization, it is a short form of the WHOQOL-100. WHOQOL-BREF comprises 26 questions from four domains: physical health, psychological health, social relationships, and environment. The social domain contains three items and the environmental domain contains eight items. The response scale is a five-point Likert scale, ranging from ‘very low’ (0), ‘low’ (1), ‘neutral’ (2), ‘high’ (3) and ‘very high’ (4) scores. Scores on the different domains are transformed into scales to compare between the domains due to the unequal number of items.

## Data analysis

Analysis was carried out via the Statistical Package for Social Science version 22 (SPSS 22.0).

**Result**

**Table 1.** Level of quality of life for people living with schizophrenia (N=287)

Variable	Levels	Score-range	Frequencies	Percentage (%)
Quality of life	Low	25-34	36	12.4
	Moderate	35-49	189	65.6
	High	50-61	62	21

Source: Author’s Field Survey (2018)

Table 1 indicates that  $n=36$  (12.4%) of the respondents had low quality of life while  $n=189$  (65.6%) of the respondents had average quality of life and  $n=62$ (21%) of respondents had a high quality of life. The level of quality of life was determined by one standard deviation above ( $\bar{x} + 1SD$ ) and below ( $\bar{x} - 1SD$ ) the mean as the cut-off points. The mean was 41.9 with standard deviation of 8.01. One standard of deviation above the mean was  $41.9+8.01= 49.91$ ; that is, approximately a score of 50. One standard deviation below the mean was  $41.9-8.01=33.89$ ; that is approximately a score of 34. Thus,

respondents with scores of 50 to 61 were categorized as having high quality of life while those with scores of 35 to 49 were regarded as having moderate quality of life and those with scores in the range of 25 to 34 were regarded as having poor level of quality of life. These were then used to categorize the respondents into the groups outlined above.

**Hypothesis One: There will be no significant influence of depression on the quality of life of people with schizophrenia.**

**Table 2a.** Simple linear regression analysis showing influence of depression on quality of life among of people with schizophrenia

Model	Sum of Squares	Df	Mean Square	R <sup>2</sup>	F	p-value
Regression	510.460	1	510.460		8.152	0.05
Residual	17845.317	285	62.615	0.28		
Total	18355.777	286				

**Table 2b.** Coefficient of simple linear regression analysis

Variables	B	SE	$\beta$	T	p-value
(Constant)	45.140	1.204		37.498	0.00
Depression	-.221	.078	-.167	-2.855	0.05

(R<sup>2</sup>= 0.28, F(1,285) =8.152,  $p<.05$ )

The hypothesis was tested with the linear regression. The result of data analysis is summarized in Tables 2a and 2b, which show that depression accounted for 28% of the variance in quality of life and depression significantly predicted quality of life in people with schizophrenia attending the Federal Medical Centre in Kogi State ( $R^2=0.28$ ,

$F(1,285)=8.152, p<.05$ ). Therefore, the hypothesis that there will be no significant influence of depression and mediation adherence on quality of life for people with schizophrenia has been rejected.

**Hypothesis Two: There will be no significant influence of medication adherence on quality of life for patients with schizophrenia.**

**Table 3a.** Simple linear regression analysis showing the influence of medication on quality of life for patients with schizophrenia

Model	Sum of Squares	Df	Mean Square	R <sup>2</sup>	F	p-value
Regression	12169.056	1	12169.056		560.5	0.05
Residual	6186.721	285	21.708	0.66		
Total	18355.777	286				

**Table 3b.** Coefficient of simple linear regression analysis

Variables	B	SE	$\beta$	T	p-value
(Constant)	13.439	1.236		10.872	0.00
Medical Adherence	1.076	.045	0.81	23.677	0.05

( $R^2= 0.66, F(1,285) =560.5, p<.05$ )

Hypothesis Two was tested with the linear regression. Data analysis is summarized in Tables 3a and 3b, which show that medication adherence accounted for 66% of the variance in quality of life and that it significantly influenced quality of life of patients with schizophrenia in Kogi State ( $R^2=0.66, F(1,285)=560.5,=0.81, t=23.677, p<.05$ ). Therefore, the hypothesis which stated

that there will be no significant influence of medication adherence on the quality of life of people with schizophrenia was rejected.

**Hypothesis Three: There will be no significant relationship between depression, medication adherence and quality of life among people living with schizophrenia.**

**Table 4.1** Inter-correlational matrix showing the relationships with depression, medication adherence and quality of life among people living with schizophrenia

	Variables	Mean(SD)	1	2	3
1	Depression	14.31(6.03)	1		
2	Medication adherence	26.52(6.06)	-.173**	1	
3	Quality of Life	41.97(8.0)	-.167**	.814**	1

Note: \*\* Correlation is significant at the .05 level (2-tailed)

Table 4.1 describes an inter-correlational matrix showing the relationship of the variables. Results showed that there is a non-significant relationship between depression and quality of life ( $r=-0.167$ ). Further, a positive significant relationship between medication adherence and quality of life ( $r=0.814$ ) was found. This suggests that depression and medication adherence play a significant role in the quality of life of people living with schizophrenia. Therefore, the hypothesis which states that there will be no significant relationship between depression, medication adherence and quality of life for people living with schizophrenia is rejected.

## Discussion

The main purpose of the current study was to examine the influence of depression and medication adherence on the quality of life of patients with schizophrenia attending the Federal Medical Centre in Kogi state. Results revealed that medication adherence and depression significantly influenced the quality of life of patients with schizophrenia.

Quality of life was classified into three levels: low, moderate and high. In the current study, 12.4% of respondents reported having a low quality of life while 21% reported having a high quality of life. The majority (65.6%) reported having a moderate quality of life. This finding suggests that a significant number of people with schizophrenia experience a moderate quality of life. It might be assumed that these patients adhered to their medication, which may also explain the lower depression levels that, in turn, positively affect their quality of life.

The primary objective of the current study was to assess patients with schizophrenia on the extent to which depression influenced their quality of life. Findings indicated that depression significantly influenced the quality of life of people with schizophrenia, which highlights the role of depression in reducing quality of life for people with the condition. It follows that if depression symptoms can be well managed, patients with

schizophrenia will likely experience an improved quality of life.

This finding supported Ganu *et al.* who found a significant correlation between depression and overall quality of life, e.g, 19% of long-term hemodialysis patients were depressive and showed low scores on quality of life.<sup>36</sup> The finding was similar to another study in which 30% of primary care patients reported having depressive symptoms and these symptoms were significantly associated with all aspects relating to their quality of life. The study concluded that severity of depressive symptoms reduced quality of life.<sup>37</sup>

Findings in the current study are also similar to those of Marcelo *et al.* who reported that depressive patients have quality of life deficits that are directly attributable to mood disturbance. The degree of detriment to quality of life is proportional to the severity of depressive symptoms and the negative relations between depression and quality of life is as great as (or worse) than that observed in medical disorders such as rheumatoid arthritis and diabetes.<sup>38</sup>

The secondary objective of the current study was to examine the influence of medication adherence on quality of life for patients with schizophrenia. Findings indicated that medication adherence can significantly influence the quality of life for patients with the condition. The importance of adherence to treatment using the medication as prescribed was supported in the current study, which also identified that attending hospital during the clinical days contributed to improved quality of life and wellbeing; such adherence is important given that many chronic mental health conditions, such as schizophrenia, involve long-term use of medication.

The current findings are also similar to Ahmad *et al.* who reported that a higher adherence intention contributed to improved quality of life among patients with epilepsy.<sup>39</sup> Similarly, this relates to Hommel *et al.* who reported an inverse relationship between 5-ASA adherence and quality of life in children with pediatric inflammatory bowel disease.<sup>40</sup> This was supported in Julian *et al.* who examined the relationship between depression and

medication adherence and established that severity of depression was a strong predictor of adherence difficulties among patients with Systemic Lupus Erythematosus.<sup>41</sup> A similar association between depression and medical adherence was found in outpatients with coronary heart disease.<sup>42</sup>

The final objective of the current study was to determine if there was any significant relationship between depression, medication adherence and quality of life in patients with schizophrenia. Current findings confirmed that there is a positive correlation in that when medication adherence is high, the quality of life will improve; likewise, when depression symptoms are mild the quality of life will also improve. This finding was similar to Marion *et al.* who established the relationship between depression, olfaction and quality of life.<sup>43</sup> Also Jannuzzi *et al.*, who established the relationship between medication adherence and quality of life among elderly people with diabetic retinopathy.<sup>44</sup>

### Limitations

Firstly, it may be argued that the current findings are relevant to the study setting. The sample size was relatively small and drawn from one health facility in Kogi State. Thus, generalizability of the findings is less achievable. Secondly, the data collected were based on self-report, which will reflect participant recall bias. Thirdly, the attitude of respondents toward completing the questionnaire proved challenging. Participants often described being too busy to complete these.

### Conclusion

Findings from the current study indicated that depression and medication adherence not only significantly influenced a patient's quality of life, but also have significant relationships with the quality of life of patients with schizophrenia attending the Federal Medical Centre in Kogi state.

### Ethics

Ethical approval was applied for and obtained from the Federal Medical Center Lokoja Research Committee. The current study was done in accordance with the institutional and national research committees' procedure and guidelines. All procedures in the current study involved human participation.

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## المخلص

قيمت هذه الدراسة تأثير الاكتئاب والالتزام الطبي على نوعية حياة الأشخاص الذين يعيشون مع مرض انفصام الشخصية في المركز الطبي الاتحادي في لوكوجا. تم استخدام البيانات الأولية للدراسة. تم جمع البيانات من المرضى المسجلين من مرض انفصام الشخصية في المركز الطبي الاتحادي Lokoja في ولاية كوجي. تكونت العينة من 287 مريضاً تم جمعهم من إجمالي عدد 832 مريضاً مسجلاً في المستشفى باستخدام حجم عينة من تركيبة تارو اليمينية. تم تبني تقنية أخذ العينات المريحة ، حيث تم الاتصال بالمستجيبين المحتملين المتاحين بشكل فردي في أيام العيادة الخاصة بهم. ثلاثة أدوات نفسية موحدة هي: مقياس التزام الدواء Morisky (MMAS-8) الذي طورته Morisky (1986) ، مقياس كالغاري للاكتئاب (CDSS) طورته Addington و Schissel (1990) و مقياس جودة الحياة في منظمة الصحة العالمية (WHOQOL-BREF) التي وضعتها منظمة الصحة العالمية ، (1998) استخدمت لجمع البيانات من المستجيبين. تم تحليل البيانات التي تم جمعها باستخدام الانحدار الخطي البسيط. أوضحت النتائج أن غالبية المشاركين لديهم مستوى معتدل من نوعية الحياة (65.6٪) في حين أن 12.4٪ لديهم مستوى منخفض من نوعية الحياة ، و 21٪ لديهم مستوى عالي من جودة الحياة. وأظهرت النتائج أيضاً أن الاكتئاب له تأثير كبير على نوعية الحياة من الأشخاص الذين يعيشون مع مرض انفصام الشخصية ( $F(1, 285) = 560.5$  ،  $P < 0.05$ ). وأظهرت النتيجة أيضاً أن الانضمام الطبي له تأثير كبير على نوعية حياة الأشخاص الذين يعيشون مع مرض انفصام الشخصية ( $F(1, 285) = 560.5$  ،  $P < 0.05$ ). وأظهرت النتائج أيضاً العلاقة بين الاكتئاب (ص = -0.167)، والتمسك الطبية (ص = 0.814)، على نوعية حياة الأشخاص الذين يعيشون مع مرض انفصام الشخصية. خلصت الدراسة إلى أن الاكتئاب والالتزام الطبي لهما أهمية كبيرة في التأثير على نوعية حياة مرضى الفصام في المركز الطبي الفيدرالي ، لوكوجا.

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## Patterns of Smartphone Use among University Students in Jordan

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### أنماط سلوك استخدام الهاتف الذكي بين طلاب الجامعات في الأردن

محمد أبو صليح، يوسف صالح خضر، باسل عمارنة، محمد البحيبي، نايل طلال العدوان

#### Abstract

**B** **background:** The intimate contact people have with smartphones has a strong impact on behavior and on the physical and psychological well-being of those who use them. **Aim:** The current study described smartphone usage patterns and practices among university students in Jordan. **Methods:** A random sample of N=1005 students ( $n=412$  men;  $n=593$  women) were recruited to the study. All participants were registered in the health faculties at the Jordan University of Science and Technology (JUST) for the second semester of the academic year 2016/2017. N=918 participants ( $n=541$  women,  $n=377$  men;  $M=19.8$ ,  $SD=1.6$  years) completed a two-part questionnaire. Part one assessed demographic data; the second surveyed smartphone usage. Independent *t*-test and one-way ANOVA were used to test the significance of differences between means. **Results:** A total  $n=547$  (59.6%) students reported spending less than five hours on the smartphone daily,  $n=371$  (40.4%) reported spending more than five hours. About three-quarter of students (70.7%) reported checking their smartphone every 30 minutes or more. The mean (SD) of daily time spent on smartphones in terms of hours was 5.9 (3.7); these means were found to be statistically different according to gender, age and years of education while having an internet package did not impact the daily time use. **Conclusions:** Findings support the view that smartphone usage is increasing among university students in Jordan. Communicating with family and friends followed by searching for information and checking social media were the most commonly described uses. The most common situational factor for using smartphones was boredom.

**Key words:** Smartphone use, Nomophobia, Smartphone addiction

**Declaration of interest:** None

#### Introduction

New technologies and social networking, especially smartphones, have become important tools to communicate and interact with others. The intimate contact people have with smartphones has a strong impact on behavior and on the physical and psychological well-being of the people using them. It was suggested that smartphone over use predisposes to musculoskeletal, ophthalmic, psychiatric and neurological complications that might impair the quality of life and present a burden on both individuals and society in terms of morbidity, productivity, and economic costs.<sup>1-15</sup>

The use of mobile phones is spreading in an accelerated manner. The World Bank reported that in 2016 there were 7.512 billion mobile cellular subscriptions compared to 7.184 billion in 2015 with a 4.34% growth.<sup>16</sup> According to the EWZOO global mobile market report in 2017, there were 2.8 billion active smartphones in use that year. By 2020, it has been estimated that there will be 3.6 billion smartphone users worldwide, which would be a 28.6% increase compared to the number of users in 2017.<sup>17</sup>

In Jordan, smartphone usage is considerably high and increasing where the number of mobile phone subscribers increased from 8.9 million in 2012 to 16.7 million in 2016, and the increase in the number of internet subscribers from 1.8 million in 2014 to reach around 9 million in 2016.<sup>18</sup>

Reports showed that around two-thirds of the Jordanian population own at least one smartphone and 93% of the social media accounts in Jordan access the internet daily.<sup>19-22</sup>

Surveys that describe patterns and practices of smartphone usage are lacking in Jordan. Describing the patterns and practices of smartphone usage among university students is important because overuse is identified as a possible risk factor for several physical and mental health issues,<sup>1-15</sup> and it may contribute to decline in the student's academic performances due to the wasted time; also, it would help to highlight the main purpose of use and the situations where smartphones are being used. This should help decision makers in their effort to regulate and improve student usage of smartphones.

Therefore, the current study was conducted to describe the patterns and practices of smartphone usage among university students in Jordan.

## **Methods**

### ***Study population***

A convenience sample of N=1005 students was selected randomly from those registered in the health faculties at the Jordan University of Science and Technology (JUST) for the second semester of the academic year 2016/2017. A total N=918 participants completed the questionnaire ( $n=541$  women,  $n=377$  men; mean=19.8, SD1.6 years). Of those,  $n=227$  were medical students,  $n=121$  were dental students,  $n=162$  were pharmacy students,  $n=237$  were nursing students and  $n=171$  were applied medical sciences students.

### ***Ethics***

All students provided informed consent. The study was approved by the Human Research Ethics Committees of the Jordan University of Science and Technology (JUST).

### ***Measures***

A questionnaire of two parts was constructed:

#### ***Socio-demographic characteristics scale***

The first part included information about socio-demographic characteristics; namely, age, gender, year of study, major and college.

#### ***Smartphone usage characteristics***

The second part of the questionnaire collected information about the characteristics of smartphone usage and included smartphone possession duration, having internet

packages, the average daily time spent using smartphones, frequency of checking a smartphone, number of daily phone calls made/received, number of daily text messages sent/received, number of daily email messages sent/received, number of applications on the smartphone, purposes of smartphone usage, a situations where the smartphone is used.

### ***Data collection***

Permission was obtained from lecturers to collect the data from students in the class. The researcher visited students in their classes and invited them to participate in the study. The researcher and lecturer assured participants that their involvement in the study was purely voluntarily. On average, students took approximately 15-20 minutes to complete the questionnaire. Data collection was conducted in October 2017.

### ***Statistical analysis***

The characteristics of the respondents were described using means and standard deviations for quantitative variables. Qualitative variables were described using percentages. Independent *t*-test and one-way ANOVA were used to test the significance of the differences between means.

## **Results**

### ***Participant characteristics***

The current study involved N=918 students from the health faculties at JUST who were aged between 17 and 26 years old ( $m=19.8$ ,  $SD=1.6$  years). Their demographic and relevant characteristics are shown in Table 1. Almost one quarter (25.9%) of participants were first-year students, 25.3% were second-year students, 17.4% were third-year students, and 31.3% were fourth to sixth-year students.

**Table 1.** Demographic characteristics of participants

Characteristics	n	%
<b>Age (year)</b>		
<20	470	51.2
20+	448	48.8
<b>Gender</b>		
Male	377	41.1
Female	541	58.9
<b>College</b>		
Medicine	227	24.7%
Dentistry	121	13.2%
Pharmacy	162	17.6%
Nursing	237	25.8%
Applied Medical Sciences	171	18.6%
<b>Years of Education</b>		
First	238	25.9
Second	233	25.4
Third	160	17.4
Fourth or higher	287	31.3

**Smartphone usage characteristics**

All students reported using a smartphone. The mean (SD) duration of smartphone ownership was M=4.1,SD=1.4 years. About two-thirds (61.8%) of students owned a smartphone for a period of more than four years (Table 2).

The majority (81.7%) had reported having an internet data package. Table 3 describes the use of mobile phone services in terms of number of certain services per day.

**Table 2.** Univariate analysis of variance of the total time spent on smartphones daily with each of the characteristics

Characteristic	Mean	Standard error	95% confidence interval
<b>Gender</b>			
Male	5.2	0.184	(5.15-5.88)
Female	6.2	0.166	(5.85-6.50)
<b>Age category</b>			
Less than 20	5.50	0.153	(5.20-5.80)
20 years and more	6.34	0.195	(5.95-6.72)
<b>Years of education</b>			
First	5.3	0.225	(4.8-5.7)
Second	5.8	0.205	(5.4-6.2)
Third	6.5	0.328	(5.88-7.2)
Fourth or more	6.2	0.243	(5.75-6.7)
<b>Having internet package</b>			
Yes	6.0	0.150	(5.7- 6.3)
No	5.6	0.334	(5.0-6.3)

**Daily time spent on smartphone**

The mean (SD) of daily time spent on a smartphone was M=5.9, SD=3.7 hours. Only one respondent reported spending less than one hour on a smartphone daily. A total of n=238 (25.9%) students reported spending between one to three hour on smartphones daily; n=308 (33.6%) reported spending between three to five hours on smartphones daily; n=158 students reported spending between five to seven hours on smartphones daily (17.2%) and the rest (23.2%) reported spending more than seven hours. Women were found to use their smartphones more than men (5.5 hours for men compared to 6.2 hours for women. The younger the student the less the daily time spent on Smartphone).

