The Arab Journal of Psychiatry (2009) Vol.20 NO.1 Page (1-17)

Lifetime Prevalence of Mental Disorders in Lebanon: First Onset, Treatment, and Exposure to War

Elie G. Karam[1,2,3*], Zeina N. Mneimneh[3,4], Hani Dimassi[3,5], John A. Fayyad[1,2,3], Aimee N. Karam[1,2,3], Soumana C. Nasser[3,6], Somnath Chatterji[7], Ronald C. Kessler[8]

. نسبة انتشار الإضطرابات النفسية على مدى الحياة في لبنان: بداية عوارضها، علاجها والتعرض لأحداث الحرب على مدى الحياة في لبنان: بداية عوارضها، علاجها

إيلي كرم ، زين منيمنه، هاني ديماس ، جون فياض ،إيمي كرم ، سومانا ناصر ، سومنا تشاترجي ورونالد كسلر.

Abstract

Background: There are no published data on national lifetime prevalence and treatment of mental disorders in the Arab region. Furthermore, the effect of war on first onset of disorders has not been addressed previously on a national level, especially in the Arab region. Thus, the current study aims at investigating the lifetime prevalence, treatment, age of onset and its relationship to war in Lebanon.

Methods and Findings: The Lebanese Evaluation of the Burden of Ailments and Needs Of the Nation study was carried out on a nationally representative sample of the Lebanese population (*n* = 2,857 adults). Respondents were interviewed using the fully structured WHO Composite International Diagnostic Interview 3.0. Lifetime prevalence of any Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) disorder was 25.8%. Anxiety (16.7%) and mood (12.6%) were more common than impulse control (4.4%) and substance (2.2%) disorders. Only a minority of people with any mental disorder ever received professional treatment, with substantial delays (6 to 28 y) between the onset of disorders and onset of treatment. War exposure increased the risk of first onset of anxiety (odds ratio [OR]: 5.92, 95% confidence interval [CI]: 2.5–14.1), mood (OR 3.32, 95% CI 2.0–5.6), and impulse control disorders (OR 12.72, 95% CI 4.5–35.7).

Conclusions: About one-fourth of the sample (25.8%) met criteria for at least one of the DSM-IV disorders at some point in their lives. There is a substantial unmet need for early identification and treatment. Exposure to war events increases the odds of first onset of mental disorders.

Introduction

Large-scale psychiatric epidemiologic studies have become increasingly common in industrialized countries in the past decade[1-5] in response to mounting concerns about the prevalence and burden of mental disorders[6,7].Psychiatric epidemiological surveys are much less common, in comparison, in the Arab World and have so far focused on small populations [8–11]. Furthermore, although war has been linked to a

higher risk of mental disorders [12–16], no previous study has comprehensively assessed on a national level the effect of war on the first onset of a broad range of mental disorders during the life span of individuals. In an effort to address these issues, the Institute for Development, Research, Advocacy and Applied Care (IDRAAC) with the Department of Psychiatry and Clinical Psychology at Balamand University and Saint George Hospital University Medical Center conducted the first nationally representative general population survey of mental disorders in Lebanon and the Arab World: the Lebanese Evaluation of the Burden of Ailments and Needs Of the Nation (LEBANON) survey. This survey is part of the World Health Organization (WHO) World Mental Health (WMH) Survey Initiative, a series of coordinated, large-scale psychiatric epidemiologic surveys being carried out in over 29 countries in the world [17].

We reported previously that 17% of Lebanese adults meet criteria for at least one Diagnostic and Statistical Manual (DSM-IV) disorder in the year preceding the interview [18]. The current report assesses the lifetime prevalence, the risk of ever developing, the age of onset, and the treatment delay of mental disorders in Lebanon. Moreover, the effect of war exposure intensity on developing a first onset of mental disorder was explored in a multivariate time-dependent analysis.

Methods

Participants

A nationally representative, stratified multistage clustered area probability sample of noninstitutionalized adults (aged ≥18 y) who had no cognitive or physical impairment preventing participation was selected for this study. A total of 342 primary sampling units (area segments) were selected with probabilities proportional to size to represent the different geographic areas in the country. Complete household listing was carried out in the area segments. A sample of households was selected from each segment, and one eligible family member was randomly selected from each sampled household using the Kish method [19]. The final stage selected the spouse of the primary respondents in a random 10% of the households for a focused analysis on assortative mating. The response rate was 70.0%, with 2,857 completed interviews [18]. The initial target sample (3,000 interviews) was set by WHO as the minimum needed to obtain sufficient level of precision for WMH participation.

Males constituted 45.4% of the sample; one-third (33.8%) of respondents were 18–34 y old, another third (32.6%) 35–49 y old, and the

remaining third (33.7%) older than 49 y (with 14.3% older than 64 y). The study procedures were approved by the Balamand University Medical School Ethics Committee.

Procedures

Face-to-face interviews were conducted in the respondents' households between September 2002 and September 2003 by 116 interviewers who were trained by certified Composite International Diagnostic Interview (CIDI) trainers. Interviews were conducted in two parts. Part I included a core diagnostic assessment of all respondents (*n* = 2,857). Part II (*n* = 1,031) included an assessment of risk factors and other correlates of disorders, and was administered to all Part I respondents who met lifetime criteria for any core disorder plus a probability subsample of the remaining Part I respondents. Part I was weighted for differential probability of selection within households and post-adjusted to government population data on sociodemographic and geographical variables [(20)]. Part II was additionally weighted for differential probability of subsampling from the Part I sample.

