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Toward a new psychiatry

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Abstract

In this paper I explore the limitations of the medical model approach to mental health problems that dominate psychiatry. Examining issues of diagnosis, treatment, stigma and the impact of globalising Western thinking on mental health, I hope to demonstrate that the scientific/empirical basis of dominant models is insufficient and that globalising what essentially are ideological positions is potentially damaging. Instead of continuing to globalise current mainstream models, readers are encouraged to join other psychiatrists who are in the process of developing alternative models that are more culturally sensitive.

Modern Western psychiatry has secured many important advances in the care of people with mental distress. We have a variety of pharmacotherapies that can help manage distressing symptoms alongside an even greater variety of psychotherapeutic approaches that help people in distress make sense of their experiences and find new ways to deal with them. The old asylums have been emptied and community care has developed a rich variety of services from early intervention to crisis management. The academic community, studying mental distress from a variety of angles have grown in numbers and sophistication with many journals and thousands of articles being published each year. These are worthy achievements and this progress has no doubt helped thousands and maybe millions of people across the world. Yet the desired story of a continuous growth of knowledge leading to better understanding and treatments is at best incomplete, at worst misleading. In this article I will explain the problems with remaining wedded to the current dominant paradigm used in psychiatry (the medical model) and outline one way in which the global community of practitioners can come together to develop ideas and practices that can take them beyond these limitations.

Declaration of interests: *I am a member of the Critical Psychiatry Network and co-founder of the International Critical Psychiatry Network.*

Diagnosis

Over the last thirty years or so, academic psychiatrists have worked hard to improve the reliability of psychiatric diagnosis. This is partly in response to critics of psychiatry who pointed out that many of the common diagnoses in use at the time were meaningless because of poor levels of agreement between psychiatrists about key symptoms. Rosenhan's 1973[1] study spurred on new attempts to 'standardize' diagnostic practice after he demonstrated that psychiatrists were often unable to discriminate between

sane and psychotic people. DSM-III and DSM-IV attempted to address these problems by effectively imposing diagnostic agreement on the profession through the use of standardised check-lists of diagnostic criteria. However, this failed to solve some basic questions about validity.

The failure of basic science research to reveal any specific biological abnormality or for that matter any physiological or psychological marker that distinguishes any psychiatric diagnosis, lack of evidence that diagnosis has a positive impact on outcome, and the poor predictability value of psychiatric diagnoses, suggests systems such as DSM-IV and ICD-10 may have outlived their usefulness. This critique is not limited to those less biologically minded psychiatrists as researchers in genetics[2] are now arguing that the use of categorical diagnosis (such as schizophrenia) is handicapping their studies too, where, they argue, a dimensional approach seems more appropriate.

Anomalies are prevalent in current diagnostic systems. For example, in DSM defined 'depression' there is one exception to the diagnosis (even if the patient has the required number of symptoms for the required number of weeks) – bereavement. This is on the basis that having the full complement of DSM defined symptoms of depression when there is bereavement is a 'normal' reaction. However, why many other life problems for which intense sadness is a common response – such as losing a job, break up of a marriage, bullying and so on – are not also counted as legitimate exceptions is curious.

Whilst DSM/ICD has produced many problems for translating the subjective process of attaining a psychiatric diagnosis into a reliable and objective one in clinical practice, it has had a huge impact on service provision and public and professional beliefs about mental distress. As a result of popularising the new diagnostic systems created by DSM/ICD it is widely argued that a significant proportion of the population suffers from mental illness, that this amounts to a significant economic burden, and that there is a strong case for investing in improved mechanisms of detection and treatment of these disorders. Across several surveys in the industrialised nations only a third of those identified as suffering a mental health problem sought or were interested in seeking professional help.[3,4,5,6] This has been interpreted as unsatisfactory case detection, provision and treatment, due to public and professional ignorance.

In response to this perceived problem campaigns have been undertaken to improve case detection and treatment. For example, the UK the Royal College of Psychiatrists and Royal College of General Practitioners launched their 'Defeat Depression' campaign[7] in the early nineties. It was

intended to raise public awareness of depression, reduce stigma, train general practitioners in recognition and treatment, and make specialist advice and support more readily available. It focused upon depression because it believed appropriate treatment could readily be made available in the form of antidepressant medication. Unfortunately three formal evaluations of treatment and education guidelines in the UK following the 'Defeat Depression' campaign failed to detect significant improvements in clinical outcome.[8,9,10] However, arguably the pharmaceutical industry gained most from such campaigns as rates of antidepressant prescribing increased rapidly after the campaign.

So with diagnosis we seem to have hit a paradigmatic brick wall. Our diagnoses have no greater reliability, validity, or clinical value than 30 years ago when the crisis of representation spurred psychiatric institutions to develop the more structured approach currently found in ICD and DSM.

Treatment

The technological paradigm is a dominant factor behind the way psychiatric services and treatments are organised in most industrialised countries. This paradigm is predicated on the assumption that the technical aspects of medical and psychological care are of primary importance, and that these can be represented through diagnostic systems and treatment protocols. Although the paradigm does not ignore contexts, values, meanings, and relationships, it sees them as of secondary importance only. Arguments for alternatives to this paradigm have been made from philosophical,[11,12] cultural,[13] service-user,[14] and political[15] perspectives. Despite this, the technological paradigm dominates current thinking about mental health practice on the grounds that it provides a scientific basis for practice.

There is a large literature on psychotherapy confirming that it is generally speaking a safe and effective intervention for common mental health problems as studied in Western populations,[16] but there is little to suggest that a positive outcome is strongly related to selecting the 'correct' psychotherapeutic technique and much to suggest that the 'common factors' such as developing a strong therapeutic alliance, are more important. For example, several studies have shown that most of the specific features of Cognitive Behaviour Therapy (CBT) can be dispensed with, without adversely affecting outcomes.[17,18] A comprehensive review of studies of the different components of CBT concluded that there is "little evidence that specific cognitive interventions significantly increase the effectiveness of the therapy".[18] The same holds for other forms of psychotherapy for depression. For example, The National Institute of Mental Health's Treatment of Depression Collaborative Research Project (TDCRP), the largest trial to

date comparing different treatments for depression (CBT, Inter-Personal Therapy [IPT], anti-depressants, and placebo) found that patients in each group had significant improvements, with no overall difference in outcome between each treatment group.[19,20] However, the best predictor of outcome across all four groups was the quality of the relationship between patient and therapist (as perceived by the patient) early in treatment.[20]

Recent meta-analyses have drawn similar conclusions. The quality of the therapeutic alliance accounts for most of the within-therapy variance in treatment outcome, and is up to seven times more influential in promoting change than treatment model.[16,21] Such data, when combined with "the observed superior value, across numerous studies, of clients' assessment of the relationship in predicting the outcome",[22] makes a strong empirical case that the non-specific aspects of psychotherapy, or 'know-how' in building a strong therapeutic alliance, are more important than specific techniques being used. This is also evident in 'real life' clinical encounters not just research projects. For example, in a recent review of some 5,613 cases treated in a variety of National Health Service settings in the UK, only a very small proportion of the variance in outcome could be attributed to psychotherapeutic technique, as opposed to non-specific effects of the therapeutic relationship.[23]

Drug treatments

There are few direct links between DSM/ICD diagnosis and treatment specificity. For example, various antipsychotic agents have also been advocated for the treatment of depression, anxiety disorders, bipolar affective disorder, personality disorders, Attention Deficit Hyperactivity disorder, as well as schizophrenia. Similarly, compounds marketed primarily as antidepressants are widely used in the treatment of a variety of presentations.

Furthermore psychiatric drug treatments, like psychological treatments rely more on non-specific factors than disease-specific therapeutic effects. For example, it is generally assumed that antidepressants work through their pharmacological effects on specific neurotransmitters in the CNS, yet the evidence points to placebo effects being more important than specific neuro-pharmacological ones. Thus Turner and Rosenthal's meta-analysis of US Food and Drug Administration (FDA) data concluded that although antidepressants were generally superior to placebo, most of the benefit from these drugs could be explained by the placebo effect.[24] Kirsch et al's examination of the FDA data found that over 80% of the improvement seen in the drug groups was duplicated in the placebo groups.[25]

The lack of treatment specificity is not limited to the more common and less severe presentations. Thus

although antipsychotic drugs are sometimes claimed to reverse a biochemical imbalance in psychotic patients, no such imbalance has been demonstrated. The drugs are more likely to work through their general suppressant effects, which they exert in anyone who takes them and not just in people diagnosed with a psychosis like schizophrenia.[26] Furthermore, researchers have long been aware of the perplexing finding in cross-cultural studies of mental illness that people diagnosed with schizophrenia in developing countries appear to fare better over time than those living in industrialized nations. Research, including that carried out by the World Health Organization over the course of 30 years and starting in the early 1970s, shows that patients outside the United States and Europe had significantly lower relapse rates. It seems that the regions of the world with the most resources to devote to mental illness – the best technology, medicines, and the best-financed academic and private-research institutions – had the most troubled and socially marginalized patients.[27] Once again the impact of our psychiatric technologies seem to be minimal compared to common factors, in this case most likely to be the effects of 'extra-therapeutic' factors such as family support, community cohesion and tolerance for behaviours and experiences considered a sign of 'illness' and 'dangerousness' in the West.

Stigma

Read et al[28] have carried out a comprehensive review of the literature on stigma and schizophrenia to assess whether the 'schizophrenia is an illness like any other' approach helps reduce prejudice towards those with the diagnosis. They found an increase in biological causal beliefs across Western countries in recent years, suggesting that this idea is gaining hold. However, biological attributions for psychosis were overwhelmingly associated with negative public attitudes. This appears particularly to be the case for the diagnosis of schizophrenia. For example, Angermeyer and Matschinger[29] subjected two representative population surveys of public attitudes to psychiatric patients conducted in Germany in 1990 and 2001 to a trend analysis. Over the period of the study an increase in public acceptance of biomedical explanations of psychosis was associated with a public desire for an increased distance from people with schizophrenia.

The 'medical model' of schizophrenia not only increases public stigma, but also contributes to patients internalising an explanatory model that can hinder recovery. For example, it has been found that the presence of 'insight' (in psychiatric terms, meaning accepting the medical model of having a brain illness) in schizophrenia lowers self-esteem, leads to despair and hopelessness, and also predicts higher levels of depression and risk of suicide

attempts four years later.[30] Hasson-Ohayon et al[31] found that the presence of this sort of 'insight' was negatively correlated with emotional well-being, economic satisfaction and vocational status. The conclusion we may draw from this body of research is that the empowerment of people with mental illness and helping them reduce their internalised sense of stigma are as important as helping them find insight into their illnesses.[32] accepting a diagnosis of schizophrenia means that the person must also accept the negative public attitudes and stigma associated the diagnosis. In line with current beliefs the diagnosis thus brings expectations of a gloomy outlook with lifelong dependency on psychiatric treatment and little chance of complete recovery.

Surprisingly perhaps, it seems that part of the reason why the outcome is better for those who develop a psychotic episode in the developing world is less stigma. For example, the anthropologist Juli McGruder spent a number of years in Zanzibar studying the families of those diagnosed with schizophrenia. Though the population is predominantly Muslim, Swahili spirit-possession beliefs are still prevalent and commonly evoked to explain the actions of those who violate social norms. McGruder found that far from being stigmatizing, these beliefs served certain useful functions. The beliefs prescribed a variety of socially accepted interventions and ministrations that kept the ill person bound to the family and kinship group. McGruder saw this approach in many small acts of kindness, watching family members use saffron paste to write phrases from the Koran on the rims of drinking bowls so the ill person could literally imbibe the holy words. The spirit-possession beliefs had other unexpected benefits. This way of viewing the mental distress allowed the person with schizophrenia a cleaner bill of health when the illness went into remission. An ill individual enjoying a time of relative mental health could, at least temporarily, retake his or her responsibilities in the kinship group. Since the illness was seen as the work of outside forces, it was understood as an affliction for the sufferer but not as an identity inscribed through unalterable internal factors such as his or her genes.[33]

Westernisation

For the last 50-odd years, Western mental-health professionals have been pushing the idea of 'mental-health literacy' on the rest of the world. Cultures are viewed as becoming more 'literate' about mental illness the more they adopted Western biomedical conceptions of diseases like depression and schizophrenia. All this is done in the name of science, believing that 'modern' approaches reveal the biological basis of psychic suffering and dispel pre-scientific approaches as harmful superstitions. In the process of doing this we not only imply that those cultures that are slow to take up these ideas are therefore in some way

'backward', but we also export disease categories and ways of thinking about mental distress that were previously uncommon in many parts of the world. Thus conditions like depression, post-traumatic stress disorder, and anorexia appear to be spreading across cultures, replacing indigenous ways of viewing and experiencing mental distress.[33] In addition to exporting these beliefs and values, Western drug companies see in such practice the potential to open up new and lucrative markets.

Despite copious evidence from research in the non industrialized world, that shows the outcome for major 'mental illnesses', is consistently better than in the industrialized world and particularly amongst populations who have not had access to drug based treatments,[27] the World Health Organization, together with the pharmaceutical industry, has been campaigning for greater 'recognition' of mental illnesses in the non-industrialized world. Like other successful marketing campaigns, this strategy has the potential to open up huge new markets for psychiatric drugs that maybe ineffective and can have serious side effects, at the same time as painting indigenous concepts of, and strategies to deal with, mental health problems, as being based on ignorance, despite their obvious success for these populations.[34]

The idea of the individual as the locus of the self is a relatively recent Western invention and such a framework creates the psychological pre-conditions necessary for accepting the 'atomized' social worlds that have been created. In the last few generations, we have seen many changes in the way we interact with each other and within and without our smaller atomized family units, competing within and between these units for narcissistic advantage. Mental well-being seems closely connected to how well you are able to compete in societies structured around an economics that leads to considerable social inequality. Thus a recent World Health Organization report concluded:

> "It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relation-ship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differen-tiation are profound and far reaching: greater inequality heightens

> status competition and status insecurity across all income groups and among both adults and children. It is the distribution of economic and social resources that explains health and other outcomes in the vast majority of studies"[35]

Thus imposing Western medical model style psychiatry on non-Western populations risks a number of things including: adoption of Western psychiatric notions of 'psychopathology' to express mental distress, undermining of existing cultural strategies for dealing with distress, more not less stigma for those with mental health problems, and the imposition of an individualistic approach that may marginalise family and community resources and divert attention from social injustice.

Toward a new psychiatry

It is time to move psychiatry forward, starting with understanding the limitations of current paradigms for all populations in general and developing world populations in particular. There is an understandable concern that without a medical model based psychiatry (however illogical it is) we would not be 'proper' doctors. However, this may not be the most appropriate response for a number of reasons. Firstly, as doctors, our concern should be what is right for our patients first rather than our guild interests (important as these may be). Secondly, our insecurity about how 'doctory' we are may have led us to importing too enthusiastically the medical model into mental health, whereas the real gift of psychiatry, is what it can offer the rest of medicine that is more unique to our field, which is an understanding of the person in their context. Psychiatry has to sit at the confluence of a variety of disciplinary discourses (such as sociology, anthropology, psychology, philosophy, medicine, cultural studies, politics, theology etc.) and it is this broader understanding of the human and their health and well-being that we bring.[36] A substantial amount of General Practitioner/Family doctor work involves psychosocial issues, physically unexplained symptoms take up many resources, chronic conditions have massive impact and are hugely impacted upon by psychosocial circumstances, and so on. In this reality where good quality healthcare cannot be divorced from social and emotional well-being, psychiatry will continue to be a vital part of successful healthcare. To underutilise the unique skills our profession brings to healthcare by the 'dumbing down' (or as I have called it in relation to child and adolescent psychiatry - the 'McDonaldisation'[37]) what we do into simplistic diagnosis driven protocols that has more to do with successful consumer culture marketing than science, or the looking after the well-being of our patients and their families and communities. One

way of supporting such an approach is through the newly created 'International Critical Psychiatry Network' (http://www.criticalpsychiatry.net).

The International Critical Psychiatry Network (ICPN)

The ICPN has been created by medical doctors as a forum (primarily for medical doctors) to discuss, critique, and publicise opinions, practices, literature, and events that support critical thinking and alternative approaches to psychiatry. Building on the work of the Critical Psychiatry Network (CPN) in Britain and motivated by a concern about the 'global mental health' movement's approach of globalising Western models of psychiatry, the ICPN wishes to consider a greater variety of ways of thinking about psychic difference and suffering. Recognising that the current dominant models (particularly the medical model) for thinking about psychiatric difficulties and helping sufferers are not the only ones, it is hoped that the ICPN can contribute toward an exchange of ideas that can promote more locally meaningful and effective practice. The ICPN avoids polemics of 'antipsychiatry' and 'propsychiatry' to consider a multiplicity of options for thinking about psychic difference and suffering across the globe. It encourages both critique and curiosity.

Critique requires a close consideration of the dominant models of psychiatry, which have solidified in much of the Western world and increasingly in other countries across the globe. These dominant models have some diversity within them, but tend toward a heavy reliance on the sciences of brain and cognition in the hopes of achieving value and culturally neutral 'truths' about psychic life. A variety of critiques challenge this reliance. Critical empiricism uses the tools of science to rigorously examine the evidence and often finds that dominant models in psychiatry use sloppy and manipulative science to over-hype the interests of dominant groups – particularly the pharmaceutical and their transnational supporters in government and academia. Other critical approaches such as 'deconstruction' use a host of additional theoretical and philosophic tools to step outside 'science as usual' and consider the founding assumptions of dominant psychiatric theory and practice.

Curiosity is as important as critique. If critique opens the door to alternatives, curiosity walks through that door. Curiosity uses a postcolonial historical and ethnographic spirit to explore models of psychiatry that have been neglected and overshadowed by dominant models. These additional models are as diverse as psychoanalytic, humanistic/existential, narrative, creative, social, political, spiritual, contemplative, mind-body, cross-cultural, traditional, and peer support (just to name a few) and they take on a variety of manifestations

across the globe. Some of these models of psychiatry are explicitly psychiatric 'alternatives,' but many use non psychiatric language to understand and organize an array of practices that can loosely be considered therapeutic for states of mental distress.

In keeping with the goal of avoiding antipsychiatry/ propsychiatry polemics, ICPN avoids idealizing any particular alternative model. A variety of approaches to psychic life (and a variety of hybrid combinations) can have value and may be useful for particular people in particular situations. The goal is not to determine which is right or best for all. The goal is to help support the creation and sustainability of many options, and to help develop ethical structures of clinical care which support and encourage this diversity in local contexts.

Anybody doctor wishes to join the ICPN (it does not cost anything and at its simplest involves being copied into circular e-mail discussions only) please send me your e-mail address (send to stimimi@talk21.com) to join the list.

الملخص

أتحرى في هذا البحث قصور طريقة النموذج الطبي في فهم معضلات الصحه النفسيه السائده في الطب النفسي. وحين دراسة قضايا التشخيص ، العلاج ، وصمة العار ، وتأثير عولمة التفكير الغربي على الصحه النفسيه ، فإنني آمل أن أبين بأن الأساس العلمي/التجريبي للنماذج السائده ناقص، وبأن عولمة ما هو في الجوهر مواقف آيديولوجيه يحمل في طياته الضرر. وبدلاً عن الاستمرار في عولمة نماذج الاتجاه السائد الحاليه ، فالقراء يشجعون بأن يلتحقوا بصفوف الاطباء النفسيين المنهمكين في عملية تطوير نماذج بديله أكثر استجابة للبيئه الثقافيه.

References

1. Rosenhan R. On being sane in insane places. Sci. 1973; 179: 251-258.
2. Marneros A, Akiskal, S. (eds.) The Overlap of Affective and Schizophrenic Spectra. Cambridge: Cambridge University Press, 2007.
3. Shapiro S, Skinner EA, Kessler LG. Utilization of health and mental health services. Three epidemiologic catchment area sites. Arch.Gen. Psychiatry 1984; 41: 971-978.
4. Kessler RC, McGonagle KA, Zhao S. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the national comorbidity survey. Arch.Gen. Psychiatry 1994; 51: 8-19.
5. Bebbington PE, Brugha TS, Meltzer H. Neurotic disorders and the receipt of psychiatric

treatment. Psychol. Med. 2000; 30: 1369-1376.
6. Andrews G, Issakidis C, Carter G. Shortfall in mental health service utilisation. Brit. J. Psychiatry 2001; 179: 417-425.
7. Paykel ES, Priest RG. Recognition and management of depression in general practice: consensus statement. BMJ 1992; 305: 1198-1202.
8. Croudace T, Evans J, Harrison G. Impact of the ICD-10 Primary Health Care (PHC) diagnostic and management guidelines for mental disorders on detection and outcome in primary care. Brit. J. Psychiatry 2003; 182: 20-30.
9. King M, Davidson O, Taylor F. Effectiveness of teaching general practitioners skills in brief cognitive behaviour therapy to treat patients with depression: randomised controlled trial. BMJ 2002; 324: 947-953.
10. Thompson C, Kinmonth AL, Stevens L. Effects of a clinical-practice guideline and practice-based education on detection and outcome of depression in primary care: Hampshire Depression Project randomised controlled trial. Lancet 2000; 355: 185-191.
11. Ingleby D. Understanding mental illness. In D. Ingleby (ed.) Critical Psychiatry: The Politics of Mental Health. Harmondsworth: Penguin, 1981.
12. Bracken P,Thomas P. Postpsychiatry: Mental Health in a Postmodern World. Oxford: Oxford University Press, 2005.
13. Kleinman A, Good B. Culture and Depression. Studies in the Anthropology and Cross-Cultural Psychiatry of Affective Disorder. Berkeley: University of California Press, 1985.
14. Stastny P, Lehmann P. (eds.). Alternatives Beyond Psychiatry. Berlin: Peter Lehmann Publishing, 2007.
15. Cohen CI, Timimi S. (eds.) Liberatory Psychiatry: Philosophy, Politics, and Mental Health. Cambridge: Cambridge University Press, 2008.
16. Wampold BE. The Great Psychotherapy Debate: Models, Methods, and Findings. Hillsdale, New Jersey: Lawrence Erlbaum, 2001.
17. Jacobson NS, Dobson K, Truax PA, Addis M, Koerner K, Gollan JK, et al. A component analysis of cognitive-behavioural treatment for depression. J. Consult. Clin. Psychol. 1996; 64: 295-304.
18. Longmore RJ, Worrell M. Do we need to challenge thoughts in cognitive behaviour therapy? Clin. Psychol. Rev. 2007; 27: 173-87.

19. Elkin I, Shea M, Watkins J, Imber S, Sotsky S, Collins J, et al. National Institute of Mental Health treatment of depression collaborative research program: General effectiveness of treatments. Arch. Gen. Psychiatry 1989; 46: 971-82.
20. Shea M, Elkin I, Imber S, Sotsky S, Watkins J, Collins J, et al. Course of depressive symptoms over follow-up. Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Arch. Gen. Psychiatry 1992; 49: 782-87.
21. Duncan B, Miller S, Sparks J. The heroic client. San Francisco: Jossey-Bass, 2004.
22. Bachelor A, Horvath A. The therapeutic relationship. In MA Hubble, BL Duncan, SD Miller, (eds.) The heart and soul of change: What works in therapy. Washington DC: American Psychological Association, 1999
23. Stiles WB, Barkham M, Mellor-Car J. Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. Psychol. Med. 2008; 38: 677-688.
24. Turner EH, Rosenthal R. Efficacy of antidepressants: Is not an absolute measure, and it depends on how clinical significance is defined. BMJ 2008; 336: 516-17.
25. Kirsch I, Deacon B, Huedo-Medina TB, Scoboria A, Moore TJ, Johnson BT. Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. PLoS Med. 2008; 5: e45.
26. Moncrieff J. The Myth of the Chemical Cure. Basingstoke: Palgrave MacMillan, 2009.
27. Hopper K, Harrison G, Janka A, Sartorius N. (eds.) Recovery from Schizophrenia: An International Perspective. Oxford: Oxford University Press, 2007.
28. Read J, Haslam N, Sayce L, Davies E. Prejudice and schizophrenia: A review of the 'Mental illness is an Illness like any other' approach. Acta Psychiat. Scand. 2006; 114: 303-318.
29. Angermeyer MC, Matschinger H. Causal beliefs and attitudes to people with schizophrenia. Trend analysis based on data from two population surveys in Germany. Brit. J. Psychiat. 2005; 186: 331-334.
30. Crumlish N, Whitty P, Kamali M. Early insight predicts depression and attempted suicide after 4 years in first-episode schizophrenia and schizophreniform disorder. Acta Psychiat. Scand. 2005; 112: 449 – 455.

31. Hasson-Ohayon H, Kravetz S, Roe D, David AS, Weiser M. Insight into psychosis and quality of life Compr Psychiatry 2006; 47: 265-269.
32. Warner R. Does the scientific evidence support the recovery model? The Psychiatrist 2010; 34: 3-5.
33. Watters E. Crazy like us: The Globalization of the American Psych. New York: Free Press, 2009.
34. Summerfield D. How scientifically valid is the knowledge base of global mental health? BMJ 2008; 336: 992-994.
35. World Health Organisation (Europe). Mental Health Resilience and Inequalities. Copenhagen: WHO, 2009.
36. Lewis BE. Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Postpsychiatry. Michigan: The University of Michigan Press, 2006.
37. Timimi S. The McDonaldization of childhood: Children's mental health in neo-liberal market cultures. Transcultural Psychiatry. In press, 2010.

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Language, Culture and Mental Health

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Abstract
The increase in cultural and linguistic diversity of contemporary societies poses major challenges to mental health services across the world. Is it possible to work in ways that respect cultural and linguistic difference in multicultural societies? In this paper we focus on the difficulties raised by the use of interpreters in the diagnosis of depression. We use a simple thought experiment in the form of two fictitious vignettes to highlight important features of language-games, an idea introduced by Ludwig Wittgenstein in his late work, *Philosophical Investigations*. The thought experiment draws attention to the importance of culture and contexts in understanding the meaning of what people say when they feel sad. This is even more important in understanding the help that people expect under these circumstances. This has implications not only for how we understand the role of interpreters in clinical settings, but more generally it draws attention to the importance of respecting the many different understandings of sadness and unhappiness that are a prominent feature of non-Western cultures. We conclude attempts to impose Western biomedical interpretations of sadness and suffering on people from non-Western societies has no ethical basis, and is to be avoided.

Key Words:
Psychiatric Diagnosis, Depression, Non-Western understandings, Interpreters, Diversity, Language-games

Declaration of interest: None

Introduction

In common with other European countries, British society is becoming increasingly multicultural, and as its cultural diversity grows, so does its linguistic diversity. In 2001, about 8% of the population identified themselves as belonging to ethnic minority groups. Indians are the most numerous, followed by Pakistanis, people from mixed cultural backgrounds, Black Caribbean's, Black Africans and Bangladeshis[1]. Over 300 different languages are spoken by London schoolchildren[2], and 18 per cent of the population of London speak a first language other than English at home[i]. This poses an enormous challenge to health workers, especially those working in mental health.

In this paper we argue that in mental health, language and culture are inextricably linked. The words and language we use to communicate with

each other reveal how we make sense of our experiences, and the sort of help we expect. Both are heavily influenced by our cultural origins, a point made by anthropologists for many years now[4,5,6]. Here, we make a broadly similar point, but from a different perspective, that of the philosophy of Ludwig Wittgenstein. We do not intend to present a detailed analysis of his ideas here; this can be found elsewhere[7.] We will, however, present a simple thought experiment to illustrate how his later philosophy of language can help to clarify the relationship between language and culture. Thought experiments have been used in Western philosophy for thousands of years to employ imaginary situations to explore reality. The form our thought experiment takes will be familiar to clinicians, two fictitious vignettes about women from different cultures who present with sadness. At the heart of our argument is a philosophical view that sees language as a tool used by human beings to convey meaning. This sees language not as something located in an individual mind, but as part of a wider set of communal symbols that are vital in the construction of meaning.

Language and diagnosis in psychiatry

Assessment and treatment in psychiatry is contingent on good communication between the clinician, patient and carer[8,9,10]. Good communication depends upon the clinician's fluency in the patient's language, the patient's fluency in English, and the availability of an appropriate vocabulary in the patient's language for signs and symptoms of mental illness set out in Western diagnostic systems. There are several problems here. Many people from Black and Minority Ethnic (BME) communities, especially elders, do not speak English[11,12,13]. Ideally, the patient should be assessed by a clinician who speaks the patient's language and belongs to the patient's culture, but this is rarely possible. Shah[8] has drawn attention to serious practical difficulties in interpretation. Of particular significance here is the lack of a matching vocabulary for the symptoms of psychiatric illness in the patient's language. The clinician may struggle to ask questions on symptoms based on Western diagnostic classifications, when, for example, there is no matching vocabulary for depression in Urdu. We can understand these problems through two vignettes. They are not real cases, but the stories are typical of those of many people. However, a caveat is necessary. It is not our intention to reduce unique human subjects to crude cultural categories, and through cultural stereotyping disregard the uniqueness of the individual. That said the two stories are idealised so as to reveal important links between language and culture in understanding distress.

'Mary'

Mary, a 55 year old White British woman, born and brought up in

Nottingham, is brought to see her GP, Dr Wilson, by Sheila, her best friend. Mary's three children have grown up and left home. The eldest son works in a bank, another son works at a call centre, the youngest (daughter) is at university. After marrying at the age of 20, she worked for a while before looking after her children when they were babies. Over the last fifteen years she worked as a secretary, but was made redundant two weeks earlier. Three months ago her husband died suddenly of a CVA. Mary tearfully told the doctor that she had been feeling depressed (her word) and that she had been crying a lot. On direct questioning she told her doctor that her concentration was poor and she had been forgetful. She had lost appetite and her weight had fallen by 5 kg over three months. She was finding it difficult to get to sleep, and had been waking earlier in the morning than usual, feeling tired and unrefreshed. At times she had felt that life wasn't worth living, but had no plans to end her life. Her physical health was otherwise good, and a physical examination was normal. On being asked, Mary told her GP that she felt she was 'useless' as a person and that she thought she was 'depressed'. On further prompting, she said she thought tablets might help, and she also asked for counselling. The GP gave her a course of antidepressants, and arranged for her to see a cognitive therapist in the surgery. Three months later she was back at work, feeling much better.

'Fatima'

Fatima, a 55 year old woman born in Pakistan and who speaks little English, is brought to see her GP, Dr Khan, by her daughter, Saima. Fatima's three children are all still at home. The eldest son works in a bank, another son works in a call centre, the youngest, Saima, is at university. Fatima came to Nottingham in England straight from Lahore when she married her husband 35 years earlier, and since then had stayed at the home, looking after her children and family. Three months before she presented to her GP her husband died suddenly of a CVA. Since then the family has experienced financial hardship. Fatima has had to handle all the family's financial affairs, something she has never had to do before. Saima tells the doctor that the family are very concerned about her. They have noticed that she is forgetful and cries a lot. She has lost appetite and her weight had fallen by 5 kg in three months. She was finding it difficult to get to sleep, and had been waking earlier in the morning than usual, feeling tired and unrefreshed. When asked, she tells the GP through her daughter that she believes that she is physically ill. She tells the doctor she wants tests to find out what the problem is. The GP wants to ask her does she feel depressed, but he pauses at the threshold of a familiar problem; he does not know how to ask that in Urdu. Instead he asks how has she has been feeling. She says she feels her heart is sinking, that she is letting her family down because her daughter has had to have time off from university to help her sort out the finances. She has also been praying a lot, and reading the Qur'an. The GP explores with Fatima and her daughter what do they think might help. Fatima says she wants to talk about her experiences. Dr Khan refers her to a group of Muslim women who have similar problems, and who gain strength by praying together. Three months later she is still attending the

group, and with her daughter's help she is taking control of the family's finances. She is feeling much better.

Language, Games and Meaning

What does a comparison of the two women reveal? First, there are similarities. They are the same age; both have lost their husbands, and have children of the same age and gender. Both present with identical physical manifestations of distress, and both appear to be doing much better three months later. There the similarities end. In terms of gender roles, an important part of Mary's life has been her work outside the family as a secretary. This, together with the fact that she presents with her best friend, suggests that a significant part of her identity is invested in areas outside the family. Her children have grown up and left home so she has a dispersed nuclear family structure. On the other hand, the most important aspect of Fatima's life is her role as wife and mother within the family. Within that context her identity has largely been defined by her relationships within the extended family. She has had few if any responsibilities outside home and family, consequently the death of her husband has had major repercussions in this area of her life. The importance of her role in the family can be seen in the fact that her daughter accompanies her to the appointment.