**Smartphone checking**

About 21% of students reported checking their smartphone at a frequency of once or more within 10 minutes while one third (30.7%) of students reported checking their smartphone once every 20 minutes. About

three-quarter of students (70.7%) reported checking their smartphones once or more every 30 minutes while the rest of the students (29.3%) reported checking their smartphones less than one time every 30 minutes.

**Purpose of smartphone usage**

The most common use of smartphones was for communicating with family and friends by either texting or calling (93.1%). The second most common use was searching for information on the internet (92%). About 90.1% of students reported using the mobile for checking social media and only half of the students reported using a smartphone for scheduling meetings and events. Women reported using a smartphone to pass the time and take study notes more than men, 82.8 % and 78.6% compared to 74.8% and 65.4%, respectively. Around half (54.8%) of men reported using a smartphone for gaming compared with 45.8% of women for the same purpose. Almost three quarters (73.1%) of the students reported using smartphones for studying purposes (see Table 3).

**Table 3.** The different uses of smartphone by participants

Smartphone use	Men n (%)	Women n (%)	Total n (%)
Communication with family and friends	351 (93.1)	504 (93.2)	855 (93.1)
Searching for information on the internet	337 (89.4)	508 (93.9)	845 (92.0)
Checking social media	335 (88.9)	492 (90.9)	827 (90.1)
Listening to music	307 (81.4)	439 (81.1)	746 (81.3)
Passing time	282 (74.8)	448 (82.8)	730 (79.5)
Taking studying notes	246 (65.4)	425 (78.6)	671 (73.1)
Getting news	264 (70.0)	382 (70.6)	646 (70.4)
Checking email	268 (71.7)	357 (66.0)	625 (68.1)
Scheduling meetings and events	195 (51.7)	281 (51.9)	476 (51.9)
Gaming	207 (54.9)	248 (45.8)	455 (49.6)
Other	54 (7.4)	40 (7.4)	94 (10.2)

**Situations of smartphone usage**

Although the most common situation in which smartphone were used was while feeling bored (91%), this was followed by using it when feeling alone (84.2%), half of the students reported smartphone use even when they were in the company of others. Women reported using

smartphones when they were alone, felt bored, were on public transportation or were between lectures more than men. Compared to women, men reported higher usage in the following situations: when in the toilet (42.4% vs. 32.5%), while driving (21.8% vs. 14.2) and while eating (33.7% vs. 28.2) see Table 4.

**Table 4.** Situations where smartphone is being used

Situations where smartphone is being used	Men n (%)	Women n (%)	Total N (%)
When bored	333 (88.3)	502 (92.8)	835 (91.0)
When alone	301 (79.8)	472 (87.2)	773 (84.2)
On public transportation	268 (71.7)	439 (81.1)	707 (77.0)
Between lectures	264 (70.0)	422 (78.0)	686 (74.7)
While talking to somebody	186 (49.3)	296 (54.7)	482 (52.5)
While hanging out with friends	179 (47.5)	246 (45.5)	425 (46.3)
While watching TV	129 (34.2)	214 (39.6)	343 (37.4)
In the toilet	160 (42.4)	176 (32.5)	336 (36.3)
During a class	120 (31.8)	192 (35.5)	312 (34.0)
In eating time	127 (33.7)	153 (28.3)	280 (30.5)
While driving	82 (21.8)	77 (14.2)	159 (17.3)
<b>Other</b>	33 (8.8)	34 (6.3)	67 (7.3)

## Discussion

The use of smartphones among university students is popular in Jordan. Advanced features on many smartphones are attracting them more and more and providing both a constant entertainment and instant connection tool. The smartphone is considered by some students as an intimate friend with which they spent most of their time. The use of smartphones to search for information and to check social media is becoming most popular after its use as a method to communicate with family and friends.

Although the electronic mode of learning supported by smartphones is still not popular in Jordan, almost three-quarters of the students reported using a smartphone for studying purposes.

Gender effect on daily time spent on a smartphone has been studied among the general population in Germany confirming that women tend to use smartphones for longer periods than men, with a mean of daily time spent on a smartphone of 2.8 hours vs. 2.5 hours.<sup>22</sup> Past studies showed that women spend more time on WhatsApp and Facebook than men do.<sup>23</sup> Previous findings support the present findings of women spending more time on a smartphone on a daily basis than men. This gender effect might reflect the gender restriction in Arab communities whereby women are more likely to be limited from participating in outdoor activities and events, which may lead to increased smartphone use to compensate.

In the current study, the majority of students reported using their smartphone when feeling lonely, bored or

alone, which interacts with many mental health issues characterized by isolation and loneliness, such as depression, anxiety, and sleep disturbance. This raises a concern about underlying psychiatric problems, which highlights the need to assess students for mental health issues that are either the cause of or caused by excessive smartphone usage.

Compared with trends in smartphone use in countries in the region (the Kingdom of Saudi Arabia 90%, United Arab Emirates 74%), students in Jordan reported a much lower rate (17%) of smartphone use while driving, which might reflect strict driving laws and penalties, close surveillance systems, and effective awareness campaigns to limit this kind of risky behavior.<sup>25,26</sup>

Moreover, concerns about both nosocomial and oral infections were raised, as the percentage of students reported using a smartphone while in toilets or while eating was 36.6%, 30.5% respectively. It is important to consider previous research that reported bacterial contamination of students' smartphones at rates of 96.2% (in KSA)<sup>27</sup> and 94.6% (in Nigeria).<sup>28</sup>

## Conclusion and Recommendations

The current findings suggest that smartphone usage is increasing among university students in Jordan. The commonest use of mobile phones was communicating with family and friends followed by searching for information on the internet and checking social media. The most common reason for smartphone use was boredom.

There is a need to broaden the research on trends in smartphone usage. A study assessing a wider range of ages could be informative since the affinity to adapt, use, and explore smartphone services and applications will likely differ between generations.

Studying the financial cost of smartphone usage and the rate of changing the device as well as acquiring newer editions could also be informative.

Assessment of the consequences of smartphone use on physiological, psychological and socioeconomic performance is also an unexplored area in many Arab communities. For example, studying the effect of smartphone use on general level of hygiene and the role of it in infection transmission is also recommended, particularly since 36.6% of students in the current study reported using their smartphones when in the toilet. Highlighting such issues can inform future research in what is a rapidly changing area of study.

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## الملخص

تهدف الدراسة الى وصف انماط وأساليب سلوك استخدام الهاتف الذكي بين طلاب الجامعات في الأردن. **الطرق:** العينة العشوائية مكونة من (1005) طالب (412 ذكور ، 593 إناث)، كانوا مسجلين في الكليات الصحية في جامعة العلوم والتكنولوجيا الأردنية في الفصل الدراسي الثاني من العام الأكاديمي 2018/2017. أنهى الاستبيان 918 مشارك (541 من الإناث ، 377 من الذكور، متوسط العمر  $19 \pm 1.6$  سنة). أنشئ استبيان مكون من جزئين ، الجزء الأول عن البيانات الديموغرافية و الجزء الثاني عن سلوك استخدام الهاتف الذكي. **النتائج:** ما مجموعه 547 (59.6%) طالب أقرّوا بأنهم يمضون أقل من 5 ساعات يومياً على هواتفهم الذكية، 317 (40.4%) أقرّوا باستخدام هواتفهم الذكية لمدة تزيد عن خمس ساعات يومياً. حوالي ثلاث أرباع الطلبة أخبروا أنهم يتفقدون هواتفهم الذكية بمعدل مرة واحدة او أكثر كل نصف ساعة. الوسط الحسابي (الانحراف المعياري) للوقت المصروف على الهواتف الذكية بالساعات كان 5.9 (3.7) ، و هذه الأوساط الحسابية وجدت بأنها تختلف احصائياً حسب الجنس و العمر و سنوات الدراسة، بينما امتلاك حزمة انترنت لم يؤثر على وقت الاستخدام اليومي. **الاستنتاجات:** جاءت ملاحظتنا داعمة لازدياد استخدام الهواتف الذكية في الأردن بين طلاب الجامعات، وكان الاستخدام الاكثر شيوعاً هو للتواصل مع الأهل والأصدقاء ثم للبحث عن المعلومات ثم لتفقد وسائل التواصل الاجتماعي. وكان أكثر المواقف التي يتم استخدام الهاتف الذكي خلالها هي عند الشعور بالملل.

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## Effect of Patient Contact on Attitudes of Student Nurses Towards People with Mental Illness: A Pilot Study

M. Fakhr El-Islam and Radwa El-Attar

تأثير الإتصال بالمرضي على اتجاه طلبة التمريض نحو المرضي النفسيين. (دراسة إستطلاعية)

م. فخر الإسلام، رضوي العطار

### Abstract

**I**ntroduction: Studies of social attitudes towards people with mental illness revealed their being stereotyped as untrustworthy, ineffective and even dangerous. It is hypothesized that contact with patients is associated with an increase in favorable attitudes towards those with mental illness. **Method:** An assessment of attitudes toward people with mental illness was administered to student nurses before and after their psychiatric nurse training rotation. **Results:** A significant increase in favorable attitudes was found at the expense of a reduction in undecided and unfavorable attitudes. **Conclusion:** Contact with patients during training, elicited empathy from trainee nurses, which was reflected in more favorable attitudes towards people with mental illness. It resulted in a positive shift away from unfavorable attitudes of fear, untrustworthiness, unpredictability and even feelings of being at-risk derived from the culture from which the student nurses came.

**Key words:** Nurse training, Stigma, Mental illness

**Declaration of interest:** None

### Introduction

Mental stigma is the social stereotyping of people with mental illness. Scales introduced to measure social attitudes were adapted to the Arab culture by Kadri<sup>2</sup> in Morocco and Sidhom<sup>4</sup> in Egypt. The present study tests the hypothesis that contact with patients who experience mental illness is associated with favorable attitude changes among student nurses.

### Method

Participants in the present study were student nurses from the High Nursing Institute in Al-Gouna, Hurgada, Egypt who attended an eight-week psychiatric training rotation in The Behman Psychiatric Hospital in Cairo from June to August 2015.

Student nurses completed an attitude questionnaire before and after their rotation in this hospital. The questionnaire used was the Bartlett<sup>1</sup> scale, which was published as

exhibit 9-21 in the book on scales for measurement of attitude.<sup>3</sup> The questionnaire was presented to students in the original English after re-wording to apply to people with mental illness rather than people with intellectual disability. The questionnaire was thought to have acceptable face-validity because most of its items were included in the scales used by Kadri<sup>2</sup> and Sidhom.<sup>4</sup> It comprised 24 statements about people with mental illness. Respondents' opinions are indicated by endorsing one of three attitudes: favorable, unfavorable or undecided.

### Results

Participants included eight men and two women aged 20-22 years. All participants and their training supervisors agreed to the study. Ethics were approved by the hospital review board. Table 1 shows the total response of students' favorable, unfavorable and undecided attitudes before and after their psychiatric training rotation.

**Table 1.** Total of attitude responses by student nurses before and after their rotation

Attitudes	Before rotation	After rotation	Total
Favorable	65	140	205
Unfavorable	110	88	198
Undecided	65	12	77
<b>Total</b>	240	240	480
	2 df	$\chi^2 = 44.0$	$p < 0.001$

Favorable attitudes increased significantly after student nurses had face-to-face contact, throughout their training rotation, with patients with mental illness. An increase in face-to-face contact appeared to contribute to a reduction in undecided responses, which confirmed the study hypothesis. The result supports Corrigan<sup>5</sup> who suggested that *in vivo* face-to-face contact with people who have mental illness greatly contributed to the reduction of stigma towards mental disorder.

### Discussion and Conclusion

Participants' initial attitudes reflected the attitudes of the community in general, which are prone to anecdotal opinions and media information about the myth of mental illness. In Arab society, mental illness is still attributable to supernatural agents known as jinn (demons), which are alleged to break patients' contact with reality and adversely influence their reasoning ability.

The social stereotyping of people with mental illness was reflected in student nurses' initial attitudes towards them in that such patients were regarded as being dangerous and unreliable or at least unproductive. Contact with patients not only reduced the bias held by the students, but also demonstrated how treatment restored their premorbid selves to varying degrees. Students empathized with patients who experienced mental suffering that interrupted their social adaptation, productivity and independence.

### Limitations

Limitations of the present study include the small sample size, which did not provide adequate power to determine statistical significance. However, findings may stimulate other researchers to conduct future studies with larger sample sizes.

### Acknowledgments

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## المخلص

الوصمة المرتبطة بالمرض النفسي تحط القدر الاجتماعي للمرضى النفسيين. وقد ارتبطت الوصمة في الوطن العربي بأبحاث نادية قادري و عماد سيدهم. ويهدف هذا البحث إلى دراسة تأثير الإتصال المباشر بالمرضى النفسيين على اتجاهات طلبة التمريض نحو المرض النفسي.

أعطي مقياس الاتجاهات نحو المرض النفسي للطلبة قبل وبعد أدائهم لدورة تدريبية مدتها ثمانية أسابيع في مستشفى بهمان للأمراض النفسية ودلت النتائج على حدوث زيادة في الاتجاهات الإيجابية نحو المرض النفسي ذات دلالة إحصائية مؤيدة لما توصل إليه كوريجان من خفض الوصمة بعد التواصل وجهاً لوجه مع المرضى النفسيين.

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## **Interview with the Assyriologist James Kinnier Wilson Who Uncovered and Translated Ancient Iraqi Psychiatric Cuneiform Texts**

Walid Abdul-Hamid

مقابلة مع عالم الآثار الشهير جيمس كينير ويلسون الذي اكتشف وترجم العديد من الرقم الطينية المسمارية التي تحمل نصوص طبية نفسية من حضارة العراق القديم

وليد عبد الحميد

### **Abstract**

The current paper describes an interview with the renowned British Assyriologist James Kinnier Wilson who is in his 90s and did a lot of work to uncover and translate the psychiatric medical cuneiform texts of ancient Iraqis. The author published an article in the Arab Journal of Psychiatry in 2004 titled Introduction to the Psychiatry of Ancient Mesopotamia, which was a review of Professor Kinnier Wilson's research on the subject.

**Key Words:** Ancient Iraq, Mesopotamia, Archaeology, Ancient medicine, Ancient psychiatry

**Declaration of interest:** None

### **Introduction**

James Kinnier Wilson was born in London on the 27<sup>th</sup> of November 1921. He is one of the most important British Assyriologists; known in the field of Archaeology of Mesopotamia (present-day Iraq) for his discovery and translation of cuneiform tablets, which evidenced that Ancient Mesopotamian physicians recognized and classified psychiatric and neurological disorders. Professor Kinnier Wilson was the Eric Yarrow Lecturer from 1955 until 1989, and is currently Emeritus Fellow, at Wolfson College Cambridge. Being the son of the famous neurologist Samuel Alexander Kinnier Wilson, he has combined his knowledge of ancient history with his interest in medicine and neurology to reconstruct Mesopotamian legends and epics. He enhanced this novel interest by studying psychiatric and neurological disorders in ancient Mesopotamian medical texts.

It has been long understood that there were established medical systems and medical educational institutions in ancient Iraq. As early as 1923, Thompson & Thompson published a book entitled 'Assyrian Medical Texts from the original in the British Museum'.<sup>1</sup> The book constituted a translation of medical cuneiform texts that were used by ancient Iraqi physicians to help in the diagnosis and treatment of diseases. Some of these cuneiform medical texts were related to psychiatric disorders. Kinnier Wilson was one of the first Assyriologists to study these psychiatric cuneiform medical texts starting from the second half of the 20th Century and establishing what he

called Ancient Iraqi Psychiatry. He described in detail these cuneiforms and the psychopathology of the disorders prevalent at that time; and, how relevant they are in comparison with current the psychopathology of psychiatric diagnoses.

### **The interview**

I met Professor Kinnier Wilson twice in Cambridge. The most recent encounter was last year. Previously, I had met him and his wife in their house in 2003. His wife was the late poet Helen Kinnier Wilson. I wrote an article in Arabic for the Arab Journal of Psychiatry on Professor Kinnier Wilson's work and my meeting with him in 2003.<sup>2</sup> More recently, I published an article on Mesopotamian Posttraumatic Stress Disorder (PTSD) that went viral through the media and social media.<sup>3</sup> The current article was inspired by the interest that meeting with Professor Kinnier Wilson stirred within me with regard to Mesopotamian Psychiatry since our meeting in 2003. I met the professor again on 30<sup>th</sup> May 2016 to return a book I borrowed from him in 2003. He kindly agreed to this interview for the Arab Journal of Psychiatry. Our meeting was organized by his friend and co-author the neurologist Ted Reynold whom I was fortunate to have met at a Royal College of Psychiatry meeting and who put me back in touch with Professor Kinnier Wilson. I met him for lunch and he kindly agreed to the interview. We then moved from the restaurant to a friend's house in central Cambridge where we had afternoon tea and where I

continued my interview. I also took some pictures one of which is included in the current article. The question and

answer format of the interview were as follows:



***Q: What led you to become an archaeologist?***

**A:** ‘When I was nine years old, my father took me to the British Museum and when we were in the Assyrian gallery there, I noticed some strange writings on the belly of the winged bull’. He later realized it was cuneiform writing. As there was no explanation as to the meaning of the ‘strange writing’, this nine-year-old boy felt compelled to learn, which ultimately led him to study Assyriology. He said proudly: ‘I am now able to understand and read what is written on the belly of the winged bull. However, initially I was hesitant to study Assyriology as I thought it might not be an adequate profession to earn a living, but I met an art dealer, Jim Byrne-Shaw near Bond Street, who encouraged me to read Classics and Hellenic studies as this will be a respectable academic profession. Later, I got a scholarship to Durham University to study that and, in 1946, I was accepted at Christ Church, Oxford where I studied Assyriology. In 1950, I was appointed as a Lecturer in Assyriology at Durham University. I went from there to do a research year at the Oriental Institute of the University of Chicago between 1951-52. After that, I was appointed as a Lecturer and then Assistant Professor at University College, Toronto between the years 1953-55. I was subsequently appointed the Eric Yarrow Lecturer in Assyriology, at the University of Cambridge between 1955 to 1989 and became the Chairman of the Faculty of Oriental Studies, Cambridge between 1965-67. I wrote many articles and books in archaeology and Assyriology many of which are related to psychiatry and neurology. The most famous of these are ‘An Introduction to Babylonian Psychiatry’ in 1965, the two chapters

“Organic Diseases of Ancient Mesopotamia”, and “Mental Diseases of Ancient Mesopotamia”, in the book “Diseases in Antiquity”, which was published in 1967. “Disease of Babylon: An Examination of Selected Texts” was published in 1996. More recently, I have published “Translation and Analysis of a Cuneiform Text Forming Part of a Babylonian Treatise on Epilepsy” with E.H. Reynolds. Lastly, “Neurology and Psychiatry in Babylon” with E.H. Reynolds’.