An important assumption in psychiatry is that scientific methods of diagnosis and treatment provide a comprehensive account of distress and suffering. We can see this in the way that evidence based medicine dominates clinical practice in psychiatry[14]. It can also be seen in the influence of Jaspers, who argued that the interests of scientific objectivity require that psychiatrists strip patients' experiences of values and contexts. The problem is that the interpretation and meaning of human affairs is heavily dependent on those values and cultural contexts. This is especially so when it comes to the language we use to talk about our experiences. One way of examining the different ways in which these two ladies talk about what appear to be identical experiences is to think of them in terms of language games.

The philosopher Ludwig Wittgenstein[15] introduces the idea of language games to show that our use of language is a communal activity. A game is usually (not necessarily) a communal activity in which our actions towards each other are determined by a set of rules. Although games take many forms, we all know in broad terms what they are. Some, like football or cricket, involve teams. Others, like tennis or chess, involve two individuals. Some card games like solitaire rely on a single player. It is almost impossible to specify a set of universal rules that would enable us to capture the essential features of all games. All we can say is that there are family resemblances between some human activities that enable us to identify them as games. However, we can say that the rules and expressions

associated with each of these different games originate in the historical and cultural activities that are unique to that particular game. For example, the activities that over time gave us the rules and language of the game of tennis, did not give us the rules and language of the game of football. The two games have different languages and rules because they originated in different traditions with different histories. To use Wittgenstein's words, they arose out of 'different forms of life'. Tradition, history and culture are really important here; they matter to us. Playing tennis, like any game, has meaning for those who play it in terms of a shared history in which the game, its rules, actions, and terminology, bind us together.

Wittgenstein points out that we can say much the same about the different ways in which we communicate through language. For example, we can make a polite request, issue an order, tell someone of our love, attempt to describe the smell of rain in the garden at dawn, or tell a close friend that we feel sad. According to Wittgenstein there are an endless variety of such activities, or language games, and it is impossible to specify universal rules that capture their essence. As far as language games are concerned, culture and tradition set out in broad terms the rules and values we must follow if we are to understand each other's speech. As native language speakers we acquire these rules as we acquire language and other cultural skills as infants. As adults we just know the rules, and take them for granted in using them with consummate ease. This know-how is a form of tacit knowledge. What can we say about the language games that take place between the two ladies and their doctors?

First, it is clear that they are quite different games, based in different rules, values and words. In broad terms the rules of Mary's game revolve around her use of the word 'depression'. The way she understands this depends in turn on a number of rules about the way we understand ourselves as human beings. For Mary, depression is a deeply personal experience rooted in her physical being as a person, but also affecting her inner view of herself. Her belief that she is depressed and needs tablets is related to the belief that depression is caused by a chemical disturbance in her brain that can be rectified by antidepressant tablets. This is an extraordinarily influential belief in Western culture, one that has grown in strength recently, not just in the specialist world of psychiatry.

Over the last fifteen years, the publication of books like *Listening to Prozac*, *Prozac Nation*, *Prozac Diary* and *Prozac Highway* together with countless magazine, newspaper and television articles suggest that Prozac and the language of neurotransmitters has become a powerful cultural trope through which we make sense of ourselves as human beings[16]. A key feature of this language game is that it sees sadness in terms of depression

arising from a chemical disturbance in an individual's brain, or from faulty thinking processes in an individual's mind. Mary's belief that she is 'useless' as a person is accounted for in terms of faulty cognitions in her mind. CBT 'rectifies' these inner faults so she can think more positively. As language games, both these approaches locate the problem in the depths of the individual's body or mind. Elsewhere, we have argued that the origins of this belief go back to the European Enlightenment[17]. To use the word depression is only meaningful in a culture that historically prioritises the

inner world of an individual subject.

In cultural terms the European Enlightenment does not feature in Fatima's heritage. Not surprisingly she engages in a very different language game to express herself. She speaks about her experiences in terms of her sinking heart and her belief that she is letting her family down. This is a language game in which her relationships, obligations and duties to her family are of paramount importance to her identity. She does not use the word depression for much the same reason that footballers do not use the words 'fifteen love' to describe what happens when they score a goal. There is no place for depression in the language game she engages in to say how she feels. On the other hand in Islamic culture there are concepts that help us to understand her language game. *Huqooq* and *Huqooqul-Ibaad* broadly concern other people's rights, and one's obligations to them, especially family, neighbours and community, as well as their obligations to you. Thus Fatima is engaged in a language game that ties her sense of who she is to her family and community, through her obligations as a good Muslim. This is central to understanding how she talks about her distress. It also means that her faith is vitally important in helping her through her distress. Her moral agency lies right at the heart of this language game. Her identity and value as a human being are set out by the extent to which she is able to do what is considered to be right in the eyes of her faith, her family and her community.

Both women seek help that is consonant with the language they use to talk about their experiences. Mary wants, and gets antidepressants; Fatima wants to be able to meet and pray with Muslim women who face similar moral dilemmas. Both GPs are doing their jobs properly. Both understand their patients' respective cultures, and know what response is required. Both women make a good recovery. There is empirical evidence that good outcomes in mental health are more likely when doctor and patient share common understandings of the problem. Callan and Littlewood[18] interviewed twenty-one White British and sixty three BME patients, asking them about their views about the care they had received, treatment preferences and explanatory models. Patients were much more

likely to express satisfaction with their care where there was concordance between the patient's and psychiatrist's explanatory model. This was independent of the patient's ethnicity.

Conclusions

Living in a multi-cultural world presents us with very special challenges. If we are to have fair and cohesive societies, it is really important that we learn to respect and understand each other's differences. Respecting cultural diversity involves much more than polite attention to dietary habits and religious observance, important though these are. We argue that in mental health care there is much more to respecting cultural diversity than providing interpreters to make sure that people with limited English can communicate effectively with their doctors. This is clearly important in general medical care, but the situation in psychiatry is quite different. This is because the great variety of cultural understandings of distress presents a radical challenge to the commonly held view that psychiatric disorders are universal biological phenomena. Mental health problems are intimately tied to fundamental aspects of our identities, where culture, language, faith and tradition lie right at the heart of our lives.

This has implications for the help offered to those from non-Western cultures who experience distress. It means that we must be aware of the ways in which complex identities shape expectations of help. For example, there is no justification in our argument for the British government's plans to provide cognitive behavioural therapy on a massive scale in the community, much of it in the form of computerised modules, in the belief that this will 'cure' chronic depression and enable long-term unemployed people to get back to work[19]. Equally, it is important to recognise that the complex processes of identity formation and acculturation mean that for some non-Western British citizens individualised forms of 'therapy' such as CBT may be consonant with the way in which they understand sadness.

The anthropologist Arthur Kleinman warns that we commit a serious error (a 'category fallacy') if we assume that the Western concept of 'depression' has the same meaning for non-Western people[20]. Our argument supports this view, and in doing so questions the basis on which authorities like the World Health Organisation plan to implement global programmes to 'conquer' depression in South East Asia, without paying due attention to the great variety of meanings of sadness in the different cultures of the region[21]. Although such programmes are no doubt well intended, respect for cultural diversity in mental health requires an acute sensitivity to the limitations of language. It means that we have to make a deliberate effort to step beyond the confines of our own cultural assumptions to acknowledge the importance of the other's culture in

shaping meaning, and, more important, the responses that meaning expects.

الملخص

إن الإزدياد في التنوع اللغوي والثقافي في المجتمعات المعاصره يطرح تحديات كبيره أمام خدمات الصحه النفسيه عبر العالم. فهل من الممكن العمل بطرائق تحترم الفروقات الثقافيه واللغويه في المجتمعات متعددة الثقافات؟ في هذا البحث نركز على الصعوبات المتأتيه من إستخدام المترجمين في تشخيص الكآبه. ونستخدم هنا تجربه فكريه بسيطه على شكل حوارين لغويين وهميين ومقتضبين من أجل إبراز سمات مهمه في العاب-اللغه ، وهذه فكره أدخلها لودفيك ويتكنشتاين في عمله الحديث "تحريات فلسفيه". التجربه الفكريه المعنيه توجه الانتباه إلى أهمية الثقافه وبيئتها في فهم معنى أقوال الناس حين شعورهم بالحزن. وهذه المسأله ذات أهمية أكبر في تفهم نوعية المساعده التي يتوقعها الناس في مثل هذه الظروف. ويترتب على ذلك تبعات ليس فقط بالنسبة لكيفيه فهم دور المترجمين في المحيط االسريري ولكن بشكل أعم في توجيه الانتباه إلى أهمية إحترام الفهم المتعدد والمختلف للحزن والتعاسه والتي هي سمه بارزه في الثقافات اللاغربيه. ونستنتج في الختام أن محاولات فرض التفسيرات البيو- طبيه الغربيه للسعاده والشقاء على الناس في المجتمعات اللاغربيه هو أمر ليس له أي أساس أخلاقي وعلينا تجنبه.

References

1. Office for National Statistics (2004) Focus on People & Migratio, Office for National Statistics: June 2004. http://www.statistics.gov.uk/downloads/theme_compendia/fom2004/migration.pdf accessed on 22nd April 2010
2. Baker, P. And Eyersley, J. (eds) (2000) Multilingual Capital, London: Battlebridge
3. Greater London Authority (2006) A Profile of Londoners by Language: An analysis of Labour Force Survey data on first language. Data Management and Analysis Group. DMAG Briefing 2006/26, London, GLA. Accessed at http://www.london.gov.uk/gla/publications/factsandfigures/dmag-briefing-2006-26.pdf accessed 22nd April 2010
4. Kleinman, A. (1977) Depression, somatisation and the new cross cultural psychiatry :Social Science and Medicine vol. 11(3-10).
5. Kleinman, A. (1980) Patients and Healers in the Context of University of California Press, Berkeley.
6. Obeyesekere, G. (1985) Depression, Buddhism, and the work of culture in Sri Lanka. In *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder (*ed. A. Kleinman and B. Good).

Berkeley: University of California Press.
7. Thomas, P., Shah, A. & Thornton, T. (2009) Language, games and interpretation: A Wittgensteinian thought experiment. *Medical Humanities:35:13-18.*
8. Shah,A,K, (1992) Difficulties in interviewing elderly people from an Asian ethnic group. International Journal of Geriatric Psychiatry. 7. 917.
9. Jones, D., Gill, P. (1998) Breaking down language barriers. The NHS needs to provide accessible interpreting services for all. British Medical Journal, 316, 1476.
10. Shah,A,K, (1999) Difficulties experienced by a Gujarati psychiatrist in interviewing elderly Gujaratis in Gujarati. International Journal of Geriatric Psychiatry, 14: 1072-1074.
11. Barker, J. (1984), Research Perspectives on Ageing: Black and Asian Old People in Britain. (1st edn) London: Age Concern Research Unit.
12. Manthor J. & Hettiaratchy. P. (1993) Ethnic minority elders in Britain. *International Review of Psychiatry,* 5, 173-180.
13. Lindesay, J. Jagger, C.. Hibbert M J... Peet... S.M. Moledina. F. (1997b) Knowledge uptake and availability of health and social services among Asian Gujarati and white elders *Ethnicity & Health, 2, 59-69.*
14. Thomas, P.; Bracken, P. & Timimi, P. (2010) Kuhn, Evidence Based Medicine and Psychiatry. Submitted to *Philosophy, Psychiatry and Psychology,* May 2010.
15. Wittgenstein, L (1967) *Philosophical Investigations,* Third edition (Trans. G.E.M. Anscombe) Oxford, Blackwell.
16. Lewis. B. (2003) Prozac and the post-human politics of cyborgs. Journal of Medical Humanities. 24, 49-63.
17. Bracken, P.& Thomas, P. (2008) Cognitive Therapy. Cartrsianism and the Moral Order Chapter 8 in (eds. R. House & D. Loewenthal) Against and *For CBT: Towards a constructive dialogue?* Ross-on-Wye. PCCS Books.
18. Callan, A. & Littlewood, R. (1998) Patient Satisfaction: Ethnic Origin or Explanatory Model? *International Journal of Social Psychiatry,* 44, 1-11.
19. The Centre for Economic Performance's Mental Health Policy (2006) The *Depression Report: A New Deal for Depression and Anxiety Disorders.* London School of Economics, Accessed 7th May 2010 at http://cep.lse.ac.uk/textonly/research/mentalhealth/DEPRESSION_REPORT_LAYARD.pdf

20. Kleinman, A. (1991) *Rethinking Psychiatry: From Cultural Category to Personal* Experience Free Press, New York.
21. WHO Regional Office for South East Asia (2008) *Conquering Depression: You can get out of the blues* Accessed 7th May 2010 at http://www.searo.who.int/LinkFiles/Conquering_Depression_ment-120.pdf

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The Psychosocial Impact of Political Violence on Palestinian and Jewish Adolescents

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الأثر النفسي للعنف السياسي على المراهقين الفلسطينيين واليهود

عليان القريناوي

Abstract

A sample of male and female school-attending adolescents aged 14-18, 453 Jewish and 508 Palestinian, participated in this study. The research instruments included a traumatic events survey (TEV), Brief Symptoms Inventory (BSI), PTSD questionnaire, Peer Relations questionnaire (PRQ), Aggression questionnaire (AQ), and Family Assessment Device (FAD). Exposure to political violence was shown to have negative effects on mental health. Findings revealed that Jewish participants reported more exposure to political violence, while Palestinian participants reported more symptoms of somatization, phobic anxiety, Psychoticism, PTSD, family functioning problems, and aggression (specifically physical aggression and anger). Parental education, socioeconomic status (SES) and family stresses are discussed in relation to these findings. The Palestinians of 1948 experienced a double trauma of exposure to political violence and negative social and psychological response to the discrimination and racism against them in the Israeli realm. The conclusion considers implications for policy and practice.

Declaration of interest: None

Introduction

Exposure to political violence is related to post-traumatic stress disorder (PTSD), depression, anxiety, and behavioral problems[3,24,35,73]. But it may also be associated with such positive outcomes as pro-social behaviour and positive self-esteem [46]. The present paper is among the first to compare Jewish and Palestinian adolescent respondents to political violence within Israel. Results show high levels of problems in both populations. In contrast to previous scholarship [21], the Paper finds that Palestinian peoples had less exposure to political violence, but experienced higher impacts; one of the major factors for this differential experience being socioeconomic status (SES). By focusing on both populations living in Israel, greater insight can be had into similar and divergent subjective experiences of political violence. Consequently the nature of the required medical and allied disciplinary responses to political violence can be tailored to suit these needs.

Political Violence in the Israeli Context

War had been part of the Middle East prior to the 1948 creation of Israel, and continues on an ongoing basis since that date [48]. Since September 2000, upwards many people have been killed and injured as a result of the ongoing political violence, with numbers much higher in the West Bank and Gaza Strip [8,21]. People from throughout the region are directly vulnerable to political violence, and experience it daily and vicariously through the experiences of those with whom they are close [48].

Today, Israel is home to approximately 7.6 million people, of these, about 1.5 million or 19.4% are Palestinian. Eighty-two percent of the Palestinians in Israel are Muslim, 9% are Christian, and 9% are Druze [51]. Prior to 1948, Palestinians made up the majority of inhabitants of Palestine, but subsequent to the establishment of the state of Israel, 84% of the Palestinian population was exiled and became refugees [41]. Those who were left became a minority. About a quarter of those who remained were displaced from their homes to other locations, thus becoming internal refugees [13,74].

The Palestinian minority is considered to be a society in transition, caught between Eastern and Western cultures due to the process of Westernization within Israel [2,1]. The minority has significantly higher rates of poverty, unemployment, infant mortality and school attrition than the Jewish majority [58]. Many Palestinian Arabs in Israel live under a military regime and experience social exclusion, leaving them in a conflict of dual identity as both Israeli and Palestinian. Although they live in the state of Israel, their Palestinian identification has been shown to be more nationally and emotionally connected with being Palestinian and with the Palestinians in the Occupied Territories [32]. Furthermore, it has been postulated that the Israeli component of the Arabs' collective identity does not include a sense of belonging to the state, identifying with it, and developing a sense of attachment because the uni-national superstructure excludes their identity [59].

Since its inception, the very definition of Israel as a Jewish state has cast Arab national identity and social status into ambiguity [59]. Social identity is thought to be the means through which individuals understand themselves in their social context. Moreover, understanding the processes of identity formation in the context of intergroup conflict is particularly important, since

social identity is critical to understanding how people act. When groups are in conflict, their members are placed under great pressure to completely conform to the values and practices of the favoured group [23]. The period of adolescence is a critical time where individuals are searching to secure a stable and consistent identity [71]. Palestinian adolescents' identity is a combination of identity formation during adolescence, the reality of belonging to a traditional culture in a Western nation, and the unique manifestations of the Israeli context, in which Muslim adolescents are viewed as part of a "hostile" non-assimilating minority. Relating to the Jewish-Israeli perspective, Kelman states that inherent to Jewish Israeli identity is the negation of the Palestinian "other" and the portrayal of this other as "the enemy" [42]. Palestinians experience a double trauma of exposure to political violence, and negative social and psychological responses; furthermore, this study raises questions about the identity of Arab youth in Israel. A previous study on Palestinian communities in Israel reveals strong identity towards Palestinian national heritage and negative attitudes towards Israeli policies towards Palestinian citizens. Scientific literature categorizes the Arab minority in Israel as significant, non-assimilating (differing from the majority in language, religion, nation, culture and ethnic descent), dissident (rejecting the State's official ideology of Zionism), and hostile (viewed by the Jewish majority as untrustworthy) [61]. Nonetheless, Smooha asserts that presently a hybrid identity is emerging that may be referred to as "Palestinians in Israel" and that "conveys the primacy of Palestinian affiliation and orientation, without renouncing Israeli connections" [62]. In addition, Amara & Schnell's empirical study found that Arabs in Israel feel strongly attached to at least three identities [12]. The identity of Muslim adolescents in Israel reflects the components of identity of the adult Muslim population in Israel outlined here. Furthermore, the identity of Muslim adolescents in Israel is an amalgamation of identity formation during adolescence, the reality of belonging to a traditional culture in a Western nation, and the unique manifestations of the Israeli context, in which Muslim adolescents are viewed as part of a "hostile" non-assimilating minority. In fact, Hujierat (2005)[38] pointed out that the identity of Muslim adolescents in Israel may change with the political situation evident in a specific moment in time. The same study asked Muslim adolescents in Israel to categorize themselves as Muslim, Arab, or Palestinian and found that those whose major identity was Muslim had relatively low collective self-esteem.[38]. Furthermore, the group that chose to characterize themselves as Muslim

expressed little interest in acculturation into Israeli society. Thus, the findings of the present study pointed out that the Arab youth in the Israeli context are living in a multi-traumatic environment; the exposure to political events, and living in the margins of Israeli society compare to their counterpart and having identity problems while living in two different worlds simultaneously.

The Jewish population in Israel is highly diverse. A country of immigrants, the majority remain Sephardim (European origins), with the remainder Ashkenazi (from other parts of the world). Most places on the globe are represented; recent places of migration include Russia, the former Eastern Bloc countries, and Ethiopia. The post-1967 context has seen a considerable number of Jewish settlements constructed in the West Bank and Gaza Strip, although now only those in the West Bank remain. Recent estimates hold that upwards of 300,000 settlers are in the West Bank [44]. There are tremendous variances in SES and most other well-being indicators throughout the Jewish sector of Israel. It is vital to emphasize the heterogeneity of this population. Palestinians in Israel and Jewish-Israelis often live in separate cities, although there are major centers that mix the two backgrounds, including: Jaffa, Tel Aviv, Haifa, Akko, Lod, and Ramlah.

Methodology

The sample consisted of male and female school-attending adolescents aged 14-18 from Israel (453 Jewish and 508 Palestinian). The sample was recruited from three urban centers: Tel-Aviv, Jaffa and Haifa are district cities with heterogeneous populations in culture, religion and class, and Ariel is a West Bank settlement and is more homogeneous. All three cities were subject to suicide bombings and other politically violent events since the outbreak of the Intifada in September 2000. To ensure comparable internal diversity, the Palestinian sample was recruited from Palestinian- villages, cities and mixed cities where Palestinian and Jewish peoples live.

We applied the questionnaire randomly to schools and then randomly selected co-educational grades (grades 8-12). Graduate and undergraduate students were trained to coordinate questionnaire distribution and to answer any respondent queries. Respondents were gender-matched with research assistants; Jewish populations were interviewed by Jewish students, and the Palestinian population by their Palestinian counterparts.

The following Research Instruments were used

1) **Background Socio-demographic Questionnaire** – Thirteen items probed the socioeconomic status of participants' family, their parent's education, and included questions regarding gender, age, family structure and dwellings.

2) **Political Violence** – This instrument aimed to capture the level of exposure to

violence resulting from political acts. In order to assess political violence the researcher created an 18-item Traumatic Event Questionnaire[7] tailored to each community's language (Hebrew or Arabic), and to their respective modes of exposure to political violence (for example, questionnaire asked about bomb or missile attacks). Nominal scale questions self-reported individual and friend/relative exposure. A total score was computed by summing all positive answers (range of scale 0–18), and thus a high score indicated more exposure to political violence. The internal reliability of the questionnaire was adequate among both the Jewish adolescents (Cronbach's alpha = 0.71) and among Palestinian-Israelis adolescents (Cronbach's alpha = 0.85).

3) **Mental Health** – Mental health was assessed by clinically relevant psychological symptoms in adolescents. For this aim, I used the Brief Symptom Inventory (BSI)[19,23]. This measure consists of 53 self-reported items covering nine symptom dimensions: somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism; and a composite measure of General Severity Index (GSI). A mean score was computed for each sub-scale and it ranged from 0-4 with a higher score indicating more mental health problems (scores of 2.52 and above indicate Positive clinical diagnosis). The internal reliability of the nine odd-scales is adequate (Cronbach's alpha = 0.71-0.81) and the test-retest reliability is satisfactory (r= 0.60-0.90). The measure also has a moderate level of validity, which was measured by comparison to the MMPI. Norms and scores among youth populations in Israel and the United States are available for comparison. The internal reliability of the current measure, in general, and of its sub-scales was measured in a Jewish research population [60] with reasonable results (Cronbach's alphas range from 0.62 to 0.90). In the current study the reliability of the sub-scales among the Jewish adolescents was Cronbach's alpha 0.66–0.85 and 0.95 for the GSI, and among the Palestinian adolescents 0.64–0.86 for the sub-scales and 0.96 for the GSI.

4) **PTSD** – *Post-traumatic stress disorder* was measured by the PTSD Symptom Scale: The PSS-I [31]. This measure is a 17-item instrument in which each symptom is rated on a 4-point scale. Sub-scale scores are calculated by summing items in each of the PTSD symptom clusters: re-experiencing, avoidance and arousal. A mean score was computed for each sub-scale and total scale with results ranging from 1–4, with a higher score indicating more PTSD. The scale has high internal

consistency (Cronbach's alpha = 0.85) and moderate to high correlations with other measures of psychopathology. The PSS-I has high test-retest reliability (r = 0.80) and inter-rater reliability (k = 0.91). In the current study the reliability of the total score was Cronbach's alpha 0.88 and sub-scales ranged from 0.76–0.79 among the Jewish adolescents and 0.89 for total score and 0.74–0.79 for the sub-scales among the Palestinian participants.

5) **Social Functioning** – To assess the social functioning of the adolescent participants we used the Peer Relations questionnaire, which is a standard measure for assessing peer group relationships [37]. The questionnaire, consisting of 25 questions, is suitable for respondents aged 12 and older. The sum score of the instrument was computed (ranging from 0-100), with a higher score indicating more problems in relationships with friends. The measure has a cut-off point at 35 points: individuals who score below 35 are categorized as being within the norm and those who score above 35 are categorized as having problems. The measure has high internal reliability (Cronbach's alpha = 0.94) and a low standard measure error (4.44). The peer group measure also has high validity and is able to discriminate between clinical and normal populations. Based on prior research the internal reliability of the measure has been found to be high in an Israeli study of Jewish adolescents [60] (Cronbach's alpha = 0.93, N=146), and in studies among Bedouin-Arab adolescents (Cronbach's alpha = 0.89, N=256) [11]. The reliability of the scales among the Jewish adolescents in the current study was Cronbach's alpha 0.93 and 0.92 among the Palestinian adolescents.

6) **Aggression** – In order to assess adolescents' aggressive responses and their ability to channel those responses in a safe, constructive manner, we used the Aggression Questionnaire (AQ). This 34-item instrument [17] assesses adolescents' aggression on four sub-scales: physical aggression, verbal aggression, anger and hostility. A mean score was computed for each sub-scale and total scale. Each scale ranges from 1-5 with a higher score indicating more aggressive behaviors. The internal consistency of the AQ is relatively high (Cronbach's alpha = 0.89). The AQ is a stable instrument with good test-retest correlations of 0.80. Scores on the AQ sub scales were moderately correlated with each other. However, when the variance in the correlations due to the anger score was partialed out, correlations were not significant. This supports the theoretical validity of the AQ in that the associations between physical aggression, verbal aggression, and hostility are due to their connection with anger. Scores also had good concurrent validity [22]. In the current study the reliability among the Jewish participants was Cronbach's alpha 0.89 for the total scale and 0.72–0.85 for the

sub-scales, and among the Palestinian participants 0.90 for the total scale and 0.67–0.85 for the sub-scales.

7) **Family Functioning** – In order to assess the overall health and pathology of participants' family functioning we used The McMaster Family Assessment Device (FAD) [26,40]. The FAD describes structural and organizational properties of the family group and the patterns of transactions among family members which have been found to distinguish between healthy and unhealthy families. This instrument includes 60 items on six dimensions of family functioning and one general functioning scale. All sub-scales range from 1-4, with a higher score indicating more problems in a family's functioning. Cut-off points discriminating between "clinical" and "normal" families in American populations are available, though there are none for Israeli families. The scale has satisfactory reliability (Cronbach's alpha = 0.72-0.92), good test-retest reliability (r = 0.66) and high validity, as indicated by comparing the scale's scores to other measures of the same matters [26,50]. At this stage we analyzed only the 12 items that assess the family's general functioning. A recent study [55] found that these 12 items give a satisfactory picture of the family's general functioning and as a result, there is no need to use all 60 questions. In the current study the reliability among the Jewish participants was Cronbach's alpha 0.84 and 0.72 among the Palestinians.

Data analysis is in four parts. First is a T test and Chi square analysis of demographic, SES , and other differences between the two sample groups. Next is an analysis of the association between ethnicity and participant exposure to traumatic events, psychosocial, family functioning, PTSD and aggression. Third, we deploy Pearson correlations to analyse the association between political violence and dependent variables. Finally, we deploy multiple regressions to assess how political violence and ethnicity might predict the dependent variables.

Results

Table 1 shows the results of Chi-square tests and independent sample t-tests. Jewish parents had higher education, higher SES, and lower unemployment than their Palestinian counterparts.

Table 2's t-tests indicate that Jewish participants reported more exposure to political violence. No systematic results were found regarding mental health symptoms, using the general severity index. Palestinian participants reported

more phobic anxiety, psychoticism, PTSD, family and social problems, and aggression (physical), while Jewish participants reported more paranoid ideation and aggression (verbal).

Table 1. Nationality differences on socio-demographic variables

	Jewish (n=453)	Palestinian (n=508)	Significant test
Gender, %			
Male	44.9	37.9	χ^2 =4.59*
Female	55.1	62.1	
Age, mean (sd)	15.35 (0.66)	15.53 (1.02)	t=3.03**
Religiosity, %			
Very religious	4.8	4.5	χ^2 =23.65***
Religious	34.2	36.3	
Traditional	51.4	40.6	
Not religious	9.6	18.6	
No. of siblings, mean (sd)	2.00 (1.14)	3.66 (1.83)	t=16.31***
Father's education			
Less than 8 years	2.4	10.5	χ^2 =47.09***
8-9 years	8.1	15.5	
10-11years	14.0	12.0	
12 years	39.2	24.9	
13 years or more	36.3	37.1	
Mother's education			
Less than 8 years	1.6	8.6	χ^2 =60.85***
8-9 years	4.0	14.2	
10-11 years	8.4	10.3	
12 years	45.9	30.5	
13 years or more	40.0	36.5	
Father's employment status			
Works	87.7	75.8	χ^2 =21.24***
Does not work	12.3	24.2	
Mother's employment status			
Works	80.4	61.9	χ^2 =166.91***
Does not work	19.6	38.1	
Parents' marital status			
Married	83.8	90.4	χ^2 =8.95**
Unmarried	16.2	9.6	
Family' economic status			
Low	4.1	5.5	χ^2 =30.74***
Average	55.4	37.0	
High	40.5	57.4	
* p<0.05; ** p<0.01; *** p<0.001			

Table 3's multiple regression shows that political violence was a positive significant correlation for Jewish participants regarding the general severity index and the PTSD index and aggression, but not for family or social functioning. For Palestinian participants, political violence was found to correlate with mental health symptoms, aggression, family and social functioning.

Table 2: A comparison of Jewish and Palestinian Participants on political violence and psychological functioning

	Israel – Jews (n = 453)		Palestinian (n = 508)		t value
	Mean	SD	Mean	SD	
Political Violence					
Traumatic Events Questionnaire	3.11	(2.61)	2.21	(2.78)	5.05***
Mental Health Symptoms (BSI)					
Somatization	0.81	(0.71)	0.84	(.66)	0.85
Obsession-Compulsion	1.16	(0.80)	1.19	(.64)	0.53
Interpersonal Sensitivity	1.01	(0.90)	0.99	(.79)	0.21
Depression	0.96	(0.76)	0.95	(.77)	0.25
Anxiety	1.13	(0.77)	1.06	(065)	1.52
Hostility	1.11	(0.93)	1.12	(.77)	0.09
Phobic Anxiety	0.56	(0.60)	0.82	(067)	6.11***
Paranoid Ideation	1.36	(0.87)	1.14	(.75)	4.04***
Psychoticism	0.77	(0.75)	0.85	(.67)	1.74*
General Severity Index	0.99	(0.64)	1.00	(.56)	0.30
Post-traumatic stress disorder (PTSD)					
PTSD Symptom Scale	1.29	(0.39)	1.25	(.48)	7.97***
Re-Experiencing	1.28	(0.44)	1.53	(.56)	7.44***
Avoidance	1.24	(0.39)	1.47	(.53)	7.38***
Arousal	1.37	(0.52)	1.59	(.58)	6.00***
Family Functioning					
Family Assessment Device	1.81	(0.51)	1.91	(0.46)	3.07**
Social Functioning					
Index of Peer Relations	17.79	(14.49)	19.24	(15.58)	1.45
Aggression					
Buss-Perry Aggression Questionnaire	1.99	(0.58)	2.21	(.60)	3.40***
Physical Aggression	1.83	(0.78)	2.08	(085)	4.72***
Verbal Aggression	2.57	(0.82)	2.46	(.78)	2.01*

Anger	1.79	(0.67)	2.11	(.70)	7.05**
Hostility	1.97	(0.67)	1.96	(.69)	0.14

PTSD – Post traumatic stress disorder; BSI – Brief symptom inventory
* p <.05; ** p<.01; *** p<.001

Insert Table 3 about here

When controlling for economic status, parents' education, gender, and religiosity, multiple regression analysis shows that exposure to political violence is a significant predictor. As summarized in table 4, respondents exposed to greater political violence reported higher levels of various mental health symptoms (somatization, obsession-compulsion, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, GSI), and more PTSD symptoms. In addition, exposure to political violence was found to be a significant predictor of problems in family functioning, social functioning and aggression.

Ethnicity was also found to be a major predictor. Palestinians had more symptoms of somatization, phobic anxiety, psychoticism and less paranoid ideation; they had more PTSD symptoms, family functioning problems and aggression, specifically, physical aggression and anger. Regression results did not indicate a significant interaction for any of the dependent variables; thus they are not reported in table 4. Findings show that exposure to political violence has a detrimental effect on social and mental health for both Jewish and Palestinian participants.

Several socio demographic factors are significant predictors of social and mental functioning. Participants with higher SES have less mental health symptoms, PTSD symptoms, less family and social functioning problems and less anger. Parents' education likewise predicts family functioning. Girls tend to have more mental health symptoms and PTSD symptoms and boys more problems with peers and more aggression. Religiosity does not predict any of the dependent variables.