***Q: Who are the people who influenced you most in your career?***

**A:** ‘When I was in Chicago, I met many eminent Assyriologists; the most prominent of whom were Leo Oppenheim and Benno Landsberger. The fact that my father was a Neurologist had also great indirect influence on me, as on the 30 years anniversary of his death in 1987, I wrote my first article on Mesopotamian neurology translating the recordings of the symptoms of epilepsy from ancient Iraqi texts and that was published in the British Medical Journal. I later met the Neurologist Dr Edward Reynold in the neurology meeting to honor 50 years of my father’s contributions to neurology, including the discovery of Wilson disease (that was named after his father) and we started collaborating and publishing articles on Mesopotamian neurology and psychiatry since then.’

***Q: Do you think that the ancient Iraqis or the Mesopotamians had a unique interest in psychiatric disorders compared to sister civilizations like the Egyptian ones?***

**A:** ‘The ancient Iraqis saw psychiatric disorders not as a mental disorder, but more like a behavioral disorder as they did not have the concept of the mind as we know it now. When they saw changes in behavior from societal norms, they recognized them as an abnormal medical phenomenon. For example, they described persecutory delusions and hallucinations that caused behaviors that might have caused problems with the law then. They related the disorders to supernatural forces like gods, demons or spirits of dead people and they used treatments that drove these forces away from patients’ bodies. For example, in the case of persecutory psychosis a procedure involving the melting or burning of the persecutor’s image was carried out in the presence of the patient. Other ancient civilizations, such as that of the Egyptians, might have written Papyrus on psychiatric disorders that have not been found or translated yet, but clearly this is outside my area of expertise.’

***Q: Why did the ancient Iraqis have these libraries of cuneiform tablets that contain documents that amount to half a million records and for what purposes did they use them?***

**A:** ‘The Mesopotamians wrote two types of tablets. Those considered as important documents were baked and kept in many types of libraries like the King Library, the Temple Library and even in personal libraries or archives that ancient Iraqi people kept.’

***Q: Why should modern psychiatrists be interested in studying Mesopotamian psychiatry?***

**A:** ‘Psychiatric disorders, including psychotic disorders were clearly recorded in cuneiform tablets. This included the symptom of passivity which is one of Schneider’s first rank symptoms in the form, but the contents of these symptoms were more appropriate to that age as they were attributed then to witches and spirits while it might now be attributed to electricity or electronic devices of the modern age. I feel it is of interest to psychiatrists to read these records to compare them with current psychopathology that changed clearly in its contents.’

***Q: What would you have done if you did not become an archaeologist?***

**A:** ‘I come from a medical family. My father was a doctor and my uncle too and my brother did medical engineering working on artificial limbs. Therefore, if I did not follow the archaeology route, I would have been in some aspects of medicine. In addition, I would have most probably been persuaded by my late father to do medicine if it was not for his early death when I was at secondary school.’

***Q: Do you have any other words to add?***

**A:** ‘I owe a lot of my success to my teachers, colleagues in the work I did. My uncle, who is a doctor, helped me to get into Oxford. I went to Iraq twice in the 1960s and 1980s. If it was not for Henry Austin Layard who discovered Nineveh with his Iraqi assistant Rassam, there would have probably been no Assyriology. In addition, friends like Donald Wiseman, who later became keeper of the British Museum, helped greatly in my studies; also, my friend the Neurologist Dr Edward Reynold and the teacher of Assyriology Oliver Gurney. I owe them all so much and we learned from each other.’ Following this reflection, and possibly referring to his old age, Professor Kinnier Wilson observed: ‘There is an interesting text that was written in Mesopotamia in the 17th Century BC, which listed the characteristics of different man’s ages that said:

‘Forty (years mean) prime of life

Fifty: short life

Sixty: maturity

Seventy: long life

Eighty: old age

Ninety: extreme old age’.

## **Epilogue**

James Kinnier Wilson wrote many books in Archaeology and Assyriology. His most recent book was a very moving selection from the Holy Qur’an titled “The Wisdom and the Beauty: A Selection of Short Passages from the Qur’an” that was published by Shephard-Walwyn in 2007. He wrote in the introduction: ‘I who write to you am but a scribe of old who would copy out from ancient manuscript parts of a Message that lie before him. They come from a High God’s Love and Light for the human family as these have been brought to us by His Archangel, Gabriel.’ He went further in the epilogue to address ‘terrorists of whatever country’ quoting Prophet

Mohammad's (PBUH) Arabic Saying 'la darara wa la dirar' which means 'Let there be no harming and no returning of harm'. He explained the meaning as 'for he who harms another, harms himself, and the way to peace is to offer peace'.<sup>4</sup>

Upon meeting Professor Kinnier Wilson again, I was reminded of his modesty combined with the depth of knowledge and experience. As my Cambridge friends commented, he is still young despite his age, knowing what he is talking about with sharp thinking and a deep sense of curiosity. I conducted the current interview principally to raise my psychiatry colleagues' awareness of Professor Kinnier Wilson's contribution to psychiatry through his study and documentation of probably the earliest psychiatric cases in history. I also endeavored to reemphasize Professor Kinnier Wilson's suggestion for us all to be interested in the application of history and historical records of psychiatric symptoms to investigate changes in psychopathology over the eras of human history.

A list of Professor Kinnier Wilson's main works on ancient Mesopotamian Psychiatry and Neurology are:

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## المخلص

هذه مقابلة مع عالم الآثار البريطاني الشهير جيمس كينير ويلسون الذي هو في التسعينيات من عمره وقام بالكثير من العمل للكشف عن النصوص المسمارية الطبية للعراقيين القدماء وترجمتها. ولقد نشرت في المجلة العربية للطب النفسي في عام 2004 مقالة بعنوان "مقدمة في الطب النفسي في بلاد ما بين النهرين" المشار إليها في مصادر هذا المقال والتي كانت في الحقيقة مراجعة وملخص لبحوث كينير ويلسون.

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## تحليل النفس وتشخيص أحوالها ووصف أمراضها وذكر علاجاتها عند الغزالي: (دراسة تحليلية مقارنة)

ميلود حميدات

### Psychoanalysis and Diagnosis of Psychiatric Conditions and Their Treatment by Al-Ghazali: an Analytic Comparative Study

Hamidat Miloud

#### الملخص

لقد اهتم الفلاسفة المسلمون بالنفس وأمراضها، وبرزوا في تشخيص أحوالها، ووصف علاجاتها، ومن الذين تميزوا بالأصالة في الموضوع والمنهج، الشيخ أبو حامد الغزالي. الذي تميزت نظرتة إلى النفس عن فلاسفة اليونان، ومن تبعهم من فلاسفة الإسلام.

إذ يبرز التميز في أنه يستمد أسس فلسفته النفسية من الإسلام، ومن تجربته الذاتية في التصوف، مع العلم أن التصوف ذو علاقة وطيدة بعلم النفس، و(الغزالي) من ناحية أخرى باحث في النفس ومتصوف، وفي التصوف مادة نفسية غزيرة، تستوقف كل باحث، لقد كان لتلك التجربة النفسية أعمق الأثر في إبداع الغزالي في علم النفس، كإدراك الدوافع والانفعالات، ومعرفة العواطف والانحرافات، وبالتالي تشخيص الحالات، ووصف العلاجات.

لذلك ارتأينا أن نتتبع تحليل الغزالي لطبيعة النشاط النفسي، والنفس وأقسامها، والغريزة وتأثيرها، والانفعالات وضبطها، والأحلام ووظيفتها، وأمراض النفس وأسبابها، ثم علاجها. كل ذلك في إطار مقارنة نقدية مقارنة مع النظريات الحديثة في علم النفس. مبرزين منهج الغزالي في التحليل الذي يقترب من المناهج الحديثة، إذ استخدم التأمل والاستبطان، واستعان بما تنبته الوقائع من خلال الملاحظة والتجربة، انطلاقاً من الحالات التي عايشها الغزالي بنفسه.

ويبدو لنا في هذا القليل من الكثير أننا أثبتنا أصالة وتميز التحليل النفسي الذي قَمَمه الغزالي، وسبقه لكثير من المدارس الحديثة في طُرُق موضوعات النفس وأحوالها، وأمراضها. ملتزمين بالنصوص الثابتة للغزالي، لإثبات ما ذهبنا إليه بكل دقة وموضوعية .

الكلمات المفتاحية: تحليل النفس، علل النفس، التشخيص، العلاج، الغزالي

اعلان الدعم: لا يوجد

#### مقدمة

يعتبر أبو حامد الغزالي (1056، 1111م) من أبرز مفكري الإسلام الذين أولوا أهمية بالغة للنفس البشرية، من جميع جوانبها. حيث وقف على الكثير من الآليات التي تحكمها، كما شَخَّص العديد من عللها وأمراضها، واجتهد في وصف علاجاتها. كما يمكن الوقوف على آراء كثيرة سبق (الغزالي) من خلالها المدارس النفسية المعاصرة، لعل من أبرزها ما جاءت به مدرسة التحليل النفسي، بزعامة مؤسسها (سيغموند فرويد) (Sigmund Freud) 1856، 1939م .

ولعلنا لا نبالغ إن قلنا إن للغزالي ملامح نظرية في تحليل النفس، تستمد أصولها من الإسلام، وستنطرق إلى أهم معالم هذه النظرية في نظرة الغزالي إلى النفس وأقسامها، وإلى الغريزة والانفعالات، وتأثيرهما على النشاط النفسي، ومفهوم الأحلام، وأمراض النفس وأسبابها ثم كيفية علاجها، ومنه تكتمل الصورة لدينا لما قدمه الغزالي من آراء سبق بها عصره. وهذا ما نحاول تسليط بعض الضوء عليه في مقالنا هذا.

#### أقسام النفس عند الغزالي

يتكلم الغزالي عن النفس في ثلاث صور مختلفة تشبه إلى حد كبير التقسيم الثلاثي لأننا الذي قال به (سيغموند فرويد) الذي يحدد الجهاز النفسي كآلاتي: الأنا: ويمثل الشخصية الواقعية المهذبة اجتماعياً، والتي تسعى إلى التوافق والتكيف.

الهُو: الرغبات والغرائز الداخلية اللاشعورية التي تسعى إلى اللذة والإشباع .

الأنا الأعلى: ويمثل أوامر ونواهي المجتمع الأخلاقية، أو جانب الضمير في الشخصية.<sup>1</sup>

أما (الغزالي) فقد قَسَم النفس إلى ثلاثة أقسام قبل(فرويد) بقرون، وإن كان التشابه موجود بين طبيعة كل قسم عندهما .

إذ يجعل (الغزالي) من النفس: «إذا سكنت تحت الأمر وزايلها الاضطراب بسبب معارضة الشهوات سميت النفس المطمئنة...وإذا لم يتم سكونها، ولكنها صارت مدافعة للنفس الشهوانية، ومعتزلة عليها سميت النفس اللوامة، لأنها تلوم صاحبها عند تقصيره. وإن تركت الاعتراض وأذعنت، وأطاعت لمقتضى الشهوات، ودواعي الشيطان سميت النفس الأمارة بالسوء»<sup>2</sup>.

وعليه نكون أمام ثلاثة أحوال للنفس:

1. النفس الشهوانية: سيطرة الأهواء، والغرائز والشهوات على العقل.
2. النفس اللوامة: النفس المتوسطة بين صراع الأضداد، الشهوة والعقل.
3. النفس العاقلة: النفس المطمئنة بحكم العقل، وقمع الشهوات والتحكم فيها.

فاختلاف أسمائها باختلاف أحوالها العارضة عليها، «فإن اتجهت إلى صواب الصواب ونزلت عليها السكينات الإلهية، فتطمئن إلى ذكر الله عزَّ وجل وتسكن إلى المعارف الإلهية، فيقال نفس مطمئنة. وإن كانت مع قواها

إذا كان (سيغمووند فرويد) يرجع أساس النشاط النفسي إلى اللاشعور وغريزة الجنس، فإن (الغزالي) يرجع النشاط النفسي إلى أربعة دوافع أساسية وهي: الرغبة أو الشهوة إلى الطعام، والجنس، والمال، والجاه. ومحرك كل هذه الدوافع، غريزة البطن التي يجعلها الأصل في بروز الغرائز الأخرى، «والبطن على التحقيق ينبوع الشهوات، ومنبت الأدوية والآفات، إذ ينبعها شهوة المرأة، وشدة الشبق، ثم تتبع شهوة الطعام والمرأة شدة الرغبة في الجاه والمال، اللذين هما وسيلة إلى التوسع في الشهوة الجنسية والمطعمومات»<sup>11</sup>.

وتترتب عن التوسع في طلب اللذات، والسعي في إرضاء الغرائز، بجمع المال والجاه، «أنواع الرعونات، وضروب المنافسات، والمحاسنات، ثم يتولد بينهما أفة الرياء، وغائلة التفاخر والتكاثف والكبرياء، ثم يتداعى ذلك إلى الحقد والحسد، والعداوة والبغضاء، ثم يفضي ذلك بصاحبه إلى اقتحام البيعي والمنكر والفحشاء. وكل ذلك ثمرة إهمال المعدة، وما يتولد عنها من بطر الشبع، والامتلاء. ولو ذلَّ العبد نفسه بالجوع، وضيق به مجاري الشيطان، لأذعنت لطاعة الله عز وجل»<sup>12</sup>.

إن التحكم في الغرائز، والاعتدال في تلبيتها هو وسيلة الصحة النفسية، والتحكم في النفس بالعقل والوعي، أما إذا حدث العكس فهو فقدان للإرادة، وسيطرة الأهواء على النفس «ومن استولت عليه النفس صار أسيراً في حب شهواتها، محصوراً في سجن هواها، مقهوراً مغلولاً زمامه في يدها، تجره حيث شاءت، فتمنع قلبه من الفوائد»<sup>13</sup>.

وهنا إشارة لا تقل أهمية عما سبق ذكره في التحليل النفسي، إذ يشير الغزالي إلا غياب الوعي والإرادة لدى مريض النفس، وكأنه يتصرف من غير شعور، وهي طبعاً الفكرة التي بنا عليه التحليل النفسي أساس المرض النفسي، وهي عدم شعور المريض بأسباب حالته، ومعرفة بالأسباب، والوعي بها يؤدي إلى العلاج، وسنجد ذلك في العلاج بالعلم والعمل الذي يتكلم عنه الغزالي فيما بعد.

### غريزة الطعام والتحكم فيها

يعتبر (الغزالي) هذه الغريزة أساس لكل الغرائز الأخرى، فإن المعدة منبع القوى، فكأنه الباب والمفتاح إلى الخير والشر جميعاً، ولذا عظم في الشرع أمر الصوم.<sup>14</sup> فإن معالجتها تؤدي إلى معالجة الغرائز الأخرى، وردها إلى حد الاعتدال.

وعليه يعتبر العلاج في معاكستها، فيبرز لنا فوائد الجوع (قلة الطعام) متمثلة في: «صفاء القلب وإيقاد القريحة وإنفاذ البصيرة، فإن الشبع يورث البلادة ويعمي القلب، بل الصبي إذا أكثر الأكل بطل حفظه وفسد ذهنه وصار بطيء الفهم والإدراك»<sup>15</sup> «كما» يستفيد من قلة الأكل صحة البدن، ودفع الأمراض، فإن سببها كثرة الأكل. ويحوج إلى الفصد والحجامة، والدواء والطبيب، وكل ذلك يحتاج إلى مؤن ونفقات لا يخلو الإنسان منها»<sup>16</sup>.

وبعد هذه الحجج التي يسوقها الغزالي للتدليل على أفضلية قلة الأكل، للجسم والعقل والمال، يتكلم الغزالي بأسلوب نفسي اجتماعي عن تأثير الشبع على الإنسان، إذ يدفعه الشبع إلى البحث عن أشياء أخرى، فيعمل على إشباع غرائز أخرى.

ومنه تنشأ الغرائز كتوابع لغريزة البطن، فيتحرر اللسان بعد الشبع، فيتكلم في الناس، ويتطلع الفرد إلى تحقيق رغباته المختلفة. إذ يقول الغزالي في أسلوب مبني على الملاحظة والخبرة بالنفس البشرية وتطلعاتها: «وإذا شبع افتقر إلى فاكهة فيفتكه لا محالة بأعراض الناس... وإذا شبع الرجل لم يملك فرجه، وإن منعه التقوى فلا يملك عينه، فالعين تزني، كما أن الفرج يزني، فإن ملك عينه بغض الطرف، فلا يملك فكه، فيخطر له من الأفكار الرديئة وحديث النفس، بأسباب الشهوة، وما يتشوش به مناجاته، وربما عرض له

وجنودها في قتال وشجار ونزاع وكانت الحرب بينهما سجال، فتارة لها اليد عليها وتارة للقوى عليها اليد فلا تكون حالها مستقيمة، فهذه النفس نفس لؤامة وهذه النفس هي حالة أكثر الخلق. ومن اتضع حتى صار في حضيض البهائم، لانسلاخه عن الفضائل الإنسانية وعدم مشاركته للإنسان إلا بالصورة التخطيطية، وهذه النفس الأمارة بالسوء»<sup>3</sup>.

والغزالي كما هو واضح يستمد تقسيمه الثلاثي من القرآن الكريم، لقوله تعالى: (يا أيها النفس المطمئنة، ارجعي إلى ربك راضية مرضية).<sup>4</sup> وقوله: (لا أقسم بيوم القيامة، ولا أقسم بالنفس اللوامة).<sup>5</sup> وقوله أيضاً: (إن النفس لأمارة بالسوء).<sup>6</sup>

ويستمد (الغزالي) ذلك في قوله: «نفسك خلقت أمارة بالسوء... وأمرت بتزكيتها... فإن أهملتها جمحت وشردت، وإن لازمتها بالتوبيخ والمعاتبة كانت نفسك هي النفس اللوامة، ورجوت أن تصير النفس المطمئنة المدعوة إلى أن تدخل في زمرة عباد الله راضية مرضية»<sup>7</sup>.

ويبدو من النصوص السابقة أن (الغزالي) يدرك جيداً خصائص النفس، إذ يجعل من الإنسان في مرتبة وسطى بين طرفي نقيض الحيوانية من جهة بما تحمله هذه الكلمة من غرائزية وتعلق بمطالب الجسد، والملائكية من جهة بما تحمله من تعالي عن مطالب الجسد والغرائز.

ولكن الإنسان في نفس الوقت يحمل في ذاته تلك الثنائية بين مطالب الجسد وتمثلها الغريزة ومطالب الروح ويمثلها العقل، وبالتالي فهو في صراع بين هذين الطرفين، بين الطبيعة الإنسانية، والطبيعة الحيوانية، إذ يسمى الغزالي: «الصفة التي بها فارق الإنسان البهائم في قمع الشهوات وقهرها، باعثاً دينياً، ولنسم مطالبية الشهوات بمقتضياتها باعث الهوى، وليفهم أن القتال قائم بين باعث الدين و باعث الهوى، والحرب بينهما سجال»<sup>8</sup>.

وعليه جعل الغزالي أغلب الناس في حالة النفس اللوامة، معتبراً أن أساس الامتحان هو السعي بهذه النفس نحو العقل وفضائله للوصول إلى درجة النفس المطمئنة التي تُنال بالرياضة والمجاهدة، وعدم السقوط في مطالب الغرائز والرغبات حتى لا تصير هذه النفس عبداً للذات، وإنما أن تحقق النفس توازنها وسيادتها وتحررها من كل ما يستعبد لها. كما لا يعني ذلك عند الغزالي أن تقمع النفس، وتُحرم كل ما تنزع إليه بطبيعتها من شهوات وغرائز، وإنما أن تكون الغرائز هي كل غابيتها، وإنما ما يحقق توازنها.

ولا يرى الغزالي في توازن النفس سوى التوفيق بين مطالب النفس، وتحقيق الاعتدال، ولا يكون ذلك في قمع الشهوات والرغبات والقضاء عليها، فإن ذلك مناف للطبيعة البشرية، وإنما بالتهذيب والتربية، والمجاهدة، ويخطئ من يعتقد «أن المقصود بالمجاهدة قمع هذه الصفات بالكلية ومحوها وهياتها! فإن الشهوة خلقت لفائدة وهي ضرورية في الجبلية، فلو انقطعت شهوة الطعام لهلك الإنسان، ولو انقطعت شهوة الوقاع لأنقطع النسل، ولو انعدم الغضب بالكلية لم يدفع الإنسان عن نفسه ما يهلكه ولهلك، وليس المطلوب إمالة ذلك بالكلية بل المطلوب ردها إلى الاعتدال الذي هو وسط بين الإفراط والتفريط»<sup>9</sup>.

وتبرز نظرة الغزالي الواقعية المعتدلة المبنية على الملاحظة والتجربة جلية في هذا التحليل، الذي يدل أيضاً على فهم الغزالي الجيد لأغوار النفس البشرية، ودعوته إلى اعتماد الممارسة والمجاهدة، لإعادة النفس إلى الوسط المحمود، وقوله أبلغ في ذلك: «وبالرياضة تعود إلى حد الاعتدال، فدل أن ذلك ممكن، والتجربة والملاحظة تدل على ذلك دلالة لا شك فيها»<sup>10</sup>.

أولاً: أن يتناولوا ما يقوي شهواتهم على الاستكثار من الوقاح، كما قد يتناول بعض الناس أدوية تُقوي المعدة لتعظم شهوة الطعام»<sup>25</sup>.

ثانياً: قد تنتهي ببعض إلى العشق لشخص واحد معين حتى يزداد به ذلاً على ذل، وعبودية على عبودية، وحتى يستخر العقل لخدمة الشهوة. وقد خُلِق ليكون مطاعاً لا ليكون خادماً للشهوة. وما العشق إلا سعة إفراط الشهوة، وهو مرض قلب فارغ لا هم له»<sup>26</sup>.

كما يعتبر (الغزالي) التفريط مرضاً وضعفاً مذموماً، بحيث لا تؤدي هذه الغريزة وظيفتها في حفظ النسل، وتحقيق الشهوة والإمتاع للطرفين، وهو إخلال بحق طبيعي.

ولكنه يحذر من سيطرة الشهوة، حتى تصير عصبية عن التغيير، أي حالات الإدمان التي هي حالات مرضية، يصعب علاجها، إذ يحذر الغزالي من حالات الإدمان: وهي سيطرة الشهوات على نفس الإنسان، بحيث لا يستطيع التحكم فيها، بل يعتبرها الغزالي حالة مرضية للنفس التي تتعود على فعل، ثم لا تقدر على التخلص منه، إذ يقول: «وإنما يجب الاحتراز من أوائله. وإلا فإذا استحك عسر دفعه؛ فكذلك عشق المال، والجاه، والعار، والأولاد، حتى حب اللعب بالطيور، والنرد، والشطرنج. فإن هذه الأمور تستولي على طائفة، بحيث تنغص عليهم الدين والدنيا، ولا يصبروا عنها البتة»<sup>27</sup>.

ويقدم الغزالي تشبيهاً بليغاً عن إدمان النفس شيئاً وكيفية علاجها، وصعوبة ذلك قبل تحكم عادة الإدمان، وبعدها، حيث يشبه ذلك بدابة تريد دخول باب دار، إذ يمكن صرفها بسهولة قبل ولوجها باب الدار، ويصعب ذلك إن تمكنت من دخول الدار، إذ يحتاج الأمر إلى جهد ووقت لإخراجها، والفرق واضح بين الحالين<sup>28</sup>.

ولا يخفى المعنى الذي يريده الغزالي من ذلك، فالنفس صافية حرة، وهي سيدة على ذاتها قبل تحكم الأهواء فيها، فإن سيطر عليها هواً وأدمنت عليه، وصارت الدابة داخل نفس الإنسان، حينها تفقد النفس صفاءها وحرمتها، ويذهب حكم العقل، ويصير حكم الغريزة، ويصل الأمر إلى مرض النفس.

### الأحلام والحدس في تحليل النفس عند الغزالي

نظرة الغزالي إلى الأحلام وما في الباطن من حقائق قريبة من التحليل النفسي الذي يجعل من اللاشعور، أو النشاط النفسي الباطني منبع حقائق النفس، فإن الغزالي أيضاً يرى أن الحقائق تستمد بالحدس من باطن النفس بعد رياضتها وصفاتها، وإن اختلف المغزى بين الغزالي والتحليل النفسي، إلا أن هناك تشابه في الأفكار، كما يدعو الغزالي إلى تأويل الأحلام، ويعطي لذلك دوراً هاماً لاكتشاف الحقائق التي تنجلي للنفس، بل يجعل الغزالي من الحلم وسيلة، أو طريق إلى المعرفة، إذ يقول: «اعلم أن القلب بابين للعلوم: واحد للأحلام، والثاني لعالم اليقظة، وهو الباب الظاهر إلى الخارج فإن نام غلق باب الحواس، فيفتح له باب الباطن ويكشف له غيب من باب الملكوت، ومن اللوح المحفوظ، فيكون مثل الضوء، وربما احتاج كشفه إلى شيء من تعبير الأحلام، وأما ما كان من الظاهر فيظن الناس أن به اليقظة أولى بالمعرفة، مع أنه لا يبصر في اليقظة شيء من عالم الغيب، وما يبصر بين النوم واليقظة أولى بالمعرفة مما يبصر من طريق الحواس»<sup>29</sup>.

### الترميز وتأويل الأحلام والرؤى

لا تتكشف الحقائق في الأحلام بشكل مباشر بل تكون مرّمة خفية، تحتاج إلى فك أسرارها، وتأويل معانيها، إذ أنها «استعارات رسمية، تحتها رموز وإشارات خفية إذ كما يستحيل الوصول إلى اللب إلا من طريق القشر، فيستحيل الترقى إلى عالم الأرواح إلا بمثال عالم الأجسام، ولا تعرف هذه

ذلك في أثناء الصلاة، وإنما ذكرنا آفة اللسان، والفرج مثلاً، وإلا فجميع معاصي الأعضاء السبعة\*، سببها القوة الحاصلة بالشبع»<sup>17</sup>.

لا يكتفي الغزالي بعرض المشاكل الناتجة عن كثرة الأكل، وعدم الاعتدال في الطعام، وإنما يقدم بعد ذلك العلاج والحلول التي يراها مناسبة، فيؤكد أولاً أن «البطنة أصل الداء، والحمية أصل الدواء، وعودوا كل جسم ما اعتاد»<sup>18</sup>.

وهو كلام صحيح بالمقاييس العلمية الحديثة، فكثير من الأمراض ناتجة عن طبيعة الغذاء الذي يتناوله الإنسان، بل أساس كثير من الأمراض الخطيرة والمزمنة هو الإفراط في الأكل، وبالتالي زيادة الوزن، الذي أصبح في حد ذاته مرضاً خطيراً، لأنه أرضية لأمراض أخرى، كالسكري، وارتفاع ضغط الدم، والفرحة، وأحياناً السرطان الناتج في كثير من الأحيان عن الاختلالات الهرمونية والغذائية.

ثم يضيف الغزالي إلى طريقته في العلاج، ضرورة التزام الوقاية، من خلال الاعتدال في الطعام، لأن «الأفضل بالإضافة إلى الطبع المعتدل، أن يأكل بحيث لا يحس بثقل المعدة، ولا يحس بألم الجوع... فإن مقصود الأكل بقاء الحياة، وقوة العبادة، وثقل المعدة يمنع من العبادة، وألم الجوع أيضاً يشغل القلب ويمنع منها، وإذا لم يكن للإنسان خلاص من الشبع والجوع، فأبعد الأحوال عن الطرفين الوسط وهو الاعتدال»<sup>19</sup>.

ويؤكد الغزالي على الوقاية من الأول، وتعويد الجسم والنفس الاعتدال في كل شيء منذ البداية، «فليكن الاحتياط في بدايات الأمور، فأما في أواخرها، فلا تقبل العلاج، إلا بجهد جهيد يؤدي إلى نزع الروح»<sup>20</sup>.

أما من تعود كثرة الأكل، فما عليه إلا أن يعود إلى الحمية، وتنظيم نفسه، ولا يكون ذلك حسب الغزالي إلا بالتدرج والمثابرة، والرياضة، حتى لا يضر جسمه من جهة، وينجح في ذلك من جهة أخرى، ولذلك يقترح الغزالي: «في تقليل الطعام فسيبيل الرياضة فيه التدرج، فمن اعتاد الأكل الكثير، وانتقل دفعة واحدة إلى القليل، لم يحتمله مزاجه، وضعف وعظمت مشقته، فينبغي أن يتدرج إليه قليلاً قليلاً، وذلك بأن ينقص قليلاً قليلاً من طعامه المعتاد»<sup>21</sup>.

والنتيجة التي يوصلنا إليها هي أن نجعل من الغذاء وسيلة لحفظ الصحة، وليس غاية في حد ذاته، وبالتالي نفهم منها أنها دعوة إلى التربية الجسدية، والاستهلاكية، إذ تحمي الإنسان من الإفراط في الأكل، ومن التفريط في صحة النفس والبدن، إذ «أن الأطعمة أدوية وإنما المقصود منها أن يقوى الإنسان بها على طاعة الله»<sup>22</sup>.

### غريزة الجنس وتهذيبها

يعتبر الغزالي هذا الدافع طبيعياً في الإنسان، وقد وُجد لسببين في اعتقاده أولهما: أنها لذة محسوسة يمكن قياس عليها لذة غير محسوسة هي لذات الآخرة، لأنها من أعظم الشهوات. وثانيهما: أنها مقصودة لبقاء النسل، وحفظ بقاء النوع الإنساني واستمرار الوجود<sup>23</sup>.

وعلاجها عند الغزالي أن يتزوج الشباب، فإن لم يقدر على الزواج، فليستعينوا بالصوم والعبادة لشغل النفس عن التفكير فيها. كما يدعو إلى الاعتدال في تحقيق هذه الغريزة، «فإن إفراط الشهوة أن يغلب العقل مذموم جداً، وتفريطها بالعنة أو الضعف هو أيضاً مذموم، وإنما المحمود أن تكون معتدلة ومطبعة للعقل والشرع. ومهما أفرطت فكسرها بالجوع والنكاح»<sup>24</sup>.

ويحذر الغزالي من الطرفين، الإفراط والتفريط، إذ أن الإفراط في هذه الغريزة قد يكون سبباً في انصراف القلب عن العبادة، وانشغال الرجل بالنساء، وقد يكون ذلك سبباً في ترك الدين، وارتكاب الفواحش. لأن سيطرة هذه الغريزة على النفس قد يدفع البعض إلى المبالغة في إشباعها بكل الطرق، على حساب النفس والصحة الآخرين.

كما يؤكد الغزالي على أن الإفراط ينتهي بالبعض إلى أمرين شنيعين وهما:

العقل والغريزة، بين الرغبة في الإشباع وطلب اللذة، وبين الاستقامة والرضا. وفي نفس الوقت الشعور بالندم والإحساس بالذنب في حالة طاعة مطالب الجسد، وعصيان أوامر العقل، ومنه ينتج القلق والتوتر، والغضب والعدوان، والخوف والانتقام، وسرعان ما يضطرب السلوك بظهور تلك الانفعالات، ومع تكرارها تسيطر على النفس وتصبح عادة تدفع إلى سلوكيات أخرى أكثر تأثيراً على النفس.

كما يُرجع الغزالي انتشار مرض القلوب أكثر من مرض الأبدان إلى ثلاثة أسباب وهي: (1) لا يدري المريض أنه مريض. (2) أن أعراضه وعاقبته غير مشاهدة في هذا العالم، بخلاف مرض البدن فإن عاقبته موت مشاهد تنفر الطباع منه، وما بعد الموت غير مشاهد وعاقبته الذنوب وموت القلب، وهو غير مشاهد. (3) فقد الطبيب، فإن الأطباء هم العلماء، وقد مرضوا وصارت لهم سلوة في عموم المرض حتى لا يظهر نقصانهم.<sup>35</sup>

## علاج الأمراض النفسية والانحرافات الأخلاقية

### انفعال الغضب وعلاجه

تحليل النفس وعلاج الرذائل والأمراض النفسية التي يتكلم عنها الغزالي فيها كثير من العمق، والسبق، والمنهج التأملي والإقناع في العلاج النفسي، إذ ينطلق مثلا من تقديم قاعدة العلاج وهي معرفة أسباب المشكل أو المرض، ويتم بعد ذلك مواجهة الأعراض بأضدادها، «قد عرفت أن علاج كل علة حسم مادتها، وإزالة أسبابها فلا بد من إزالة هذه الأسباب».<sup>36</sup>

فمثلا بالنسبة للغضب، يقدم الغزالي وصفا دقيقا، لا يقل دقة وتحليلا عما قاله أصحاب المدرسة الفيزيولوجية، في وصفهم للمظاهر الجسمية، كما يوضح في تحليله العلاقة الوثيقة بين الجسد والنفس في حدوث الانفعالات، مبرزاً أن الجسد مرآة وصورة لما يحدث في الداخل من تغيرات، إذ يقول في ذلك: «من آثار الغضب في الظاهر تغير اللون وشدة الرعدة في الأطراف، وخروج الأفعال عن الترتيب والنظام، واضطراب الحركة حتى يظهر الزبد على الأشفاق، وتحمس الأحداق وتقلب المناخر، وتستحيل الخلفة، ولو رأى الغضبان في حالة غضبه قبح صورته لسكن غضبه حياء من قبح صورته، واستحالة خلقته، وقبح باطنه، أعظم من قبح ظاهره، فإن الظاهر عنوان الباطن، وإنما قبحت صورة الباطن أولاً، ثم انتشر قبحها إلى الظاهر ثانياً، فتغير الظاهر ثمرة تغير الباطن، فقس الثمرة بالثمرة، فهذا أثره في الجسد».<sup>37</sup> «بعد هذا الوصف الدقيق للمظاهر الجسمية، وعلاقة ذلك بما يحدث في النفس، يواصل (الغزالي) تحليل نتائج الإنفعال والأفعال التي تصاحبه، وما يمكن أن يصاحب الغضب الشديد من انحراف في السلوك، حيث يقول: «أثره في اللسان فانطلقه بالشتم والفحش من الكلام، الذي يستحي منه ذو عقل، ويستحي منه قائله عند فتور الغضب، وذلك مع تخبط النظم، واضطراب اللظ. وأما أثره على الأعضاء فالضرب والتهجم، والتمزيق والقتل، والجرح عند التمكن، من غير مبالاة. فإن هرب منه المغضوب عليه بسبب أو عجز عن التشفي رجح الغضب على صاحبه فمزق ثوب نفسه ويطم نفسه. وقد يضرب بيده على الأرض، ويعود عدو الواله السكران، والمدهوش المتحير. وربما يسقط (سريعاً)، لا يطيق العدو والنهوض، بسبب شدة الغضب، ويعتريه مثل العشبية. وربما يضرب الجمادات والحيوانات، فيضرب الفصعة مثلاً على الأرض، وقد يكسر المائدة، إذا غضب عليها. ويتعاطى أفعال المجانين فيشتم البهيمة والجمادات ويخاطبها. ويقول على متى منك هذا يا كيت وكيت، وكأنه يخاطب عاقلاً، حتى ربما رفته دابة، فيرفس الدابة، ويقابلها بذلك. وأما أثره في القلب مع المغضوب عليه فالحقد، والحسد وإضمار السوء، والشماتة بالمسات والحزن بالسرور، وهتك الستر والاستهزاء، وغير ذلك من القباح، فهذه ثمرة الغضب المفرط».<sup>38</sup>

الموازنة إلا بمثال، فانظروا إلى ما ينكشف للنائم في نومه من الرؤيا الصحيحة».<sup>30</sup>

ويفسر الغزالي ذلك بأن الحقائق لا تتكشف للنفس الكشف الصريح، وإنما بالإشارة والتلميح، لأن هناك فرق بين عالم الروح وعالم المادة.<sup>31</sup>

بل يقدم الغزالي أمثلة من التراث، فمثلاً «رأى بعضهم إنه كان في يده خاتم يختم به فروج النساء، وأفواه الرجال، فقال له (ابن سيرين) أنت رجل تؤذن في رمضان قبل الصبح، فقال: نعم، ورأى آخر أنه يصب الزيت في الزيتون، فقال له إن كان تحتك جارية فهي أمك، قد سببت وبيعت واشتريتها أنت ولا تعرف، فكان كذلك».<sup>32</sup>

وتبرز هنا نظرة الغزالي في الربط بين الأحلام والحقائق راندة، وبهيمنا في ذلك المنهج والدلالة النفسية التي يعطيها الغزالي لذلك، إذ يحتاج الحلم إلى تأويل لأن له معنى، ويستمد التأويل من مصادر اللغة والثقافة والدين، وهذا ما يقول به التحليل النفسي بعد قرون بعد ذلك، وهذا ما توصل إليه الغزالي بقوله: «فانظر ختم الأفواه والفروج بالخاتم، مشاركا للأذان قبل الصبح في روح الخاتم، وهو المنع وإن كان مخالفاً في صورته، وقس على ما ذكرته ما لم أذكره، واعلم أن القرآن والأخبار تشتمل على كثير من هذا الجنس».<sup>33</sup>

وقد ذهبت مدارس التحليل النفسي إلى ذلك بقولها: أن لكل حلم معنى، وأن الأحلام تتخفي من خلال رموز، تحتاج إلى تأويل، وأن مصادر التأويل هي ثقافة الفرد وكل ما يستمد من المجتمع والدين من تعبيرات، أو ما يطلق عليه اللاشعور الجمعي.<sup>34</sup>

## أمراض النفس

يتكلم الغزالي عن أمراض النفس التي يطلق عليها أمراض القلب، وذلك لأنه يعطي للنفس والقلب والروح نفس المعنى أحياناً، وتنشأ هذه الأمراض عادة من اختلال التوازن بين أقسام النفس البشرية، وغلبة طرف على الأطراف الأخرى من جهة، وعدم قدرة العقل على التحكم والسيطرة من جهة أخرى، فصبح أمام حالات من انحراف السلوك، وطاعة الرغبات والشهوات، التي تسيطر على صاحبها، فتسيهه.