Insert Table 4 about here

Table 3. Pearson product moment correlation coefficients between the research variables: Jewish participants above the diagonal, Palestinian participants below the diagonal

		1	2	3	4	5	6
1.	Political violence	.20***	.27***	.07	.06	.17***	
2.	General Severity Index (GSI)	.20***		.47***	.47***	.39***	.54***
3.	Post-traumatic stress disorder (PTSD)	.31***	.58***		.25***	.23***	.25***
4.	Family Assessment Device (FAD)	.18***	.40***	.36***		.42***	2.9***
5.	Index of Peer Relations (IPR)	.17***	.42***	.37***	.38***		.25***
6.	Aggression	.21***	.39***	.40***	.14***	.24***	

Discussion

Seven points bear emphasis. First, political violence is a major predictor of psychosocial functioning. This was true for both Jewish and Palestinian respondents; and it is highly consistent with findings in previous scholarship. Exposure to war can lead to such major problems as PTSD responses, and anxiety attacks [16,68,69,67,34]. Like exposure to domestic and community violence (among victims and witnesses), war can produce psychological trauma; cognitive, emotional, and behavioral problems; [45] and other maladaptive strategies for coping with violent behavior [29,30,54]. Children exposed to violence are more likely to develop violent behavior leading to juvenile delinquency [53,78] and are more likely to display aggression and to legitimate violence. [15,28]. Previous research on Palestinians in the West Bank shows well-established connections between political, domestic, community, and school violence. [10] Among Jewish Israeli adolescents exposed to war, there is comparable evidence of self-perceived problems in psychological growth and mild to severe PTSD [47].

The second point: My data finds important differential responses to political violence. The sample's female respondents had more mental health symptoms and PTSD symptoms. Boys had more problems with peers and increased aggression. But other demographic factors are not as significant. Religiosity does not predict any of the dependent variables. Jewish participants, on the other hand, were more exposed to political violence than their Palestinian-Israeli counterparts. But for both sample groups, and indeed for anyone, exposure to violence can be a major influence on adolescent development [9]. Adolescence itself is already a critical period, characterized by major changes in biological, psychological, and social systems [27,63] as well as by major social and situational challenges [20]. Moreover, adolescents have reached a stage of cognitive development and awareness [52] wherein consequences of exposure to violence may include PTSD reactions, dropping out of school, behavior problems, delinquency; lack of security and dissolution of social structures, and perceived threats to physical, emotional, and social development [20,30,53,77]. Previous research shows that responses to living in a context of violence and trauma are not universal in nature and can manifest in a range of mild-to-severe psychological disorders [14], or no disorder at all. Indeed, there is no universal response to highly stressful events, and many of those exposed to the excesses of war heal within community, as personal recovery is deeply rooted in social recovery [66].

The third related point: Palestinian respondents have more mental health problems, PTSD symptoms, family and social problems and more aggression. The preceding discussion outlines the negative impact on a precarious period of human development – adolescence. But one needs to read these findings in the context of the already existent stresses on the Palestinian-Israeli families

because of pressure to survive economically and other ways. Almost 60% of non-Jewish children in Israel live in poverty; this is 2.5 times higher than the Jewish population poverty rates (Israeli Central Bureau of Statistics, 2009). In the Jewish sector, 15% of children have unemployed parents, compared with 23% of Palestinian-Israeli children [39].

Families are already weakened and therefore people might need to seek outside support services. Yet research confirms lack of services and lower service utilization rates for relevant services, for youth in particular [56,57]. And funding for social and allied services for the Palestinian-Israeli sector is markedly lower than those for their Jewish counterparts. There are long-term implications that bear emphasis. The youth demographics are particularly profound; those who are 15 years old and under constitute about 41% of the Palestinian-Israeli community in Israel; those under age 20 are a little under 50% of the Palestinian-Israeli sector [39]. For both populations, there are great issues of risk, given the proportions of youth who are exposed to political violence. Yet the Palestinian-Israelis experience a double trauma: like their Jewish counterparts they are exposed to political violence; but their population has higher unemployment, lower SES, and lower funding for educational, health, and social services [18].

There are likewise implications to family structures. The impact on the family unit – in Palestinian-Israeli and Jewish sectors – bears emphasis. Various studies have shown that exposure to political violence leads to a multitude of significant changes in the structure and every day actions of the family unit [40,75]. The family unit, when subjected to political violence, becomes highly vulnerable to various stress-related factors [9,43,64]. Familial relations become overburdened by conflict as traditional normative understandings that define the family unit, structure and hierarchy are challenged; parents may lose employment, and gender and age roles may be challenged [65].

The fourth major point relates strongly to the above notion of a double trauma: it is expected that the group that was exposed to more political violence (Jewish) will show more mental health symptoms; but the reverse is true. Palestinian-Israelis experience more symptoms, social, and family problems. One wonders why this is. In part, it may be because Palestinian-Israeli communities receive less money for helping professional services; are less inclined to seek outside services; and are the clients of service systems that are already underfunded [4,5]. Then there is the social significance of death – which needs to be understood in its immediate impact on those who are associated with the dead, as well as a wider community and political symbol of ongoing war-related trauma. Traumatic events such as the death of friends, community members, and relatives require culturally specific, and clinically

particular, services [8,9]. Particularly with high context communities in which community linkages are vital, bereavement responses need to be situated collectively, and such community responses may be an impetus for consciousness development and community learning, as we discuss below.

Fifth and also related to the double trauma, the socio-economic status of the Palestinian in Israel is lower than his Jewish counterpart; and this has implications for all areas of life, including responses to trauma and health. Economic status and level of education are known to be associated with the psychological well-being of families and individuals. Previous scholarship correlates low levels of education and unemployment with high risk factors for poor mental health [36]. Indeed, chronic poverty has a deleterious impact on many life domains, including basic needs, family and social relations, leisure, and self-esteem [76]. According to Tolman & Wang (2005)[70], domestic violence is associated with various forms of material deprivation, as well as increased welfare dependence and decreased work reliance. Other studies have linked job loss to domestic violence (e.g., Moore & Selkowe, cited in Tolman & Wang, 2005)[70]. Low educational attainment has also been found to be associated with domestic violence [72]. Domestic violence, in turn, has been linked to increased rates of mental health problems, including depression, suicidal ideation and PTSD [70]. Moreover, since the education system is a part of the broader society, there is reason to believe that there is a relationship between an environment of political violence and high rates of school violence [10].

The sixth point deals with the impact of political violence on the identity formation of Palestinian adolescents in Israel. This study demonstrates evident differences between Palestinian adolescents and their Jewish counterparts in the degree of exposure to political violence; whereas the Jewish adolescents experienced more exposure to acts of political violence, the Palestinians experienced higher social and emotional consequences. In addition, it has been shown that Palestinian adolescents' ability to cope with their complex reality is harder than that of their Jewish counterparts, due to lower educational levels, unemployment, domestic violence, and social and economic discrimination and deprivation. According to Slone (2003)[59], the adolescent period is a developmental one – with its predominance of identity-seeking characteristics, the quest for autonomy, and the facility of emotionality – while in the midst of a volatile external situation. It has been noted that the overall issue of Arab in Israel identity has become even more complex against the background of the Israeli-Palestinian conflict (Slone, 2003). These multiple aspects of the Palestinian-Israeli adolescent's reality raise questions as to their implications on that individual's social and personal identity as s/he grows into adulthood. The period of adolescence is a critical time, in which individuals search to

secure a stable and consistent identity[71]. Following one study's assertion that under constructivist assumptions, one's identity is not eternally fixed but can be shaped by external events and the attempts of ethnic entrepreneurs to mobilize constituencies [49], there is a need to examine the identity construction of adolescent Palestinian in the context of both their immediate environment and Israeli society as a whole.

Finally, there are myriad implications for human service and teaching professionals, policy makers, and political actors. Psycho-educational and psychotherapeutic models of intervention need to be developed for Palestinian and Jewish populations that are culturally sensitive and relevant[2,3]. Services could take into account distinctive characteristics within populations; there is profound diversity in Jewish and Palestinian communities in terms of geographic and other forms of identity. Leverage may be made to encourage Palestinian families who might be reluctant to receive services, and one such leverage is the well-being of children – a priority around which all community members may rally [6]. Sufficient funding, and sufficient relevance need to occur; and all community stakeholders can be usefully brought together to ensure collaboration and the maximized targeting of needs with services. Likewise, popular psycho-educational campaigns can be aptly deployed in schools and community milieu, in order to bring about awareness and to provide support and access to services. Strategies of poverty reduction and community economic development could likely reduce the double trauma of Palestinian life. And throughout, there are linkages between all aforementioned systems; political actors, policy people, service administrators and providers, as well as the communities they serve, need to work collaboratively and the insights from each constituency need to be reciprocally shared [33].

Conclusion

The present study provides compelling evidence that while political violence and behavioral and emotional problems were high among all respondents, they were particularly high among Palestinian youth. Any increase in mental health services, directed towards youth and their families, would be beneficial to either population, but especially those who are vulnerable to various trauma-related health problems.

The researcher was surprised by the extent of the relationship between low socioeconomic status and problematic responses to trauma, as well as by the impact of the Palestinian double trauma. The findings provide evidence that Palestinians, particularly those in poverty, suffer significantly, raising questions about the long-term health of this sector of society, their feelings of social exclusion, and hence the peace process. Investments in jobs, funding for municipal, health, and social

services, and other means of increasing social inclusion and raising socioeconomic status are all worthy goals for reducing gaps between Jewish and Palestinian populations in Israel. This double trauma that Palestinians face is central to this analysis; thus for the long term's sake and for the future of the region, investment in the Palestinian community is worthwhile. In the end, helping those vulnerable who are exposed to trauma is a viable objective for service providers, scholars, and perhaps most importantly of all, policy makers and political actors.

الملخص:
شارك في هذه الدراسة عينه من الذكور والإناث من طلاب المدارس المراهقين بين السن 14-18 سنة، وكان منهم 453 يهودي و508 فلسطيني. واستعملت أدوات قياس نفسية في هذه الدراسة هي: مسح لأحداث الشدة، قائمة الأعراض المختصرة، استبيان اضطراب شدة ما بعد الصدمة، استبيان العلاقة مع الأقران، استبيان العنف ومقياس تقييم العائلة. وتبين أن العنف السياسي له آثار سلبية على الصحة النفسية وأظهرت النتائج أن المشاركين اليهود أكثر عرضه للعنف السياسي، بينما أظهر المشاركون الفلسطينيون أعراض الجسدنه والقلق الرهابي والميل للذهان بالإضافة إلى اضطراب شدة ما بعد الصدمة ومشاكل في وظائف الأسرة والعنف (خصوصاً العنف الجسدي والغضب). تم بحث درجة تعليم الآباء والأمهات بالإضافة للمستوى الاجتماعي والاقتصادي والضغوط العائلية في إطار نتائج الدراسة. الفلسطينيون في المناطق المحتلة عام 1948 يعانون من شدة مضاعفة نتيجة للتعرض للعنف السياسي بالإضافة إلى التجاوب السلبي الاجتماعي والنفسي للتفرقة والعنصرية التي تمارس ضمن الإطار الإسرائيلي. وخلصت الدراسة إلى تطبيق هذه المفاهيم على الممارسة والسياسة.

References

1. Al-Haj, M. (1989). Social research on family lifestyles among Arabs in Israel. *Journal of Comparative Family Studies, 20*(2), 175-95.
2. Al-Krenawi, A., & Graham, J.R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work, 25*(1), 9-22.
3. Al-Krenawi, A., & Graham, J.R. (2004). Somatization among Bedouin-Arab women: Differentiated by marital status. *Journal of Divorce and Remarriage, 42*(1/2), 131-143.
4. Al-Krenawi, A., & Graham, J.R. (2006). A comparison of family functioning, life and marital satisfaction, and mental health of women in polygamous and monogamous marriages. *International Journal of Social Psychiatry, 52*(1), 5-17.
5. Al-Krenawi, A., & Graham, J.R. (2007). The provision and use of social services among the Bedouin-Arab indigenous population in

Israel. *Social Development Issues*. *29*(1), 100-118.

6. Al-Krenawi, A., Graham, J.R. & Al-Krenawi, S. (1997). Social work practice with polygamous families. *Child and Adolescent Social Work Journal*, *14*(6), 444-458.
7. Al-Krenawi, A., Graham, J.R., & Kanat-Maymon, Y. (2009). Analysis of trauma exposure, symptomatology and functioning in Jewish Israeli and Palestinian adolescents. *British Journal of Psychiatry*, *195*, 427-432.
8. Al-Krenawi, A., Graham, J.R., & Sehwail, M. (2002). Bereavement responses among Palestinian widows, daughters, and sons following the Hebron massacre. *Omega: Journal of Death and Dying*, *44*(3), 241-255.
9. Al-Krenawi, A., Graham, J.R., & Sehwail, M. (2004). Mental health and violence/trauma in Palestine: Implications for helping professional practice. *Journal of Contemporary Family Studies, 35*(2), 185-210.
10. Al-Krenawi, A., Lev-Wiesel, R., & Sehwail, M. (2007). Psychological symptom-atology among Palestinian male and female adolescents living under political violence 2004–2005. *Community Mental Health Journal*, *43*(1), 49-56.
11. Al-Krenawi, A., & Slonim-Nevo, V. (2002). Mental health aspects of Arab-Israeli adolescents from polygamous versus monogamous families. *The Journal of Social Psychology*, *142*(4), 446-60.
12. Amara, M., & Schnell, I. (2003). Identity repertoires among Arabs in Israel. *Journal of Ethnic and Migration Studies, 3*(1), 175-193.
13. Arab Association for Human Rights, (15-22 July, 2003). More house demolitions in the Negev. *Weekly Review of the Arab Press in Israel*, 126. Retrieved August 1, 2003, from http://www.arabhra.org
14. Baker, A.M. & Shalhoub-Kevorkian, N. (1999). The effects of political and military trauma on children: The Palestinian case. *Clinical Psychology Review*, *19*, 935-950.
15. Bandura, A. (1998). Mechanisms of moral disengagement. In W. Reich (Ed.), *Origins of terrorism: Psychologies, ideologies, theologies and state of mind* (pp. 161-191). Washington DC: Woodrow Wilson Center Press.
16. Barber, B.K. (1999). Political violence, family relations, and Palestinian youth

functioning. *Journal of Adolescent Research, 14*, 206–230.
17. Buss, A.H., & Perry, M. (2002). The aggression questionnaire. *Journal of Personality and Social Psychology, 63*(3), 452-59.
18. Boudreaux, R. (2008, February 26). Israel: Digital gap between Arabs and Jews. *Los Angeles Times.* Retrieved September 14, 2009, from http://latimesblogs.latimes.com/babylonbeyond/2008/02/israel-digital.html
19. Canetti, L., Shalev, A.Y., & De-Nour-Kaplan, A. (1994). Israeli adolescents' norms of the Brief Symptom Inventory (BSI). *Israel Journal of Psychiatry and Related Sciences, 31*(1), 13-18.
20. Cicchetti, D., & Rogosch, F. A. (2002). A developmental psychopathology perspective on adolescence. *Journal of Consulting and Clinical Psychology, 70*, 6-20.
21. Cohen, M., & Eid, J. (2007). The effect of constant threat of terror on Israeli Jewish and Arab adolescents. *Anxiety, Stress, and Coping, 20*(1), 47-60.
22. Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice*. New York: Free Press.
23. Derogatis, L., & Spencer, P. (1982). *The brief symptom inventory (BSI): Administration, scoring and procedures, Manual I.* Baltimore: Johns Hopkins.
24. Durakovic-Belko, E., Kulenovic, A., & Dapic, R. (2003). Determinants of post-traumatic adjustment in adolescents from Sarajevo who experienced war. *Journal of Clinical Psychology, 59*, 27–40.
25. Elbedour, S., Bastien, D.T., & Center, B.A. (1997). Identity Formation in the Shadow of Conflict: Projective Drawings by Palestinian and Israeli Arab Children from the West Bank and Gaza. *Journal of Peace Research, 34*(2), 217-231.
26. Epstein, N.B., Baldwin, L.M., & Bishop, D.S. (1983). The McMaster Family Assessment Device: Reliability and validity. *Journal of Marital and Family Therapy, 9*(2), 171-180.
27. Feldman, S., & Elliott, G. (Eds.). (1990). *At the threshold: The developing adolescent.* Cambridge, MA: Harvard University Press.
28. Fitzpatrick, K.M. (1997). Fighting among America's youth: A risk and protective factors approach. *Journal of Health and Social Behavior, 38*, 131-148.
29. Flannery, D., Singer, M., & Wester, K. (2001). Violence exposure, psychological trauma, and suicide risk in a community sample of

dangerously violent adolescents. *Journal of the Academy of Child and Adolescent Psychiatry, 40*(4), 435-444.

30. Flannery, D., Wester, K., & Singer, M. (2004). Impact of violence exposure at school on child mental health and violent behaviour. *Journal of Community Psychology, 32*(5), 559-574.
31. Foa, E.B., Riggs, D., Dancu, C.V., & Rothbaum, B.O. (1993). Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *Journal of Traumatic Stress, 6*, 459-73.
32. Ganim, A., & Smooha, S. (2001). *Attitudes of the Arabs to the State of Israel.* Haviva Institute of Peace Research. Retrieved September 14, 2009, from http://66.155.17.109/peace/publications
33. Graham, J., & Barter, K. (1999). Collaboration: A social work practice method. *Families in Society: The Journal of Contemporary Human Services, 80*(1), 6-13.
34. Gurwitch, R.H., Kees, M., & Becker, S.M. (2002). In the face of tragedy: Placing children's reactions to trauma in a new context. *Cognitive and Behavioral Practice, 9*(4), 286-295.
35. Hadi, F.A. (1999). Predicting psychological distress in children. *Journal of the Social Sciences, 27*(1), 73- 87.
36. Harpham, T., Grant, E., & Rodriguez, C. (2004). Mental health and social capital in Cali, Colombia. *Social Science & Medicine, 58*(11), 2267–2277.
37. Hudson, W.W. (1982). *The Clinical Measurement Package: A field manual*. Chicago: Dorsey Press.
38. Hujierat, M. (2005). *The collective identity of Arab-Israeli students: Identity complexity and collective self-esteem.* Ph.D dissertation, Beer-Sheva, Israel: Ben-Gurion University of the Negev.
39. Israeli Central Bureau of Statistics. (2009). *Statistical Abstract of Israel 2009 No. 60.* Retrieved September 14, 2009, from http://cbs.gov.il/reader/
40. Joshi, P.T., O'Donnell, D.A., Cullins, L.M., & Lewin, S.M. (2006). Children exposed to war and terrorism. In M.M. Feerick and G.B. Silverman (Eds.), *Children exposed to violence* (pp, 53-84). Baltimore, MD: Paul H. Brookes Publishing.
41. Kanaana, S. (1992). *Still on vacation! The eviction of the Palestinians in 1948.* Ramallah and Jerusalem:

Shaml-Palestinian Diaspora and Refugee Centre.
42. Kelman, H.C. (1987). The Political Psychology of the Israeli-Palestinian Conflict. *Political Psychology*, *8,* 347–63.
43. Khamis, V. (2005). Posttraumatic stress disorder among school age Palestinian children. *Child Abuse & Neglect*, *29*(1), 81-95.
44. Kraft, D. (2009, July 28). Number of settlers in West Bank has doubled. *The Independent.* Retrieved September 14, 2009, from http://www.independent.ie/world-news/middle-east/number-of-settlers-in-west-bank-has-doubled-1843605.html
45. Kuther, T. L. (1999). A developmental-contextual perspective on youth co-victimization by violence. *Adolescence, 34*, 669-714.
46. Laufer, A., Raz-Hamama, Y., Levine, S. Z., & Solomon, Z. (2009). Posttraumatic growth in adolescence: The role of religiosity, distress and forgiveness. *Journal of Social and Clinical Psychology*, *28*, 862-880.
47. Laufer, A & Solomon, Z. (2006). Posttraumatic Symptoms and Post-traumatic Growth among Israeli Youth Exposed to Terror Incidents. *Journal of Social and Clinical Psychology*, *25*(4), 429-447.
48. Lavi, T., & Solomon, Z. (2005). Palestinian youth of the Intifada: PTSD and future orientation. *Journal of the American Academy of Child Adolescent Psychiatry*, *44*, 1176–1183.
49. Lowrance, S. (2005). Being Palestinian in Israel: Identity, protest, and political exclusion. *Comparative Studies of South Asia, Africa and the Middle East*, *25*(2), 487-499.
50. Miller, I.W., Epstein, N.B., Bishop, D.S., & Keitner, G.I. (1985). The McMaster Family Assessment Device: Reliability and validity. *Journal of Marital and Family Therapy, 11*(4), 345-356.
51. Nir, O. (2003). *Israel's Arab minority, policy brief: Middle East Institute*. Retrieved September 29, 2008, from www.mideasti.org/articles/doc22.html
52. Osofsky, J.D. (2004). *Young children and trauma: Intervention and treatment.* New York: The Guilford Press.
53. Osofsky, H.J., & Osofsky, J.D. (2001). Violent and aggressive behaviors in youth: A mental health and prevention perspective. *Psychiatry: Interpersonal & Biological Processes, 64*(4), 285-295.
54. Overstreet, S., & Braun, S. (2000). Exposure to

community violence and post-traumatic stress symptoms: Mediating factors. *American Journal of Orthopsychiatry, 70,* 263-271.

55. Ridenour, T.A., Daley, J.G., & Reich, W. (1999). Factor analysis of the family assessment device. *Family Process*, *38*(4), 103-129.
56. Savaya, R. (1995). Attitudes towards family and marital counseling among Israeli Arab women. *Journal of Social Service Research*, *21*(1), 35-51.
57. Savaya, R. (1998). The under-use of psychological services by Israeli Arabs: An examination of the roles of negative attitudes and the use of alternative sources of help. *International Social Work*, *41*, 195-209.
58. Sikkuy. (2004). *Sikkuy Report 2004*. Retrieved September 14, 2009, from http://www.sikkuy.org.il/english/reports.html
59. Slone, M. (2003). The Nazareth Riots: Arab and Jewish Israeli Adolescents Pay a Different Psychological Price for Participation. *The Journal of Conflict Resolution*, *47*(6), 817-836.
60. Slonim-Nevo, V., & Shraga, Y. (2000). Psychological and social adjustment of Russian-born and Israeli-born Jewish adolescents. *Child and Social Work Journal, 17*(6), 455-75.
61. Smooha, S. (1999). The status quo option. In: S. Ozacky-Lazar, A. Ghanem, & I. Pappe (Eds.), *Seven roads: Theoretical options for the status of the Arabs in Israel* (pp. 23-28). Geva'at Haviva, Israel: Peace Research Institute.
62. Smooha, S. (2004). Arab-Jewish relations in Israel as a deeply divided society. In: A. Shapira (Ed.), *Israeli Identity in Transition*. (pp. 31-67). New York: Praeger.
63. Spear, L.P. (2000). The adolescent brain and age-related behavioral manifestations. *Neuroscience & Biobehavioral Reviews*, *24*, 417-463.
64. Srour, R.W. (2005). Children living under a multi traumatic environment. *Israel Journal of Psychiatry*, *42*(2), 88-95.
65. Suad, J. (2004). Conceiving family relationships in post-war Lebanon. *Journal of Comparative Family Studies, 35*(2), 271-293.
66. Summerfield, D. (2000). War and mental health: A brief overview. *British Medical Journal, 321*, 232-235.
67. Thabet, A.B.M., Abed, A.M., & Vostanis P. (2002). Emotional problems in Palestinian children living in

a war zone: A cross-sectional study. *Lancet*, *359*(9320), 1801-1805.

68. Thabet, A.B.M.**,** & Vostanis, P. (2004). Co morbidity of PTSD and depression among refugee children during war conflict. *Journal of Child Psychology and Psychiatry*, *45*(3), 533-542.
69. Thabet, A.B.M., & Vostanis, P. (2005). Child mental health problems in the Gaza strip. *Israel Journal of Psychiatry*, *42*(2), 84-87.
70. Tolman, R.M., & Wang, H.C. (2005). Domestic violence and women's employment: Fixed effects models of three waves of women's employment study data. *American Journal of Community Psychology, 36*, 147-158.
71. Tsou, A. (2002). *Understanding the influence of ethnic identity and acculturation on psychological adjustment among Chinese American adolescents.* PhD dissertation, Berkley: California School of Professional Psychology.
72. Vest, J. R., Catlin, T. K., Chen, J. J., & Brownson, R. C. (2002). Multistate analysis of factors associated with intimate partner violence. *American Journal of Preventive Medicine, 22*(3), 156-164.
73. Vizek-Vidovic, V., Kutervac-Jagodic, G. & Arambasic, L. (2000). Posttraumatic symptomatology in children exposed to war. *Scandinavian Journal of Psychology*, 41, 297- 306.
74. Wakim, W. (1994). The National Committee for the Defence of the Rights of the Uprooted in Israel, presented at the first *Conference for Human Rights in Arab Society*, held in Nazareth.
75. Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A., Muzurovic, J., Spahovic, D., Feetham, S., Ware, N., Knafl, K., & Pavkovic, I. (2004). Family consequences of refugee trauma. *Family Process*, *43*(2), 147-60.
76. Wilton, R. (2004). Putting policy into practice? Poverty and people with serious mental illness. *Social Science and Medicine, 58*, 25-39.
77. Yurtbay, T., Alyanak, B., Abali, O., Kaynak, N., & Durukan, M. (2003). The psychological effects of forced emigration on Muslim Albanian children and adolescents. *Community Mental Health Journal, 39*, 203-212.
78. Zingraff, M.T., Leiter, J., Myers, K.A., & Johnson, M.C. (1993). Child maltreatment and youthful

problem behavior. *Criminology, 31*, 173-202.

Table 4.

Political violence, nationality, and socio-demographic variables as predictors of Psycho-social functioning: Standardized coefficients (β), unstandardized coefficients (b) and 95% confidence intervals of multiple regression

	Political violence	Nationality	Economic status	Parents education	Gender	Religion	R^2	F value
Mental health symptoms (BSI)								
Somatization								
B	.16***	.07*	-.18***	.04	.19***	-.03	.10	15.21***
B	.04	.10	-.12	.02	.26	-.03		
95% CI	.02 to .05	.01 to .19	-.16 to -.08	-.02 to .07	.17 to .35	-.09 to .03		
Obsession-compulsion								
B	.15***	.04	-.20***	-.01	.13***	.02	.09	13.76***
B	.04	.06	-.14	-.01	.19	.02		
95% CI	.02 to .06	-.03 to .16	-.18 to -.09	-.06 to .04	.09 to .28	-.04 to .08		
Interpersonal sensitivity								
β	.13***	.04	-.25***	.03	.20***	.04	.13	20.69***
b	.04	.07	-.20	.02	.44	.05		
95% CI	.02 to .06	-.04 to .18	-.25 to -.15	-.03 to .07	.23 to .45	-.02 to .12		
Depression								
β	.18***	.04	-.25***	-.01	.14***	-.03	.12	20.08***
b	.05	.07	-.18	-.01	.22	-.03		
95% CI	.03 to .07	-.04 to .17	-.23 to -.13	-.05 to .04	.13 to .32	-.10 to .03		
Anxiety								
β	.15***	-.02	-.17***	-.01	.20***	.06	.11	17.37***
b	.04	-.03	-.11	-.01	.29	.05		
95% CI	.02 to	-.13 to .06	-.16 to -	-.05 to .03	.20 to	-.01 to		

	.06		.07		.39	.11		
Hostility								
β	.17***	.05	-.12***	.01	-.01	.02	.05	7.13***
b	.05	.08	-.10	.01	-.01	-.01	.03	
95% CI	.03 to .07	-.03 to .20	-.185 to -.05	-.05 to .06	-.13 to .10	-.05 to .10		
Phobic anxiety								
β	.11**	.22***	-.19***	.05	.19***	.02	.14	22.56***
b	.03	.28	-.12	-.03	.25	.02		
95% CI	.01 to .04	.19 to .36	-.16 to -.08	-.07 to .01	.17 to .33	-.04 to .07		
Paranoid ideation								
β	.17***	-.10**	-.16***	.02	.12***	.03	.09	14.07***
b	.05	-.16	-.12	.01	.19	.03		
95% CI	.03 to .07	-.27 to -.05	-.17 to -.07	-.04 to .07	.09 to .30	-.04 to .10		
Psychoticism								
β	.18***	.10**	-.24***	-.03	.12****	-.02	.12	19.03
b	.05	.15	-.16	-.02	.18	-.02		
95% CI	.03 to .06	-.01 to .15	-.17 to -.10	-.04 to .04	.14 to .29	-.04 to .06		
General Severity Index								
β	.20***	.06	-.24***	-.01	.18***	.01	.14	22.80***
b	.04	.07	-.14	-.01	.22	.01		
95% CI	.03 to .06	-.01 to .15	-.17 to -.10	-.04 to .04	.14 to .29	-.04 to .06		
Post traumatic stress disorder (PTSD)								
PTSD								
β	.30***	.31***	-.14***	-.02	.10**	-.01	.18	31.63***
b	.05	.27	-.06	-.01	.09	-.01		
95% CI	.04 to .06	.21 to .23	-.08 to -.03	-.03 to .02	.03 to .14	-.04 to .04		
Re-experiencing								
β	.26***	.29***	-.13***	-.02	.11**	.02	.16	26.54***

b	.05	.29	-.06	-.01	.11	.02		
95% CI	.04 to .06	.22 to .36	-.09 to -.03	-.04 to .02	.05 to .18	-.03 to .06		
Avoidance								
β	.26***	.28***	-.14***	-.02	.06	.01	.14	23.88***
b	.04	.26	-.06	-.01	.06	.01		
95% CI	.03 to .06	.20 to .32	-.09 to .03	-.04 to .02	-.01 to .12	-.04 to .04		
Arousal								
β	.26***	.24***	-.10***	.01	.10**	-.02	.12	19.54***
b	.05	.27	-.05	.01	.11	-.02		
95% CI	.04 to .07	.19 to .34	-.08 to -.02	-.04 to .04	.04 to .18	-.06 to .03		
Family functioning								
Family assessment device								
β	.13***	.14***	-.19***	-.09*	-.06	-.10**	.09	14.01***
b	.02	.14	-.09	-.04	-.06	-.06		
95% CI	.01 to .04	.07 to .20	-.11 to .06	-.07 to -.01	-.13 to .01	-.10 to -.02		
Social functioning								
Index of peer relations								
β	.12***	.05	-.20***	-.01	-.07*	-.04	.06	9.70***
b	.02	.06	-.10	-.01	-.08	-.03		
95% CI	.01 to .04	-.02 to .13	-.14 to -.07	-.04 to .03	-.15 to -.01	-.08 to .02		
Aggression								
Buss-Perry aggression questionnaire								
β	.18***	.14***	-.05	-.03	-.13***	-.01	.06	9.76***
b	.04	.17	-.03	-.02	-.16	.01		
95% CI	.02 to .05	.09 to .25	-.07 to .01	-.05 to .02	-.24 to -.08	-.05 to .06		
Physical aggression								
β	.14***	.19***	-.02	-.05	-.32***	.01	.14	23.77***

b	.04	.31	-.02	-.04	-.53	.01		
95% CI	.02 to .06	.21 to .42	-.07 to 03	-.09 to .02	-.64 to -.43	-.06 to .08		
Verbal aggression								
β	.09*	-.05	-.01	.01	.02	-.02	.01	1.73
b	.03	-.09	.01	.01	.04	-.02		
95% CI	.01 to .05	-.20 to .03	-.05 to .05	-.05 to .05	-.08 to .15	-.09 to .05		
Anger								
β	.17***	.24***	-.03	-.04	-.04	-.02	.08	12.32***
b	.05	.35	-.02	-.03	-.07	-.02		
95% CI	.03 to .06	.25 to .44	-.06 to .02	-.07 to .02	-.16 to .03	-.08 to .04		
Hostility								
β	.15***	.02	-.11**	.01	.01	.04	.04	6.01***
b	.04	.03	-.07	.01	.01	.04		
95% CI	.02 to .06	-.07 to .12	-.11 to .03	-.04 to .05	-.08 to .11	-.02 to .10		

* p <.05; ** p<.01; *** p<.001
Nationality: 0=Jewish, 1=Palestinian-Israelis
Gender: 0=male, 1=female

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Child Abuse and its Long-Term Consequences: An Exploratory Study on Egyptian University Students

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إساءة معاملة الأطفال وآثاره طويلة الأمد: دراسة استطلاعية لطلاب من الجامعات المصرية

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Abstract:

Introduction: child abuse and its long-term consequences in adulthood have been recently gaining increased attention in the Arab world. This study is an extension of a similar study in Saudi Arabia, and aims to explore some epidemiological characteristics of the problem in Egypt.

Aims: to study the prevalence of child abuse and associated psychological problems in adulthood, as presented in a sample of university students in Egypt.

Method: 963 students, from three different colleges of Zagazig University (Medicine, Education and Arts and Literature) answered multi-questionnaires including: General health Questionnaire (GHQ), Child Traumatic Questionnaire (CTQ) and Psychological Problem Scale (PPS).

Results: Students reported having suffered Emotional neglect (19%), Emotional abuse (8.9%), Physical neglect (44%) and Physical abuse (6%) and Sexual abuse (13%). Moderate to severe childhood abuse was correlated with various combinations of psychological problems (Low Self-Esteem, Dissociation, Self Harm, Impulsivity and Aggression) in adulthood. Gender and situational stresses, as indicated by GHQ, did not seem to influence the results as much as low income and large family size.