لقد تكلم (الغزالي) عن أمراض النفس التي لم يتطرق إليها علم النفس، وإن فعل ذلك فلم يحدد تلك الأمراض بالضبط، أو اعتبرها لم تصل إلى درجة الشدة التي تتطلب علاجاً، إلا أن ذلك نعتبه سيقاً علمياً للغزالي في تناول تلك الأمراض ووصف العلاج لها، وإن استفاد الغزالي كما هو واضح من الدين في كشف واستخراج تلك الأمراض، إلا أننا نحسب له السبق في قدرته على تحديدها وضبطها ووصفها وتبيين أسبابها ثم العمل على وصف علاجها، ويتضح هنا منهج دراسة حالة في التعامل مع هذه الأمراض، ولذلك يحسب للغزالي الإبداع في الموضوع وفي اكتشاف المنهج معاً، وللتدليل على ذلك نذكر بعض هذه الأمراض (التكبر، الغرور، الحسد، الكذب، البخل، الرياء، إلخ) كما نمثل ببعض النماذج لتعامله مع تلك الأمراض لإثبات ما ذكرناه.

## أسباب الأمراض النفسية

لعل من المسلم به أن الأسباب الأساسية في الأمراض النفسية، أو أمراض القلوب كما يسميها الغزالي هو الصراع بين قوى الخير وقوى الشر، بين

## أساليب علاج أمراض النفس عند الغزالي

### العبادات

العبادات في الإسلام ليست طقوساً مبهمة مغرقة في الرمزية، لا غاية دنيوية لها، وإنما هي أعمال مرتبطة ارتباطاً وثيقاً بالصحة النفسية والجسدية للفرد من جهة، ولها علاقة وثيقة باستقرار المجتمع أخلاقياً واجتماعياً، لهذا أدرك الغزالي مثل غيره من فلاسفة الإسلام، أن العبادات لها وظيفة كبيرة في علاج المشاكل والانحرافات لدى الفرد والمجتمع، فتأمل ما تحقّقه الصلاة من طمأنينة، وشعور بالأمن والاستقرار النفسي، زيادة على ما فيها من نظافة للنفس والجسد، وما يحققه الصيام من صحة للجسد، زيادة على ما تؤدي إليه الزكاة من تعاون وتكافل اجتماعي، ومع تكافل هذه العبادات وما تدعو إليه من معاملات بين الأفراد يكون السعي نحو مجتمع فاضل، عادل تنتفي فيه، أو تقل الأفاعات الاجتماعية، لأن صلاح الأفراد من صلاح المجتمع. والمتأمل لكثير من الآيات والأحاديث يتأكد من ذلك، حيث يقول تعالى: (وأقم الصلاة إن الصلاة تنهى عن الفحشاء والمنكر، ولذكر الله أكبر، والله يعلم ما تصنعون).<sup>42</sup>

(خذ من أموالهم صدقة تطهرهم وتزكّيهم بها).<sup>43</sup>

وقول النبي (ص): (من لم يدع قول الزور والعمل به، فليس لله حاجة في أن يدع طعامه وشرابه).<sup>44</sup>

ولو تتبعنا نموذجاً يقدمه الغزالي للعبادات، نتبين منه التحليل النفسي الدقيق للنفس البشرية الذي يقدمه الغزالي، ونظرته إلى العبادة على أنها أساس تحقيق الاتصال بالله، لتصل النفس إلى التوازن والاستقرار النفسي والطمأنينة. إذ يرى مثلاً أن روح الصلاة في حضور القلب، أما «إذا كان القلب غافلاً ولسانه يتحرك بحكم العادة، فما أبعد هذا عن المقصود بالصلاة التي شرعت لتصفيل القلب وتجديد ذكر الله عز وجل، ورسوخ عقد الإيمان».<sup>45</sup>

ومع معرفة الغزالي للطبيعة البشرية فهو يدرك أن الخشوع التام يبدو مستحيلاً، إذ لا يمكن التخلص من مشاغل الدنيا، وأهواء النفس، إلا أن الغزالي يجتهد في فهم أغوار النفس البشرية ليحدد الأسباب التي تشغل النفس عن الخشوع، ملتزماً بمنهجه العلمي يبين لنا في نفس الوقت الدواء وكيفية علاج شرود الذهن، ودفع المثيرات، وهنا تبرز عبقرية الغزالي في تحليل النفس، إذ يقول: «وسبب موارد الخواطر إما أن يكون أمراً خارجاً، أو أمراً في ذاته باطنياً. أما الخارج فما يقرع السمع أو يظهر للبصر، فإن ذلك قد يختطف الهم (أي الفكر) حتى يتبعه ويتصرف فيه، تنجر الفكرة إلى غيره ويتسلسل، ويكون الإبصار سبباً للإفكار، ثم يصير بعض تلك الأفكار سبباً للبعث، ومن قويت نيته، وعلت همته لم يله ما جرى على حواسه، ولكن الضعيف فلا بد وأن يتفرق به فكره».<sup>46</sup>

وفي هذا التحليل والوصف يحدد (الغزالي) طبيعة العوامل الذاتية والموضوعية التي تؤثر على المصلي وحواسه، فتشغله عن الخشوع، وتشتت انتباهه البصري والسمعي. ولا يكتفي بعرض المثيرات المختلفة بل يصف أيضاً الحلول، «وعلاجه قطع هذه الأسباب بأن يغمض بصره، أو يصلي في بيت مظلم، ولا يترك بين يديه ما يشغل حسه، ويقرب من حائط عند صلاته، حتى لا تنتسج مسافة بصره. ويحترز من الصلاة على الشوارع، وفي المواضع المنقوشة المصنوعة وعلى الفرش المصبوغة، وأما الأسباب الباطنة فهي أشد، ويعينه على ذلك أن يستعد له قبل التحريم، بأن يجدد على نفسه ذكر الآخرة، وموقف المناجاة، وخطر المقام بين يدي الله سبحانه، وهو المطلع ويفرغ قلبه قبل التحريم بالصلاة عما يهيمه، فلا يترك لنفسه شغلاً يلتفت إليه خاطره».<sup>47</sup>

بعد هذا الوصف العلمي الدقيق الذي يبرز لنا ما يمكن أن يؤدي إليه التطرف في هذا الإنفعال من عدوانية وعنف، وإلحاق الأذى بالذات وبالغير، وغياب للإرادة والعقل، ولذلك يأتي دور الحلول، والعلاج ليتحكم الإنسان في الغضب كأنفعال، وقس على ذلك في كل الانفعالات والعواطف الأخرى، وبداية يرى الغزالي ضرورة أن يسعى الإنسان إلى الوسطية والاعتدال في كل أفعاله النفسية، فمثلاً في الغضب «خير الأمور أوسطها فمن مال غضبه إلى الفتور حتى أحس من نفسه بضعف الغيرة وخسة النفس، في احتمال الذل والضيم في غير محله، فينبغي أن يعالج نفسه، حتى يقوى غضبه. (قد نفهم من ذلك حتى يحفظ بقاءه، وهيبته واحترامه). ومن مال غضبه إلى الإفراط حتى جره إلى التهور، واقتحام الفواحش، فينبغي أن يعالج نفسه لينقص من سورة الغضب، ويقف على الوسط الحق بين الطرفين».<sup>39</sup>

أما في حالات اشتداد الغضب فيقدم الغزالي علاجاً لذلك، مذكراً دائماً على أن الوقاية خير من العلاج، أي يتوقى الغضب من الأول بتربية النفس من البداية على الاعتدال، والصبر، والحلم، «حتى لا يهيج، فإذا جرى سبب هياجه، فعنده يجب التثبّت حتى لا يضطر صاحبه إلى العمل به على الوجه المذموم. وإنما يعالج الغضب عند هيجانه بمعجون العلم والعمل».<sup>40</sup>

ولا يخرج هذا عن العلاج المعرفي والعلاج السلوكي كما يعرف حديثاً، وسيثبت ذلك بعد التحليل.

### أما العلم فهو ستة أمور

- أن يتفكر في فضل كظم الغيظ والعتو والحلم، والاحتمال فيرغب في ثوابه.
- تخويف نفسه من عقاب الله إذا ظلم غيره، فإن كان أقوى من خصمه فالله أقوى منه.
- الحذر وتخويف النفس من عواقب الغضب عليه في الدنيا.
- أن يتفكر في قبح صورته عند الغضب، بأن يتذكر صورة غيره في حالة الغضب، وتشبيهه الغاضب بالحيوان الضاري.
- أن يتفكر في السبب الذي يحمله على الغضب والانتقام.
- يعلم أن غضب الله عليه أعظم من غضبه، فيغلب مراد الله لا مراده.

### وأما العمل فهو

- التعوذ من الشيطان، والاستغفار من الله، والدعاء.
- الجلوس إن كان الشخص واقفاً، والاضطجاع إن كان جالساً.
- التوضؤ بالماء، أو الاغتسال لإطفاء نار الغضب.<sup>41</sup>

نستنتج من هذا أن الغزالي يبني العلاج النفسي على أمرين، الأول نظري (العلم كما يسميه)، والثاني تطبيقي (عملي)، وهذا الكلام لا يختلف كثيراً عن ما يُطرح حديثاً، من استخدام العلاج المعرفي المبني على الاقتناع، والوعي والمعرفة بالمرض، ثم الإرادة والتصميم على التخلص منه. وبعدها يأتي العلاج العملي أو السلوكي مكملاً لذلك، متمثلاً في الجهد الإرادي للعمل على التخلص من المرض، بالممارسة، والجهد الذاتي المبذول.

وهو سبق معرفي ومنهجي يحسب للغزالي دون شك. ويمكن تطبيق هذا العلاج عن طريق جهد ذاتي داخلي، يقوم به الشخص نفسه. ويمكن الاستعانة بجهد خارجي، يقوم به معالج أو مرشد، خبير بداء القلوب، أو النفوس كما يقول الغزالي.

« وكذلك الشهوة والغضب ينبغي أن يكونا تحت يد العقل، فلا يفعلنا شيئا إلا بأمره، فإن فعل ذلك صح له حسن الخلق، وهي صفات الملائكة، وهي بذر السعادة »<sup>53</sup>.

### العلاج العملي عند الغزالي

ويكمن ذلك في وجهين متكاملين، ترك وفعل، أي تجنب الرذائل، والتخلي عنها، واكتساب الفضائل والتحلي بها .

العلاج بتترك الرذائل: وسماها الغزالي المهلكات، وهي الحسد والكذب، والرياء والتكبر، وغيرها من الموبقات. وهي الصفات السيئة التي تتصف بها النفس.

العلاج باكتساب الفضائل: وهي كثيرة وتشكل أساس العلاج عند الغزالي وقد أفرد لها الغزالي فصولا في الإحياء، سماه ربع المنجيات ويتمثل في التزام الصبر والعفة والصدق، والأمانة، وغيرها من الفضائل، أو الصفات الحسنة.

إذ يستخدم مع الجميع طريق الوعظ والإرشاد، لتترك الرذائل واكتساب الفضائل، لكن يكون ذلك حسب حالة كل شخص، أي بالموازنة بين الرجاء والخوف، «أما الذي غلب عليه الخوف، حتى هجر الدنيا بالكلية، وكلف نفسه ما لا تطيق، وضيق العيش على نفسه بالكلية، فتكسر سورة إسراره في الخوف، بذكر أسباب الرجاء، ليعود إلى الاعتدال، كذلك المصر على الذنوب المشتهية للتوبة، الممتنع عنها بحكم القنوط واليأس، استعظما لذنوبه التي سبقت، يعالج أيضا بأسباب الرجاء حتى يطمع في قبول التوبة فيتوب »<sup>54</sup>.

### توازن الشخصية عند الغزالي

يستخدم (الغزالي) مصطلحا مهما للدلالة على حصول التوازن النفسي، وتوافق الشخصية مع محيطها، وهو مصطلح الرضا، الذي صار مستخدما أيضا في علم النفس الحديث.

إذ الرضا عند (الغزالي) هو ثمرة المحبة، أي محبة العبد خالقه، وطاعته له، ويتصور الرضا من وجهين:

**الوجه الأول:** يبطل الإحساس بالألم، فلا يحس الشخص بالألم، ويتقبل الإنسان الأفعال رغم ضررها ويتزود بالصبر، مثاله الرجل المحارب في الغضب أو الخوف يتعرض للجراح ولا يحس بالألم.<sup>55</sup>

**الوجه الثاني:** أن يحس الألم ويدركه، ولكن يكون راضيا به، راعياً فيه بعقله، وإن كان كارها بطبعه، مثله من يسافر في طلب الربح، يدرك مشقة السفر، ولكن حبه لثمرة سفره طيب عنده مشقة السفر، وجعله راضيا بها مهما أصابه.<sup>56</sup>

والرضا عند الغزالي هو الحالة التي يتم فيه التغلب على الشهوات والغرائز، بعد صراع بين باعث الهوى وبعث الأخلاق. وتحلي الإنسان في هذه المرحلة بالصبر والمواظبة على رياضة النفس على تجنب الرذائل، وبالتالي تتحقق حرية الإنسان وقيادته لنفسه، وذلك حين «بملك العبد شهوته وغضبه فينقادان لبعث الدين، إذ به يصير صاحبه حرا »<sup>57</sup>.

أما إذا حدث العكس ولم يفلح في التحكم في نفسه، واستولت عليه غرائزه. فإنه «يصير عبدا مسخرا مثل البهيمة، مملوكا يستجره زمام الشهوة، أخذاً بمخنتقه إلى حيث يريد ويهوى »<sup>58</sup>.

فالغزالي أدرك منذ ذلك الوقت منهج العلاج المتكامل المبني على الجمع بين العلاج الذاتي الذي يقوم به الفرد نفسه، والعلاج الموضوعي الذي يقوم به

وكما لاحظنا يقترح الحل لإبعاد تأثير المثيرات الخارجية، ثم تحرير النفس من الخواطر الداخلية، لتحقيق التركيز وحضور القلب في الصلاة، ويبرز في تحليله إدراك جيد للعوامل المختلفة التي تؤثر في النفس البشرية.

### الاعتدال والتوازن

وقد تنبه الغزالي وغيره من فلاسفة الإسلام كابن سينا إلى ذلك، حيث يقول الغزالي: «إن الاعتدال في الأخلاق هو صحة النفس والميل عن الاعتدال سقم ومرض... وكما أن البدن في الابتداء لا يخلق كاملا، وإنما يكمل ويقوى بالنشوء والتربية بالغذاء، فكذلك النفس تخلق ناقصة قابلة للكمال وإنما تكمل بالتربية وتهذيب الأخلاق والتغذية بالعلم »<sup>48</sup>.

ويؤكد الغزالي على مبدأ الاعتدال والتوازن على المستويين الجسمي والنفسي، فإذا كنا لاحظنا ذلك سابقا على الجسم، فهو يرى أيضا ضرورة التوازن والاعتدال بين قوى النفس، وذلك بتحكيم العقل، كما انه لا يؤمن بقمع ومحو الغريزة والانفعالات، والعاطفة، وإنما يعتبرها جزءا ضروريا من الإنسان، وإنما يجب تنظيم ذلك النشاط النفسي «فإذ رأيت واحدا منهم قد عصى عليك مثل الشهوة والغضب، فعليك بالمجاهدة ولا تقصد قتلها، لأن المملكة لا تستقر، إلا بهما فإذا فعلت ذلك كنت سعيدا، وأديت حق النعمة وإلا كنت شقيا »<sup>49</sup>.

كما أن الاعتدال والرجوع إلى الوسطية مهم في حدوث الشفاء والتوازن للنفس، في مواجهة الحالات النفسية كالخوف المفرط، واليأس والقنوط وبالتالي الاكتئاب، ويكون التعامل حسب (الغزالي) بحسب الحالة، إذ «الذي غلب عليه الخوف حتى هجر الدنيا بالكلية، وكلف نفسه ما لا يطيق، وضيق العيش على نفسه بالكلية، فتكسر سورة إسراره في الخوف، بذكر أسباب الرجاء، ليعود إلى الاعتدال، وكذلك المصر على الذنوب المشتهية للتوبة الممتنع عنها بحكم القنوط واليأس استعظما لذنوبه »<sup>50</sup>.

ويظهر هنا جلجا أسلوب العلاج المبني على الإرشاد والإقناع، واستعادة الثقة إلى المريض حتى يسترجع توازنه النفسي، وبالتالي يحدث العلاج، وهو نفس الأسلوب المعتمد في المدارس الحديثة .

### تربية الغرائز والتحكم فيها

ويؤكد أن الانفعالات والعواطف جزء من الحياة النفسية، إذ لا يمكن إزالتها بالكلية وإنما تربيتها والتحكم فيها، إذ يقول: «أعلم أنه ظنون أنه يتصور محو الغضب بالكلية، وزعموا أن الرياضة إليه تتوجه وإياه تقصد، وظن آخرون أنه أصل لا يقبل العلاج، وهذا رأي من يظن أن الخلق كالخلق، وكلاهما لا يقبل التغيير، وكلا الرأيين ضعيف بل الحق فيه ما نذكره، وهو أنه ما بقي الإنسان يحب شيئا ويكره شيئا فلا يخلو من الغيظ والغضب، وما دام يوافق شيئا ويخالفه آخر، فلا بد من أن يحب ما يوافق، ويكره ما يخالفه، والغضب يتبع ذلك »<sup>51</sup>.

ولما كانت تلك الانفعالات جزءا حيا من الإنسان، فما عليه إلا أن يتحكم فيها ويوجهها توجيها صحيحا ما دام مستحيل محوها بالكلية كما يقول الغزالي: «فليست الرياضة فيه لينعم غيظ القلب، ولكن لكي يقدر على أن لا يطبع الغضب، ولا يستعمله في الظاهر، إلا على حد يستحبه الشرع ويستحسنه العقل، وذلك ممكن بالمجاهدة، وتكلف الحلم، والاحتمال مدة يصير الحلم والاحتمال خلقا راسخا. فأما قمع أصل الغيظ من القلب، فذلك ليس مقتضى الطبع، وهو غير ممكن، نعم يمكن كسر سوره، وتضعيفه »<sup>52</sup>.