Conclusion: a large proportion of our sample reported both child abuse and several long-term pathological consequences of abuse in adulthood. The problem seems to be serious in this middle class sample and it remains possible that these problems could be worse in lower social classes.

Declaration of interest: None

Introduction

The subject of child abuse and its long-term implications in adulthood has been widely studied in literature in different areas of the world and across different cultures.[1,2,3,4,5,6,7]. The effects of child abuse vary depending on the circumstances of the abuse or neglect, personal characteristics of the child, and the child's environment. Consequences may be mild or severe; disappear after a short period or last a lifetime. Consequences could affect the individual physically, psychologically, the way they behave or a combination of all three ways. Ultimately, due to related costs to society such as health care, social services and educational systems, abuse and neglect impact not just on the child and family, but also on the whole of society [8,9].

It is unfortunate that this area of research has not received much attention in Arabic literature for a long time. It has been only recently, within the last 10 – 15 years, that this subject started to be covered in the media and by social and political establishments [10].

During this period, the subject of child abuse started to be covered by five main establishments; (1) the independent satellite TV channels and internet web-sites, (2) political organisations especially those interested in the recent Middle East wars, (3) Middle East academics, (4) the international organisations concerned with children's rights and (5) govern-mental agencies.

It is probably the emergence of the new independent media sector in the Middle East during the last 25 years, which has been the main factor in breaking the taboos about child abuse and sexual harassment in the Arab world [10]. A fairly large number of satellite TV channels and a much larger number of internet websites started to compete to engage the public by producing this brave and new coverage of a long tabooed problem and bring it to the open. Dozens, if not hundreds, of websites (including e-bloggers, chat room and e-forums), have been discussing such subjects freely in an unprecedented way. However they have been focused mainly on the subjects of child sexual abuse and sexual harassment of adult women. This has clearly been associated with a significant increase in public interest and awareness as well as an increase in the interests of other agencies.

The second major source of interest in child abuse has been the organisations concerned with victims of wars and political crises in the Middle East (e.g. human rights organisations and some political parties). In this regard, the literature about the children suffering in wars such as those in Lebanon, Palestine and Iraq have been the most prominent.[11,**12,**13]

During the same period, a relatively large number of scientific publications have been produced by different scientific disciplines (e.g. public health sociology, mental health and paediatric departments). Between 1995 and 2009, the Child Abuse & Neglect Journal (the Official Publication of the International Society for Prevention of Child Abuse and Neglect) published about 40 psychiatric and psychological articles about child abuse in the Middle East and the Arab world [14,**15,16,17**]**.** Many studies have been produced in Arabic[18,19]**.** Publications from Paediatrics departments about child abuse have been mainly about physical abuse and physical complications of child abuse [20,21]**.**

International organisations working in the Middle East[22,23,24,25,**26,27**] have also been working mainly with governmental agencies to combat child abuse in the area and provide some services. They have also been organising conferences and publishing research (see web sites of these organisations). These organisations have played a significant role in increasing the awareness of the problem. Some Arabic governments have since started to develop specialised organisations to combat child abuse [28].

The recent emergence of interest in child abuse has freed the subject from some old taboos but has also attached some new ones. The new controversies would perhaps influence the debate about child

abuse for some time to come. The subject of child abuse has been covered by political opposition and independent parties in the context of their criticism of the living conditions in the Arab countries [29,30,31,32]. Child abuse has also been a subject used in the local Middle Eastern war propagandas. Most of the independent Arabic views highlight the children suffering in the war zones in an attempt to condemn Israel and its American and western allies. On the opposite side, many Israeli and western media agencies in the area, supported by some local voices, express the view that traditional Arab and Islamic culture could be facilitating abuse of women and children.

One example of these new sensitivities is the scepticism about the publications about child abuse in Palestine produced by Palestinian academics and others who worked at the time in Israeli universities. These papers constitute probably more than half of the Child Abuse and Neglect Journal publications mentioned above.

Research Design:

In this study, we have followed a fairly similar methodology as in the Saudi study [33]**.** Two of our authors have been involved in that study. 1500 questionnaires (see appendix) were distributed to students in three colleges in Zagazig University (Medicine, Education and Arts and Literature). 963 responses were received (458 from College of Education, 341 from College of Art and Literature and 164 from College of Medicine). Some of the responses were partially incomplete and subsequently the missing parts have not been included in the statistical analysis.

The three colleges were chosen to represent different levels of functioning and socioeconomic status among Egyptian students. In accordance with general public attitude in Egypt, students from Faculty of Medicine have usually been considered to be of higher academic status, more motivated and have relatively higher economic and social status compared to other students. It is also widely assumed that students from colleges of Art and Literature are from relatively lower economic and social status, while students from the colleges of Education lie in-between.

The following psychological tools have been included in the questionnaires:

The Arabic version of General health Questionnaire-12 (GHQ – 12)[34]: The General Health Questionnaire[35] has been extensively used in different settings and different cultures. The GHQ focuses on two major areas – the inability to carry out normal functions and the appearance of new and distressing psychological phenomena such as depressive symptoms, social dysfunction, sleep disturbance, anxiety, and dysphoria in people in community and medical settings. The GHQ assesses the respondent's current state (state-stress) and asks if that differs from his or her usual trait-stress. The questionnaire was originally developed as a 60-item instrument but at present a range of shortened versions of the

questionnaire including the GHQ-30, the GHQ-28, the GHQ-20, and the GHQ-12 are available. The scale asks whether the respondent has currently been experiencing a particular symptom or behaviour difficulties. Each item is rated on a four-point scale (less than usual, no more than usual, rather more than usual, or much more than usual).

Child Traumatic Questionnaire (CTQ) (Bernstein & Fink, 1998[36]): The CTQ is a 28-item self-report inventory that provides brief screening for histories of abuse and neglect. The CTQ is appropriate for adolescents (aged 12 and over) and adults. The CTQ inquires about five types of maltreatment: emotional, physical, and sexual abuse and emotional and physical neglect with five items representing each type. The CTQ also includes a 3-item minimization/Denial Scale for detecting false-negative trauma reports. Each item consists of 5 options such as; never true; rarely true; sometimes true; often true; and very often true. Al-Zahrani's (2005)[33] study condensed the five questions in the CTQ that originally dealt with sexual abuse to one, in order to avoid cultural sensitivities especially considering that participants may not be accustomed to these kind of questions. The Arabic translation of the questionnaire has been standardised to the Saudi Arabic dialect.

Psychological problem scale: Al-Zahrani **(2005)[33]** collected several questions from different scales in order to explore the various areas of psychological problems caused by child abuse. The Arabic translation of the questionnaire has been standardised to the Saudi Arabic dialect. The questions are related to the feelings of the subjects during the last few weeks. They consist of 13 questions intended to explore the following:

a. Low self-esteem: (Q13 & Q14) **[37]**.
b. Dissociation: (Q15 & Q16) **[38]**.
c. Post-traumatic Stress disorder: (Q17 & Q18) **[39]**.
d. Self-harm: (Q19): **[40]**.
e. Impulsiveness: (Q20 & Q 21) **[40]**.
f. Eating Disorder: (Q22 & Q23) **[33]**
g. Aggression (Q24 & 25) **[41]**.

Data Preparation and Analysis

All data were stored and analysed using SPSS for Windows® Version 18.0.0. (2009). initially, given the large sample size, data were inspected for significant departures from normality by examining appropriate histograms. Examination revealed difficulties with skewness and/or kurtosis for the psychological variables and the abuse variables. As a consequence, it was decided to make use of appropriate non-parametric statistics. Comparisons were made between male and female participants across demographic, psychological and abuse variables using χ^2 or the Mann Whitney U test. Differences between colleges were examined using the Kruskal Wallis Test and post hoc tests were calculated using the Conover-Inman method. Finally, participants were grouped according to the level of abuse reported, and two groups were formed: those who reported none to minimal abuse, and those who reported moderate to extreme

abuse. These two groups were compared using Mann Whitney U tests.

Results

Males vs. Females (table 3): Analysis of the demographic data revealed that males were significantly older in age than females ($z=2.724$, $p=0.006$), while there was no significant difference between males and females regarding paternal or maternal age, or number of siblings (Table 3). There was no significant difference between males and females in terms of maternal education (χ^2 (2)=1.32, p=0.52), but there was for paternal education (χ^2 (2)=8.87, p=0.012). A higher proportion of males had fathers who attended university in comparison to females. There was no significant difference between males and females regarding parental income (χ^2 (2)=2.89, p=0.24), parental marital status (χ^2 (2)=1.30, p=0.52), or area of residence (χ^2 (2)=3.76, p=0.153). There was a significant sex difference regarding the type of college attended. Males tended to study medicine and art and literature more than females, while females tended to study education more than males (χ^2 (2)=242.82, p<0.001). Comparing males and females across the psychological variables revealed that females had a significantly higher mean score on the GHQ (p<0.001), and significantly lower self esteem (p=0.043). There were no other significant differences between males and females across the psychological variables (Table 3). Considering abuse, males reported experiencing significantly highly levels of physical abuse (p<0.001), emotional abuse (p<0.001), emotional neglect (p<0.001) and sexual abuse (p=0.018) than females (Table 3). However, females reported significantly higher levels of denial than did males (p=0.001).

Colleges (table 4): Comparing across groups of colleges revealed that there was a significant difference between education, art and literature and medicine in terms of participants' age (χ^2 (2, N=903)=303.44 p<0.001), maternal age (χ^2 (2, N=892)=55.42, p<0.001), paternal age (χ^2 (2, N=845)=29.42, p<0.001), and number of siblings (χ^2 (2, N=921)=20.76, p<0.001; Table 4). Further inspection of these differences using post hoc tests revealed that all types of colleges were significantly different from each other across these variables (Table 4). There was also a significant difference between colleges in terms of parental income. Fewer than the number of expected students attending education and medicine came from families with less than average income, while more than the number of expected students attending art and literature came from families with less than average income (χ^2 (4)=25.54, p<0.001). Considering psychological problems overall, there was a significant difference between colleges on the PPS total score (χ^2 (2, N=875)=9.08 p=0.011) and Self-Harm (χ^2 (2, N=948)=16.99 p<0.001). Examination of these differences revealed that those attending art and literature colleges reported a significantly (p<0.05) higher PPS total score and self-harm score than those

attending education or medicine colleges, while there was no significant difference between those attending education and medicine colleges ($p>0.05$) on these two variables. There was a significant difference between the colleges regarding physical neglect (χ^2 (2, N=849)=10.25 p=0.006), physical abuse (χ^2 (2, N=857)=66.14 $p<0.001$), emotional neglect (χ^2 (2, N=846)=48.10 $p<0.001$), emotional abuse (χ^2 (2, N=816)=18.78 $p<0.001$), and sexual abuse (χ^2 (2, N=867)=24.06 $p<0.001$). Considering physical neglect, those attending art and literature colleges reporting a significantly ($p<0.05$) lower score on physical neglect than those attending medicine, while there was no difference between art and literature and education ($p<0.05$) or medicine and education ($p<0.05$). With the exception of physical neglect, consistently across all of the abuse and neglect variables, those attending art and literature colleges reported significantly greater levels ($p<0.05$) of abuse and neglect than those attending education and medicine, while there was no significant difference between education and medicine ($p<0.05$). In the meantime, participants from education and medical colleges scored significantly higher on the denial scale compared to participants from the Art and Literature colleges (χ^2 (2, N=856)=37.76 $p<0.001$).

Prevalence of Abuse (table 5): Examining the prevalence of different kinds of abuse within this sample revealed that 3.9% of the sample indicated that they had experienced moderate to extreme emotional abuse, while 6.0% indicated that they had experienced moderate to extreme emotional neglect. The prevalence of physical abuse and neglect categorised as moderate to extreme was 4.0% and 9.0% respectively. Sexual abuse that was categorised as moderate to extreme was found to exist within 9% of the sample (Table 5).

Psychological impact of different types of abuse (table 6): Those who reported none to minimal abuse were compared to those who reported moderate or higher levels of abuse (Table 6). Those who reported suffering moderate to extreme levels of emotional abuse were significantly younger in age ($p=0.017$), and reported significantly higher scores on the GHQ ($p=0.020$), and PPS total ($p<0.008$). This group also reported significantly lower self esteem ($p=0.043$), higher self-harm ($p<0.001$) and higher aggression ($p=0.001$; Table 6). Those reporting moderate to extreme emotional neglect were significantly younger age ($p=0.005$) and had more siblings ($p=0.001$) than those reporting none to minimal emotional neglect. Those reporting moderate to extreme emotional neglect also had significantly a higher self harm score ($p=0.005$) and a higher total PPS score ($p=0.042$; Table 6). Considering those who reported experiencing moderate to extreme physical abuse, they were significantly younger in age ($p=0.002$), had significantly more siblings ($p=0.003$), and reported that their mother ($p=0.005$) and father ($p=0.019$) were younger (parental ages) than those who

reported experiencing none to minimal physical abuse. Those reporting moderate to extreme physical abuse reported engaging in significantly higher levels of self harm (p=0.015) and aggression (p=0.029). There were no significant differences between the two groups across the remaining variables for physical abuse (Table 6). Considering physical neglect, those reporting moderate to extreme levels were significantly younger in age (p=0.012) and reported that their mothers were also significantly younger (p=0.007) than those who reported experiencing none to minimal physical neglect. Those reporting moderate to extreme physical neglect also reported significantly higher self harm (p<0.001), aggression (p=0.003), and PPS total (p=0.032) than did those reporting none to minimal physical neglect. Finally, comparing those who reported moderate to extreme sexual abuse to those who reported none to minimal revealed that the moderate to extreme group were younger in age (p=0.027) had significantly more siblings (p=0.001), and significantly higher GHQ (p=0.003) and PPS total scores (p<0.001). They also had significantly higher levels of dissociation (p=0.002), self-harm (p=0.015) and aggression (p=0.046). The difference between the two groups on the measure of self-esteem (p=0.080), impulsivity (p=0.057), and eating disorders (p=0.057) all approached significance at the two tailed level. There were no other significant differences between these two groups (Table 6).

Table 1: Demographic Characteristics and Descriptive Data.
(NB: all statistical tests regarding demographic data and descriptive data are two-tailed):

Variable	**%**	**N=**
Sex ,		
Male	31.6	304
Female	63.9	615
Missing	4.6	44
College		
Education	47.6	458
Art and Literature	35.4	341
Medicine	17.0	164
Parental Marital status		
Divorced	2.8	27
Widowed	11.7	113
Married	82.6	795
Missing	2.9	28
Area of Residence		
Urban	34.9	336
Rural	60.0	578

Abroad	2.1	20
Missing	3.0	29
Parental Income		
Less than Average	6.7	65
Average	64.7	623
More than Average	24.6	237
Missing	3.9	38
Maternal Education		
Primary School	25.1	242
Secondary School	29.6	285
University	31.9	307
Missing	13.4	129
Paternal Education		
Primary School	18.6	179
Secondary School	24.3	234
University	48.9	471
Missing	8.2	8.2
Variable	***M* (SD)**	**N=**
Age	19.25 (1.73)	903
Maternal Age	44.45 (6.04)	894
Paternal Age	51.12 (6.09)	845
Number of Siblings	3.65 (1.81)	921

Table 2: Gender * College Cross-tabulation

		College			Total
		Faculty of education	Faculty of arts and literature	Faculty of Medicine	
Gender	Male	31	178	95	304
	Female	397	152	66	615
Total		428	330	161	919

Table 3: Demographic and descriptive data regarding males and females (p<0.01 - *p<0.05)**

Variable	**Male**		**Female**		
	***M* (SD)**	**N=**	***M*(SD)**	**N=**	**Mann Whitney U p= two tailed)**
Age	19.52** (2.34)	294	19.11 (1.32)	599	0.006
Maternal Age	44.39 (6.19)	283	44.70 (5.48)	586	0.442
Paternal Age	51.22 (6.68)	281	51.12 (5.78)	542	0.470
Number of Siblings	3.68 (2.03)	298	3.62 (1.69)	598	0.651
General Health Questionnaire (GHQ)	14.71 (6.79)	280	16.03** (5.82)	592	<0.001
Psychological Problems Scale Total (PPS)	4.69 (2.14)	268	4.84 (2.31)	566	0.616
Self Esteem	0.42 (0.64)	296	0.53* (0.74)	606	0.043
Dissociation	0.86 (0.61)	299	0.86 (0.56)	604	0.969
Post Traumatic Stress	1.09 (0.66)	293	1.05 (0.66)	603	0.472
Self-Harm	0.11 (0.31)	297	0.14 (0.35)	607	0.18
Impulsivity	1.12 (0.79)	294	1.17 (0.77)	598	0.353
Eating Disorders	0.41 (0.59)	296	0.44 (0.57)	609	0.353
Aggression	0.70 (0.73)	298	0.62 (0.68)	606	0.203
Childhood Trauma Questionnaire (CTQ)					
Physical Neglect	7.25 (2.64)	256	7.02 (2.16)	563	0.632
Physical Abuse	2.43** (3.84)	266	1.31 (3.22)	551	<0.001
Emotional Neglect	6.33* (4.90)	258	5.55 (4.74)	548	0.016
Emotional Abuse	3.80** (4.19)	250	2.64 (3.58)	527	<0.001
Sexual Abuse	0.68* (1.28)	270	0.44 (1.02)	557	0.018
Denial	6.20 (2.87)	274	6.91** (2.92)	544	0.001

Table 4: Descriptive data across the three colleges. (E=Education; AL=Art & Literature; M=Medicine; *p<0.05)

Variable	**Education**	**Art and Literature**	**Medicine**		
	***M* (SD)**	***M*(SD)**	***M* (SD)**	**χ^2 (df, N=)**	**Post Hoc Tests**
Age	19.22 (1.163)	18.36 (1.23)	20.56 (0.82)	χ^2 (2, N=903)=303.44 p<0.001	AL<M*; AL<E*; M>E*
Maternal Age	44.49 (5.50)	42.73 (6.51)	46.73 (4.74)	χ^2 (2, N=892)=55.42, p<0.001	AL<M*; AL<E*; M>E*
Paternal Age	51.72 (5.88)	49.45 (6.68)	52.61 (4.87)	χ^2 (2, N=845)=29.42, p<0.001	AL<M*; AL<E*; M>E*
Number of Siblings	3.59 (1.69)	3.99 (2.04)	3.32 (1.69)	χ^2 (2, N=921)=20.76, p<0.001	AL>M*; AL>E*; M<E*
General Health Questionnaire (GHQ)	15.52 (5.64)	14.72 (6.47)	15.45 (5.63)	χ^2 (2, N=914)=1.33, p=0.515	AL<M; AL<E; M<E
Psychological Problems Scale Total (PPS)	4.54 (2.14)	5.03 (2.43)	4.40 (2.21)	χ^2 (2, N=875)=9.08 p=0.011	AL>M*; AL>E*; M<E
Self Esteem	0.47 (0.70)	0.52 (0.74)	0.45 (0.67)	χ^2 (2, N=946)=2.68 p=0.262	AL>M; AL>E; M<E
Dissociation	0.84 (0.54)	0.87 (0.64)	0.81 (0.58)	χ^2 (2, N=947)=3.25 p=0.197	AL>M; AL>E; M<E
Post Traumatic Stress	1.06 (0.62)	1.07 (0.69)	1.02 (0.69)	χ^2 (2, N=939)=1.28 p=0.529	AL<M; AL>E; M>E
Self-Harm	0.09 (0.29)	0.16 (0.37)	0.09 (0.30)	χ^2 (2, N=948)=16.99 p<0.001	AL>M*; AL>E*; M<E
Impulsivity	1.09 (0.77)	1.41 (0.70)	0.98 (0.87)	χ^2 (2, N=935)=1.97 p=0.374	AL>M; AL>E; M<E
Eating Disorders	0.39 (0.54)	0.47 (0.61)	0.38 (0.56)	χ^2 (2, N=947)=0.19 p=0.374	AL>M; AL>E; M<E
Aggression	0.59 (0.68)	0.70 (0.73)	0.54 (0.64)	χ^2 (2, N=947)=5.53 p=0.062	AL>M; AL>E; M<E
Childhood Trauma Questionnaire (CTQ)					
Physical Neglect	7.13 (1.58)	7.09 (3.01)	7.58 (1.84)	χ^2 (2, N=849)=10.25 p=0.006	AL<M*; AL<E; M<E
Physical Abuse	0.96 (2.19)	2.87 (4.78)	0.86 (2.54)	χ^2 (2, N=857)=66.14 p<0.001	AL>M*; AL>E*; M>E
Emotional Neglect	4.97 (4.01)	7.82 (5.69)	4.59 (3.67)	χ^2 (2, N=846)=48.10 p<0.001	AL>M*; AL>E*; M<E
Emotional Abuse	2.33 2.92)	4.10 (4.83)	2.42 (4.26)	χ^2 (2, N=816)=18.78 p<0.001	AL>M*; AL>E*; M>E
Sexual Abuse	0.34 (0.83)	0.80 (1.40)	0.41 (1.02)	χ^2 (2, N=867)=24.06 p<0.001	AL>M*; AL>E*; M>E
Denial	7.26 (2.73)	6.23 (3.06)	7.22 (2.63)	χ^2 (2, N=856)=37.76 p<0.001	AL<M*; AL<E*; M<E

Table 5: Prevalence of Abuse

Variable	None to Minimal		Low to Moderate		Moderate to Severe		Severe to Extreme	
	N=	%	N=	%	N=	%	N=	%
Total Emotional Abuse N=816	743	91.1	41	5.0	17	2.1	15	1.8
Males (N=250)	218	87.0	18	7.0	7	3.0	7	3.0
Females (N=527)	490	93.0	20	4.0	10	2.0	7	1.0
Missing (N=39)	35	90.0	3	8.0	0	0.0	1	2.0
Total Emotional Neglect N=846	683	81.0	103	12.0	36	4.0	24	3.0
Male (N=258)	198	77	37	14	13	5	10	4
Female (N=548)	452	82	59	11	23	4	14	3
Missing (N=40)	33	83	7	17	0	0	0	0
Total Physical Abuse N=857	809	94.0	15	2.0	9	1.0	24	3.0
Male (N=266)	241	90.5	10	4.0	4	1.5	11	4.0
Female (N=551)	529	96.0	4	1.0	5	1.0	13	2.0
Missing (N=40)	39	98	1	2	0	0	0	0
Total Physical Neglect N= 859	484	56.0	302	35.0	57	7.0	16	2.0
Male (N=256)	140	55.0	85	33.0	22	8.5	9	3.5
Females (N=563)	314	56.0	209	37.0	33	6.0	7	1.0
Missing (N=40)	30	75	8	20	2	5	0	0
Total Sexual Abuse N=867	751	87.0	33	4.0	35	4.0	48	5.0
Male (N=270)	221	82.0	12	4.0	14	5.0	23	9.0
Female (N=557)	495	89.0	20	4.0	17	3.0	25	4.0
Missing (N=40)	35	88	1	2	4	10	0	0

Table 6: Comparisons across psychological and family related variables according to severity of abuse.
(*p<0.05 **p<0.01 ***p<0.001)

	Emotional Abuse				Emotional Neglect			
	None to Minimal (N=507)		Moderate to Extreme (N=83)		None to Minimal (N=678)		Moderate to Extreme (N=131)	
	M=	SD	M=	SD	M=	SD	M=	SD
Age	19.22	1.39	19.16*	1.28	19.33	1.82	18.91**	1.31
Maternal Age	44.55	5.99	44.31	5.37	44.66	5.54	44.32	6.54
Paternal Age	51.46	5.68	51.42	6.95	51.25	5.66	50.55	7.77
No of Siblings	3.54	1.62	3.89	2.20	3.49	1.66	4.10 **	2.07
GHQ	15.08	5.82	15.92*	5.38	15.16	6.01	16.15	6.82
Self-Esteem	0.48	0.68	0.53	0.70	0.47	0.69	0.44	0.71
Dissociation	0.81	0.57	0.92	0.52	0.84	0.57	0.86	0.56
PTSD	1.05	0.66	1.13	0.69	1.03	0.65	1.05	0.68
Self Harm	0.11	0.31	0.23 ***	0.42	0.11	0.31	0.19 **	0.39
Impulsivity	1.10	0.78	1.30	0.76	1.13	0.78	1.18	0.79
Aggression	0.60	0.68	0.81 **	0.72	0.63	0.70	0.74	0.75
Eating Disorders	0.40	0.54	0.55	0.65	0.41	0.57	0.46	0.61
Total Psychological Problems	4.51	2.15	5.47 **	2.40	4.59	2.23	5.05*	2.30

Physical Abuse				Physical Neglect				Sexual Abuse			
None to Minimal (N=543)		Moderate to Extreme (N=63)		None to Minimal (N=318)		Moderate to Extreme (N=87)		None to Minimal (N=507)		Moderate to Extreme (N=53)	
M=	SD	M=	SD	M=	SD	M=	SD	M=	SD	M=	SD
19.24	1.36	18.92**	1.33	19.29	1.44	18.92*	1.20	19.24	1.38	18.96*	1.18
44.68	5.92	43.56**	6.05	44.97	5.56	43.71**	6.42	44.58	5.97	44.90	5.36
51.44	5.62	50.46**	6.85	51.56	5.22	50.73	7.04	51.37	5.79	51.29	5.52
3.56	1.61	3.98 **	2.36	3.73	1.76	3.92	2.05	3.55	1.72	4.19 *	1.72
15.22	5.80	15.80	6.15	15.48	6.01	16.47	5.78	15.17	5.81	17.09**	6.11
0.46	0.69	0.59	0.77	0.50	0.72	0.61	0.76	0.46	0.69	0.67	0.80
0.84	0.56	0.90	0.55	0.85	0.56	0.94	0.52	0.83	0.57	1.02*** *	0.58
1.06	0.67	1.17	0.66	1.10	0.67	1.11	0.69	1.06	0.67	1.17	0.73
0.11	0.31	0.23*	0.42	0.11	0.31	0.26***	0.44	0.12	0.32	0.21*	0.41
1.13	0.78	1.22	0.77	1.15	0.76	1.24	0.74	1.13	0.78	1.38	0.64
0.61	0.69	0.77*	0.67	0.60	0.67	0.81**	0.69	0.61	0.69	0.78*	0.73
0.41	0.56	0.50	0.63	0.39	0.52	0.53	0.67	0.42	0.55	0.58	0.68
4.62	2.21	5.38	2.30	4.70	2.15	5.50*	2.36	4.63	2.20	5.78***	2.46

Discussion

Limitations of the study:

In this study, there is a lack of formal randomisation in allocating participants. The questionnaires are too brief and the translation used has not been standardised on Egyptian dialects. This may lead to possible errors in understanding questions. There has been only one question used to identify history of sexual abuse. We made it this way, as in the Saudi study, to minimise any cultural sensitivities among our participants. The Al-Zahrani questionnaires[33], used in this study, have been designed to be brief, to avoid exhausting participants with too many questions. This has meant that some of the other important long term consequences of child abuse not being included, e.g. "Misuse of Psychoactive Substances"[42,43], "Revictimisation"[44], physical health implications[45,46], offending and abusive behaviour[47,**48**] and others.

There are other limitations that need to be considered when interpreting results from this study. There is the possibility that "recall" bias and selection bias may have affected the participants' responses. There are no clinical assessments based on direct interviews to verify the results of the questionnaires. The high numbers of female subjects compared to male subjects could be due to selection error. The sample in this study is not fully representative of Egyptian society, and it is quite possible that the prevalence of abuse is much higher in uneducated and poorer social classes. The data about "parents' employment" and "parents' income" may lack validity and reliability because the questions were relatively brief.

Demographic and descriptive data regarding males and females (table 3):

In the table it was demonstrated that Female subjects are significantly; younger in age and have higher mean scores on the GHQ and on PPS-self-esteem difficulties scale. These results are consistent with the general perception that females in Arabic modern cultures are under more pressure due various added challenges (i.e. the expectation to do well in both education and work on top of their traditional role as wives and mothers).

However, it came as a surprise that the male participants have had significantly higher scores on the CTQ regarding physical abuse, sexual abuse, emotional abuse and the emotional neglect subscales. They are also descriptively higher on the physical neglect subscale. This is different from the stereotypes that boys receive preferential treatment from their parents compared to girls. However, middle class Arabic families also tend to be more protective towards girls than boys. However, it remains possible that these results were affected by the higher scores on the CTQ-denial subscale.

These results might be explained by the observation that middle class Egyptian families tend to underestimate

the adverse experiences their boys go through during childhood while giving most their attention towards protecting girls. These families are usually less protective about boys outside home which can increase risks of some types of abuse including sexual abuse, away from parents' supervision. It is also known that Egyptian parents can use more physical punishment as a mean of disciplining boys as compared with girls, as it is the case in schools [15, 16], which slightly increase risks of physical and emotional abuse among boys compared to girls.

Demographic and descriptive data across the three colleges (table 4)

Total GHQ score is descriptively higher in participants from Education and Medical colleges compared to college of Art and Literature. This probably indicates higher situational-stresses among the first group more than trait-stresses. It is well known that studying in Medical and Education colleges is harder than it is in college of Art and Literature.

Participants from the Art and Literature colleges are higher in all scores on the PPS though statistically significant only in total score PPS and "self harm" score. They are also scored significantly higher on the physical abuse, emotional abuse, emotional neglect and sexual abuse subscales of the CTQ as compared to participants from both colleges of Medicine and Education. However the "denial" score is significantly higher in participants from Medical and Education colleges. This could mean that participants from these two colleges are underreporting child abuse. Unfortunately, difficulties with skewness and kurtosis within the data prevented the use of parametric statistical analysis where Denial could have been entered as a covariate (e.g., ANCOVA). However, these participants reported higher scores, on emotional neglect subscale than participants from the Arts and Literature colleges.

The differences between the participants from the college of Art and Literature compared to the participants from the other two colleges may be associated with the fact that they have less parental income, less parental education and higher number of siblings.

Prevalence of abuse (table 5):

Comparing the prevalence findings from this study to other studies is difficult. Different studies use different samples in each country, and have made use of differing questionnaires from the current study. Results can also vary widely in the same country at different times. The most relevant outcome from the current study is that childhood abuse and its psychological implications are far more prevalent in our societies than mental illnesses without abuse. Childhood abuse is also a major trigger of mental illness in later adulthood [9]. This means that mental health services need to further develop resources and facilities to detect and manage this kind of problems. Social, educational and legal establishments need to give similar attention to this phenomenon.

Table 7: Prevalence studies of child abuse in different countries

Country	Authors	Year	Number of cases	Breakdown of cases (%)
United kingdom	**May-Chahal & Cawson[49]**	**2005**	2,869	Total abused (16%), Physical abuse (7%), Sexual abuse (11), Emotional abuse (6%), Emotional Neglect (6%), absence of care (6%), Absence of supervision (5%)
USA	**Briere & Elliott[50]**	**2003**	935	Physical abuse (20.9%: 22.2% of males & 19.5% of females), Sexual abuse (23.3%: 14% of males & 32% of females),
USA	**Hussey, Chang & Kotch[51]**	**2006**	15 197	Supervision neglect (41.5%), Physical assault (28.4%), Physical neglect (11.8%), Sexual abuse (4.5%)
Canada	**MacMillan et al[52]**	**1997**	9953	Physical abuse (31.2% of males & 21.1% of females), Severe physical abuse (10.7% of males & 9.2% of females), Sexual abuse (4.3% of males and 12.8% of females),
Saudi Arabia	**Al-Zahrani[33]**	**2005**	832	Emotional neglect (26.6%) Emotional abuse (22.8%) Sexual abuse (22.7%) Physical neglect (18.4%) Physical abuse (12.2%)
Egypt	**This study (Mansour et al)**	**2010**	963	Emotional neglect (19%) Emotional abuse (8.9%) Sexual abuse (13%) Physical neglect (44%) Physical abuse (6%)

In our study, the prevalence of physical abuse (6%) seems to be an underestimation as corporal punishment is a widespread phenomenon in Egyptian families and in Egyptian schools.[15,16] did a survey of corporal punishment in a number of preparatory and secondary schools in Alexandria in 1998. Their studies revealed that 37.47% of children were disciplined physically, by their parents, in the form of beating and a few were also burned or tied. In 25.83% of them, this harsh discipline led to physical injuries of variable degrees of severity amounting to fractures, loss of consciousness, and

permanent disability. The study also revealed that a substantial proportion of boys (79.96%) and girls (61.53%) incurred physical punishment at the hand of their teachers. Teachers were using their hands, sticks, straps, shoes, and kicks to inflict such punishment without sparing a part of their students' body. Physical injuries were reported by a significantly higher percentage of boys, the most common being bumps and contusions followed by wounds and fractures. Among boys, serious injuries such as loss of consciousness and concussion were encountered.

The lower prevalence of physical abuse in our study may be due to errors in reporting, or associated with a "normalisation" of physical abuse within Egyptian society, considering that it is commonly used within home and schools. The participants could have also been underreporting physical abuse due to "denial", and corporal punishment may be considered by some as something different from abuse (e.g. "discipline", "educational motivator", "harsh form of care", etc"). It is also possible that the reporting of physical abuse has been affected by recall bias. In a society where corporal punishment is the norm, when participants are asked about "physical abuse in childhood" they tend to report only exceptional incidents of corporal punishment which hurt them more than usual.

Long term impact of abuse (table 6):

In this study, as shown in table 6, we have separated each type of abuse and considered their associations with other psychological difficulties. However, this is an artificial separation, as in real life, child abuse is more likely to occur in more than one form than not. So it is better to interpret results in this context.

The results of this study are consistent with the international literature about the link between childhood abuse and a number of psychological problems in adulthood as listed in the PPS questionnaire. Descriptively, all types of abuse, have been found to be associated with higher scores on PPS and many are statistically significant (table 6). However, this association is not dependent on the scores of the GHQ (indicative of current stress level) and seems to be due to "trait" problems and not "state" problems.

However, certain points need to be considered while interpreting these results. One example is the influence of demographics data on the results e.g. income, number of siblings and parents level of education. It is possible that poverty, and large size families, could be a confounding factor for both the occurrence of abuse as well as the high scores on the PPS.

In the results of table 6, it seems that "Self harm" is the most sensitive psychopathological variable to different types of childhood abuses. These results suggest that a special attention needs to be given to history of self harm and its possible

connection to abuses during childhood. This is also consistent with the literature[53,54]. "Aggression" is also highly related to childhood abuse in our study. This could be one of the mechanisms how the abused could turn into abusers[55,56].

In contrast with the international literature [57], our study has revealed that the scales of "Post Traumatic Stress Disorder", Eating Disorder, "Impulsivity" and to some extent "Dissociation" have not been statistically correlated with any form of abuse ("Dissociation" is statistically related to "sexual Abuse") despite that they have been descriptively higher in all forms of abuse. This could be explained as due to the lack of awareness of these concepts in Egyptian and Arabic cultures. There is also the factor of vague wording of the Arabic translation of the questions of these subscales, which may have contributed to these results.

Conclusion:

This study aims at drawing attention to the phenomenon of child abuse in Arabic societies. Our study and the Saudi study suggest that it is a fairly wide spread problem which affects many individuals. The prevalence of child abuse found, suggests that it is more prevalent than most of the well known mental disorders like depression and schizophrenia (without abuse). We hope that clinicians in the Arab world will make more effort to identify these problems, provide effective therapies and increase public awareness. We hope that resources can be provided by Arab governments to make this possible. We also hope that our research would encourage other Arab researchers to produce more studies in this field.

الملخص :

مقدمة : ظهر في الآونة الأخيرة اهتماما متزايدًا في العالم العربي حول الاعتداء على الأطفال وآثاره على المدى الطويل في مرحلة ما بعد البلوغ. هذه الدراسة تعتبر امتدادا لدراسة مماثلة في المملكة العربية السعودية ، وتهدف الدراسه إلى استكشاف بعض الخصائص الوبائية لهذه المشكلة في مصر.

الأهداف : لدراسة مدى انتشار إساءة معاملة الأطفال وما يرتبط بها من مشاكل نفسية في مرحلة مابعد البلوغ ، حسب ما ورد في عينة من طلاب الجامعات في مصر.

الطريقة : 963 طالبا ، من ثلاث كليات مختلفة من جامعة الزقازيق (الطب والتربيه والفنون والآداب) أجابوا علي استبيانات متعددة بما في ذلك : استبيان الصحة العامة (القيادة العامة) ، استبيان الصدمة للطفل الصدمة (CTQ) و قياس المشكلة النفسية.

النتائج : أفادوا الطلاب بأنهم عانوا من الإهمال العاطفي (19 ٪) ، والاساءه العاطفيه (8.9 ٪) ، والإهمال البدني (44 ٪) والاساءه الجسديه (6 ٪) والاعتداء الجنسي (13 ٪). تم ربط الاساءه في الطفولة (من الدرجه المعتدلة إلي الدرجه الشديده) مع توليفات مختلفة من مشاكل نفسية (انخفاض احترام الذات ، انحلال ، إيذاء الذات ، الاندفاع والعدوان) في مرحلة ما بعد البلوغ. لا يبدوللضغوط الجنسيه و الظرفيه (كما هو مبين من قبل القيادة العامة) التأثير على النتائج بقدر ما يكون الحال في حالات الدخل المنخفض وحجم الأسرة الكبيرة.

ختاما : أفادت لدينا نسبة كبيرة من العينة بحدوث إساءة معاملة الأطفال والعديد من النتائج المرضية على المدى الطويل لسوء المعاملة في مرحلة ما بعد البلوغ. ويبدو أن المشكلة خطيرة في هذه العينة من الطبقة المتوسطة ، وأنه لا يزال ممكنا أن هذه المشاكل يمكن أن تكون أسوأ في الطبقات الاجتماعية الدنيا.

References

1. Dunn SE. Childhood Maltreatment and Adult Post-Traumatic Stress Disorder Symptomatology in Abused, Suicidal, Low-Income, African American Women: A Moderated Mediational Model (**2009**). http://etd.gsu.edu/theses/available/etd-07172009-104106/unrestricted/dunn_sarah_e_200908_phd.pdf.
2. Bouchard EM, Tourigny M, Joly J, Hébert M, Cyr M. Psychological and health sequelae of childhood sexual, physical and psychological abuse, Rev Epidemiol Sante Publique **2008** ; Oct; 56(5):333-44.
3. Finkelhor D, Ormrod R, Turner HA, & Hamby SL. The victimization of children and youth: A comprehensive, national survey. Child Maltreatment **2005** ; 10, 5-25.
4. Arias I. Report from the CDC. The Legacy of Child Maltreatment: Long-Term Health Consequences for Women. Journal of Women's Health. June **2004**, 13(5): 468-473.
5. Briere JN, & Elliott DN. Immediate and long-term impacts of child sexual abuse. The Future of Children **1994** ; 4, 54-69.
6. Turner HA, Finkelhor D, & Ormrod R. The effect of lifetime victimization on the mental health of children and adolescents. Social Science and Medicine **2006**; 62,13-27.
7. Widom CS. Posttraumatic stress disorder in abused and neglected children grown up. American Journal of Psychiatry 1999; 156, 1223-1229.
8. Child Welfare Information Gateway. Long-Term Consequences of Child Abuse and Neglect**:** Factsheet. www.childwelfare.gov. U.S. Department of Health and Human Services; Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Washington, DC **2008**.
9. Gilbert R, Kemp A, Thoburn J, Sidebotham P, Radford L, Glaser D & MacMillan, HL. Child maltreatment one. Burden and consequences of child maltreatment in high-income countries. The Lancet 2009; Vol. 373 No. 9657 pp 68-81

10. BBC. Arab meeting tackles child abuse (2004). http://news.bbc.co.uk/1/hi/world/middle_east/3487806.stm
11. Baker A & Shalhoub-Kevorkian N**.** Effects of political and military traumas on children: The Palestinian case. Clinical Psychology Review 1999 ; Volume 19, Issue 8, Pages 935-950.
12. Khamis V**.** Child psychological maltreatment in Palestinian families. Child Abuse & Neglect 2000; Volume 24, Issue 8, Pages 1047-1059
13. Macksoud MS & Aber JL. The War Experiences and Psychosocial Development of Children in Lebanon. Child Development 1996 ; 67, 70-8.
14. Abu Baker K & Dwairy M**.** Cultural norms versus state law in treating incest: a suggested model for Arab families. Child Abuse & Neglect **2003** ; Volume 27, Issue 1, Pages 109-123
15. Youssef RM, Attia MS & Kamel MI. Children experiencing violence I: parental use of corporal punishment - A review of the past 10 years. Child Abuse and Neglect 1998 ; Volume 22, Number 10, pp. 959-973.
16. Youssef RM, Attia MS & Kamel MI. Children experiencing violence II: prevalence and determinants of corporal punishment in schools. Child Abuse & Neglect 1998 ; Volume 22, Issue 10, Pages 975-985
17. Shalhoub-Kevorkian N. The politics of disclosing female sexual abuse: a case study of Palestinian society. Child Abuse & Neglect 1999 ; Volume 23, Issue 12, Pages 1275-1293
18. Al-Sayed SH. Children Abuse; Clinical Study (in Arabic); Psychological Studies 1993 ; volume 3; Number 4: pp 499-524.
19. Essali MA. Protecting children from abuse and neglect in Syria (in Arabic). APN e.Book. Arabpsynet **(2008**). http://www.arabpsynet.com/apneBooks/eB13/eB13AMCont&Pref.pdf
20. Al-Mahroos FT**.** Child abuse and neglect in the Arab Peninsula. Saudi Med J 2007 ; Vol. 28 (2): 241-248
21. Al-Moosa A, Al-Shaiji J, Al-Fadhli A, Al-Bayed K & Adib SM. Paediatricians' knowledge, attitudes and experience regarding child maltreatment in Kuwait. Child Abuse & Neglect 2003 ; Volume 27, Issue 10, Pages 1161-1178
22. UNICEF Arabic website. http://www.unicef.org/arabic/
23. UNRWA. http://www.un.org/unrwa/
24. WHO Arabic website. http://www.who.int/ar/

25. ISPCAN in the Middle East. The First Arab ISPCAN Regional Conference on Child Abuse and Neglect, 2004, Jordan: Violence against Children, Breaking the Silence; Strengthening Responses. http://www.ispcan.org/PastConferences.htm
26. Save The Children. http://www.savethechildren.org.uk
27. Human rights Watch in Arabic. http://www.hrw.org/ar.
28. National Commission for Childhood of Saudi Arabia. www.childhood.gov.sa
29. Ikhwan-web. http://www.ikhwanweb.com/article.php?id=17415&ref=search.php
30. Syrian Women Observatory. www.nesasy.org/
31. Egyptian Centre For Women's Rights. http://ecwronline.org/
32. IslamOnLine.net. http://www.islamonline.net/Arabic/index.shtml
33. Al-Zahrani AH. Child Abuse and Neglect; Its Causes and Consequences in the Kingdom of Saudi Arabia. Ali Hassan Al-Zahrani, Riyadh, Saudi Arabia **2005**. ISBN: 9960-47-454-2
34. Daradkeh TK, Ghubash R & El-rufaie OE. Reliability, validity, and factor structure of the Arabic version of the 12-item General Health Questionnaire. Psychol Rep 2001 ;89:85–94.
35. Goldberg D. The general health questionnaire. Nfer-Nelson, Windsor, Berkshire 1978.
36. Bernstein DP & Fink L. Childhood Trauma Questionnaire: A retrospective self-report manual San Antonio, TX: The Psychological Corporation 1998.
37. Rosenberg MS. Rosenberg Low self-esteem Scale. In M. Johnston; S. Wight; & J. Weinman (Eds), Measures in health psychology: a user's portfolio, individual and demographic differences, NFER-NELSON: UK **1965**.
38. Vanderlinden J, Van Dyck R, Vandereyken W, Vertommen H & Verkes RJ. The Dissociation Questionnaire (DIS-Q): Development and Characteristics of a new self-report questionnaire. Clinical Psychology and Psychotherapy 1993 ; 1: 21-27.
39. Joseph S, Williams R, Yule W. Understanding Post-traumatic Stress: A Psychosocial Perspective on PTSD and Treatment. John Wiley & Sons Ltd: England **1997**.
40. First MB, Gibbon M, Spitzer RL, Williams JBW & Benjamin LS. Structured Clinical Interview For DSM-IV AXIS II Personality Disorders, SCID- II, American Psychiatric

Press, Inc: Washington, DC 1997.

41. Briere J & Runtz M. Differential adult symptomatology associated with three types of child abuse histories. Child Abuse & Neglect: The International Journal 1990 ; 14, 357-364.
42. Dube SR, Anda RF, Felitti VJ, Chapman D, Williamson DF & Giles WH. Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. Journal of the American Medical Association 2001 ; 286, 3089-3096.
43. Swan N. Exploring the role of child abuse on later drug abuse: Researchers face broad gaps in information. NIDA Notes 1998 ; 13(2). Retrieved April 27, 2006, from the National Institute on Drug Abuse website: www.nida.nih.gov/NIDA_Notes/NNVol13N2/exploring.html
44. Coid J, Petruckevitch A, Feder G, Chung W, Richardson J & Moorey S. Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-sectional survey. The Lancet 2001 ; Volume 358, Issue 9280, 450 – 454.
45. Flaherty EG, Thompson R, Litrownik AJ, Theodore A, English, DJ, Black MM, et al. Effect of early childhood adversity on health. Archives of Pediatrics and Adolescent Medicine 2006 ; 160, 1232-1238.
46. Springer KW, Sheridan J, Kuo D, & Carnes M. Long-term physical and mental health consequences of childhood physical abuse: Results from a large population-based sample of men and women. Child Abuse & Neglect 2007 ; 31, 517-530.
47. Siegel J. The Relationship Between Child Sexual Abuse And Female Delinquency And Crime: A Prospective Study. Journal of Research in Crime and Delinquency 2003 ; Vol. 40, No. 1, 71-94.
48. English DJ, Widom CS, & Brandford C. Another look at the effects of child abuse. NIJ journal 2004 ; 251, 23-24.
49. May-Chahal C & Cawson P. Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. Child Abuse & Neglect **2005** ; Volume 29, Issue 9, Pages 969-984.
50. Briere J, Elliott DM. Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. Child Abuse Negl 2003 ; 27(10):1205-22

51. Hussey JM, Chang JJ & Kotch JB. Child Maltreatment in the United States: Prevalence, Risk Factors, and Adolescent Health Consequences. Pediatrics 2006 ;118(3):933–942.
52. MacMillan HL, Fleming JE, Trocme N, Boyle MH, Wong M, Racine YA et al**.** Prevalence of child physical and sexual abuse in the community. Results from the Ontario Health Supplement. Journal of the American Medical Association 1997 ; 278(2): 131-135.
53. Glassman LH, Weierich MR, Hooley JM, Deliberto TL & Nock MK. Child maltreatment, non-suicidal self-injury, and the mediating role of self-criticism. Behaviour Research and Therapy 2007 ; 45(10): 2483-2490.
54. Yates TM, Carlson EA & Egeland B. A prospective study of child maltreatment and self-injurious behavior in a community sample. Development and Psychopathology 2008 ; 20:651-671.
55. Widom CS. The cycle of violence. Science 1989 ; 244, 160-166.
56. Widom CS & Maxfield MG. An update on the "cycle of violence." Washington, DC: U. S. Department of Justice, Office of Justice Program, National Institute of Justice 2001.
57. Goldman J, Salus MK, Wolcott D & Kennedy KY. A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect 2003.

Appendix 1:

بسم الله الرحمن الرحيم

جامـــعـــة الزقازيق
قسم الطب النفسي

عزيزي الطالب

استميحكم عُذراً في اقتطاع عشرة دقائق من وقتكم الثمين للإجابة على هذا الاستبيان والذي نهدف من ورائه إلى التعرف على: *العلاقة بين خبرات الطفولة والاضطرابات النفسية الناتجة عنها في الكبر*"

أود أن أطمئنكم هنا بأن إجابتكم ستكون في غاية السرية والكتمان كما اقتضت به المواريث العلمية وتأكدوا من حرصنا الشديد على ذلك انطلاقا من الأمانة العلمية. وتأكيدا على ذلك نرجو منكم عدم ذكر اسمكم أو أي شي يدل عليكم.

تذكروا بأنه ليس شرطا أن تكونوا قد تعرضتم إلى أي خبرة سلبية ولكن كما تعلمون هدفنا هنا هو معرفة حجم المشكلة ومدى انتشارها ولهذا يظل رأيكم وإجابتكم على هذا الاستبيان مهم لدينا.
تأكدوا بأن مصداقيتكم في الإجابة على هذه الأسئلة ستكون دافع وباعث للمهتمين على الارتقاء بالخدمات التي ستقدم للأطفال في المستقبل بمشيئة الله تعالى من اجل تهيئة الأجواء الصحية السليمة وقاية لهم من الاضطرابات النفسية، فضلا على أن إجابتكم على هذا الاستبيان إنما ينم عن عقليتكم الراقية والمتفتحة والداعمة للبحوث العلمية.
نرجو منكم التكرم عند الانتهاء من الإجابة اتباع مايلي:
ضع الإجابة في الظرف المخصص لذلك والمرفق مع هذا الاستبيان
اغلق الظرف جيدا وضعه في الصندوق المخصص
إذا كان لديكم أي استفسار أو تعليق رجاء الاتصال بنا على العنوان الاكتروني التالي:
omaimadaoud@btinternet.com

مع خالص الشكر و التقدير لكم لاقتطاع جزءا من وقتكم الثمين للإجابة على هذا الاستبيان.

بالنيابة عن فريق البحث
د. أميمة عبدالله داود
قسم الطب النفسي
كلية الطب
جامعة الزقازيق

الجزء الأول

الجنس ( ) ذكر ( ) أنثى

العمر: .....

الجزء الثاني

نود هنا بالحصول على معلومات كافيه عن أسرتك. لذا نرجو كرما الإجابة على جميع الأسئلة.

عمر الأم:.....

عمر الأب:.....

وظيفةالأم:.....

وظيفة الأب.....

عدد اخوتك:.....

برجاء وضع علامة √ أمام الاجابة الصحيحة:

تعليم الأم (1) ابتدائي (2) ثانوي (3) جامعي

تعليم الأب (1) ابتدائي (2) ثانوي (3) جامعي
:

دخل الأبوين (1) دون المتوسط (2) متوسط (3) فوق المتوسط

الوضع الإجماعي للوالدين: (1) يعيشون مع بعض (2) مطلقين (3) ارمل/ارمله

محل سكن الوالدين: (1) مدينه (2) قريه (3) هجره الي الخارج

الجزء الثالث:

سوف يعرض عليك فيما يلي مجموعة من العبارات الهدف من ورائها هو التعرف على صحتك العامة، من خلال معرفة ما إذا كان لديك أي شكوى مرضيه وكيف كانت صحتك بصفة عامة ، لذا نرجو منك وضع إشارة(√) أمام العبارة التي تنطبق عليك.
تذكر بأننا نبحث عن الشكاوي المرضية الحاضرة وليست الماضية.

1- هل تشعر بأنك قادر على تركيز انتباهك في أي شي تؤديه؟
□ أحسن من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

2 هل تشعر أن نومك قل نتيجة للهموم
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد بقليل □ أكثر من المعتاد بكثير

3 هل تشعر بأنك تقوم بدور مهم في الأمور المحيطة بك؟
□أكثر من المعتاد بكثير □ كالمعتاد تقريبا □ أقل من المعتاد □ أقل من المعتاد

4 هل تشعر بأنك قادر على اتخاذ قرارات بشان بعض الأمور
أكثر من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

5 هل تشعر بأنك تعاني من ضغوط مستمرة؟
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد بقليل □ أكثر من المعتاد بكثير

6 هل تشعر بأنك لا تستطيع التغلب على الصعوبات التي تواجهك؟
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد بقليل □ أكثر من المعتاد بكثير

7- هل تشعر بأنك قادرا على الاستمتاع بأنشطتك اليومية؟
□أكثر من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

8- هل تشعر بأنك قادرا على مواجهة مشاكلك؟
□أكثر من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

9- هل تشعر بأنك مكتئب وغير سعيد ؟
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد قليلا □ أكثر من المعتاد بكثير

10- هل تشعر بفقدان الثقة بنفسك؟
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد قليلا □ أكثر من المعتاد بكثير

11- هل تشعر بأنك إنسان عديم الفائدة؟
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد قليلا □ أكثر من المعتاد بكثي

12- هل تشعر بأنك سعيد بدرجة معقولة؟

□كثر من المعتاد □ كالمعتاد تقريبا □ أقل من المعتاد □ أقل من المعتاد بكثير

الجزء الرابع:

الأسئلة التالية تهدف إلى التعرف على شخصيتك بصفة عامة، كيف كان شعورك وتصرفك أو سلوكك بصفة عامة. لذا من فضلك ضع دائرة حول كلمة "نعم" إذا كانت العبارة تنطبق عليك في الغالب أو دائرة حول "لا" إذا كانت لا تنطبق عليك:

الرقم	العبـــــــــــــــارة		
13	اعتقد أحيانا بأنني غير نافع على الإطلاق.	نعم	لا
14	لدي اتجاه إيجابي نحو نفسي.	نعم	لا
15	أحيانا عندما استمع إلى شخص ما أدرك فجأة بأنني لم استمع الى جزء من كلامه أو كله.	نعم	لا
16	أجد نفسي أحيانا فجأة في مكان لا اعرفه ولا ادري كيف وصلت أليه.	نعم	لا
17	اعتقدت أحيانا بأنني غير جدير بان أكون شخص جيد.	نعم	لا
18	شعرت أحيانا بأنني على وشك الإصابة بمكروه.	نعم	لا
19	أحيانا أتعمد خدش أو جرح أو حرق نفسي	نعم	لا
20	هل عملت الأشياء باندفاع؟	نعم	لا
21	هل تجعلك الأشياء البسيطة غضبان؟	نعم	لا
22	اقضي قدرا كبيرا من الوقت أفكر في الأكل ومتى سأتناول الطعام.	نعم	لا
23	كنت عندما انتهي من الآكل استخدم بعض المسهلات أو التمارين الرياضية... الخ حتى لا يزداد وزني.	نعم	لا
24	أحيانا ادخل في مضاربات (عراكات) مع الآخرين.	نعم	لا
25	كنت أخشى أحيانا من أنني قد أقوم بإيذاء بدني لشخص ما دون سبب وجيه.	نعم	لا

الجزء الخامس:

الأسئلة التالية تدور حول خبراتك السابقة خلال مراحل عمرك الأولى والممتدة من بداية طفولتك حتى أوائل فترة المراهقة. لذا حاول قدر المستطاع التذكر بكل أمانة واخلاص.
غالبية هذه الأسئلة يغلب عليها الطابع الشخصي. ليس شرطا هنا أن تكون أنت المعني بهذه الخبرات ولكن كما أشرت
في المقدمة من أن الهدف هو معرفة مدى انتشار هذه أتظاهره.
لهذا أخي الكريم أرجو عدم الأحجام أو ترك الإجابة على هذه الأسئلة بسبب حساسيتها لأنك ستخدم بإجابتك هذه المجتمع بآسره.
أقرا السوال جيدا ومن ثم ضع دائرة على النقطة السوداء في الخانة التي تراها تنطبق عليك. لا تنسى قبل أن تضع الدائرة بان تنظر إلى أعلى الصفحة للتأكد من انك اخترت الإجابة الصحيحة والتي تنطبق عليك خلال فترة الطفولة أو المراهقة.

لرقم	العبـــارة	غير صحيح مطلقا	صحيح نادرا	صحيح أحيانا	صحيح غالبا	صحيح على الأغلب
26	في طفولتي كنت أتعرض للحرمان بما في ذلك الحرمان من الطعام	●	●	●	●	●
27	في طفولتي كنت أحظى بالعناية والرعاية ممن هم حولي	●	●	●	●	●
28	في طفولتي كان بعض أفراد عائلتي ينعتونني بألقاب نابية بشكل منتظم	●	●	●	●	●
29	في طفولتي كانا والدي لاهيان عنا لدرجة انهما لم يستطيعا العناية بالعائلة	●	●	●	●	●
30	في طفولتي كان هناك أحد أفراد عائلتي يحسسني باني مهم أو مميز	●	●	●	●	●
31	في طفولتي لم أجد إلا ملابس باليه لارتديها	●	●	●	●	●
32	في طفولتي شعرت بأنني محبوب	●	●	●	●	●
33	في طفولتي شعرت بان والدي تمنيا بأنني لم اخلق	●	●	●	●	●
34	في طفولتي تعرضت إلى ضرب مبرح من أحد أفراد عائلتي احتجت على أثرها إلى عناية طبية	●	●	●	●	●
35	في طفولتي لم أتمنى بأنني ولدت لأبوين آخرين	●	●	●	●	●
36	في طفولتي كان بعض أفراد عائلتي يضربني بقسوة مما ترك اثر لعلامات وكدمات على جسمي	●	●	●	●	●
37	في طفولتي كنت أعاقب بربطي بلوح أو حبل أو أي شي آخر صلب	●	●	●	●	●
38	في طفولتي كان أفراد عائلتي حريصين على بعضهم البعض	●	●	●	●	●
39	في طفولتي كان أفراد عائلي يقولون لي كلام مؤلم ومهين	●	●	●	●	●
40	في طفولتي أسيئت معاملتي جسديا هل تذكر من الذي فعل ذلك؟..... وكم كان عمرك آنذاك تقريبا؟.....	●	●	●	●	●
41	في طفولتي عشت طفولة ممتازة	●	●	●	●	●
42	في طفولتي ضربت بشكل سيئ لوحظ علي من قبل المعلم أو الجار أو الطبيب	●	●	●	●	●
43	في طفولتي شعرت بان أحد أفراد عائلتي يكرهني	●	●	●	●	●
44	في طفولتي كان أفراد عائلتي يشعرون بالتقارب فيا بينهم	●	●	●	●	●
45	في طفولتي كنت اشعر بان عائلتي من افضل العوائل.	●	●	●	●	●
46	في طفولتي أظن بان مشاعري قد أهينت هل تذكر من الذي فعل ذلك؟..... وكم كان عمرك آنذاك تقريبا؟.....	●	●	●	●	●
47	في طفولتي كان هناك من يأخذني للطبيب عندما احتاج أليه	●	●	●	●	●
48	في طفولتي كانت عائلتي مصدر دعم وقوة لي	●	●	●	●	●
49	في طفولتي تعرضت إلى موقف جنسي غير لائق أخلاقيا أساء إلى شخصيتي لدرجة أنني لم استطع البوح به حتى لاقرب الناس الي هل تذكر من الذي فعل ذلك؟..... وكم كان عمرك آنذاك تقريبا؟.....	●	●	●	●	●

في نهاية هذا الاستبيان أود أن أتقدم لكم بجزيل الشكر وعظيم الامتنان على ما قمتم به مجهود إضافة إلى اقتطاعكم جزء من وقتكم الثمين للإجابة على هذه الأسئلة. ونحن واثقون من أن صنيعكم هذا ينم عن وعي وأدراك من شخصكم الكريم بأهمية البحث العلمي.
كما إنني على أتم الاستعداد بتزويدكم بصورة من نتائج هذا البحث إذا أردتم ذلك
واخيرا وليس أخيرا نوجه هنا دعوة خالصة لله عز وجل أن يجعل هذا العمل الذي قمتم به في موازين أعمالكم الصالحة وان يديم عليكم نعمة الصحة والعافية انه سميع مجيب.
وأخر دعوانا أن الحمد لله رب العالمين
والسلام عليكم ورحمة الله وبركاته

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Quality of Life in Substance Abusers; Impact of Personality Disorders

Soheir El-Ghonemy

نوعية الحياة في مرضى سوء استخدام العقاقير؛ تأثير إضطرابات الشخصية

سهير الغنيمي

Abstract:

Objectives*:* The subjective sense of well being is central to the concept of quality of life (QoL) and a good QoL should be the ultimate goal to any therapeutic measure. Quality of life and disability are important indices that may help change the perception, treatment and care of those with alcohol or drug dependence problem. The essential objective of this study is to investigate the impact of personality disorders (PD) on the quality of life in a sample of substance use disorder (SUD) patients. **Methods:** a cross-sectional study, 32 patients were included selected from inpatient addiction unit at the Institute of Psychiatry, Ain Shams University, Cairo, Egypt, fulfilling the diagnosis of substance use disorder according to DSM-IV classification. They were assessed by; Semistructured psychiatric interview sheet of institute of Psychiatry Ain Shams University, and were subjected to: 1) PCASEE questionnaire for quality of life, 2) Addiction severity index (ASI), and 3) Structured clinical interview for DSM IV, for axis II personality disorder (SCID II). **Results*:*** Statistical analysis of the data was conducted. Regarding sociodemographic data it was found that the marital status, employment were significantly and highly significantly related to subjective QoL of patients respectively. In addition, patients who have mixed and multiple PD were significantly related to lower QoL. Moreover, depressive, histrionic and borderline personalities were significantly related to lower QoL. Regarding the severity profile measured by ASI; drug, legal and psychiatric profiles were significantly related to QoL of patients. **Conclusion:** We concluded that patients with comorbid PD suffer from poorer QoL as well as more complications.

Key words: Quality of life, Substance use, Personality disorders

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Declaration of interest: none

Introduction:

Drug and alcohol dependence currently represent one of the main concerns of public health experts. It has clear consequences for personal health. Usually, deterioration is gradual and caused by their continuous use.[1] Moreover, it is a chronic relapsing disorder causing many harmful and disabling effects not only to the users but also to their families and to the society in general. It is thought to cause considerable disability and changes to the quality of life (QoL) of an individual.[2]

Recently, QoL has been considered an important component of functional outcome in any treatment program.[3] Good QoL

encompasses more than just good health. At a basic level, it can represent the sum of a person's physical, emotional, social, occupational and spiritual well-being, the study of which is complicated by the fact that there is no consensus as to what constitutes QoL.[4] The World Health Organization has described QoL as "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns".[3, 5]

Many definitions and theories of what constitutes QoL have been proposed. Most agree that the concept is multidimensional, but disagree on how to define the parameters. The definitions were as divergent as: " *Happiness*; *life-satisfaction*; *well-being*; *self-actualization*; *freedom from want*; *objective functioning*; '*a state of complete physical, mental and social well-being not merely the absence of disease*'; *balance, equilibrium or 'true bliss'*; *prosperity*; *fulfillment*; *low unemployment*; *psychological well-being*; *high Gross Domestic Product*; *the good life*; *enjoyment*; *democratic liberalism*; *a full meaningful existence*".[6]

Moreover, Self-perception influences the subjective perception of the QoL and depends on several aspects of mental life, such as personality features, affective disorders, state characteristics (e.g. level of withdrawal or physical illness).[7]

The comorbidity of substance abuse and personality disorder (PD) is common 60% [8]; 58% [9], especially for cluster B and C personality disorders, with a higher prevalence of antisocial, borderline, and dependent personality disorders.[10]

This study focuses on the relationship between quality of life assessed by PCASEE quality of life questionnaire and personality disorders assessed by structured clinical interview for DSM IV, for axis II personality disorder (SCID II) in a sample of substance abusers.

The aim of this study is to investigate the impact of PD on the quality of life in substance abusers and verify the hypothesis that abusers with comorbid PD are more subjected to worse subjective sense of well being together with poorer prognosis and treatment outcome.

Subjects and Methods:

The study was performed as cross-sectional study in the Institute of Psychiatry, Ain Shams University over three months from January 2010 till March 2010. A total number of 32 substance abusers were selected during their admission in the institute. Patients were informed of the research after admission and were approached on their 2nd week of their admission. An informed consent was taken from all patients, after being informed in detail about the study and about what they were asked to do.

The patients were selected irrespective of their sex, socioeconomic or educational status. They were fulfilling the diagnosis of substance use disorder according to DSM-IV classification.

The interview procedures:

The patients were assessed by semi-structured interview based on the sheet of

Institute of Psychiatry, Ain Shams University Hospital. This sheet contains the following items:

1- Sociodemographic data, 2- Family history, 3- Past history, 4- Level of education, 5- Work records, 6- Sexual history, 7- Marital history, 8- History of substance abuse.

In addition, the patients were subjected to:

1. Addiction Severity Index (ASI) [11]

This is a semi-structured clinical interview designed to provide a multidimensional assessment of problems presented by patients with substance use disorders to guide initial treatment planning and to allow monitoring of patient progress over time. ASI took 45-60 minutes to be completed. It is designed for use in inpatient and outpatient alcohol and drug abuse treatment settings. It gathers information on seven functional areas of behaviors often affected by drug use:

i. Medical status.
ii. Employment and support status.
iii. Alcohol use.
iv. Drug use.
v. Legal status.
vi. Family and social status.
vii. Psychiatric status.

Interviewer severity ratings are adjusted slightly to take into account the patient's own rating of the problem's severity, in which:

0=0-1: No real problem, treatment not indicated.

1=2-3: Slight problem, treatment probably not necessary

2=4-5: Moderate problem, some treatment indicated.

3=6-7: Considerable problem, treatment necessary.

4=8-9: Extreme problem, treatment absolutely necessary.