14. الغزالي: ميزان العمل، تحقيق وتقديم: سليمان دنيا، دار المعارف، ط 1، القاهرة، 1964، ص 314.  
15. الغزالي: الإحياء، ج 3، مصدر مذكور سابقاً، ص 72، 73.  
16. المصدر نفسه، ص 75.

\* زيادة على الحواس الخمس، البطن والفرج.

17. المصدر نفسه، ج 3، ص 74.  
18. المصدر نفسه، ص 75.  
19. المصدر نفسه، ص 83.  
20. المصدر نفسه، ص 87.  
21. المصدر نفسه، ص 77.  
22. المصدر نفسه، ص 63.  
23. راجع المصدر نفسه، ص 85.  
24. المصدر نفسه، ص 87.  
25. المصدر نفسه، ص 86.  
26. المصدر نفسه، الصفحة نفسها.  
27. المصدر نفسه، الصفحة نفسها.  
28. راجع المصدر نفسه، ص 87.  
29. الغزالي: كيمياء السعادة، المكتبة العصرية، ط 1، صيدا-بيروت، 2003، ص 107، 108.  
30. الغزالي: جواهر القرآن ودرره، تحقيق: لجنة إحياء التراث العربي، دار الأفاق العربية، ط 5، بيروت، 1983، ص 28، 29.  
31. (راجع المصدر نفسه، ص 31.  
32. (المصدر نفسه، ص 29.  
33. المصدر نفسه، الصفحة نفسها.  
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35. راجع الغزالي: الإحياء، ج 4، مصدر مذكور سابقاً، ص 45.  
36. المصدر نفسه، ج 3، ص 149.  
37. المصدر نفسه، ج 3، ص 145.  
38. المصدر نفسه، ص 145، 146.  
39. المصدر نفسه، ص 146.  
40. المصدر نفسه، ص 150.  
41. راجع المصدر نفسه، ص 150، 151.  
42. قرآن كريم: العنكبوت 45.  
43. قرآن كريم: التوبة 103.  
44. حديث نبوي صحيح: رواه البخاري، كتاب الصوم.  
45. الغزالي: الإحياء، مصدر مذكور سابقاً، ج 1، ص 143.  
46. المصدر نفسه، ج 1، ص 146.  
47. المصدر نفسه، ج 1، ص 146، 147.  
48. المصدر نفسه، ج 3، ص 52.  
49. الغزالي: كيمياء السعادة: المكتبة العصرية، الطبعة الأولى، صيدا-بيروت، 2003، ص 104.  
50. الغزالي: الإحياء، ج 4، مصدر مذكور سابقاً، ص 45.  
51. المصدر نفسه، ج 3، ص 146.  
52. المصدر نفسه، ص 147.  
53. الغزالي: كيمياء السعادة، مصدر مذكور سابقاً، ص 106.  
54. الغزالي: الإحياء، ج 4، مصدر مذكور سابقاً، ص 45، 46.  
55. راجع الإحياء، ج 4، مصدر مذكور سابقاً، ص 297.  
56. المصدر نفسه، الصفحة نفسها.  
57. المصدر نفسه، ص 68.  
58. المصدر نفسه، الصفحة نفسها.  
59. المصدر نفسه، ج 3، ص 49.

ملاحظ خارجي، كالمعلم أو المرشد، حيث يقول مثلاً: «الإنسان الغفل الذي لا يميز بين الحق والباطل، والجميل والقيح. بل بقي كما فطر عليه خالياً عن جميع الاعتقادات... فهذا سريع القبول للعلاج جداً، فلا يحتاج إلا إلى معلم ومرشد، وإلى باحث من نفسه يحمله على المجاهدة، فيحسن خلقه في أقرب في أقرب زمان.»<sup>59</sup>

وهو ما يؤكد على إدراك الغزالي لطرق العلاج النفسي، أي المنهج العاطفي، الذي يجمع بين المنهج الذاتي، والمنهج الموضوعي، بين الاستبطان والمنهج السلوكي، بين العمل الذاتي والملاحظة الداخلية، والعمل الموضوعي والملاحظة الخارجية، وهو منهج المدارس الحديثة في العلاج النفسي.

## الخلاصة

يمكننا أن نقول دون وجل، أن الغزالي هو مؤسس علم النفس الإسلامي، وأنه سبق غيره في تأسيس هذا العلم موضوعاً ومنهجاً، وقد بنينا هذا الحكم على الأدلة التي سقناها من مصادره الأصلية، وقد أخذنا قليلاً من كثير تميز به الغزالي في موضوعات النفس. والتي بدا لنا أنها جديرة بدراسة أكثر عمقاً وتوسعاً لأصالتها. كما يبرز من خلال النماذج المختصرة التي قدمناها، أن الغزالي قد أدرك كثير من مشكلات وأمراض النفس، ووصفها بطريقة موضوعية، تدل على اعتماده الملاحظة، واستفادته من التجربة، وتمكّنه من المنهج.

إضافة إلى أن الغزالي تنبّه إلى دور العامل الروحي في نجاح العلاج النفسي، دون أن يغفل ما للعوامل النفسية، والجسدية والاجتماعية من تأثير. مع إشارات العلمية الدقيقة التي نراه سبق بها كثير من علماء النفس والتربية المعاصرين، رغم اختلاف الزمان والظروف والإمكانات بين عصرنا وعصره.

ولا نكون مبالغين إن قلنا أن الغزالي رائد من الرواد الأوائل في علم النفس والتربية. ولعلّ البحوث العلمية الجادة ستكشف ما في تراثنا من سبق وأصالة وتميز. وذلك لإنصاف هذا التراث الثري الذي عانى كثيراً من الإجحاف في الأوساط العلمية الغربية.

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8. المصدر نفسه، ج 4، ص 55.
9. الغزالي: الإحياء، ج 3، مصدر مذكور سابقاً، ص 49.
10. المصدر نفسه، الصفحة نفسها.
11. المصدر نفسه، ص 69.
12. المصدر نفسه، الصفحة نفسها.
13. المصدر نفسه، ص 57.

## **Abstract**

Muslim philosophers and scholars have long been interested in the psyche and its disorders. They did well in the diagnosis of various psychological conditions and prescribing the appropriate treatment. Abu-Hamed Al-Ghazali was a prominent figure in the field who established the basics of the Islamic philosophy of the psyche. The personal experience of Al-Ghazali in Sufism contributed to the formulation of those basics, taking into consideration the close link between Sufism and psychology. As a researcher in psychology, Al-Ghazali used his experience of Sufism as a rich resource for understanding the psyche and generalising it to all aspects of psychology, such as the perception of reality and emotions, the functions of dreams, and deviations from the norm and consequently the diagnosis and treatment of psychiatric conditions.

The author presents an analysis of psychological activity according to Al-Ghazali, which includes the division of the psyche, the influence of the instincts, the control of emotions, the functions of dreams, the extent of psychiatric disorders and their causes and treatment. The current paper compared modern schools of psychology with Al-Ghazali's approach to analysis. Al-Ghazali used meditation and introspection. He relied on evidence from observations, experiments and his experience of cases in real life. The current paper highlights the originality and authenticity of his psychoanalysis. Al-Ghazali had the pioneering precedent over modern schools of psychology and the various approaches in psychiatry and psychology in the diagnosis and treatment of various conditions.

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## إعادة تقنين مقياس أعراض الوسواس القهري

وائل محمد أحمد أبو هندي ، داليا عزت مؤمن ، أحمد محمد عبد الله

### Re-standardizing the Obsessive-Compulsive Symptom Scale

Wa-il Mohamed Ahmed Abohendy, Dalia Mohamed Ezzat Moemen, Ahmed Mohamed Abdalla

#### ملخص الدراسة

تهدف الدراسة الحالية إلى إعادة التحقق من الصلاحية السيكومترية لمقياس أعراض اضطراب الوسواس القهري<sup>1</sup>، من خلال إعادة حساب صدقه وثباته ومعايير ه على عينة مرضية أكبر، تم تطبيق المقياس على عينة مكونة من 301 فرداً مُشخصاً باضطراب الوسواس القهري و113 من الأسوياء وتم حساب الصدق عن طريق: صدق الاتساق الداخلي والصدق التمييزي، وحسب الثبات باستخدام معامل ألفا كرونباخ وثبات التجزئة النصفية، كما تم إعادة وضع مقاييس فرعية وأخيراً تم إعداد معايير محدثة للمقياس، وخلصت الدراسة إلى أن مقياس أعراض الوسواس القهري أداة صممت بما يتلاءم مع المجتمع المصري، والوصول إلى درجات أعلى من الثبات والصدق، وإعادة حساب المعايير وتحديد شدة الأعراض، ولم يتم اختصار عدد البنود ذلك أن كل العبارات دالة إحصائياً بما لا يسمح بإهمال إحداها، وكان من المناسب أن نقرده بعداً عاماً للأعراض الدينية.

الكلمات الدالة: اضطراب الوسواس القهري – مقياس أعراض الوسواس القهري – أعراض الوسواس الدينية

إعلان المصالح: لا يوجد

#### أهداف الدراسة

تهدف الدراسة بوجه عام إلى مراجعة الصلاحية السيكومترية لمقياس أعراض اضطراب الوسواس القهري، ويقصد بذلك إعادة حساب الصدق والثبات والمعايير على عينة مرضية أكبر شُخصت بالوسواس القهري وفق الدليل التشخيصي الخامس<sup>8</sup> DSM5، وعلى عينة أكبر أيضاً من غير مرضى الوسواس ونلخص أهداف الدراسة فيما يأتي:

1- إعادة تقنين مقياس أعراض الوسواس القهري على البيئة المصرية.

- مراجعة المقاييس الفرعية للمقياس.
- الوصول إلى ثبات وصدق بأفضل ما يمكن للمقياس تحقيقه.
- وضع معايير للمقياس.
- تحديد مدى شدة الأعراض.

#### معنى الوسواس

الوسواس لغةً هو حديث النفس، يقال وسوست إليه نفسه "وسوسة" و"وسوساً" أما القهر فهو الغلبة، وقهره قهراً أي غلبه فهو قاهر وقهار، ويقال أخذهم قهراً أي من غير رضاهم<sup>9</sup>.

الوسواس القهري هو اضطرابٌ نفسي يصيبُ واحداً من كل خمسين من الكبار وطفلاً من بين كل مائة طفل على مستوى العالم، وتشمل أعراضه الأفكار التسلطية (المحتويات العقلية التسلطية) أو الوسواس والأفعال القهرية أو القهورات، فأما المحتويات العقلية التسلطية فهي أفكارٌ أو صور أو نزعات أو أحاسيس يزج الشخص أن تطرأ على وعيه أو لا يريد أن تخطر على فكره لكنها كلما حاول التخلص منها أو قمعها تزيد من إلحاحها عليه، وأما الأفعال القهرية فهي أفعالٌ يكررها الشخص وهو يحسُّ أنه مجبورٌ على تكرارها لأنه لا يستطيع تحمل أو مواجهة الفلق والتوتر الناتجين عن منع نفسه من تكرارها، رغم أن هذه الأفعال كثيراً ما تكون أفعالاً تافهة، أو بلا معنى من وجهة نظر المريض نفسه، ومن أي وجهة نظر أخرى بل وأحياناً ما يكون تكرارها مؤذياً للشخص، إلا أنه رغم كل ذلك لا يستطيع منع نفسه

#### مقدمة

منذ صدور مقياس أعراض الوسواس القهري في صورته الأولى في 2006 تم استخدامه كأداة تقييم لمرضى الوسواس القهري سواء في العمل العيادي أو في الأبحاث الأكاديمية ومنها: أعراض الوسواس القهري الدينية وعلاقتها بالاكنتاب في عينة من مرضى الوسواس القهري المصريين<sup>2</sup>، الاضطراب التناقضي بين مرضى الوسواس القهري في مستشفيات جامعة الزقازيق<sup>3</sup>، الوظائف التنفيذية في مرضى الوسواس القهري<sup>4</sup>، مدى انتشار العوامل المصاحبة لتوابع الرهاب الاجتماعي والوسواس القهري<sup>5</sup>، الوسواس القهري واضطرابات الشخصية<sup>6</sup>.

إلا أن دراسة أحمد عبد الخالق وآخرون<sup>7</sup> على مقياس أعراض الوسواس القهري تشير إلى الحاجة إلى تطويره.

#### أهمية الدراسة

كان من المهم بعد وضع مقياس أعراض الوسواس القهري وهو الأول والأكثر حساسية للأعراض الدينية عالمياً وليس فقط عربياً كما نشر سنة 2006، أن تختبر حساسيته للأعراض الوسواسية دينية المحتوى على عينة أكبر من المرضى، وأن تختبر تلك الحساسية للأعراض الدينية كذلك مقابل عينة أكبر من غير مرضى الوسواس القهري.

- قلة الدراسات التي قامت بإعداد مقاييس الوسواس القهري بما يتناسب مع البيئة المصرية.
- الحاجة إلى قياس مدى واسع من أعراض اضطراب الوسواس الموجودة بمجتمعنا، والمختلفة الأعراض عن الشائع عالمياً.
- توفير مقياس يتمتع بدرجة عالية من الصدق والثبات تم حسابها على عينات مُشخصة بالوسواس القهري.
- وضع معيار واضح لتحديد درجة شدة الأعراض مما يسهم في تحديد مقدار التحسن أثناء العلاج.

(3) أفكار وأفعال وسواسية مختلطة :

يعاني أغلب مرضى الوسواس القهري من عناصر كل من التفكير الوسواسي والسلوك القهري. ويجب استخدام هذه الفئة إذا كانت الظاهرتان واضحتين بالتساوي، ومع ذلك فمن المفيد تسجيل إحدهما فقط إذا كانت بارزة بشكل واضح، ذلك أن الأفكار والأفعال قد تستجيب لعلاج مختلفة<sup>14</sup>.

**اضطراب الوسواس القهري واضطراب الشخصية الوسواسية**

يعد اضطراب الشخصية الوسواسية نوعاً من أنواع اضطرابات الشخصية وهي كما عرفها الدليل الأمريكي التشخيصي الخامس: شخصية تتسم بالانشغال بالتنظيم والترتيب والكمالية والسيطرة على العقل والعلاقات البيشخصية، على حساب المرونة والانفتاح والفعالية، كما يتجلى ذلك في ثمانية معايير: الانهماك بالتفاصيل والترتيب والانتظام والقواعد؛ الصلابة الذهنية؛ الدقة والكمالية، والعطاء المفرط في العمل والتردد في تفضيل غيره، فرط التدنن، البخل. والاكنتان. وهي تتشابه مع اضطراب الوسواس القهري فقد يشتركان في فرط الانشغال بالترتيب والانتظام والكمالية والتعمق "فرط التدقيق" والصلابة السلوكية (الحاجة إلى السيطرة) أو الصلابة المعرفية (العناد)، فكل هذا تداخل بين معايير الاضطرابين ليس فقط من الناحية السريرية (الإكلينيكية) والعلاجية بالعلاج السلوكي المعرفي وإنما أيضاً في تعصيب القياس النفسي.... فقياس هذه السمات المعرفية مشترك بالأساس، ومن الجدير بالذكر أن قائمة لايتون للوسواس (أول قائمة قياس مختصة بالوسواس)<sup>15</sup> كانت تقيس كلاً من الأعراض الوسواسية والسمات الوسواسية وكان من أهم عيوبها التناقضات المدونة بين الأعراض والسمات، فبعض الأبعاد المعرفية تمت تغطيتها مرتين بشكل متناقض، فتجد السؤال في قسم الأعراض مصاعاً بطريقة الشكوى أو عدم السرور وفي نفس الموضوع في قسم السمات تجد السؤال مصاعاً بطريقة تكون الإجابة عليها بالإيجاب يفهم منها ضمناً القبول والارتياح<sup>16</sup>... لم يكن وضع أسئلة لقياس مظاهر الاضطرابين موقفاً إذن... ورغم سهولة العمل السيكومتري لقياس سمات الشخصية القسرية دون انشغال بأعراض الوسواس القهري إلا أن تصميم مقياس لأعراض الوسواس القهري لا يتأثر بوجود سمات قسرية ما زال أمراً يبدو بعيد المنال.

ورغم ما كان يقال من أن "الفرق الحاسم بين الشخصية الوسواسية واضطراب الوسواس القهري يكمن في أن صاحب الشخصية الوسواسية ينظر إلى ما يقوم به من تدقيق وحب للتفاصيل بالفخر وبتوقير الذات وتقديرها، بينما يرى المصاب باضطراب الوسواس القهري هذه الخصال بغيضة وغير مرغوبة ومصدر عذاب وأنها غريبة على الذات"<sup>17</sup>، فإن المظاهر السلوكية لصفات الشخصية القسرية (الوسواسية) يمكن أن يكون لها صفة القهرية<sup>14</sup> (أي أنها تكون متعمدة، منكرة، مستهلكة للوقت، وتضعف مقاومتها أو السيطرة عليها، وليست متمعة بل ترتبط بالضيق) وهو ما يعني أن التداخل الظاهر في الأعراض والسلوكيات المرضية بين الاضطرابين يبقى حاضراً إلى الحد الذي شجع البعض على اقتراح تصنيف الشخصية القسرية كاضطراب ذي صلة بالوسواس أو اضطراب طيف وسواسي إضافة إلى تصنيفها كاضطراب شخصية<sup>18</sup>.

وأظهرت دراسة حديثة<sup>19</sup> وجود سمات اضطراب الشخصية القسرية في ما بين 9.4% و 24.4% ، وبذلك يمكننا استنتاج أن الشخصية الوسواسية القهرية ليست سابقة أو مندرجة باضطراب الوسواس القهري، وأن الأشخاص الذين يتصفون بالتدقيق الشديد ويمارسون حياة منظمة جداً ليس لديهم احتمال

من فعلها، وأداء الفعل القهري يعطي المريض بعض الراحة من القلق والتوتر، إلا أنها راحة زائفة لا تستمر طويلاً، فسرعان ما يعاوده القلق والتوتر ويستمران في التضخم إلى أن يعيد الفعل القهري مضطراً، ويعتبر اضطراب الوسواس القهري نوعاً من أنواع اضطرابات القلق، وأهم ما يميز هذا الاضطراب هو الوسواس المتكررة أو الطقوس القهرية.