2. **Structured Clinical Interview for DSM-IV (SCID II)** [12]

The SCID-II is the counterpart of the SCID for making DSM diagnoses of personality disorders. It is a semi-structured clinical interview that was developed to categorically and/or dimensionally assess the DSM-IV personality disorders. It is an instrument designed to enable a clinically trained interviewer to make their diagnoses. The translated Arabic version of SCID-II for DSM-III-R,[13] was used with some modification to fit for the new version of SCID-II for DSM-IV. It was validated through its use in many studies that were conducted in the Institute of Psychiatry-Ain Shams University, Cairo, Egypt.

3. **PCASEE quality of life questionnaire**: [14]

The PCASEE (explained below) quality of life scale (QoL) is a clinical instrument designed for interview administration; it provides information on symptoms and functioning over the last month. It is a 30-item self-rating scale, completed on the basis of a semi-structured interview in which the clinician completes ratings on the basis of a patient's self-reports and the clinician's judgment about the patient's functioning and life circumstances. The 30-items are rated from 0-5.

High scores reflect less impaired or unimpaired functioning and six domains are covered: ***(P)*** *Physical component,* ***(C)*** *Cognitive component,* ***(A)*** *Affective*

*component, (**S**) Social component, (**E**) Economic component, and (**E**) Ego functioning.*

This clinical instrument showed good inter-rater reliability, ranging from 0.85 to 0.97. The construct validity of the scale is fairly supported by factor analysis and convergent validation with the Lehaman QoL interview. [14]

The Arabic version used in this work was translated and validated in a previous Egyptian research study. [15]

Socioeconomic status was defined low, middle, and high according to parents' education, family income, and crowding index.

Statistical analysis:

Data were collected, verified, revised then edited on PC. The data were then analyzed statistically using SPSS "Statistical Package for Social Science version 15. Data were described by frequency and percentage for qualitative data, Mean and SD for quantitative data. Tests used were Chi-sq test, Student t-test and paired student t test, One-way analysis of variance. The following tests were done:

1. *Mean*.
2. *Standard Deviation (SD)*
3. *Student T-test*: A statistic used to test for significance of an independent variable in experiments where there are only two levels of these variables.
4. *Chi-square test (X^2):* it determines whether a systematic relationship exists between two qualitative variables.
5. *A one-way analysis of variance (ANOVA);* used to compare means between groups.

A cut off point for significance were chosen (0.05). Where P value was < 0.05, the test was considered significant.

Results:

I-Description of the sample:

The mean age of the sample was 30.03 years (SD=5.83); the minimum age was 18 years and the maximum age was 40 years.

As regards sociodemographic data; ***marital status***; 17 patients (53.1%) were single, 11 (34.4%) were married and only 4 (12.5%) were divorced. ***Socioeconomic status*** *(SCS)* 10 (31.3%) were of high SCS, 13 (40.6%) were middle SCS and the remaining 9 (28.1%) were of low SCS. Regarding ***Personality disorder*** *(PD)*; 22 (68.8%) patients were having mixed PD and 10 (31.2%) were suffering from multiple PD. The most prevalent PD found with SCID II was; *borderline PD* 25 patients (78.1%) followed by *narcissistic PD* 22 (68.8%), *depressed PD* 17 (53.1%) and antisocial PD 15 (46.9%) respectively **(Table I).**

Most of the patients 22 (68.8%) scored 4 on the ASI drug profile. On the other hand, 16 (50 %) scored 3 and 7 (21.9%) scored 4 on ASI family profile.

II-Quality of life correlations:

No significant difference was found between patients' ages or SCS and their quality of life (P>0.05).

Comparing their marital status, both **physical** and **economic** components of PCASEE were significantly correlated to marital status of the patients with P=0.011 and 0.038 respectively **(Table II)**.

When previewing the ASI profiles of the patients; ***employment profile*** was significantly correlated to **physical**,

affective, and **economic** components of PCASEE as well as **total** score with P=0.043, 0.04, 0.025, 0.048 respectively. While the **cognitive** component was highly significantly correlated to employment profile P=0.007 **(Table III)**.

Regarding the ***drug profile***; **physical**, **affective**, **economic** components and **total** score were significantly correlated to severity of substance abuse decided by ASI with P=0.038, 0.03, 0.023 and 0.042 respectively **(Table III)**.

Legal profile; **physical** (P=0.04), **cognitive** (P=0.04), **social** (P=0.045), **ego function** (P=0.045) and **total** (P=0.035) score were significantly correlated to the legal profile of the patients **(Table III)**.

Moreover, ***psychiatric profile***; **affective** (P=0.042), **economic** (P=0.049) and **ego function**
(P=0.041) were significantly correlated to the patients psychiatric status **(Table III)**.

Yet, the ***medical***, ***alcohol***, as well as ***family*** profiles of ASI were insignificantly correlated to QoL of patients (P> 0.05).

In assessment of the PD, patients suffering from *mixed* and *multiple* PD were significantly correlated to **cognitive** (P=0.042), **affective** (P=0.045), **ego function** (P=0.05) and **total** score (P=0.034) of PCASEE **(Table IVa)**.

In addition, patients who were suffering from ***depressive PD*** were significantly correlated to **cognitive, social, ego function** components as well as the **total** score with P= 0.038, 0.048, 0.039 and 0.024 respectively.

Patients with ***histrionic PD*** were significantly correlated to **cognitive**, **affective**, **ego function** as well as **total** score P= 0.032, 0.027, 0.021 and 0.04 respectively.

Patients who were suffering from ***borderline PD*** were significantly correlated to **cognitive** (P=0.032)**, affective** (P=0.041), **social** (P=0.032) as well as **ego function** (P=0.024) components and **total** (P=0.045) score of PCASEE **(Table IVb)**.

Discussion:

Health and social problems related to substance use are often not identified until they have become chronic and interfere significantly with the health and life of individuals and their families. Most treatment resources are concentrated on management of withdrawals and dependence but little focus on the quality of life and disabilities of those with dependence. [2]

QoL is a multidimensional construct encompassing several core domains, generally identified as material conditions, physical status and functional abilities, social interactions, and emotional well-being. [16]

It has been proved that PDs are associated with impaired functioning. Patients with PDs had poorer work and interpersonal relationships. Having a PD in addition to a symptom disorder reduces social functioning. [17]

The current study demonstrates the impact of comorbid PDs with substance use disorder implies poorer quality of life and subjective sense of well being.

In our sample, the patients were middle aged since most of substance use disorder patients who seek treatment in Institute of psychiatry are considered chronic patients with late presentation in agreement with others,[10,18]

who found most of the patients fall in this age group. No significant difference was found between the age of the patients and their quality of life confirming the subjectivity of quality of life and its independence on specific age group.

On the other hand, no specific socioeconomic status for substance abusers, [19] with insignificance relation to their quality of life in accordance with the multi-dimensional definition of QoL that minimized the impact of external factors on individual self perception..

All of our patients were inpatient males admitted during the period of conducting the study because of the preponderance of male patients who usually seek and receive treatment more than females for fear of stigmatization, as the male/female concept within Egyptian culture may affect the motivation of female patients to seek help as previously reported .[20,21]

In addition, women with substance use problems is less likely than men to enter treatment over the lifetime and men are more likely to be coerced into treatment by external mandates. [22]

Regarding the marital status of the patients; Physical and economic components of PCASEE were found significantly correlated to marital status of patients that can be attributed to the importance of family life and interpersonal relationships reflecting its significant impact on subjective wellbeing of individuals. Moreover, it has been reported,[23] that interpersonal relationships are more closely related with the internal, affective aspects of people's life than are the external, socioeconomic conditions, and therefore are better predictors of QoL. Married people have a higher QoL than those who are single, divorced or widowed.

When previewing the ASI profiles of the patients; employment profile was significantly correlated to physical, affective, and economic components of PCASEE as well as total score while the cognitive component was highly significantly correlated to employment profile. Since employment can provide more than just financial benefits for individuals with subjective functioning. Other studies have demonstrated,[24, 25] that unemployed individuals generally report more depression, anxiety, social isolation, and low self-esteem than employed individuals.

Regarding the drug profile; physical, affective, economic components and total score were significantly correlated to severity of substance abuse recorded by ASI which can explain the negative impact of drug use on the individual life aspects with worsening of his subjective wellbeing in accordance with others, [3] who stated that the severity of dependence appeared to be the variable that had the strongest impact of QoL. On the other hand, examining the legal profile; we found that physical, cognitive, social, ego function and total score were significantly correlated to the legal profile of the patients. A possible explanation may be because legal consequences which may accompany those who suffer from SUD lead to worsening of their social and interpersonal relationship and consequently their overall QoL in addition,[21] to their severity of dependence.

On the psychiatric profile; affective, economic and ego function were significantly correlated to the patients

psychiatric status decided by ASI. This could infer that patients with *Dual diagnosis* often experience more social and emotional problems, require longer treatment, have more crises and progress more gradually in treatment than those who have only one disorder. It has been mentioned,[26] that psychiatric comorbidity especially mood and anxiety disorders considerably reduces QoL of patients with SUD.

The medical, alcohol, as well as family profiles of ASI were insignificantly correlated to QoL of patients. It is worth mentioning, that in Egypt we seldom encounter alcohol problem among patients presented to Institute of Psychiatry mostly from cultural and religious background that forbid alcohol use. In addition, among Egyptian culture, family and extended family usually provide the maximum support for individuals suffering from SUD out of cultural and moral pressures. Moreover, none of our subjects suffer from serious medical problem that proved by many other studies to affect QoL negatively.[27]

In assessment of the PD, although our subjects were suffering from either mixed and multiple PD both were significantly correlated to cognitive, affective, ego function and total score of PCASEE. It is worth mentioning that those who suffer from PD often use drugs to diminish symptoms of the disorder, to enhance low self-esteem, to decrease feelings of guilt and to amplify feelings of diminished individuality and finally to enhance their life satisfaction.

Many have reported,[17,28] that having PDs implies poor functioning, impairment of interpersonal relationships and self – realization with global poor QoL.

Moreover, PDs are characterized by enduringly deviating patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Such patterns lead to "clinically significant distress or impairment in social, occupational, or other important areas of functioning". Having one PD subject the individual to poorer QoL compared to age and gender adjusted norm data. [29]

There was a continually negative relationship between the number of PD criteria fulfilled (PD traits) and the quality of life. The more the PD criteria fulfilled, for most of the PDs, the poorer the quality of life. The implication is that comorbidity is important for quality of life. Comorbid PD predict poor treatment response and/or outcome among drug abusers; problems in the therapeutic relationship or working alliance, resistance to change, non-compliance and premature treatment dropout.

In addition, we found that patients who were suffering from depressive, histrionic and borderline PD were significantly correlated to their poorer QoL which could be explained that specific personality traits implies poorer subjective wellbeing.

In accordance with others,[17,30] having borderline PD correlated strongly to subjective well-being and negative life events. Avoidant, schizotypal, dependent, paranoid, schizoid, and antisocial PDs are strongly related to deficiency in quality of life.

In conclusion, the study shows that patients who suffer from PD in addition to their

substance use problem had reported poorer subjective QoL and worse outcome. Thus, an appreciation of personality disorders among patients suffering from substance use will minimize the severity of patients' suffering with improving of their subjective wellbeing and overall quality of life reflecting positive impact on the treatment outcome. Quality of life measurement can be viewed as a broader assessment of patients with a drug and alcohol dependence. Thus, Quality of life measures should be combined with traditional clinical and biochemical assessments.

Limitation and recommendations; it is important to point that our study is a single cross-sectional assessment. A longitudinal assessment may provide a better assessment of the quality of life and functioning. No and/or single PD was not found among our subjects which needs more evaluation in future studies. In addition our subjects were not grouped according to their main substance of abuse or psychiatric comorbidities. This may be attributed to the small sample size that hinder such comparison moreover may not be enough to generalize the results to the population based subjects. Our finding of a reduced QoL should be replicated in a SUD sample with no comorbid or single PD for more accurate evaluation of PD influence on the patients' subjective well being, their motivation for change and finally their global outcome. QoL evaluation should be involved in every patient evaluation in addiction treatment programs for better outcome.

الملخص

يعتبر رضا الفرد عن الحياة هو المفهوم المركزي لنوعية الحياة , لذلك يجب اعتباره هدفا اساسيًا لأي من المقاييس العلاجية. إن نوعية الحياة و درجة الإعاقة يعتبران من أهم المؤشرات التي قد تساعد علي تغيير البرامج العلاجية و الرعاية لمرضي سوء استخدام العقاقير.

هدفت هذة الدراسة إلي الإشارة لمدي تأثير اضطرابات الشخصية علي جودة الحياة لدي عينة من مرضي سوء استخدام العقاقير و بالتالي علي نتائج هولاء المرضي.

طريقة البحث: أجريت هذة الدراسة كدراسة عرضية, و تم تضمين 32 مريض سوء استخدام العقاقير اختيروا من المرضي الراقدين بقسم الأدمان بمركز الطب النفسي- بمستشفيات جامعة عين شمس. والذين تم تشخيصهم باستخدام الدليل الإحصائي لتشخيص الإضرابات النفسية- الطبعة الرابعة. تم تقييم الحالات باستخدام : 1- مقياس شدة الأدمان 2-اجراء المقابلة الإكلينيكية المقننة وفقًا للدليل الأحصائي لتشخيص اضطرابات الشخصية 3- مقياس جودة الحياة.

النتائج: وجد أن الحالة الإجتماعية و العمل لهما دلالة احصائية عالية و عالية جدًا بالتتابع مع الإدراك الشخصي لجودة الحياة. إلي جانب أن المرضى الذين يعانون من اضطرابات الشخصية المختلطة و المتعددة لهما دلالة احصائية تجاه قلة جودة الحياة. و أظهرت دراسة الاضطرابات الشخصية كلاً علي حدى أن اضطراب الشخصية الإكتئابية, الهستيرية و الحدية لهم دلالة احصائية مع قلة جودة الحياة. كما وجد دلالة احصائية لكل من محور العقاقير والمحور القانوني والمحور الطبي النفسي لمقياس شدة الإدمان ونوعية الحياة.

الاستنتاج: يعاني مرضي سوء استخدام العقاقيير واضطرابات الشخصية من قلة في الاستمتاع جودة الحياة و زيادة للمشاكل الناتجة.

References

1. Francisco González-Saiz, Oscar Lozano Rojas, and Ioseba Iraurgi Castillo: Measuring the Impact of Psychoactive Substance on Health-Related Quality of Life: An Update, Current Drug Abuse Reviews, 2, 5-10, 2009.
2. George Philip, Whelan Greg, Nicolle Ait Khelifa: Quality Of Life And Disability In Alcohol And Drug Dependent Patients Undergoing Treatment At Depaul House, IeJSME 1: 35-40, 2007.
3. Pierre Lahmek, Ivan Berlin, Laurent Michel, Chafia Berghout, Nadine Meunier, Henri-Jean Aubin: Determinants of improvement in quality of life of alcohol-dependent patients during an inpatient withdrawal programme. International Journal of Medical Sciences; 6(4):160-167, 2009.
4. Michalak EE, Yatham L, and Lam R.: Quality of life in bipolar disorder: A review of the literature. Health and Quality of Life Outcomes, 3:72, 2005.
5. The WHOQOL Group: The world health organization quality of life assessment (WHOQOL): position paper from the world health organization. Soc. Sci. Med. Vol. 41, no 10 pp. 1403-1409, 1995.
6. Rapley M.: Quality of life research: A critical introduction. 1st ed. London: SAGE Publications.pp 28-29. 2003.
7. Giacomuzzi SM, Riemer Y, Kemmler G, Ertl M, Richter R, Rossler H, Hinterhuber H: Subjective well-being and somatic markers in methadone substitution. Evaluation of 61 heroin addicts. Fortschr. Med. Orig. 119, 103-108, 2001.
8. Skodol AE, Oldham JM, Gallaher PE: Axis II comorbidity of substance use disorders among patients referred for treatment disorders. Am. J. Psychiatry 156, 733-738, 1999.
9. Frei A, Rehm J, Arbeitsgruppe HeGeBe Doppeldiagnosen: Comorbidity: psychiatric disorder of opiate addicts at entry into heroin assisted treatment. Psychiatr Prax 29 (5), 251-257, 2002.
10. Fassino S, Abbate Daga G, Delsedime N, Rogna L, Boggio S: Quality of life and personality disorders in heroin abusers. Drug and Alcohol Dependence 76, 73-80, 2004.
11. McLellan AT; Luborsky L; Cacciola J, Griffith J: New data from the Addiction Severity Index: reliability and validity in three centers. Journal of Nervous and Mental Diseases; 173:412-423, 1985.
12. First MB, Gippon M, Williams J, Benjemen LS: Structured Clinical Interview for DSMIV. Axis II Personality disorder (SCID) Washington D.C., Am Psych Press, 1997.
13. Assad T, Okasha A, Kamel H, Zakaria M: Psychiatric morbidity after cerebrovascular accidents. M.D thesis, Ain Shams University, 1992.
14. Beck P, Dunbar GC & Stocker MJ: Developing an instrument to measure the changes in psychiatric patients' quality of life. In: Jonsson B and Rosenbaum J (eds): the health economics of depression. Wiley: ChiChester, 1993.
15. Youssef A, Okasha A, Sadek A, Sief Aldawla AA & Okasha T: A ten year outcome study of schizophrenia in a sample of Egyptian patients. Submitted M.D. thesis. Institute of Psychiatry Ain Shams University, Cairo, 2002.
16. White-Koning M, Arnaud C, Bourdet-Loubère S.: Subjective

quality of life in children with intellectual impairment – how can it be assessed? Developmental Medicine & Child Neurology. 47: 281–285, 2005.

17. Victoria Cramer, Svenn Torgersen, Einar Kringlen: Personality disorders and quality of life. A population study. Comprehensive Psychiatry 47; 178–184, 2006.
18. Maremmani I, Pacini M, Lamanna F, Pani PP, Trogu M, Perugi G, Deltito J, Gerra G: Predictors of none relapsing in Methadone Maintained Heroin Addicts. A long term perspective study. Heroin Addict Relat Clin Probl. 10:(4) 19-28, 2008.
19. Hatata HA; Khalil AH, Assad T; AboZeid MY; Okasha TA: Dual diagnosis in substance use disorder, a study in Egyptian sample. MD Thesis, Ain Shams University, 2004.
20. El Ghonemy S , Lotaief F, Assad T, Essawy H, Haroun El Rasheed A: Relapse Predictors in Egyptian Substance Use Disorder Patients. MD Thesis, Ain Shams University, 2005.
21. Hamilton A. B. and Grella CH E.: Gender Differences among Older Heroin Users J Women Aging. 21(2): 111–124, 2009.
22. Suni Lee: Marital Status, Gender, and Subjective quality of life in Korea. Development and Society Vol (27) 2; 35-49, 1998.
23. Abd El-Azim KA; Lotaief F; El-Mahalawy N; Seif El-Dawla A; Assad T: Psychosocial correlates of substance abuse. MD Thesis, Ain Shams University, *2001*.
24. Swindells S, Mohr J, Justis JC, Berman S, Squier C, Wagener MM, Singh N: Quality of life in patients with human immunodeficiency virus infection: impact of social support, coping style and hopelessness. Int J STD AIDS; 10:383–391, 1999.
25. Andrew C. Blalock, J. Stephen Mcdaniel, Eugene W. Farber: Effect of Employment on Quality of Life and Psychological Functioning in Patients With HIV/AIDS. Psychosomatics; 43:400–404, 2002.
26. Pieter J. Carpentier, Paul F. M. Krabbe, Mijke T. van Gogh, Lieke J. M. Knapen, Jan K. Buitelaar , Cor A. J. de Jong: Psychiatric Comorbidity Reduces Quality of Life in Chronic Methadone Maintained Patients; American Journal on Addictions, Volume 18, Issue 6, P. 470 – 480, Nov. 2009.
27. A.de Graeff, J.R.J de Leeuw, W.J.G. Ros, G.J. Hordijk, G.H.Blijham, J.A.M.Winnubst: Sociodemographic factors and quality of life as prognostic indicators in head and neck cancer; European journal of cancer; 37, 332-339, 2001.
28. Kjersti Narud , Arnstein Mykletun and Alv A Dahl: Quality of life in patients with personality disorders seen at an ordinary psychiatric outpatient clinic; BMC Psychiatry, 5:10, 2005.
29. Beals J, Novins DK, Spicer P, Orton HD, Mitchell CM, Barón AE, Manson SM, the AI-SUPERPFP Team: Challenges in operationalizing the DSM-IV clinical significance criterion.

Arch Gen Psychiatry, 61:1197-1207, 2004.

30. Fossati A, Feeney JA, Donati D, Donini M, Novella L, Bagnato M et al.: Personality disorders and adult attachment dimensions in a mixed psychiatric sample: a multivariate study. J Nerv Ment Dis; 191:30 – 7, 2003.

Table (I) ***Personality disorders:***
(PD found among patients together with the most predominance type of PD)

Personality disorder:	No.:	%:
Mixed:	22	68.8
Multiple:	10	31.2
Total:	32	100
Borderline PD:	25	78.1
Narcissistic PD	22	68.8
Depressed PD:	17	53.1
Antisocial PD	15	46.9

The correlation between of the patients' variables and their PCASEE:

Table (II): ***MS of the patients and their PCASEE:***

PCASEE	Marital Status	
	f	P value
P	5.346	0.011*
C	0.707	0.501
A	0.859	0.434
S	2.292	0.119
E	3.684	0.038*
E	2.370	0.111
Total	2.542	0.096

***Physical and economic components of PCASEE were significantly correlated to marital status of patients.*

Table (III) ***ASI profiles of the patients and their PCASEE:***

PCASEE	P		C		A		S		E		E		Total	
ASI	**f**	**P value**	**F**	**P value**	**f**	**P value**	**f**	**P value**	**f**	**P value**	**f**	**P value**	**f**	**P value**
Medical	1.254	0.300	0.143	0.867	0.708	0.501	0.449	0.642	0.672	0.518	0.378	0.689	0.410	0.668
Employment	2.523	**0.043***	4.895	**0.007***	2.035	**0.049***	1.611	0.209	3.617	**0.025***	0.840	0.484	2.837	**0.048***
Alcohol	0.172	0.843	0.394	0.678	0.247	0.783	1.141	0.333	0.150	0.861	2.449	0.104	0.178	0.838
Drug	5.741	**0.038***	1.928	0.164	3.784	**0.038***	0.644	0.533	4.289	**0.023***	0.796	0.461	3.10	**0.042***
Legal	2.9	**0.04***	3.89	0.04*	1.233	0.316	3.24	**0.045***	1.834	0.164	3.42	**0.045***	4.21	**0.035***
Family	0.127	0.881	0.725	0.439	1.828	0.179	0.432	0.653	0.288	0.752	0.829	0.447	0.116	0.891
Psychiatry	0.095	0.909	0.384	0.684	3.24	**0.042***	1.379	0.268	3.1	**0.049***	1.724	**0.041***	0.650	0.529

Table (IVa) ***PD of the patients and their PCASEE:***

PCASEE	Personality Disorders			
	Mixed PD Mean	**Multiple PD Mean**	**t**	**P value**
P	0.523	0.672	-1.515	0.143
C	0.529	0.616	-3.21	0.042*
A	0.548	0.711	-3.4	0.045*
S	0.522	0.664	-1.654	0.109
E	0.492	0.672	-1.644	0.111
E	0.529	0.637	-2.4	0.05*
Total	0.578	0.660	-2.7	0.034*

Table (IVb) ***Individual PD of the patients and their PCASEE:***

PCASEE	Depressive PD			Histrionic PD			Borderline PD		
	Mean	**T**	**P value**	**Mean**	**t**	**P value**	**Mean**	**t**	**P value**
P	0.572	-0.048	0.96	0.66	-1.404	0.172	0.595	-0.94	0.35
C	0.625	2.4	0.03*	0.512	-2.21	0.032*	0.578	2.4	0.032*
A	0.611	-2.297	0.76	0.587	-3.64	0.027*	0.612	1.942	0.041*
S	0.75	2.7	0.04*	0.627	-1.077	0.290	0.525	3.42	0.032*
E	0.557	-0.168	0.86	0.656	-1.532	0.136	0.575	-0.976	0.337
E	0.67	3.2	0.03*	0.522	-2.62	0.021*	0.570	2.43	0.024*
Total	0.68	2.8	0.02*	0.588	-3.42	0.04*	0.550	3.42	0.045*

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Cultural imprint on Symptom profile of mood disorders: An epidemiological study in different subcultural sites in a Nile delta governorate

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الأثر الثقافي على اعراض اِضطراباتِ المزاج: دراسة في علم أوبئة في المواقع الثقافيةِ الفرعيةِ المختلفة في محافظة من دلتا النيل

محمد عزت الحديدي، محمد عادل الحديدي، ورده فتحي ابو عزت

Abstract

Affective disorders are the most common psychiatric disorders. Their symptoms profile varies in different cultures. Several studies try to identify a core syndromal symptoms and secondary manifestations of the syndrome that changes with geographical, socioeconomic, and cultural areas or political status.

Objective: is to find out the differences in clinical symptoms profile of mood disorders between rural and urban areas in Egypt.

Method: A sample of people was selected using the multistage random sampling technique then a survey study was done using Mini Inter National Neuropsychiatric Interview over 600 people from two villages and 400 people from two cities in Dakahlia governorate. All patients who were diagnosed as mood disorder according to DSM IV TR criteria enter depth study including complete physical and neurological examination to exclude organic causes and clinical symptoms profile of mood disorders in rural and urban population, according to (DSM-IV TR).

Results: There was a statistically significant difference between rural and urban population as regard prevalence of major depressive disorder (9.5%, 6.6%) (p 0.023) while there are no statistical differences as regard other mood disorders The depressed mood, lost appetite, low energy, death ideas, motor retardation and somatic symptoms were statistically significant more among rural population while lack of pleasure, insomnia, lack of concentration and agitation were significant more among urban population. There is no significant statistical difference between rural and urban population regarding most of manic symptoms.

Conclusion: the culture effect on mood disorder is more prominent in depression than in mania.

Key ward: culture, depression, epidemiology, mood, Egypt

Declaration of interest: None

Introduction

Affective disorders are the most common psychiatric disorders, and their frequency in clinical and community populations has been the subject of considerable research[1]. A recent, extensive review of most studies contains estimates of a life time prevalence of 17% to 20% and one-year prevalence 5% to 8%.[2].

There are several conflicting findings on symptoms manifestations of mood disorders in different cultures. International studies have identified a

core of depressive syndrome in patients in diverse geographical and cultural areas, regardless of developmental, socioeconomic, or political status[3] cultural elements appear to influence the expression of a number of secondary manifestations of the syndrome. Guilt and suicidal tendencies, for example, have been found to be rare in depressed individuals from developing cultures[4], but an excess of somatization or hypochondriacal features have been found to be common in those countries.[5], unfortunately, methodological problems limit generalization of these reports. Two recent studies using more sophisticated methods have reinforced the original observations of increased somatization in developing societies. WHO[6] and Stefanson, et al,[7] showed that a significant majority of psychiatric patients attending primary health facilities in four developing countries (Colombia, the Philippines, Sudan, and India) cited only physical symptoms as presenting complaints.

Murphy[8] tried to draw profiles of depressive symptoms reported from different European countries. He noticed that the French have a rather low incidence of suicide with a high incidence of somatic preoccupation, the Germans have a high incidence of anorexia, the polish a higher incidence of preoccupation with poverty and the suicide, Pacheri et al[9] concluded that the diagnostic criteria of depressed neurotic psychopathology seemed to be much stricter in the Swiss population than in Italian one and that some manifestations of anxiety and depression are tolerated more readily in an Italian context than in the Swiss. Perris, et al[10] reported that Italian patients have high score to motor retardation, hypochondriasis, hopelessness, loss of interest and dissatisfaction, and Swedish patients have agitation, weight loss, and tachycardia.

Mood disorder symptoms profile varies in different cultures. Several studies try to identify a core syndromal symptoms and secondary manifestations of the syndrome that changes with geographical, socioeconomic, and cultural areas or political status. Our aim of the work is to differentiate between rural and urban communities in clinical symptoms profile of mood disorders.

Study design

1- Place and time of the study: This study was carried out in the period from January 2004 to January 2005. In randomly selected geographical areas in Dakahlia governorate representing both the rural and the urban population.

2- Methodology and sample size: A cross sectional study was carried out on a suitable sample size of rural and urban areas.

The first step of the study (location of study) 3 centers were chosen randomly, (Mansoura center representing urban area, Met Salseel and Dekirins representing rural areas).

A. **Sampling technique from rural areas:** a sample from rural areas was selected using the multistage random sampling technique as follow: **First stage of the study**: 2

centers were chosen randomly from all centers in Dakahlia governorate. They were Dekirnis and Met Salseel, whose populations are 27.342 and 59202 respectively. **The second stage**: 2 villages has been selected by (simple random method) from the above two centers. These villages are El-Kobab El sogra from Dekirnis center and El-Ethad from Met Salseel center whose population are 7645 and 6103 respectively. **The third stage is selection of houses**: all houses would be enumerated and a (systematic random sample) is obtained by choosing every 15th house.

B. **Sampling technique from urban area:** samples from urban areas were chosen using (multistage random sampling) technique as follow: **The first stage**: East and west districts whose population were 180834 and 222810 respectively would be divided into multiple locations. **The second stage**: 2 locations one from each district was chosen randomly. The locations are Ezbet Shall and El Hawoar whose population were 40493 and 39493 respectively. **The third stage**: Each region was divided into streets. The streets under investigation were chosen randomly. Each street was divided into houses which was chosen by (systematic random sample), in which the house number 15 was the one chosen.

The second step of the study (Determination of the sample size): The sample size was calculated using total population in Dakahlia is (4,808 million people). The expected frequency of mood disorder 18% according to Weissman and Klermans[11], the worst expected frequency is 20% at level of confidence 95%, so the sample size was 1417 according to Epi info WHO (2000). The sample size would be 2000 nearly to avoid error defaulter, drop out of cases. The sample was divided into two parts according to population in which percentage of rural / to urban areas was 2/3: 1/3 of total simple size, so 600 nearly would be taken equally from two sites of rural area whose El kobab El Sogra and El Ethad and 400 nearly would be taken equally from two urban areas whose Ezbet El shall and El Hawoar. (Epi Info version 5.01 October 2000) (Public Domain software for epidemiology and disease surveillance).

Pilot study was performed for one month in Mansoura out patient clinic to satisfy following aims: **1)** Assess the ability of the subjects to understand the used questionnaire, gain training of investigator and to determine the method of administration of the questionnaires. **2)** Assess the reliability of the clinical diagnosis

First, Permission was taken from Faculty of Medicine of Mansoura University for this study performing.

Permission was taken from health center concerned with these areas.

Data collection: Data was collected after taking informed consent from chosen people after discussing with them about the aim of the study. **A survey study** was done by using Mini Inter National Neuropsychiatric Interview: [11]. **Depth study**: All patients who were diagnosed as mood disorder according to DSM IV TR criteria (verification of the diagnosis was done by two independent psychiatrists holding a master degree with 2 years clinical experience) and fulfilling the following criteria were taken for the in-depth study:- **Inclusion criteria**: Above 18 years and of both sexes. Exclusion: Mental subnormality, Dementia, delirium and other cognitive disorders, Mood disorder due to general medical condition and Mood disorder due to substance use.

Those diagnosed as having disorders (total 202 patients, 167 depression, and 35 manic patients) (138 patients from rural area and 64 from urban area) from the previous steps were subjected to the following**:**

- Complete physical and neurological examination to exclude organic causes.
- Clinical symptoms profile of mood disorders in rural and urban population, according to (DSM-IV TR).

Results

Table (1) shows depressive symptoms among depressed patients in rural and urban areas. The depressed mood, lost appetite, low energy, death ideas, motor retardation and somatic symptoms were statistically significant more among rural population while lack of pleasure, insomnia, lack of concentration and agitation were significant more among urban population.

Table (1): Depressive symptoms among depressed patients in rural and urban population according to DSM IV-TR:

	Depression							
	Rural (n=114)		**Urban (n=53)**		**Total (n=167)**		**Chi square**	
	n	%	n	%	n	%	X^2	P
Dep mood	109	95.6%	37	69.8%	146	87.4%	21.911	.000***
Lack of pleasure	15	13.0%	29	49.2%	44	25.3%	26.911	0.000***
Lost appetite	74	64.3%	17	28.8%	91	52.3%	19.737	0.000***
Inc appetite	8	7.0%	3	5.7%	11	6.6%	.108	0.742
Insomnia	47	41.2%	31	58.5%	78	46.7%	4.331	0.037*
Hypersomnia	7	6.1%	4	7.5%	11	6.6%	0.116	.733
Low energy	89	78.1%	27	50.9%	116	69.5%	12.551	.000***

Low SE	36	31.6%	18	34.0%	54	32.3%	0.094	0.759
Lack conc.	67	58.8%	40	75.5%	107	64.1%	4.383	0.036*
Death ideas	17	14.9%	2	3.8%	19	11.4%	4.452	0.035*
Agitation	26	22.8%	20	37.7%	46	27.5%	4.040	0.044*
Motor retard	45	39.5%	11	20.8%	56	33.5%	5.688	0.017*
Somatic	50	43.9%	14	26.4%	64	38.3%	4.658	0.031*
guilt feeling	13	11.4	5	9.4	18	10.8	0.13	0.71

Table (2) shows manic symptoms among manic patients in rural and urban population. There are no significant statistical differences between rural and urban populations regarding all symptoms except disruptive behavior which was significant more among rural population and irritable mood which was significant more among urban population.