وكنا في بداية دراسة الوسواس القهري قد عبرنا عن أن ترجمة كلمة Obsession إلى وسواس لم تكن ترجمة موفقة<sup>10</sup> بسبب ما حسبناه وقتها خطأ بين مفهوم الشيطان الديني وبين ذلك الاضطراب النفسي، إلى أن عرفنا من قراءتنا الفقهية أن تسمية وسواس قهري هي في الأصل تسمية عربية فقد جاء في "حاشية إعانة الطالبين" للدمياطي الشافعي [343/1]: (..قوله: بوسواس قهري: وهو الذي يطرُق الفكر بلا اختيار). وجاء فيها أيضاً [75/2]: (الشك يكون بعلامة، بخلاف الوسوسة، فإنها الحكم بالنجاسة [مثلاً] من غير علامة)... وقال المؤايق المالكي في "التاج والإكليل" [102/4]: (...وقال عز الدين: الوسوسة ليست من نفس الإنسان،...، ولا إنم على الإنسان فيها لأنها ليست من كسبه وصنعه، ويتوهم الإنسان أنها من نفسه... فيتحرج لذلك ويكرهه) كما قال القرطبي في تفسيره [222/7]: (..فالأحوط التي ليست بمستقرة، ولا اجتنبت الشبهة، فهي التي تُدفع بالأعراض عنها، وعلى مثلها يطلق اسم الوسوسة)... إلخ<sup>11</sup>.. ويتضح جلياً من هذا وغيره عمق فهم فقهاء المسلمين الأوائل لطبيعة الأحداث العقلية الوسواسية فهي تقفح الوعي بغير اختيار ولا تكون لها علامة منطقية ويلتبس على الإنسان هل هو مسئول عنها أو لا لكنه يتحرج منها وهي تدفع بالإعراض عنها وبمعرفة الإنسان أنه غير مسئول عنها، ولا يبدو في ذلك الفهم شيء يختلف عن ما نلمسه في مرضى الوسواس القهري ولا شيء يخالف النظرية المعرفية للوسواس القهري، وأما عبارة [الوسواس القهري] بنصها هذا فقد ذكرها الفقيه الشافعي ابن حجر الهيثمي (909-974هـ=1504-1567م) في كتابه "تحفة المحتاج بشرح المنهاج"<sup>12</sup>، وهذا معناه أن الإشارة إلى المرض المسمى وسواس قهري جاءت قديماً في تراثنا الفقهي دون ربط واضح لها بالشيطان ودون خلط كذلك، فحين نتأمل قول الدمياطي الشافعي: (الشك يكون بعلامة، بخلاف الوسوسة، فإنها الحكم بالنجاسة [مثلاً] من غير علامة) نجد أنه يتحدث عن عيب من عيوب التفكير يسميه الوسوسة ويقارنه بالشك فيجعل الشك مبنياً على المنطق والوسوسة مبنية على لا شيء!

**أنواع اضطراب الوسواس القهري**

يقسم اضطراب الوسواس القهري تبعاً لتصنيف منظمة الصحة العالمية<sup>14</sup> أهمها:

(1) اضطراب قهري تغلب عليها أفكار أو اجترارات وسواسية :

تأخذ هذه الاضطرابات شكل أفكار أو صور نفسية أو نزوات لإتيان فعل بعينه ، وتنبأين في مضمونها ولكنها مزعجة للشخص. وأحياناً تكون الأفكار لا طائل من ورائها تتناول تفكيراً لا نهائياً وشبه فلسفي في احتمالاتٍ عسيرة التقدير، وهذا التفكير في البدائل يعتبر عنصراً هاماً في اجترارات وسواسية أخرى كثيرة، وعادةً يصاحبه انعدام القدرة على اتخاذ قراراتٍ بسيطة ولكن ضرورية.

(2) اضطراب قهري تغلب عليها أفعال قسرية (طقوس وسواسية):

تدور أغلبية الأفعال القهرية حول النظافة، أو التحقق المتكرر من تأمين وضع معين يحتمل أن ينجم عنه خطر، أو التحقق من النظام والترتيب. ووراء هذا السلوك خوف من خطر يصدر ضد الشخص أو منه. وتكون هذه الطقوس محاولاتٍ غير مؤثرة أو رمزية لمنع هذا الخطر. وقد تستغرق أفعال الطقوس القهرية ساعاً طويلة كل يوم ويصاحبها أحياناً تردد وبطء شديداً .

الوسواسية وقائمة "مودسلي" للوسواس القهري وقائمة "بادوا"، واعتمدت على الصدق الظاهري، وطبقت الصيغة الأولى على عينة من طلاب الجامعة وتم حساب ارتباط كل بند بالدرجة الكلية، وحساب معاملات الارتباط المتبادلة، فأصبحت هذه البنود الأخيرة هي الصيغة الثانية للمقياس ثم طبقت على عينة طلاب وحسبت معاملات الارتباط المتبادلة بين كل بند والدرجة الكلية، وكانت دالة، ولما كان الهدف هو تكوين قائمة أكثر اختصاراً من ذلك، استبعدت البنود التي قل ارتباطها عن 0.4 فتكونت الصيغة النهائية من 32 بند وتم استخراج ثمانية عوامل هي لكن لا يمكن تحديد درجة لأي منها<sup>1</sup>.

أما مقياس أعراض اضطراب الوسواس القهري<sup>1</sup> فكانت مصادر جمع البنود هي: السؤال المفتوح الموجه إلى مرضى تشخيصهم بالوسواس حول شكاويهم النفسية، والخبرة الإكلينيكية، والمراجع المتخصصة. تم تطبيق الصيغة الأولى للمقياس على عينة مكونة من 54 منهم شخصوا باضطراب الوسواس القهري، 48 من الأسوياء بمصر، وتم حساب الصدق عن طريق: صدق المحك والصدق التلازمي والصدق التمييزي على هذه العينة إضافة إلى صدق المحكمين، ثم طبقت الصيغة الثانية على عينة عشوائية قوامها 105 شخص وتم حساب صدق الاتساق الداخلي، وحسب الثبات باستخدام معامل ألفا كرونباخ وثبات التجزئة النصفية، كما تم إعداد مقياس فرعية وأخيراً تم إعداد معايير للمقياس.

وإن جهدا عربيا مثمنا قام فيه أحمد عبد الخالق وآخرون<sup>7</sup> بدراسة الخصائص السيكومترية والتحليلي العاملي التوكيدي لمقياس أعراض الوسواس القهري لدى عينة من طلاب جامعة الكويت، واستنتج أن معاملات الثبات كانت مقبولة في ستة مقاييس فرعية فقط من الأربع عشر، إضافة إلى معامل الثبات للمقياس والأخير كان مرتفعاً ووصل إلى 0.96 مما يشير إلى ثبات واستقرار جيد عبر الزمن وإلى اتساق داخلي مرتفع إذا استخدم المقياس ككل، واعتبر المقياس نموذجياً من ناحية شموليته وإحاطته بمدى واسع من أعراض الاضطراب الوسواسي القهري كما اقترح اختصار المقياس وأوصى بتكرار دراسته على عينات مصرية وحساب التحليل العاملي الاستكشافي والتوكيدي واستخراج عوامل أكثر قوة، وتطرق إلى الحاجة إلى ربط وسواس الطهارة بالوسواس الدينية. كل ذلك يوضح ضرورة تطوير المقياس إلى صلاحية سيكومترية أعلى من حيث الصدق والثبات.

في 2009 ظهر مقياس اضطراب الوسواس القهري<sup>28</sup> ويتكون من 80 بنداً ليس فيها بند واحد يقيس الأعراض الدينية، وينطبق ذلك على مقياس الوسواس القهري من إعداد محمد<sup>29</sup>، ومقياس الوسواس القهري إعداد حميد<sup>30</sup> ومقياس الوسواس القهري إعداد الزبون وعباس<sup>31</sup>.

ثم ظهرت إحدى المحاولات العربية للباحث نائل عبد الرحمن أخرس<sup>32</sup> الذي أعد مقياساً من 48 بنداً مناسباً للمرضى الأردنيين، وتبين مقارنة بنوده بنود المقاييس العربية السابقة ما يشبه الاتفاق على حساسية بنود معينة لأن معظم بنوده دينية المحتوى وغيرها (16 بنداً من 48) مأخوذة بنصها من مقياس "أعراض الوسواس القهري" (1) فضلاً عن أكثر من 3 بنود تم تحويلها لغوياً، وكذلك 3 بنود بنصها ومثلها محورة لغوياً من المقياس العربي للوسواس القهري<sup>33</sup>.

كبير لتطوير اضطراب الوسواس القهري أكثر من أي فرد آخر، إلا أنه ليس من الممكن حتى الآن استبعاد وجود علاقة خاصة نوعاً بين الاضطرابين.

## الدراسات السابقة

استعرضنا في دراسة سابقة<sup>1</sup> أن أغلب مقاييس الوسواس القهري المتاحة باللغة العربية هي غربية الإعداد بداية من قائمة لايتون الوسواسية Layton Inventory<sup>15</sup> والتي عربتها نجمة الخرافي<sup>16</sup>، ومرورا بقائمة مودسلي Maudsley Obsessional Compulsive Inventory التي أعدها هودجسون وراثشمان<sup>20</sup> وعربها أحمد عبد الخالق، وأيضاً قائمة النشاط القهري Compulsive Activity Checklist والتي ظهرت أول نسخة عام 1977 وظهرت في صورتها الأخيرة Obsessive Compulsive Inventory في 1998<sup>21</sup> وقام شوقي يوسف بهنام بتعريبها ونشرها على الإنترنت على الشبكة العربية للعلوم النفسية<sup>22</sup>، كل هذه المقاييس تفتقر لما يقيس الأعراض الدينية. باستثناء فقرة 18 في قائمة النشاط القهري ونصها في ترجمة شوقي بهنام "أحتاج أن أصلي لكي أطرد من ذهني الأفكار والمشاعر السيئة".... ثم في الإصدار الأخير المختصر لهذه القائمة حذف هذا البند<sup>23</sup>، وأخيراً نشير إلى قائمة بادوا للوسواس القهري والتي أعدت في الأصل بالإيطالية<sup>24</sup> وصدرت نسخة معدلة منها في الولايات المتحدة الأمريكية على يد بيرنز وآخرون<sup>25</sup>، ولا يوجد في النسخة الأولى ولا المعدلة أيضاً ما يقيس الأعراض الدينية.... ووصلنا إلى استعراض بنود المقياس الأشهر والأوسع استخداماً في الآونة الأخيرة على مستوى العالم وليس فيه أيضاً ما يفهمه مرضى الوسواس العرب على أن له علاقة بالدين بما في ذلك فقرته هل تمضي وقتاً طويلاً في التفكير في الكفر والخطيئة هل تبدي اهتماماً بالغاً بالأخلاقيات وبما هو صواب وما هو خطأ؟ فعلاقتها هل بالدين ليست مباشرة أو ليست واضحة في ذهن المسلمين، فضلاً عن أن السؤال هل تغسل يديك كثيراً عادة يجيب عليه المريض بلا، بينما هو يقضي ساعات يغسل يديه في الوضوء، فمفهوم التطهر عند المسلمين يختلف عن مفهوم التنظيف أو الغسيل ومفهوم النجاسة عندهم يختلف عن مفهوم القذارة الغربي، ومن الواضح أن المقاييس السابقة على مقياس أعراض الوسواس القهري كلها أغفلت ذلك فضلاً عن إغفالها الصريح لكل ما يتعلق بوسواس أداء العبادات (الوضوء والصلاة والصيام.. الخ) والتي تمثل أكثر من نصف وسواس وقهور المسلمين<sup>2</sup> ورغم ذلك فعلى نفس هذا المنوال مع الأسف سار الباحثون العرب فيما استخدموا ترجمات أي من تلك المقاييس الغربية أو استخدموا المقياس العربي للوسواس القهري وهو المقياس العربي الأول والذي ينتقد في إعداده اعتماده على المقاييس الغربية رغم أن الهدف كان وضع مقياس نابع من المفهومين العرب، وفي أنه لم يميز بين السمات الوسواسية والأعراض الوسواسية، ولم يتضمن مقاييس فرعية، واعتمدت الدراسات جميعاً على عينات غير إكلينيكية من طلاب الجامعات والخلاصة أن الاطلاع على مقاييس وقوائم الوسواس القهري المتاحة بالعربية كلها والتي استخدمت في مئات الدراسات العربية تفتقر لما يقيس الأعراض الدينية أي أكثر من نصف أعراض مرضى الوسواس القهري العرب.

وقد ترجم مقياس يل- براون للوسواس القهري (بمركز الطب النفسي بجامعة عين شمس)، واستخدم في دراستين لعكاشة وزملائه لأعراض اضطراب الوسواس القهري لدى عينات من المصريين<sup>26</sup>، دون إجراء ثبات أو صدق للمقياس في البيئة العربية في أي من الدراستين.

بينما أعد أحمد عبد الخالق المقياس العربي للوسواس القهري مستمداً بنوده من المراجع المتخصصة إضافة إلى العوامل المستخرجة من التحليلات العاملية لبعض قوائم الوسواس القهري الأجنبية منها قائمة "لايتون"

## تعليق على الدراسات السابقة

حساب صدق المقياس الحالي نظرا لأن صياغة الأبعاد الفرعية في المقياس الأصلي جاءت بناء على المحكات التشخيصية للوسواس القهري بدليل الجمعية الأمريكية الإصدار الرابع.

- 1- كثير من المقاييس العربية هي ترجمة لمقاييس غربية.
- 2- المقاييس العربية ليس لها مقاييس فرعية بل تعتمد على الدرجة الكلية.
- 3- لا توجد معايير للمقاييس العربية، باستثناء مقياس أعراض الوسواس القهري.
- 4- العينات المستخدمة في الدراسات العربية من الأسوياء فيما عدا دراسة نجمة الخرافي<sup>16</sup>.
- 5- ما تزال دراستنا السابقة متفردة في اعتمادها السؤال المفتوح للمرضى كمصدر رئيسي للبيانات.
- 6- اعتمد المقياس العربي الأول على المقاييس الغربية، ولم يميز بين السمات والأعراض الوسواسية، ولم يتضمن مقاييس فرعية، وطبق على عينات غير إكلينيكية.
- 7- ظلت البنود التي تقيس الأفكار الوسواسية الدينية غير مدرجة بالمقاييس العربية التي كنت متاحة حتى صدور المقياس<sup>1</sup>.
- 8- تمت دراسة أحمد عبد الخالق<sup>7</sup> على عينة من ثقافة تختلف عن الثقافة التي أعد فيها المقياس، مما يؤثر على مصداقية الدرجات، فضلا عن أن استخدام التحليل العملي الاستكشافي كأحد أساليب حساب الصدق غير مناسب في

## المنهج والجراءات

### عينة الدراسة:

منذ يناير 2016 بدأت إجراءات إعادة التقنين، وتم الاعتماد على المقابلة الإكلينيكية لاختيار العينة. تم تطبيق المقياس على عينة قوامها 360 فردا مُشخصا باضطراب الوسواس القهري من مرضى العيادات النفسية في كل من القطاع الخاص ومستشفيات جامعة الزقازيق بمصر تم استبعاد 59 منهم بسبب أخطاء أو عدم الإجابة على بعض بنود فأصبح العدد النهائي لعينة المرضى 301 فردا، وكذلك طبق المقياس على 150 فردا لا يعاني من أعراض الوسواس القهري وتم استبعاد 37 منهم لنفس الأسباب السابقة لتصبح عينة الأسوياء 113 فردا، وفيما يلي وصف مفصل لخصائص عينة التقنين الحالية:

جدول (1) عينة الدراسة من الأسوياء والمرضى

المرضى		الأسوياء		خصائص العينة
النسبة	العدد	النسبة	العدد	
<b>1- النوع:</b>				
	148	58%	66	• ذكور
	153	42%	47	• إناث
<b>2- المستوى التعليمي:</b>				
	4	--	--	• أمي
	120	24%	27	• متوسط
	169	73%	83	• جامعي
	8	3%	3	• دراسات عليا
<b>3- السن:</b>				
	192	62%	70	• من 15 إلى 30 عام
	96	33%	37	• من 31 إلى 45 عام
	12	3%	4	• من 46 إلى 60 عام
	1	2%	2	• من 61 فما فوق
<b>4- النطاق الجغرافي:</b>				
	89	28%	32	• محافظة القاهرة
	205	70%	79	• محافظات الوجه البحري
	7	2%	2	• محافظات الوجه القبلي

### أولا: صدق الاتساق الداخلي :

- تم حساب صدق الاتساق الداخلي من خلال حساب الارتباط بين درجة الفقرة والدرجة الكلية للبعد، وحساب الارتباط بين الدرجة الكلية لكل بُعد والدرجة الكلية للمقياس ككل وهو ما يوضحه الجدول الآتي :

يظهر جدول (1) مقارنة المعلومات الديموجرافية للعينتين الأسوياء والمرضى قدرًا كبيرًا من التجانس والتطابق بينهما.

الصلاحية السيكمترية للمقياس:

جدول (2) صدق الاتساق الداخلي للمقاييس الفرعية

البُعد	الفقرة	قيمة الارتباط	البُعد	الفقرة	قيمة الارتباط
اجترار الأفكار	1	.682(**)	الوساوس الدينية	1	.690(**)
	2	.535(**)		2	.553(**)
	3	.686(**)		3	.728(**)
	4	.726(**)		4	.702(**)
	5	.792(**)		5	.639(**)
	6	.600(**)		6	.798(**)
	7	.800(**)		7	.735(**)
الوساوس الجنسية	8	.687(**)	1	.694(**)	
	9	.578(**)	2	.788(**)	
	1	.784(**)	3	.844(**)	
الوساوس الدعوانية	2	.794(**)	4	.888(**)	
	3	.579(**)	1	.345(**)	
	4	.806(**)	2	.640(**)	
	5	.651(**)	3	.691(**)	
	6	.612(**)	4	.581(**)	
	7	.811(**)	5	.708(**)	
	8	.669(**)			
	9	.386(**)			
	الانفعالات الوساوسية	1	.660(**)	الطهارة والنقاوة القهرية	1
2		.745(**)	2		.593(**)
3		.488(**)	3		.636(**)
4		.715(**)	4		.628(**)
5		.752(**)	5		.582(**)
6		.656(**)	6		.480(**)
7		.676(**)	7		.630(**)
8		.640(**)	8		.734(**)
الصور الوساوسية	2	.542(**)	البطء	1	.734(**)
	3	.809(**)		2	.773(**)
	4	.779(**)		3	.791(**)
	1	.725(**)		4	.726(**)
أفعال قهرية عامة	2	.730(**)	المراجعة	1	.658(**)
	3	.723(**)		2	.723(**)
	4	.630(**)		3	.757(**)
	1	.834(**)		4	.617(**)
أفعال قهرية دينية	2	.797(**)	طفوس اللبس	5	.437(**)
	3	.845(**)		1	.658(**)
	4	.637(**)		2	.718(**)
	5	.859(**)		3	.587(**)
				4	.656(**)

Re-standardizing the Obsessive-Compulsive Symptom Scale

.515(**)	1	تأثير الوسواس على الأنشطة اليومية
.754(**)	2	
.617(**)	3	
.785(**)	4	
.835(**)	5	
.688(**)	6	
.739(**)	7	
.638(**)	8	
.546(**)	1	الأعراض الدينية
.564(**)	2	
.474(**)	3	
.543(**)	4	
.493(**)	5	
.386(**)	6	
.521(**)	7	
.480(**)	8	
.451(**)	9	
.689(**)	10	
.420(**)	11	
.490(**)	12	
.521(**)	13	
.370(**)	14	
.560(**)	15	
.465(**)	16	الأعراض الدينية
.256(**)	17	
.464(**)	18	
.467(**)	19	
.440(**)	20	
.545(**)	21	
.525(**)	22	
.413(**)	23	
.528(**)	24	
.557(**)	25	
.582(**)	26	

\*\*القيمة دالة عند مستوى 0.01 \* القيمة دالة عند مستوى 0.05

أما عن حساب الارتباط بين مجموع درجات الأبعاد والدرجة الكلية للمقياس فالجدول التالي يوضح قيمة الارتباط ودلالته:

يوضح جدول (2) أن جميع فقرات المقياس دالة عند مستوى 0.01 مما يدل على درجة عالية من الثقة.

جدول (3) الارتباط بين مجموع درجات الأبعاد والدرجة الكلية للاختبار

م	الأبعاد	قيمة الارتباط
1	اجترار الأفكار	.614(**)
2	الوساوس الجنسية	.480(**)
3	الوساوس العدوانية	.639(**)
4	الوساوس الدينية	.468(**)
5	وساوس الطهارة والنظافة والخوف من المرض	.724(**)
6	الاندفاعات الوسواسية	.583(**)
7	الصور الوسواسية	.559(**)
8	أفعال قهرية عامة	.617(**)
9	الأفعال القهرية الدينية	.561(**)
10	الطهارة والنظافة القهرية	.703(**)
11	البطء	.639(**)
12	المراجعة	.649(**)
13	طقوس اللمس	.597(**)
14	تأثير الوسواس على الأنشطة اليومية	.679(**)

## ثانياً: الصدق التمييزي :

- تم حسابه بهدف تحديد مدى قدرته على التمييز بين المرضى والأسوياء في أعراض الوسواس القهري، واستخدم اختبار "ت" للكشف عن دلالة الفروق بين مجموعتي الدراسة، وذلك ما يوضحه الجدول الآتي :

جدول (4) الصدق التمييزي للمقياس

قيمة	المرضى (ن = 113)		الأسوياء (ن = 113)		العينة
	ع	م	ع	م	
ت					أبعاد المقياس
*7.49	5.35	26.96	6.48	21.03	اجترار الأفكار
*3.26	4.20	8.48	3.50	6.80	الوساوس الجنسية
*6.68	3.53	10.77	2.76	7.95	الوساوس العدوانية
*7.36	8.02	23.51	6.46	16.37	الوساوس الدينية
*10.39	9.02	24.65	5.27	14.43	وساوس الطهارة والنظافة والخوف من المرض
*5.99	5.88	15.52	3.91	11.53	الاندفاعات الوسواسية
*6.56	3.75	9.60	2.89	6.67	الصور الوسواسية
*9.30	4.30	14.25	3.52	9.38	أفعال قهرية عامة
*7.75	3.49	8.95	2.14	5.96	الأفعال القهرية الدينية
*10.32	6.51	16.68	3.15	9.65	الطهارة والنظافة القهرية

تم حساب ثبات التجزئة النصفية من خلال حساب الارتباط بين نصفي المقياس وتصحيح القيمة الناتجة عن الارتباط بمعادلة سبيرمان براون ليعادل ثبات المقياس ككل.

كما تم حساب معامل ثبات ألفا باستخدام برنامج SPSS

المقياس بالإضافة إلى حساب معامل ثبات القائمة ككل. (Statistical package for the Social Sciences) لكل بعد من أبعاد

يتضح من جدول (4) وجود فروق دالة إحصائية عند مستوى 0.01 في التمييز بين مجموعة الأسوياء والمرضى لصالح المجموعة المضطربة، مما يشير إلى صدق المقياس وقدرته المرتفعة على التمييز.

ثالثاً: ثبات التجزئة النصفية، ومعامل ثبات ألفا كرونباخ :

جدول (5) حساب ثبات التجزئة النصفية

م	الأبعاد	معامل الثبات قبل المعالجة	معامل الثبات بعد المعالجة	معامل ثبات ألفا
1	اجترار الأفكار	.67	.80	.81
2	الوساوس الجنسية	.70	.82	.82
3	الوساوس العدوانية	.44	.61	.57
4	الوساوس الدينية	.72	.84	.85
5	وساوس الطهارة والنظافة والخوف من المرض	.74	.85	.85
6	الاندفاعات الوسواسية	.57	.73	.76
7	الصور الوسواسية	.57	.73	.74
8	أفعال قهرية عامة	.58	.73	.69
9	الأفعال القهرية الدينية	.38	.55	.55
10	الطهارة والنظافة القهرية	.60	.75	.80
11	البطء	.61	.77	.67
12	المراجعة	.54	.70	.65
13	طقوس اللمس	.70	.82	.85
14	تأثير الوسواس على الأنشطة اليومية	.72	.83	.85
15	الأعراض الدينية	.80	.88	.87
16	الدرجة الكلية	.88	.93	.94

1. اجترار الأفكار (7 بنود): ويقاس إعادة التفكير في نفس الموضوع وفي تفاصيل كثيرة بطريقة تسبب الكرب، وأرقام البنود هي) 1-15-29-43-57-65-72.
2. الوسواس الجنسية (4 بنود): ويتضمن التفكير في أمور جنسية غير مرغوبة وغير مقبولة للشخص نفسه. 2-16-44-30.
3. الوسواس العدوانية (5 بنود): تشمل الخوف من التسبب في ارتكاب أشياء فظيعة ورهيبة. 3-17-31-45-58.
4. وساوس والنظافة والخوف من المرض (9 بنود): الشك في النظافة والطهارة والتفكير في الطهارة والنجاسة، والخوف من التعرض للجراثيم. 5-19-33-47-60-67-74-79-83.
5. الاندفاعات الوسواسية (8 بنود): ويقاس أفكار تتضمن أن الشخص على وشك القيام بفعل مزعج وهو غير قادر على التحكم فيه، والخوف من تنفيذ أفكار عدوانية باستعمال سلاح أو بالضرب والسب القهري. 6-20-34-48-61-80-75-68.
6. الصور الوسواسية (4 بنود): يتضمن صور مزعجة تفرض نفسها على الشخص. 7-21-35-49.

يتبين من الجدول (5) ارتفاع معامل ثبات المقياس حيث تراوح معامل ثبات التجزئة النصفية بين .55 وحتى .93، كما يتضح ارتفاع معامل ثبات ألفا سواء للأبعاد الفرعية والدرجة الكلية، كما يبين ارتفاع معامل ثبات المقياس ككل والذي بلغ .94.

#### مقاييس الأبعاد الفرعية للمقياس

بعد استعراض نتائج الدراسة والتي تشير في مجملها إحصائياً إلى صلاحية سيكومترية عالية لكل بنود وأبعاد المقياس، تم دمج بعدي الوسواس والأفعال القهرية الدينية في بعد واحد هو أعراض الوسواس القهري الدينية، وإضافة بنود أخرى من أبعاد أخرى للمقياس، دون أي حاجة لحذف أو تغيير أي من بنود المقياس، وكان من المهم تخصيص مقياس لأعراض الوسواس القهري الدينية والتي تمثل 57.4% من أعراض العينات المماثلة (2) لعينة الدراسة، فضلاً عن كونها شائعة إكلينيكية، وقد ثبتت العلاقة بين التدين والوسواس القهري<sup>34</sup>.

فأصبح هناك 13 مقياس فرعي وهي:

قهرى ليتأكد من طهارته مثلاً، والوسواس الدينية تشمل 9 بنود: (4-18-32-46-59-66-73-78-82) والأفعال القهرية الدينية (4 بنود): (9-23-37-51) و بعضها مكتنف ضمن أبعاد أخرى لأعراض الوسواس القهرى فمن فئة البطء البند (11) ومن وسواس الطهارة (5-33-60-74-79)، ومن فئة الصور الوسواسية (21-49) والطهارة القهرية (10-62-76) ومن فئة الاندفاعات الوسواسية (61-68)، والبنود ككل هي 4-5-9-10-11-18-21-23-32-33-37-46-49-51-59-60-61-62-66-68-73-74-76-78-79-82.

### طريقة التصحيح

يتم تصحيح المقياس من خلال: إعطاء «5» درجات لاختيار «دائماً»، «4» لاختيار «كثيراً»، «3» لاختيار «أحياناً»، درجتان لاختيار «نادراً»، «1» لاختيار «مطلقاً».

الفروق بين الدراسة السابقة (1) والحالية للخصائص السيكومترية للمقياس وبشكلها جدول 6:

7. أفعال قهرية عامة ومتباينة (5 بنود): أفعال متكررة يشعر الشخص أنه مجبر على تأديتها كالرغبة في تكرار أسئلة حول موضوع ما، أو عد أشياء معينة. 8-22-36-50-69.
8. النظافة الطهارة القهرية (7 بنود): تكرار الأفعال المتعلقة بالنظافة والطهارة بدون أسباب منطقية. 10-24-38-52-62-70-76.
9. البطء (4 بنود): ويشمل البطء في تنفيذ الأعمال والواجبات حتى البسيط منها. 11-25-39-53.
10. المراجعة (4 بنود): وتشمل مراجعة الأشياء بغرض التحقق من القيام بها. 12-26-40-54.
11. طقوس اللمس (5 بنود): العمل على تجنب لمس أشياء معينة، أو أن تلمس أشياء معينة ملابس الشخص. 13-27-41-55-63.
12. تأثير الوسواس على الأنشطة اليومية (8 بنود): أي استهلاك الوسواس والأفعال القهرية للوقت، وإعاقتها بدرجة كبيرة لنظام الشخص اليومي أو أداءه الوظيفي أو الأكاديمي أو الأنشطة الاجتماعية. 14-28-42-56-64-71-77-81.
13. مقياس الأعراض الدينية (26 بنداً) : يقيس الوسواس الدينية وتتضمن شكوك في العبادات من صلاة وصيام وفي الوضوء، وقد تجعل لأفكار الوسواسية الفرد يقوم بسلوك

جدول (6) الفروق بين الدراستين في الخصائص السيكومترية للمقياس

محاور الفروق	الدراسة السابقة	الدراسة الحالية
طبيعة العينات	العدد (54) مرضى (48) أسوياء. النوع ذكور (41) إناث (61) التعليم أمي (2) يقرأ (1) متوسط (33) جامعي (69) المدى العمري من 15 ع إلى 55 عام.	العدد (301) مرضى (103) أسوياء النوع ذكور (214) إناث (200) التعليم أمي (4) متوسط (147) جامعي (252) دراسات عليا (11) المدى العمري 15 إلى 60 عام فأكثر. النطاق الجغرافي القاهرة (121) محافظات الوجه البحري (284) محافظات الوجه القبلي (9)
معاملات الصدق والثبات	أعلى معامل صدق للاتساق الداخلي للأبعاد (.82). معامل ثبات التجزئة النصفية للدرجة الكلية فقط .93. معامل ثبات ألفا كرونباخ للدرجة الكلية فقط .96.	أعلى معامل صدق للاتساق الداخلي للأبعاد (.89). معامل ثبات التجزئة النصفية للمقياس والأبعاد الفرعية من .55 إلى .94. معامل ثبات ألفا كرونباخ للمقياس والأبعاد الفرعية من .55 إلى .94.
المعايير	14 بعداً فرعياً للمقياس. حُسبت الدرجات التائية للدرجة الكلية والأبعاد الفرعية.	13 بعداً فرعياً للمقياس تم حساب المعايير بالاعتماد على الدرجات المعيارية والتائية للوصول إلى فئات تصنيفية تسهل عملية التشخيص والمتابعة العلاجية.

مقاييس عربية... كذلك ما يزال من الصعب الوصول إلى مقياس يستطع قياس أعراض الوسواس القهرى دون التأثير بوجود سمات قسرية، لأن التداخل الظاهر في الأعراض والسلوك المرضي بين اضطرابي الوسواس القهرى والشخصية القسرية يبقى حاضراً في حدود المقاييس التي تقيس أبعاد مثل التعمق والكمالية والانسجام مع الذات.... وكلها تحتاج إلى تصميم مقاييس عربية المضمون.

### معايير المقياس

يمكن لمن يرغب في استخدام معايير المقياس، والاطلاع على جداول شدة الأعراض الخاصة بكل بعد وللدرجة الكلية العودة إلى دليل المقياس (تحت النشر) أو التواصل مع المؤلفين.

### قيود الدراسة واقتراحات للباحثين

تعتبر هذه الدراسة تأسيسية لمقياس أعراض الوسواس القهرى كأول مقياس عربي صادق المضمون من حيث حساسيته لأعراض الوسواس القهرى في مصر، لكنه ما يزال ينتظر من الباحثين العرب تطبيقه وتقنيته في الدول العربية لمعرفة مدى حساسية أعراض الوسواس القهرى. كذلك ما تزال أعراض الوسواس القهرى الدينية في المسلمين بحاجة إلى إعداد مقاييس أكثر تخصصاً لأن أبعاداً معرفية مهمة مثل التعمق أو فرط التورع ليست لها

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## Abstract

**Objective:** The Obsessive-Compulsive Symptoms Scale (OCSs) is a unidimensional, reliable, valid and short patient-report outcome measure for screening Obsessive-Compulsive Disorder (OCD). The current study aimed to develop a formal Egyptian-Arabic translation, calculate norm scores, and assess its validity and reliability for use with the Egyptian population. **Method:** Using the OCSS questionnaire, N=301 participants diagnosed with OCD were compared with N=113 participants who did not present with OCD. Diagnosis followed the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM 5). Validity was measured by internal consistency and discriminative validity. Reliability was measured by Cronbach's alpha coefficient and the split-half correlation. **Results:** Subscales were re-established and a further subscale for religious obsessive-compulsive symptoms added. Updated norms were prepared for subscales. **Conclusion:** The current investigation provides validity and reliability of OCSs as well as norm scores and a new tool to facilitate the clinical interpretation of patient scores. The OCSs was made suitable for routine use in clinical practice in Egypt.

## الملحق:

## مقياس أعراض الوسواس القهري

الاسم : السن : الجنس :  
المستوى التعليمي : العنوان :

فيما يلي مجموعة من العبارات من فضلك اقرأ كل عبارة وضع علامة (x) تحت الخانة المناسبة، لا توجد إجابة صحيحة وأخرى خاطئة، المهم هو أن تعبر عما بداخلك . لا تترك أي سؤال بدون إجابة.

العبارات	دائماً	كثيراً	أحياناً	نادراً	مطلقاً
1- أتذكر (غصبا عنى) تفاصيل مملة جدا مما يرهقني .....	....	....	....	....	....
2- تسيطر على فكرة الفعل الجنسي مع المحارم.....	....	....	....	....	....
3- أخشى أن أكون قد وضعت سما في الطعام بدلا من الملح.....	....	....	....	....	....
4- أخشى أن أكون قد وقعت في الشرك أو الكفر.....	....	....	....	....	....
5- تراودني أفكار خاصة بالتنطهر والطهارة والنجاسة.....	....	....	....	....	....
6- تسيطر على فكرة ارتكاب جريمة معينة (قتل شخص معين).....	....	....	....	....	....
7- تراودني صور مزعجة تفرض نفسها علي بشدة.....	....	....	....	....	....
8- أقوم بأفعال لا معنى لها بالنسبة للآخرين.....	....	....	....	....	....
9- في الصلاة أعيد قراءة الفاتحة (أو آياتنا الذي في السماوات) أكثر من مرة.	....	....	....	....	....
10- أكرر غسل أعضاء الوضوء أكثر من ثلاث مرات.....	....	....	....	....	....
11- أستغذ وقتاً طويلاً في الوضوء.....	....	....	....	....	....
12- أراجع الأشياء أكثر من مرة حتى أرتاح.....	....	....	....	....	....
13- هناك أشياء معينة في منزلي لا أستطيع لمسها.....	....	....	....	....	....
14- الأفكار الملحة تستغرق عدة ساعات يوميا.....	....	....	....	....	....
15- تلح على أفكار لا أستطيع الهرب منها مع أنني أعرف أنها غير حقيقية أو تافهة	....	....	....	....	....
16- تتنابني أفكار متسلطة تتعلق بالعادة السرية أو بغشاء البكارة.....	....	....	....	....	....
17- أفكر في أنني سافقد السيطرة أو أصاب بالجنون.....	....	....	....	....	....
18- لم أعد أشعر بحلاوة الإيمان أو الخشوع في صلاتي لله.....	....	....	....	....	....
19- لدى شك في النظافة.....	....	....	....	....	....
20- أشعر أنني مقهور على ممارسة العادة السرية.....	....	....	....	....	....
21- أتخيل مشاهد غير أخلاقية تضايقتني أثناء الصلاة.....	....	....	....	....	....
22- يتضايق الناس من تكراري للأسئلة.....	....	....	....	....	....
23- في الصلاة لدي وسوسة في اتجاه القبلة (أو الاتجاه ناحية الشرق).....	....	....	....	....	....
24- أعيد الاستحمام أكثر من مرة.....	....	....	....	....	....
25- أقضي وقتاً طويلاً في قص أظافري.....	....	....	....	....	....
26- كلما أقيت شيئاً في القمامة شعرت بالخوف أن يكون فيه ما بهمني.....	....	....	....	....	....
27- أحذر من أن يلمسني أحد في الشارع (كي لا يلوثني.. يُغديني ... ينجسني).....	....	....	....	....	....
28- أضع في طقوسي عدة ساعات يوميا.....	....	....	....	....	....
29- أعاد التفكير فيما يقال لي.....	....	....	....	....	....
30- تراودني بعض الأفكار غير الأخلاقية.....	....	....	....	....	....
31- أفكر في سب أشخاص لهم وضعهم.....	....	....	....	....	....
32- أسأل نفسي من ربنا؟ وأين ربنا؟.....	....	....	....	....	....
33- أشك في نيبي أو استعدادي للصلاة وغيرها.....	....	....	....	....	....
34- أشعر أنني على وشك أن أؤذي نفسي أو الآخرين.....	....	....	....	....	....
35- تراودني صور جنسية (كالشذوذ الجنسي..) وترعجني.....	....	....	....	....	....

.....	.....	.....	.....	.....	36- يتضايق الناس من استغراقني في التفاصيل.....
.....	.....	.....	.....	.....	37- لا أصلى بالملابس التي دخلت بها دورة المياه.....
.....	.....	.....	.....	.....	38- أتفل كثيرا حتى لا ابتلع رقي الملوث بالغبار والملوثات.....
.....	.....	.....	.....	.....	39- أصبحت بطيء جداً.....
.....	.....	.....	.....	.....	40- أتأكد من حافظة نقودي يوميا، عدة مرات.....
.....	.....	.....	.....	.....	41- أتحاشى أن ألمس أو تلمس ملابسي أشياء معينة (كحوائط المنزل- الأرض- الأحذية- السلم- وسائل المواصلات).....
.....	.....	.....	.....	.....	42- استمراري في الأفكار يؤثر على أنشطتي اليومية بدرجة كبيرة.....
.....	.....	.....	.....	.....	43- أركز بعمق شديد ولوقت طويل في مواقف معينة.....
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