Table (2): Manic Symptoms among bipolar patients in rural versus urban according to DSM IV-TR:

	Residence						**Chi square test**	
	Rural (n=24)		**Urban (n=11)**		**Total (n=35)**			
	n	**%**	**n**	**%**	**n**	**%**	X^2	**P**
Elevated mood	18	75%	6	54.5%	24			
Irritable mood	6	25%	5	45.5%	11		1.469	>0.05
Grandiosity	10	41.7%	5	45.5%	15	42.9%	0.044	0.833
Increased motor activity	23	95.8%	10	90.9%	33	94.3%	0.339	0.560
Increased pleasure activity	12	50.0%	7	63.6%	19	54.3%	0.565	0.452
Decreased need to sleep	23	95.8%	11	100.0%	34	97.1%	0.472	0.492
Talkativeness	24	100.0%	11	100.0%	35	100.0%	-	-
Flight of ideas	16	66.7%	8	72.7%	24	68.6%	0.129	0.720
Distractibility	14	58.3%	6	54.5%	20	57.1%	0.044	0.833
Disruptive behavior	12	50.0%	2	18.2%	14	40.0%	3.182	0.047

Discussion

Regarding depressive symptoms in patients with depression and dysthymia in rural versus urban population: in the present study it was found that, low energy, insomnia and depressed mood were more common than other depressive symptoms in both population. This result gives more evident to the previous study which reported that these symptoms have a biological base rather than cultural factors. This agreed with Pfeiffer[12] who found that no marked variations could be observed across different cultures. He reviewed 40 reports from non-western countries and concluded that in these countries the core symptomatology of depression is quite comparable to the depressive symptoms described in the West. He identified mood changes, loss of sleep, appetite and libido, and variation in diurnal-rhythm as the core depressive symptoms, while he found that guilt, hopelessness and hypochondriasis were modified by culture. Also, the WHO collaborative study on depression identified a core of depressive symptoms in the majority of cases in the 5 participating centers. These include sadness, joylessness, anxiety and tension, lack of energy, loss of ability to concentrate and ideas of inadequacy and worthlessness[6].

On the other hand, the present study shows that there were many secondary syndromal manifestations that change with cultural factors as, agitation, insomnia and lack of concentration were more common in urban depressive and dysthymic patients but motor retardation, lost appetite, depressed mood and low energy were more common in rural depressive patients. However this result was expected to some extent and may be explained by urban population subjected to many stressors as over-crowding, pollution and low financial resources in comparison to the increasing need for civilization.

Also it was found that, somatic symptoms were more common in major depression and dysthymia of rural population than urban population. This may be explained by rural subjects who tend to translate their feelings into body language. This may be because of a greater social acceptance for physical complaints than psychological complaints, which are either not taken seriously or rarely believed to recover with some rest or extra praying. They mask their effect with multiple somatic symptoms which occupy the foreground and the affective component of their illness recedes to the background. Accordingly, they either resort to the general practitioner or the primary health care physician asking for unnecessary investigations which are costly for a developing country or they ask the traditional healers to alleviate their sufferings. A considerable number did not ask for help at all, especially in rural population, in which absenteeism from work or in ability to face day to day affairs are not much criticized by their community.

Lack of pleasure was more common in urban than rural population with highly significant differences. This may be explained on the basis of existence of means of recreation and entertainment available to urban population and relatively unavailable in rural life. Guilt feelings and suicidal ideation were less than other depressive symptoms in both population and this agrees with El-**Islam et al**,[13] who found that guilt feelings and suicidal ideation and behavior were not frequently present in Kuwait. Two explanations have been involved namely the persisting influence of Islam compared to the declining presence of Christianity in the west and a different social fabric allowing cohesiveness and reinforcing belonging rather than individuality and social alienation in the West.

On the other hand suicidal ideations were more common in rural population in contrast to urban population in spite of religious attitudes so religion seems to suppress the actions but not the thoughts. This agrees with previous studies conducted by [14, 15].

The present study supports the result of **Okasha et al**.,[14] revealed some differences between western and Egyptian populations. In Egypt, depression is manifested mainly by agitation, somatic symptoms, hypochondriasis, physiological changes such as decreased libido and anorexia, and insomnia, which is not characterized by early morning awakening symptoms, also ideas of guilt, sin and reproach are not common in Egyptian patient.

In reference to Manic symptoms among bipolar patients in rural versus urban population: the present study found that, talkativeness, decreased need to sleep, and increased motor activity were the most common symptoms in bipolar patients of both populations (100%, 95.8%). However, distractibility, flight of ideas and grandiosity were nearly equal in both populations this may reflect that the biological base of this disorder plays a greater role in pathogenesis of these symptoms than cultural and environmental factors. On the other hand, disruptive behavior was more common in rural patients than urban patients (50%,18.2%) this may be explained by the fact that low level of education and social classes were more observed among rural population which have major coloring of this type of behavior.

Murphy et al,[16] revealed that the variations in the symptomatology of mania are less easy to assess due to the unavailability of that diagnosis in the past and overlap with reactive psychosis and schizophrenia.

Recommendations

- Further studies in different Governorates could be done, with the aim of cooperation between different governmental studies in order to reach a full organized mental health policy in Egypt. Also for actual assessment of morbidity risk, so effective policy should address the primary, secondary and tertiary prevention approaches.
- Comparative studies in epidemiology of psychiatric disorders in Arab countries could be done and compare it to data obtained from western countries that have different urbanization profile.
- We should improve the orientation of the general practitioners about psychiatric disorders especially mood disorders. They would be trained for early detection and intervention and/or refer them to the nearest psychiatric center which can provide psychiatric help instead of doing many investigations and prescribing many medications, which are expensive and spares time, which has adverse effects on the economy.

الملخّص

الاضطرابات العاطفية هي أكثر الاضطراباتَ النفسية شيوعاً. الا ان أعراضُها تَتفاوتُ في الثقافاتِ المختلفةِ. في عِدّة دِراساتِ صينية لتَمييز الأعراض الاساسية و الثانوية مِنْ المتلازمةِ الذي يَتغيّران بالمناطق الثقافيةِ والإجتماعية الإقتصاديةِ والجغرافيةِ أو المنزلةِ السياسيةِ. الهدف من الدراسة: أنْ يَتم اكتشافَ الإختلافاتَ في الأعراض السريريةِ لاضطراباتِ المزاج بين المناطق الريفيةِ و الحضريةِ في مصر. الطريقة: تم اخذ عيّنة من الناس بإستعمال تقنيةِ العينة العشوائيةِ المتعددة المراحل ثمّ عمل دراسة مسح عُمِلتْ و مقابلة نفسية لأكثر من 600 شخص مِنْ قريتين و400 شخص مِنْ مدينتين في محافظةِ الدقهلية وبعد ذلك كُلّ المرضى الذين تم تشُخّيصهم كمرضى مزاج طبقاً لدي إس إم الرّابعة معايير تي آر يَدْخلُون دْراسُة اعمق لاكتشاف الفرق بين الريف و الحضر في الأعراض السريريةِ لاضطراباتِ المزاج. النتائج: كان هناك إختلاف هامّ بشكل إحصائي بين الريفيين والحضريين بالنسبة لنسبة انتشارالنوبة الاكتائبية (9.5 %, 6.6 %) بينما ليس هناك إختلافات إحصائية في نوبات المزاج الاخري. كما لوحظ ان فقد الشهية ، انخفاض الطاقة الأفكار المتعلقة بالموتِ، انخفاض معدل الحركة والأعراض الجسدية كَانا أكثر انتشاراً بشكل إحصائي بين سكان الأرياف عن الحضر . بينما قلةِ السرور، أرق، قلة التركيز والهياج كَانا أكثر انتشاراً بين الحضريين. ليس هناك إختلاف إحصائي هامّ بين ريفيين وحضريين بخصوص أغلب الأعراض الهوسيةِ. الخاتمة: إنّ تأثيرَ الثقافة على فوضى المزاج أكثرُ بروزاً في الكآبةِ مِنْ الهوس.

References

1. Turns D. The epidemiology of major affective disorder. Am J psycho 1978; 32: 5-19.
2. Boyd JH and Weissman MM. Epidemiology of affective disorders: A reexamination and

future direction in psychiatry 1981; 38: 1039-41.
3. Sartorius N and Jablensky A. Toward a public health approach to depression. Abstracts of the VI world congress of psychiatry, Honolulu, Hawaii. 1997; P 37.
4. Singer M. Depressive disorders from a Tran cultural perspective. Soc. Sci Med 1995; 9: 289-301.
5. Racy J. Somatization in Saudi Women: a therapeutic challenge. Br J Psychiatry 1980; 137: 212-216.
6. World health organization. Depressive disorders in different cultures. Geneva. World Health organization; 1992.
7. Stefanson JG, Messina JA, Meyerowitz S. Hysterical neurosis, conversion type. Acta psychiatr scand 2002; 53: 119-123.
8. Murphy, R.S. Rural community attitudes to mental disorders. Indian J. Clin. Psych. 1977; 4, 141.
9. Pacheri, L.B.; Padloff, D.C. and alex. T. Measurement of mental health in a general population. Survey. Am. J. of Epidem. 1975; 99: 2, 105-111.
10. Perrise, Eisemann M, Eriksson U, Perris H, Kemal D, Amati A. Transeultural aspects of depressive symptomatology. Psychiatr chin (Basel): 1981;14 (2): 69-80
11. Mini International Neuropsychiatric Interview. Department of Psychiatry, Faculty of medicine, Mercer University, Georgia, USA. Translated by Prof. Othman A.T, and El-Rady E.O (in Arabic) 1992.
12. Pfeiffer, W.M. Comparative psychiatric studies in various population groups in West Java. Arch psychiat. Nervenkr.1963;204:404-14.
13. El-Islam M.F, Moussa, M, Malasi T.H, Suleiman, M.A and Mirza, I.A. Assessment of depression in Kuwait by Principal component analysis . Journal of affective disorder, 1988; 14 :109-114.
14. Okasha A, Khalil, El Fiky MR, Ghanem M and Abdel Hakeem. prevalence of depressive disorders in a sample of rural and urban Egyptian communities , Egyptian Journal of psychiatry 1988; 11 : 167 – 181.
15. Gawad, M.S.A and Arafa, M. Trans cultural study of depressive symptomatology. Egyptian Journal of psychiatry 1980; vol. 3, No., 2, 163-183.
16. Murphy, A.; Alex, T. and David, H. : A comprehensive study of opinion and knowledge about mental illness in different societies psychiatry. 1986; 31: 4, 354-410.

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CASE REPORT

HALOPERIDOL INDUCED NEUTROPENIA:

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إبيضاض الدم الناجم عن عقار الهلوبيردول

محمد اكرام الله و صالح الحلو

Abstract

Leukopenia, neutropenia and agranulocytosis (low white blood cells count) are rare but serious side effects of antipsychotics, notably clozapine. We here report a case of an Afro-Caribbean patient who developed neutropenia on haloperidol, which was reversed when he was switched to quetiapine. It is recommended that caution should be exercised when treating patients with antipsychotics and patients should be told to report high fevers and painful sore throats to their doctors as soon as possible.

Key Words: Leukopenia, Neutropenia, Agranulocytosis, Antipsychotics

Declaration of interest: none

Introduction

Many drugs can cause agranulocytosis and neutropenia, which are rare but serious and potentially life threatening side effects. They have been associated with the use of psychotropic medications especially antipsychotics, most notably clozapine.[1] Although clozapine has the greatest potential to cause this, the same adverse effects have been described and reported with many other medications including antipsychotics, mood stabilizers, antidepressants, benzodiazepines, barbiturates, hypnotics, anti-thyroid medications, some antibiotics and non-steroidal anti-inflammatory derivatives. They can also be side effects of chemotherapy and radiation treatment.[2]The degree of neutropenia is not always drug dose-related. There is now some evidence that drug-induced neutropenia is immunological in nature. On discontinuation of the offending drug, the marrow recovery takes place and rebound leucocytosis may occur. Benign ethnic neutropenia (BEN) can be defined as: "The occurrence of neutropenia, defined by normative data in white populations, in individuals of other ethnic groups who are otherwise healthy and who do not have repeated or severe infections". It occurs in 25-50% of people of African descent.[3,4] Statistically and significantly lower white cell neutrophils counts have been demonstrated in Africans and Afro-

Caribbeans compared with Caucasians.[5] We here report a case of reversible leukopenia and neutropenia developing in an Afro-Caribbean patient treated with haloperidol and reversed after switching to quetiapine.

Case Report

A 26-year-old Afro-Caribbean male, single, unemployed patient, with a long history of schizophrenia and substance abuse,. He has had seven previous admissions to the local acute psychiatric hospital between 2005 and 2008. His schizophrenia has been well controlled on oral haloperidol 15 mg twice daily, which he has been taking for many years.

On 18th September 2008, he attended the A&E department of the neighbouring District General Hospital. having reportedly jumped from the 6th floor of a high-rise block of flats for unidentified reason. On admission, his Glasgow Coma Scale (GCS) was 15/15. When assessed by the liaison psychiatrist (M I), his mental state was quite stable with no evidence of affective or psychotic symptoms. He was not suicidal.

His head and abdomen CT scans were within normal. CT chest scan showed lower chest retrosternal haematoma, small pneumothorax; L1 and L2 fracture incomplete spinal injuries with motor loss and fracture shaft of the left femur. He underwent various surgical procedures with which he coped quite well. He was regularly reviewed by M I.

In view of his immigration status and the potential risk he was unable to return back to his address and was kept in the DGH's rehabilitation unit longer than similar cases. Whilst there, it was found that his total white blood cells and neutrophils counts were below normal for which no physical cause was identified and hence Haloperidol was suggested as a possible cause. His treating medical team expressed concern about his low absolute neutrophils count and the risk of complications if it fell below 1.0 and an urgent intervention was requested. On 14th April 2009, a joint agreement was reached by the treating team including the physician, haematologist and liaison psychiatrist to gradually reduce haloperidol by 5mg weekly to nil and commence him on Quetiapine XL 300mg nocte to be increased to 600mg nocte the next day. During the cross tapering period, the liaison psychiatrist reviewed him regularly. His mental state remained stable and his absolute neutrophils count gradually reverted back to normal.

Given below is the chart of his white blood cells (WBC) and neutrophils absolute counts. The latter is the measure of all neutrophils granulocytes.

Blood Count

DATES	25/09/08	06/11/08	03/12-08	20/02/09	1/3/09	4/03/09	07-4-09	20/04/09
WBCs Count	7.6	7.0	4.7	3.7	3.5	3.7	3.5	3.6
Neutrophils Absolute Count	5.32	4.84	2.59	1.63	1.52	1.69	1.27	1.75

DATES	28/04/09	12.05.09	26.05.09	11.06.2009	23.07.09	
WBC Counts 4.0-11.0	4.1	4.1	4.1	3.9	4.4	
Neutrophils absolute Count 1.70-7.50	1.42	1.89	1.67	1.47	2.57	

Discussion

The normal range of the WBC count in Afro-Caribbean's is, on average, slightly lower than that of Caucasians. Our patient's initial WBC and neutrophils absolute counts were in the normal range. His WBC and neutrophils counts started to decrease in December 2008 and no physical causes were found. This was confounded by the patient's ethnic background. As the patient was not taking any other drugs that could cause neutropenia, haloperidol was suggested as a possible cause.

Haloperidol is known to cause only rare instances of haematoxicity.[6,7] NICE 3 guidance on the use of antipsychotic drugs recommended atypical antipsychotics for the treatment of newly diagnosed schizophrenia.[8] Therefore, conventional antipsychotics have been increasingly less prescribed. However, haloperidol, in its oral and parenteral, formulations, is still being quite frequently prescribed especially as PRN. As our patient has failed to show any significant response to other antipsychotics, he was treated with a relatively high dose of haloperidol and his schizophrenia was well controlled and managed. Although it may be that some of the medications, anaesthetists, etc to which the patient was subjected after his fall may have exacerbated any effects of haloperidol; it was felt that

haloperidol was the main cause of the persisted neutropenia. Benign fluctuating neutropenia, which is similar to benign ethnic neutropenia and comes in episodes, was also ruled out. Therefore, haloperidol was discontinued and quetiapine XL was commenced. His mental state remained stable and his blood picture gradually reverted back to normal during the cross tapering period. Leukopenia is listed in the summary of product characteristics as a common side effect of quetiapine, but neutropenia as a very rare side effect (< 0.01%).[9,10]

Although clozapine has the greatest potential to cause leukopenia and neutropenia, the same side effects have been reported with other atypical antipsychotics, namely risperidone, olanzapine and quetiapine.[11,12,13,14,15,16] Cowan and Oakley reported a case of leukopenia and neutropenia induces by quetiapine in a 36-year-old Caucasian female with a treatment resistant schizophrenia.[17] She was treated with quetiapine in conjunction with the mood stabilizer semisodium valproate (Divalproex). Therefore, the possibility of semi-sodium valproate being the causative agent in the combination with quetiapine has to be considered.[18] Semisodium valproate has been associated with increase of 77% in quetiapine plasma levels, suggesting that quetiapine induced leukopenia can be dose-related.[19] Two other cases of neutropenia in association with quetiapine were reported.[15,16] Our case could be added to Yatham et al.'s (2004) who found no abnormal laboratory results in 196 patients taking quetiapine with either divalproex or lithium.[20]

Conclusion

Haloperidol shares a propensity for causing leukopenia and neutropenia with other antipsychotic, psychotropics and other drugs. As there is no mandatory white cell count monitoring as with clozapine, this side effect with its associated risks is more likely to be missed. Therefore, careful monitoring of white cell count is advisable.

الملخص

نقص الكريات البيضاء يعتبر نادرًا ولكنه عرض خطير يمكن أن ينجم عن المعالجه بمضادات الذهان كعلاج الكلوزابين. في هذا التقرير نبرز حالة مريض من أصل كاريبي حدث لديه نقص الكريات البيضاء **Neutropenia** ناجمه عن العلاج بالهالوبيردول. وقد زال النقص عندما أوقف العلاج وأعطي علاج الكيوتايابين بدلاً منه. وينصح بتوخي الحذر عند المعالجه بمضادات الذهان ويحذر المريض أن عليه أن يخبر الطبيب المعالج عند حصول ارتفاع حروري و ألم في الحلق بالسرعه الممكنه.

References

1. Copolov DL, Bell WR, Benson WJ, et al. Clozapine treatment in Australia: a review of haematological monitoring. Med J Aust 1998;168:495-7.
2. Prashant Gajwani, George E. Tesar: Olanzapine induced Neutropenia. Psychosomatics 41:150-151, April 2000.
3. Neutropenia - John E Godwin
4. Haddy TB, Rana SR, Castro O. Benign ethnic neutropenia: what is a normal absolute neutrophils count? J Lab Clin Med 1999 Jan; 133(1):15-22.
5. Bain BJ. Ethnic and sex differences in the total and differential white cell count and platelet count. J Clin Pathol 1996 Aug; 49(8):664-666.
6. Consumer information of Haloperidol. www.drugs.com/pro/haloperidol
7. N. Abdullah, L.Voronovitch, S.Taylor, and S Lippmann: Olanzapine and Haloperidol: Potential for Neutropenia? Psychosomatics February 2003 44[1]:83-84.
8. NICE Guidance on use of newer antipsychotic drugs for treatment of schizophrenia.
1. June 2002.
9. BNF (British National Formulary) 57 March 2009.
10. Seroquel SPC, (date of revision23rd June 2005) electronic Medicines Compendium(eMC).
11. Dernovsek Z, Tavcar R. Risperidone-induced leucopenia and neutropenia. Br J Psychiatry 1997; 171:393-394.
12. Sluys M, Guzelcan Y, Casteelen G, et al. Risperidone-induced leucopenia and neutropenia: a case report . Eur Psychiatr 2004;19(2):17
13. Buchman N, Strous R D, Ulman A M, et al. Olanzapine-induced leukopenia with human leucocyte antigen profiling. Int Clin Psychpharmacol 2001; 16(1): 55-57.
14. Stergiou V, Bozikas VP, Garyfallos G, et al. Olanzapine-induced leucopenia and neutropenia. Prog Neuro-psychopharmacol Biol Psychiatry 2005;29:992-4
15. Croarkin P, Rayner T. Acute neutropenia in a patient treated with quetiapine. Psychosomatics 2001; 41(4):368.
16. Jackson RS. Continuing treatment with novel antipsychotic drugs despite Leukopenia or thrombocytopenia. Arch Gen Psychiatry 2001; 58:706-7.
17. Cowan C, Oakley C. Leukopenia and neutropenia induced by quetiapine. Prog Neuro-Psychopharmacol Biol Psychiatry 31 (2007) 292-294

18. Vesta KS, Medina PJ. Valproic acid-induced neutropenia. Ann Pharmacother 2003;37(6):819-21
19. Aichhorn W, Marsteiner J, Walch T, et al. Influence of age, gender, body weight and valproate comedication on quetiapine plasma concentrations. Int Clin Psychopharmacol 2006; 21(2):81-5.
20. Yatham LN, Paulsson B, Mullen J, et al. Quetiapine versus placebo in combination with lithium or divalproex for the treatment of bipolar mania.. J Clin Psychopharmacol 2004;24(6):599-606

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أصل مفهوم تلبس الجان في بدن الأنسان في الثقافة الأسلامية

محمد رشيد العبودي

The origin of the concept of Jin possession in Islamic culture

Mohamad Rashid Abbudi

Abstract:

Genie Inside Human Body (GIHB) concept was in circulation among the people since many centuries before the advent of Islam. This concept was consolidated and was linked by some people with the Islamic culture and even considered as part of the Shari'a (Islamic teaching).

Physicians faced – till now- group of people who insist that epilepsy and other psychiatric and mental disorders are just GIHB, which needs ways to eliminate Genie by many methods and beating the patient is the commonest method.

In this study, we try to recognize and discuss the solid evidences from the Shari'a and review old and new different doctrinal Islamic views from several respected resources.

The study concluded that the concept of GIHB is purely a legacy of popular culture and subsequently added to the Islamic heritage in the late Islamic centuries, which calls for a firm stand to get rid of it.

البحث :

أشارت العديد من الدراسات إلى وجود ذكر الجان وعلاقته بالانسان ومنذ أزمنة سحيقة وقبل ظهور الإسلام [1، 2] بل إن هناك ما يشير منها صراحة الى الضرر الذي تنزله الجان والشياطيين والأرواح الشريرة بجسد وعقل الإنسان وذلك في الحضارات السومرية والفرعونية وكذلك في العصر الجاهلي . [1، 3، 4، 5]

ذكرت العرب الجان وعنيت به وأفردت له أسماءًا وصفات وأمكنة عديدة وعشائر وقبائل. [1،5]

الجن في اللغة هو ما استتر وجن الليل إذا أظلم وسموا بالجن لأختفائهم عن عين الناظرين. [6،7]

أشار القران الكريم إلى الجن في مواضع عديدة بل ان هناك سورة سميت كذلك (سورة الجن)،كذلك تناولت السنة النبوية الشريفة ظاهرة الجان في موارد شتى .

لانريد من دراستنا هذه دراسة عموم ظاهرة الجن وانما دراسة مفهوم محدد وواضح يتناول جانبًا واحدًا من جوانب الجان، ألا وهو ظاهرة ما يدعى بتلبس الجان أي دخول الجان إلى بدن الإنسان وحسب ما ورد في الثقافة والفكر الإسلامي .

لقد توسع مفهوم تلبس الجان وأصبح جزءًا من الثقافة الشعبية، ويالية ظل واحدًا من الموروثات الفكرية والتراثية، ولكنه تمدد وأصبح ظاهرة كبيرة نراها بوضوح نحن الأطباء، من خلال مشاهدة الكم الكبير والهائل من المرضى الذين يساء اليهم من خلال مفهوم التلبس في تفسير مما يعانونه من أمراض وأعراض وخصوصًا النفسية والعصبية منها .

إن المطلع على حجم الإساءة البالغة التي يتعرض لها هؤلاء المرضى يستطيع أن يفهم الداعي وراء كتابة مثل بحثنا هذا ونحن ندعو الآخرين لتناول الموضوع بصراحة كبيرة لأن مادة البحث تكاد تهم الملايين من الناس.

من خلال تتبع ما أطلعنا عليه من الإرث الثقافي الإسلامي حول ظاهرة تلبس الجان نجد أن علماء المسلمين قد انقسموا إلى فريقين متناقضين، أحدهما يؤيد وبشدة ظاهرة تلبس الجان في بدن الإنسان والفريق الآخر ينكر ذلك ويستهجنه .

ومن تتبع الى مصادر أراء الفريقين وجدنا أنهما يرجعان إلى تفسيرين مختلفين و متناقضين لنصين أحدهما قراني والاخر حديث نبوي وكما موضح في ادناه :

1. ورد في الآية 275 من سورة البقرة ما يلي ({الَّذِينَ يَأْكُلُونَ الرِّبَا لَا يَقُومُونَ إِلَّا كَمَا يَقُومُ الَّذِي يَتَخَبَّطُهُ الشَّيْطَانُ مِنَ الْمَسِّ ذَلِكَ بِأَنَّهُمْ قَالُوا إِنَّمَا الْبَيْعُ مِثْلُ الرِّبَا وَأَحَلَّ اللَّهُ الْبَيْعَ وَحَرَّمَ الرِّبَا فَمَنْ جَاءَهُ مَوْعِظَةٌ مِنْ رَبِّهِ فَانْتَهَى فَلَهُ مَا سَلَفَ وَأَمْرُهُ إِلَى اللَّهِ وَمَنْ عَادَ فَأُولَئِكَ أَصْحَابُ النَّارِ هُمْ فِيهَا خَالِدُونَ (275) يَمْحَقُ اللَّهُ الرِّبَا وَيُرْبِي الصَّدَقَاتِ وَاللَّهُ لَا يُحِبُّ كُلَّ كَفَّارٍ أَثِيمٍ (276)} [البقرة]

2. جاء في الحديث النبوي الشريف في موضعين مهمين حديثان انصب رأي العلماء حول تفسيرهما والاستشهاد بهما في موضوع تلبس الجان بالرغم من وجود أحاديث أخرى لكنها لم ترقى إلى أهمية الحديثين المذكورين وهما :

أ . – ما رواه البخاري ومسلم وأبو داود عن صفية بنت حيي زوج النبي(ص) قالت: "كان النبي(ص) معتكفاً، فأتيته أزوره ليلاً، فحدثته، ثم قمت لأنقلب، فقام ليقلبني، وكان مسكنها في دار أسامة بن زيد، فمر رجلان من الأنصار، فلما رأيا النبي (ص) أسرعا، فقال النبي(ص): "على رسلكما، إنها صفية بنت حيي، فقالا: "سبحان الله يا رسول الله! فقال(ص): "**إن الشيطان يجري من الإنسان مجرى الدم، وإني خشيت أن يقذف في قلوبكما شراً، أو شيئاً**".[8، 9]

ب . ما رواه البخاري ومسلم عن عطاء بن أبي رباح قال: قال لي ابن عباس:" ألا أريك امرأة من أهل الجنة؟ قلت: بلى، قال: هذه المرأة السوداء أتت النبي (ص) فقالت: إني أصرع، وإني أتكشف، فادع الله لي، قال: إن شئت صبرت ولك الجنة، وإن شئت دعوت الله أن يعافيك؟ فقالت: أصبر، فقالت: إني أتكشف فادع الله لي أن لا أتكشف، فدعا لها." [10، 11]

وقد روى البخاري في صحيحه عن عطاء أن اسم هذه المرأة أم زفر،[10، 12]

هذه هي النصوص الإسلامية التي أستند اليها الفريقان المتناقضان في موضوع تلبس الجان، ولم نجد أي دليل معتبر آخر يضاف إلى تلك الأدلة الشرعية عدا حديث المرأة والصبي وهو حديث ضعيف جدًا ومشكوك في صحته لدى معظم الرواة.

المنكرون :

لقد أنكر فريق من المسلمين تلبس الجان وناقشوا تلك الأدلة حيث ذكر الزمخشري المعتزلي في تفسيره لسورة البقرة اية 275 أن "وتخبط الشيطان من زعمات العرب، يزعمون أن الشيطان يخبط الإنسان فيصرع.. فورد على ما كانوا يعتقدون" [13] ، كذلك أورد أبو علي الجبائي المعتزلي أن "هذا باطل لأن الشيطان ضعيف لا يقدر على صرع الناس وقتلهم وأن الشيطان يمس الإنسان بوسوسته فقط " [14، 15] وهو ما شدد عليه القاضي عبد الجبار الهمذاني في "إن مس الشيطان إنما هو في الوسوسة كما قال تعالى في قصة أيوب (مسني الشيطان بنصب وعذاب) سورة ص: 31، كما يقال فيمن تفكر في شيء يغمه قد مسه التعب، وبين ذلك قوله في صفة الشيطان (وما كان لي عليكم من سلطان إلا أن دعوتكم فاستجبتم لي) سورة إبراهيم:" [16].

أشار القاضي عبد الجبار إلى أن قدرة الشيطان في التأثير على الإنسان محصورة في الوسوسة ولا يحدث فيمن يوسوس له تغيير عقل وجسم .[16]

لقد ذهب معظم المفسرين المعاصرين إلى أنكار دخول الجن بدن الإنسان وسلكوا في تفسير الآية 275 من البقرة سلوكًا ونهجًا موحدًا ومنهم الشيخ

طنطاوي جوهري[17] والشيخ أحمد مصطفى المراغي[18] واية الله السيد فضل الله[19] والشيخ مكارم الشيرازي[20] .

لقد نفى الشيخ محمود شلتوت أن تكون للجن مقدرة على تلبس جسد الإنسان[21] وقال " إن هذا من أوهام الناس ومصدره خارج عن المصادر الشرعية " [21] وأضاف "ليس للجن مع الإنسان شيء وراء الدعوة والوعد والوسوسة والإغراء والتزيين "[21]

ذهب كذلك الشيخ محمد الغزالي الى أن عداوة الشيطان للانسان لاتعدو سوى الوسواس والخداع والأستغفال وأنكر دخول جسد الانسان وأعتبر هذا الاعتقاد من الأوهام والخرافات التي شاعت بين الناس [22] .

أنكر كذلك الشيخ يوسف القرضاوي مسألة تلبس الجان نكراناً شديدًا وعدها ظاهرة تشير إلى الفراغ الروحي والعقائدي حيث أشار إلى أن الناس لم يتحدثوا بهذا في عصر الرسول الكريم " وما رأيناهم يشغلون أنفسهم بهذه التفاهات لأن حياتهم كانت مليئة وحافلة " [23] ، بل لقد عدها من ثقافة عصور التراجع والهزيمة [23].

أشار السيد فضل الله إلى أن " الله تعالى لم يسلط الجن على الانسان بهذا المعنى بل غاية ما أعطاه أن أنظره إلى يوم يبعثون ، مع قدرة الوسوسة للإنسان سعيًا لأغوائه [24] ،وأشار كذلك إلى أنه "لم يظهر من القران الكريم أن الجن يتلبسون بالإنسان وأنهم يؤذونه وما إلى ذلك " [24] وفي رده على سؤال مكتوب وجهه له المؤلف أجاب السيد فضل الله بما يلي " مسألة تلبيس الجن للإنسان أمر لم يثبت واقعيته بالأدلة الشرعية، وهذا لا سبيل إلى معرفته بغير أن يدل عليه دليل معين من إخبار الله عز وجل أو المعصومين، لأنه لا نستطيع علمياً أن نفسّر ظاهر الأمراض العصبية وما يصاحبها من تصرفات غير طبيعية للمريض بأنها حالة تلبس للجن فكيف السبيل لإثبات ذلك، بل إنه يفسّر بحالة مرضية لها أسبابها وطبيعتها، فإن الإنسان جسم ونفس، وكما أن هناك أمراضاً وأعراضاً للجسم تخرجه عن طور الحالة الطبيعية لعمل أجهزته ووظائفه فهناك أيضاً أمراض للنفس قد تخرجها عن طبيعتها إلى اختلال معين، ما أخبرنا الله عز وجل به من أمر الشيطان وعلاقته بالإنسان هو إنه يوسوس لبني آدم ويشاركهم في الأموال والأولاد ويأتيهم من بين أيديهم ومن خلفهم وعن أيمانهم وعن شمائلهم وغير ذلك مما يندرج ضمن حركته في الإغواء وحرف المسيرة الإنسانية عن الخط المستقيم في كل المجالات، وأما أنه يدخل الجسم على نحو يصرع الإنسان فهذا لم يثبت، وأما ما ذكره القرآن في الحديث عن تشبيه آكل الربا بأن لا يقوم إلا كما يقوم الذي يتخبطه الشيطان من المس، فهذا لا يفيد معنى التلبس الذي يظنه الناس، بل هو التأثير عليه في حركة عمله ليخرج عن توازنه، فما ورد هو التعوّذ بالله تعالى من شر الجن والإنس والتحرّز عن ذلك بذكر الله تعالى والتعقّل والإعتماد على الهداية الإلهيّة، وليس معالجة ما يظن بأنه تلبس بأعمال لا صحة لها." [25]

أجاب أية الله الشيخ اليعقوبي في معرض رده على سؤال مكتوب من قبل المؤلف بما يلي " لا نجد دليلاً للتلبس بالجن . بل الدليل على خلافه ، لأن الجن لم يُسلطوا على بني آدم بهذا الشكل ، وهذا كبيرهم ابليس يقول بحسب القرآن الكريم (وَمَا كَانَ لِيَ عَلَيْكُم مِّن سُلْطَانٍ إِلاَّ أن دَعَوْتُكُمْ فَاسْتَجَبْتُمْ لِي)إبراهيم22 ، وما يتحدث عنه الناس مما يسمونه تلبساً هي أوهام وأمراض نفسية وعصبية كالشيزوفرينيا ونحوها ."[26]

المؤيدون :

تبين أن من أوضح وأشد المؤيدين لمفهوم تلبس الجان في الثقافة الاسلامية وأقدمهم هو الشيخ ابن تيمية (661-728 هجرية اي 1263-1328 م) ،بل ربما يكون أول من تحدث صراحة وبوضوح حول هذا المفهوم اذ قال " أن دخول الجني في بدن الإنسان ثابت باتفاق أئمة أهل السنة والجماعة، قال الله تعالى: الَّذِينَ يَأْكُلُونَ الرِّبَا لا يَقُومُونَ إلا كَمَا يَقُومُ الَّذِي يَتَخَبَّطُهُ الشَّيْطَانُ مِنَ المَسِّ)، وفي الصحيح عن النبي صلى الله عليه وسلم قال: ((إن الشيطان يجري من ابن آدم مجرى الدم)). [27]

كذلك صرح الشيخ أبن تيمية وبوضوح على أن "، وليس في أئمة المسلمين من ينكر دخول الجني في بدن المصروع، ومن أنكر ذلك وادعى أن الشرع يكذب ذلك فقد كذب على الشرع" [28] أورد الشيخ ابن تيمية نصًا لعبد الله بن الامام أحمد بن حنبل "(قلت: لأبي إن قوماً يزعمون أن الجني لا يدخل في بدن الإنسي، فقال: يا بني يكذبون هو ذا يتكلم على لسانه وهذا مبسوط في موضعه)[28، 29] ،ولم نجد مصدرًا أخر ينقل هذا الحديث غير الشيخ أبن تيمية ومن نقله عنه من المتأخرين.

لقد تحدث الشيخ ابن تيمية عن مشاهدات بل وعن ممارسات جرت على يديه لإخراج الجن في حوادث كثيرة "فإنه يصرع الرجل فيتكلم بلسان لا يعرف معناه، ويضرب على بدنه ضرباً عظيماً لو ضرب به جمل لأثر به أثراً عظيماً، والمصروع مع هذا لا يحس بالضرب ولا بالكلام الذي يقوله، وقد يجر المصروع غير المصروع ويجر البساط الذي يجلس عليه ويحول الآلات وينقل من مكانٍ إلى مكان، ويجري غير ذلك من الأمور من شاهدها أفادته علماً ضروريًا بأن الناطق على لسان الإنسي والمحرك لهذه الأجسام جنس آخر غير الإنسان" [29، 30، 31، 32]

لقد عالج ابن تيمية الانسان المصروع مرات عديدة وذلك بإخراج الجن وتحدث عن نفسه قائلاً "ولهذا قد يحتاج في أبراء المصروع ودفع الجن عنه إلى الضرب ،فيضرب ضربًا كثيرًا جدًا ،والضرب انما يقع على الجني ولا يحس به المصروع ، حتى يفيق المصروع ويخبر أنه لم يحس بشيء من ذلك ، ولا يؤثر في بدنه ، ويكون قد ضرب بعصا قوية على رجليه نحو ثلاثمائة ،أو أربعمائة ضربة أو أكثر أو أقل بحيث لو كان على الإنسي لقتله ، وانما هو على الجني ، والجني يصيح ويصرخ ويحدث الآخرين بأمور متعددة ،كما قد فعلنا نحن هذا وجربناه مرات كثيرة يطول وصفها بحضرة خلق كثيرين" [29، 31]

ذكر كذلك ابن تيمية " أن صرع الجن للإنس قد يكون عن شهوة وهوى وعشق، وقد يكون عن بغض ومجازاة لمن آذاهم، وقد أنكر طائفة من المعتزلة دخول الجن في بدن المصروع، وليس في أئمة المسلمين من ينكر دخول الجن في بدن المصروع وغيره" [33، 34، 35].

إن ما يؤاخذ عليه الشيخ ابن تيمية من قبل الكثير من معاصريه والمتأخرين عنه هو كثرة التعميم والاستعجال باستخدامه كلمات مثل اتفاق السلف أو اتفاق أهل السنة والجماعة. [36، 37]

نقل ابن قيم الجوزية مشاهداته لشيخه ابن تيمية وهو يتعامل مع هؤلاء المرضى حيث قال "وشاهدت شيخنا يرسل إلى المصروع من يخاطب الروح التي فيه ويقول: قال لك الشيخ أخرجي، فإن هذا لا يحل لك، فيفيق المصروع، وربما خاطبها بنفسه، وربما كانت ماردة فيخرجها بالضرب، فيفيق المصروع، وقد شاهدنا نحن وغيرنا منه ذلك مرارًا". [38، 39]

ذكر ابن حجر العسقلاني في تعليقه على حديث المرأة التي صرعت (أم زفر) بأن صرعها كان من الجن لا من صرع الخلط. [12]

أعاد أيضًا الشيخ الشبلي ما طرحه ابن تيمية وما جاء به من اعتقاد بتلبس الجان. [34]

لقد وجدنا في كتاب (طبقات الحنابلة) للقاضي ابي يعلى الفداء ذكر لحادثة مع الإمام أحمد بن حنبل لم نجدها في أي مصدر أخر من كتب الحنابلة، بل لقد وجدنا أن الآخرين ينقلون هذه الحادثة عن هذا الطريق فقط ولايوجد مصدر آخر يؤيد تلك الحادثة ومفادها " أن الإمام أحمد بن حنبل كان يجلس في مسجده فانفذ إليه الخليفة العباس المتوكل صاحباً له يعلمه أن جارية بها صرع، وسأله أن يدعو الله لها بالعافية، فأخرج له أحمد نعلي خشب بشراك من خوص للوضوء فدفعه إلى صاحب له، وقال له: امض إلى دار أمير المؤمنين وتجلس عند رأس الجارية وتقول له، يعني الجن: قال لك أحمد: أيما أحب إليك تخرج من هذه الجارية أو تصفع بهذه النعل سبعين. فمضى إليه، وقال له مثل ما قال الإمام أحمد، فقال له المارد على لسان الجارية: السمع والطاعة، لو أمرنا أحمد أن لا نقيم بالعراق ما أقمنا به، إنه أطاع الله، ومن أطاع الله أطاعه كل شيء، وخرج من الجارية وهدأت ورزقت أولاداً، فلما مات أحمد عاودها المارد، فأنفذ المتوكل إلى صاحبه أبي بكر المروذي وعرفه الحال، فأخذ المروذي النعل ومضى إلى الجارية، فكلمه العفريت على لسانها: لا أخرج من هذه الجارية ولا أطيعك ولا أقبل منك، أحمد بن حنبل أطاع الله، فأمرنا بطاعته." [34، 40].

لقد جاء لدى بعض المشايخ المعاصرين مايعزز مفهوم التلبس ويؤيده كما جاء في فتاوى بعض كبار علماء السعودية وكما يلي " ومس الجن للإنس أمر معلوم من الواقع، وتستعمل للعلاج من مسه الأدوية الشرعية من الدعاء والقراءة عليه بشيء من القرآن". [41]

أفتى الشيخ عبد العزيز ابن باز من" إن إنكار دخول الجني في بدن الانسي نشأ عن قلة العلم بالامور الشرعية وبما قرره أهل العلم من أهل السنة والجماعة، وإذا خفي هذا الامر على كثير من الأطباء لم يكن ذلك حجة على عدم وجوده بل يدل ذلك على جهلهم العظيم بما علمه غيرهم من العلماء

المعروفين بالصدق والأمانة والبصيرة بأمر الدين بل هو إجماع من أهل السنة والجماعة ." [42، 43]
كذلك افتى الشيخ عبد الله بن الجبرين " أن الجن يتلبس بالإنس، لأن الجني مجرد روح بلا جسد، فهذه الروح لخفتها تدخل في جسد الإنسان وتتغلب عليه، بحيث لا يبقى لروح الإنسان إحساس، فلذلك ينطق الجني على لسانه ويتصرف فيه، وإذا ضرب فإنما يقع الألم على الجني، بحيث إذا فارقه لم يتذكر الإنسي ما حصل له، ولا يرى عليه آثار الألم، وبحيث يشاهد حال التلبس يفعل أشياء غريبة، كدخوله في النار وابتلاعه الجمر منها، وحمله الأشياء الثقيلة، وضرب نفسه بالحجر الكبير ونحو ذلك. [44] ويستمر في فتواه فيقول "، ومتى ابتلي أحد بالصرع وملابسة الجني فإنه يعالج بالقرآن، فهناك قراء متخصصون لإخراج الجن، ولهم معرفة بكيفية إخراجه ولو بالقتل، وذلك معروف عندهم بطرق متبعة " .[44]

المناقشة :
هذه هي معظم الآراء الفقهية التي وردت عن الفريقين وكيف أستندت إلى النص القرآني والحديث ، حيث أن الآية 275 :سورة البقرة تم تفسيرها وبشكل واضح وعلى يد جملة من المفسرين بما ينفي مسألة التلبس ولا يتسع المجال لسردها وبالإمكان الرجوع إلى معظم كتب التفسير لفهمها و ادراك ارتباطها بشرح الحالة النفسية التي تصاحب من يدخل عالم المعاملات الربوية . [13، 14، 15، 16، 18، 19، 45، 46، 47، 48]
أن الحديثين النبويين الشريفين الذين وردا في سرد قصة زوجة النبي الكريم وفي قصة الصحابية أم زفر، قد ذكرا في الصحيحين في أبواب ليست لها علاقة بالتلبس كما يتضح ذلك من أبواب الحديث التي نقلت فيها الروايتين ولا يوجد ما يشير الى قصة التلبس في الحديثين .
أن ما ورد في حديث زوجة النبي يدل وبوضوح تام على أن تعبير الشيطان يجري مجرى الدم في العروق إنما هو تعبير مجازي محض إذ أن الحديث يشير وبوضوح تام إلى دفع الشبهات واتقاء وساوس الشيطان .
أما ما ورد في قصة الصحابية أم زفر فيمكن تفسيره علميًا وببساطة شديدة إذ أن هناك نسبة لابأس بها من مرضى الصرع لديهم فترة زمنية قصيرة (دقيقة أو أكثر) قبل حدوث النوبة يعلمون فيها بتحقق وقوع نوبة الصرع مما يجعلهم يأخذون الاحتياطات اللازمة من ابتعاد عن مواطن الخطر وعن الطريق العام أو الجلوس وغيرها من المواقف اليومية .هذا هو ما حصل مع الصحابية الجليلة ببركة دعاء النبي الأكرم (ص) حيث طلبت أن يدعو لها بأن لا تتكشف وحصل لها ذلك، أذ أنها بعد ذلك أخذت تعلم بوقت النوبة فتتجنب الطريق وتجلس كي لا تتكشف وتحاول بذلك الاستتار .

أننا باستعراض تلك الادلة نجد وبوضوح أن مفهوم تلبس الجان وان كان قد سبق الاسلام إلا أنه لم يظهر في العصور الاسلامية الأولى، ولم نجد حوادث معتبرة تنقل عن النبي الاكرم (ص) أو أهل بيته الكرام أو صحابته والتابعين لهم إلى ما يشير إلى شيوع مفهوم التلبس، ولم نسمع ولم نجد أثرًا له في بطون الكتب يشير إلى وجود جلسات لإخراج الجن من بدن المصروع وغيره من البشر .
أننا نرى أن مفهوم التلبس الحالي المصاحب للمصروع وغيره من المرضى قد نشأ وترعرع في عصور أسلامية متأخرة ومنحطة ومظلمة كثرت فيها مظاهر التفكك والظلام كما أشار الى ذلك الشيخ يوسف القرضاوي " وأن أول من أشار إلى هذا المفهوم هو الشيخ ابن تيمية ونقله عنه المتأخرون بدون مناقشة للأدلة الشرعية التي أوردها الشيخ" .[23]

يقول د جمال أبو حسان وهو أستاذ التفسير في جامعة الزرقاء بالاردن "أن ما قاله الشيخ ابن باز وأخرون ليس إلا ترديدًا حرفيًا لما نقل من ابن تيمية وتلميذه ابن القيم وكان سبب انتشار هذه الظاهرة ثقة الناس بكتب ابن تيمية وهو الذي نشر هذه الفكرة بعد أن سيطر عليه الاعتقاد بصوابها .لقد تحولت هذه القضية في زمن ابن تيمية من موروثات شعبية إلى قضية دينية صار الناس يحاكم بعضهم بعضًا بناءًا عليها ".[49]

نعم لقد تحولت من موروث جاهلي شعبي إلى قضية دينية كثيرًا ما استند اليها المشعوذون والدجالون الذين يمارسون مهنة إخراج الجن وهم ليسوا بالقليل ففي دراسة واحدة أجريت في مصر وجد أن أكثر من 350000 شخص يزاولون هذه المهنة في مصر وحدها .[50]

يقول د جمال أبو حسان "لم يثبت عن الرسول (ص) أنه عالج بالضرب أو الخنق وأنما ثبت العلاج بالضرب عن ابن تيمية فقط، كما ذكر ذلك ابن القيم ولم يثبت التأريخ الاسلامي أن عرب الجزيرة توافدوا بالمئات أو بالالوف طلبًا للعلاج بالرقيا على يد الرسول أو صحابته الكرام، وأنما كانوا يتوافدون لمعرفة الاسلام كدين ينظم حياتهم الدنيوية والاخروية " . [49]

يشدد الشيخ القرضاوي على أنه " عندما كان المسلمون سادة العالم وكانوا معلمي البشرية وحينما كانت الأمة الإسلامية هي الأمة الأولى ماكان هذا يحصل وإنما حصل – ويعني به مفهوم التلبس- حينما ضعفت الأمة وانحطت هممها " [23]

الأستنتاج :

يبدو أن مفهوم تلبس الجن هو مفهوم أختلطت فيه الثقافة والموروثات الشعبية بالتفسيرات والتأويلات الدينية المتأخرة والتي وردت على لسان مشايخ متأخرين (في القرن الثامن الهجري) حيث حاول أولئك الرجال تأويل النص القراني والحديث النبوي الشريف بما ينسجم مع الموروث الشعبي حول مفهوم الجن والذي سبق ظهور الاسلام بعصور طويلة ، ومما زاد في تعقيد الأمر أن أخبار الجن وأحوالهم قد وردت في القران الكريم وفي أيات عديدة مما جعل الموضوع قابلاً للتأويل وسلاحًا بيد الكثير من الأفاقين الذين يبتزون عامة الناس وذلك بخلط الأوراق والمفاهيم وإيهام الناس أن مفهوم تلبس الجن هو مفهوم قراني مقدس، وبالتالي فإن طرق إخراج الجن هي طرق شرعية وأسلامية مما يضفي قدسية على عملهم ويمنع بذلك الآخرين من مناقشتهم ورد مزاعمهم .

لقد كان الأطباء هم الحلقة الأضعف في هذه السلسلة حيث أنهم وبسبب عملهم ومشاهداتهم السريرية تصدوا لشرح ما يجري من أمراض عصبية ونفسية كالصرع وغيره على أسس علمية والتي سرعان ما أصطدمت بما يزعمه طائفة من المتكسبين بالرقي واخراج الجن المستقوية بأراء فقهية قاصرة وفجة ،وكان اتهام الأطباء سهلاً حيث اتهموا بأنهم غير روحانيين أو غير إسلاميين وبالتالي فهم أضعف من أن يتصدوا ويردوا مزاعم هؤلاء، والتي كثيرًا ما تأخذ منحى التهديد وهي تحاصر الأطباء وتدعي أنهم ينكرون وجود الجن وبالتالي فهم ينكرون ما جاء في الشريعة السمحاء والقران الكريم .

لقد آثر الأطباء– وللأسف الشديد- الابتعاد عن المواجهةوأكتفوا بمعالجة الضحايا بصمت تاركين الحبل على الغارب للمشعوذين الذين روجوا لهذا الوهم وأساؤا إلى الإسلام برجوعهم إلى تأويلات قاصرة لمشايخ لم يفهموا هذه الظاهرة بسبب قصور في تفهم ظواهر طبية ليست بالهينة، وأعني بها امراض الدماغ فتناولوها بتأثير واضح لمفاهيم شعبية سائدة، وحاولوا اضفاء بعض الإشارات الدينية عليها من هنا وهناك فأساؤا التقدير.

الخلاصة :

تلبس الجان في بدن الإنسان مفهوم متداول بين الناس منذ دهور طويلة سبقت ظهور الإسلام، تعزز هذا المفهوم وارتبط لدى البعض بالثقافة الإسلامية وعدَه بعضهم جزأ من مفاهيم الشريعة السمحاء . واجه الأطباء – ولازالوا- مجموعة تصر على أن الصرع وبعض الأمراض العصبية والنفسية هي محض تلبس للجن تستدعي طرقًا للإخراج لا زال ضرب المصاب من أبرزها .

تم في هذه الدراسة التعرف على الأدلة الشرعية ومناقشتها ونقل وجهات نظر فقهية معتبرة – قديمة وحديثة- ومن عدة مصادر بحثية .

خلصت الدراسة إلى أن مفهوم تلبس الجان هو محض ثقافة وموروث شعبي، أضيف لاحقًا للتراث الإسلامي و في العصور الإسلامية المتأخرة مما يستدعي وقفة حازمة للتخلص منه .

المصادر :

1. علي جواد (1980) : المفصل في تاريخ العرب قبل الاسلام .ط2 . دار العلم للملايين . بيروت
2.الالوسي محمود شكري (1923) : بلوغ الارب في معرفة أحوال العرب . المحقق محمد بهجت الاثري .دار الكتب العلمية .مصر
3.الجاحظ (1948) : الحيوان .تحقيق عبد السلام هارون .ط1 مصر
4.زيتوني عبد الغني (1985) :الجن وأحوالهم في الشعر الجاهلي . مجلة التراث العربي –العدد 20 السنة الخامسة –تموز . دمشق

5.صالح حليمة خالد (2005) : الجن في الشعر الجاهلي – دراسة ماجستير في اللغة العربية – جامعة النجاح الوطنية .نابلس . فلسطين
6.أبن منظور (1981) : لسان العرب .دار المعارف .القاهرة
7.ياسين غالب (2004) : ألفاظ الجن في العربية . ط1 المكتبة العصرية . جدة
8.البخاري محمد بن أسماعيل (1994) : الجامع الصحيح . رقم 2035 في الأعتكاف ، باب هل يخرج المعتكف لحوائجه الى باب المسجد ورقم 2038 باب زيارة المرأة زوجها في أعتكافه ورقم 2039 باب هل يدرأ المعتكف عن نفسه . دار الفكر . مصر
9.النيسابوري مسلم بن الحجاج (1954) : صحيح مسلم . تحقيق محمد فؤاد 2175 في السلام ، باب يستحب لمن رئي خاليا بأمرأة أن يقول هذه فلانة . دار أحياء الكتب العربية . القاهرة
10.البخاري محمد بن أسماعيل (1994) : الجامع الصحيح . رقم 5652 في المرض. دار الفكر . مصر
11.النيسابوري مسلم بن الحجاج (1954) : صحيح مسلم . تحقيق محمد فؤاد رقم 2576 باب ثواب المؤمن فيما يصيبه من مرض أو حزن . . دار أحياء الكتب العربية . القاهرة
12.العسقلاني أبن حجر (1998) : فتح الباري شرح صحيح البخاري . ترقيم فؤاد عبد الباقي . دار المعرفة .بيروت
13.الزمخشري أبو القاسم (1998) : تفسير الكشاف .دار الكتاب العربي للطباعة والنشر والتوزيع .مصر
14 . الطوسي محمد بن الحسن (1945) : التبيان في تفسير القران .تحقيق أحمد حبيب العاملي .النجف
15 .الرازي أبو عبد الله محمد (1990): التفسير الكبير .دار الكتب العلمية .مصر
16 .الهمذاني القاضي عبد الجبار (1983) : تنزيه القران عن المطاعن .الشركة الشرقية . دار النهضة الحديثة . بيروت
17 .الحلبي مصطفى الباني (1921) : الجواهر في تفسير القران الحكيم . القاهرة
18 .المراغي أحمد مصطفى (1998) : تفسير المراغي .دار الكتب العلمية .مصر
19 .فضل الله محمد حسين (1998) : من وحي القران .دار الملاك . بيروت
20 .الشيرازي ناصر مكارم (1988) : الأمثل في تفسير كتاب الله المنزل .ترجمة د .محمد علي أذرشب.مؤسسة النشر الأسلامي . قم .ايران
21 .شلتوت محمود (1980) : الفتاوى . دار الشروق .ط10 . القاهرة
22 .الغزالي محمد (1989) : السنة النبوية في أهل الفقه والحديث .دار الشروق .ط4 .القاهرة
23 .القرضاوي يوسف (2007) :عالم الجن . برنامج الشريعة والحياة وهو برنامج تلفزيوني بث من قناة الجزيرة الفضائية بتاريخ 22 / 3 / 2007 .
24 .فضل الله محمد حسين (2010) : أجابات على الاسئلة الفقهية كما وردت في موقع بينات وهو الموقع الالكتروني الرسمي لمكتب سماحة المرجع محمد حسين فضل الله
25 .فضل الله محمد حسين (2010) : أجابة خطية على أستفتاء وجهه المؤلف ممضية بتوقيع سماحة السيد محمد حسين فضل الله بتاريخ 2010/4/5
26 .اليعقوبي الشيخ محمد (2010) : أجابة خطية على أستفتاء وجهه المؤلف ممضية بتوقيع الشيخ المرجع محمد اليعقوبي بتاريخ 3/ 4 / 2010
27 .أبن تيمية أحمد بن عبد الحليم (1386) : الفتاوى الكبرى . دار المعرفة ط1 . بيروت
28 .أبن تيمية أحمد بن عبد الحليم (1966) : مجموع الفتاوى . جمع وترتيب الشيخ عبد الرحمن بن قاسم والشيخ محمد بن عبد الرحمن بن قاسم . ط1 . دار العربية للطباعة والنشر . الرياض
29 .أبن تيمية أحمد بن عبد الحليم (1976): الرد على المنطقيين . أدارة ترجمان السنة ط2 لاهور . باكستان
30 .أدهم أبراهيم (1993) : العلاقة بين الجن والانس من منظار القران والسنة . دار بيروت المحروسة للطباعة والنشر . لبنان

31 .أشقر عمر سليمان (1986) : عالم الجن والشيطان . دار الجيل . بيروت
32 .عبد الله محمد محمود (1993) : صفوة البيان في علاج السحر والحسد ومس الجان . ط1 . دار الشواف للنشر والتوزيع .السعودية
33. العيني بدر الدين (2000) : عمدة القاريء في شرح صحيح البخاري .دار أحياء التراث العربي .بيروت
34 .الشبلي بدر الدين (1982) : غرائب وعجائب الجن كما يصورها القران والسنة . مكتبة القران للنشر والطبع والتوزيع . مصر . وهو نفسه كتاب (أكام المرجان في أحكام الجان) المطبوع بالازهر الشريف عام 1356 هجرية .
35 .السيوطي جلال الدين (1986) : لقط المرجان في أحكام الجان . ط1 . دار الكتب العلمية .بيروت
36.الكثيري السيد محمد (1997) : السلفية بين اهل السنة والامامية ..الطبعة الاولى . الغدير للطباعة والنشر والتوزيع .بيروت
37 ..عبد الله عادل كاظم (2007) : موقف علماء اهل السنة من ابن تيمية ..الطبعة الاولى .دار وادي السلام للتحقيق والنشر .بيروت .
38 .الجوزية ابن القيم (1955) : زاد المعاد في هدى خير العباد تحقيق محمد حامد الفقي . مطبعة السنة لمحمدية القاهرة
39 .الجوزية ابن القيم (1981) : الطب النبوي . تحقيق شعيب وعبد القادر الأرناؤوط . دار أحياء التراث العربي . بيروت
40 .الفداء أبو يعلى (1999) : طبقات الحنابلة .تحقيق محمد حامد الفقي . مطبعة السنة المحمدية . القاهرة
41 .الدويش أحمد بن عبد الرزاق (1990) : فتاوى اللجنة الدائمة للبحوث العلمية والافتاء – قسم العقيدة- ط1 .الرئاسة العامة لأدارات البحوث .الرياض
42 .أبن باز عبد العزيز (1994) : أيضاح الحق في دخول الجني في الانسي . مجلة الدعوة .العدد 1416 بتاريخ 1994/11/11. السعودية
43 .أبن باز عبد العزيز (1995) : مجموع فتاوى ومقالات متنوعة .صحيفة المسلمون العدد 549 بتاريخ 12 / 8 / 1995 وفي مجلة الدعوة العدد 1504 بتاريخ 18 / 8 / 1995 .السعودية
44 .الشتري أبو حامد (1996) : الفتاوي الشرعية في المسائل الطبية (الجزء الاول) لفضيلة الشيخ عبد الله بن عبد الرحمن الجبرين . الرياض
45 .الدمشقي أبو الفداء (1999) : تفسير القران العظيم . المحقق سامي محمد ط2 دار طيبة للنشر والتوزيع
46 .البغوي الحسين بن مسعود (1997) : معالم التنزيل . دار طيبة للنشر والتوزيع
47 .السعدي عبد الرحمن (2000) : تيسير الكريم الرحمن في تفسير كلام المنان .مؤسسة الرسالة.
48 .الشنقيطي محمد الامين (1995) : أضواء البيان في أيضاح القران بالقران . دار الفكر للطباعة والنشر والتوزيع . بيروت
49 .أبو حسان جمال (2002) : ظاهرة تلبس الجن . برنامج الشريعة والحياة في قناة الجزيرة الفضائية بتاريخ 2002 / 7/28
50 .عبد العظيم محمد والكتامي احمد (2004) : دراسة ميدانية عن ظواهر الشعوذة والدجل والمعالجة بالقران في المركز القومي للبحوث الاجتماعية والجنائية في القاهرة .جريدة الشرق الاوسط العدد 9498 في 29 / 11 / 2004 و العدد 9672 في 22 / 5 / 2005 .
51 .شعراوي محمد متولي (1977) : الشيطان والانسان . مطابع دار أخبار اليوم . مصر
52 .أسماعيل سعيد (1984) : الانسان والشيطان والسحر .ط1.مطابع الأخبار .القاهرة
53 .الأشعري أبو حسن (1950) : مقالات الاسلاميين وأختلاف المصلين . مكتبة النهضة المصرية . القاهرة

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Letter to the Editor

Invited commentary on Mansour et al paper entitled: "Child Abuse and its Long-Term Consequences: An Exploratory Study on Egyptian University Students"

I read with a lot of interest Mansour et al paper entitled: "Child Abuse and its Long-Term Consequences: An Exploratory Study on Egyptian University Students" published in current issue of the Arab Journal of psychiatry.

I am very pleased to see a research project in the Arab World by a group of Arab researchers which is in itself a big step forwards and I hope in the near future we will be able to witness serious Arab research programmes in the field of schizophrenia and Bipolar Disorder as it is in Europe. I feel it is time to work hard to develop such research programmes not only for the purpose of research but also for the benefit of the millions of Arab patients and Arab Nation. In addition the study addresses an important area of mental health for young Arab generations. This area has been given lot of interest worldwide particularly in the western or so called civilized countries that have progressed in this area as part of their growing interest in human rights and prevention in the area of mental health of the new generation.

However I felt a bit reserved in accepting the study outcome as what could have been normal in certain period could be seen as an act of abuse 20 – 40 years later in the same culture. At the same time an experience or practice could be considered some type of abuse in one culture but not in another culture. This does not minimize the importance of the study especially in our current era where human rights activists are fighting hard to stop various types of abuse and violation of human rights in the Arab World.

In the abstract, the authors stated that their aim was to study the prevalence of child abuse associated psychological problems in adulthood, and I think it would be more appropriate if we put it as attributed or related but not resulting or associated as the temporal relation is relatively long and may not be considered as associated with childhood abuse and appear later in adult life.

The authors described their study as a "Child Abuse and its Long-Term Consequences: An Exploratory Study on Egyptian University Students" and I think it would have been

more appropriate to describe the study as "Child Abuse and its Long-Term Consequences: An Exploratory Study on a sample of Egyptian University Students"

The study is a good attempt to explore the extent of abuse experienced by a sample of university students in Egypt during their childhood and study its long-term consequences which could provide clinicians with a good source of evidence based originating from an original Egyptian study rather than relying on evidence from another culture with different norms. However, the study pointed out that students from faculty of medicine tended to have higher levels of denial. This may be one way of interpretation but it is also possible that those students felt that the strict upbringing (so called abuse) may have been viewed by those students as one the factors that helped them to progress in their academic career and join the medical school. Therefore it would have been helpful if the questionnaire covered this possibility by 1 or 2 questions to cover this possibility. It is interesting that the study results show that sexual abuse is less than in international particularly western studies which is expected bearing in mind that such abuse is more likely to happen within the context of broken homes, alcohol and drug misuse which do exist in Arab culture but are less common compared with the western society.

Te authors in different areas in the article used the term "Middle East" and "Arab World" as synonymous while I think this may not be correct. Middle East is a term that has been introduced to accommodate the inclusion of non-Arab countries in the region. I hope the authors of this paper and other authors in the Arab Journal of Psychiatry would be vigilant to this in future writings.

In recognition to the authors, this is an important paper from various aspects:

1. To encourage more collaborative Arabic studies with collaboration of researchers from various Arab countries.
2. To put plans for wider Arabic studies using assessment tools that are culturally compatible and not imported.
3. To publish these studies as a model of Arabic studies that would benefit the Arabic clinician than using data or evidence from a different culture that may not suit the Arabic patients.

Finally, we must look forward for collaborative studies including academicians from various Arab universities and set plans for joint research that cover all kind of studies with emphasis on epidemiology. It is estimated that Arab psychiatrists in North America are about 1000, UK around 1000, France is around 1000 & if we consider smaller numbers in Germany, Italy, Scandinavian countries, Australia and New Zealand this may

put the numbers of the immigrant Arab expertise in mental health to over 4000. How could a nation build up its future without benefiting from such wealth of knowledge and expertise!.

The role for the Arab Federation to lead is widely open. By this the Arab unity can be proved to be a reality at least in the field of mental health forgetting about the failed & corrupt Arabic political system.

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***COMMENTARY ON*:**
"Language, Culture and Mental Health"Published in the current issue

This is a brief thoughtful contribution to cultural psychiatry which deals with a sector limited to the experience and expressions of emotions especially verbal expression. Non verbal expressions are also important e.g. in the face, in behaviour and through internal organs.

Culture has cognitive, emotional and behavioural contributions to the code of conduct e.g. in the patient-doctor relationship. The experience of stress and the expression of distress have terms of reference, not only in the mind and body but also in the spiritual world. Expectations of care patterns are determined by the cultures of patients and members of the caring professions integration of which has been recently dealt with in an editorial in the May 2010 issue of the Arab Journal of Psychiatry.

Broadening of the limited sector of cultural contribution to verbal expression of the emotion of sadness to the broader issue of cultural inputs in mental health and ill-health will enrich the paper and make it more worthy of publication in the Arab journal of Psychiatry.

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