Diagnostic Assessment

The diagnostic instrument used in the survey was the WHO Composite International Diagnostic Interview (CIDI 3.0) [(21)], a fully structured, lay-administered interview generating International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) diagnoses. DSM-IV criteria are used in the current report to generate diagnoses of anxiety, mood, impulse control, and substance disorders. The list of disorders assessed is presented in Table 1. Two childhood impulse control disorders, conduct disorder (CD) and attention deficit/hyperactivity disorder (ADHD), were limited to respondents ages 18–44 y to reduce recall bias. Retrospective age-of-onset reports were obtained using a unique probing method designed to stimulate active memory search and accurate reporting. Methodological research has shown that this method yields much more plausible age-of-onset reports than those obtained using standard questioning [22].

The Arabic version of CIDI 3.0 was translated from the original English using a rigorous WHO-monitored five-step process that included forward translation, backward translation, and resolution of discrepancies between translations, pilot testing, and final revision. More details on this process and other aspects of instrument adaptation have been published

elsewhere [18]. Although the Arabic CIDI 3.0 has not yet been validated, validation against the Structured Clinical Interview for DSM-IV (SCID) [22] has been completed in WMH surveys carried out in France, Italy, Spain, and the United States [23,24], documenting consistently good individual-level CIDI–SCID concordance as well as aggregate prevalence estimates that were either unbiased or conservative in the CIDI relative to the SCID.

Sociodemographic Correlates

The sociodemographic correlates used in the analysis include age (18–34, 35–49, 50–64, and older than 64 y), sex, education (student, low [none/only primary], middle-low (intermediate\some secondary), middle [completed secondary without university], high (university degree), and marital status (single, married, and previously married: separated/divorced/widowed). In the time-dependent analysis that linked war exposure to first onset of disorder, age was defined based on onset of the Lebanon wars in 1975, which ended in 1990. These age groups were appropriately corrected for the impulse control subsample: young children (0–10 y for anxiety and mood; 0–6 y for impulse control), adolescents (11–18 y for anxiety and mood; 7–16 y for impulse control), young adults (19–35 y for anxiety and mood; not applicable for impulse control), and adults (>35 y for anxiety and mood; not applicable for impulse control). This study was completed before a more recent outbreak of war in July 2006.

War-Related Traumatic Events

In light of previous evidence that prevalence of psychiatric disorders during the years of the Lebanon wars was strongly related to exposure to war-related traumata [10], information on exposure to a list of war-related traumatic events was added to the CIDI 3.0. Ten war events were assessed and included in this analysis: civilian in war region, civilian in terror region, refugee, rescue worker, witness death or injury, witness atrocities, death of close one, trauma to close one, kidnapped, and robbed or threatened by weapon. These war events were summarized into one index that reflects the level of war exposure as follows: none, one event, two events, three events, and four-plus events.

Use of Mental Health Services

Information on whether respondents ever talked about their symptoms to a physician or other professional (psychologist, counselor, spiritual advisor, herbalist, acupuncturist, and other healing professionals) was assessed in each diagnostic section of the CIDI 3.0.

Information was also obtained on age at first treatment contact.

Statistical Analysis

Projected lifetime risk was estimated using retrospective age-of-onset reports to estimate conditional probability of first onset at each year of life up to and including age 74 y. The actuarial method [25] was used to cumulate these conditional probability estimates. Predictors of first onset of disorder were analyzed using discrete-time survival analysis with person-year the unit of analysis[26]. Moreover, marital status, education, and war exposure were used as time-variant variables controlling for each year of the respondent's life. Survival coefficients were exponentiated and were reported as odds ratios (ORs). All the models included age cohorts defined at the onset of the Lebanese wars. The first set of models had the five war exposure levels entered as dummy variables producing multiple ORs, with no exposure as a reference. To increase statistical power, we combined the war dummy variables into one index by generating individual level-predicted probabilities of the outcome based on the coefficients of the dummy variables. Interactions between this war index and demographics (age cohorts and sex) were tested. Significant interactions were explored further with contrast statements to identify differential associations. All the analyses were weighted to account for differential sample selection and subsampling for specific questionnaire sections. Design variables were also used in all of the analyses to adjust for stratification and clustering when estimating standard errors. Standard errors of prevalence estimates and 95% confidence intervals (CIs) of ORs were obtained using the Taylor series method [27]. Standard errors of the projected lifetime estimates were obtained from using the jackknife repeated replication method [28]. Analyses were carried out using SAS 9.1 and SUDAAN.

Results

Lifetime Prevalence of Mental Disorders

About one-fourth of the sample (25.8%) met criteria for at least one of the DSM-IV disorders at some point in their lives, with 10.5% having more than one disorder. Anxiety disorders were more common (16.7%) than mood (12.6%), impulse control (4.4%), and substance use disorders (2.2%). The most prevalent individual disorder was major depression (9.9%). A number of disorders varied across the different age groups, consistently being most common in younger age groups. Females had more lifetime anxiety and mood disorders than

males, whereas the latter had more substance abuse and conduct disorders (Table 1).

Projected Lifetime Risk

Projecting lifetime risk to age 75 y, approximately one-third of respondents (32.9%) were expected eventually to meet criteria for one or more of the DSM-IV disorders. The highest projected risk was for major depression (17.2%). Median estimated age-of-onset ranged from a low of 11 y for specific phobia to a high of 39 y for generalized anxiety disorder (GAD) (Table 2). Half of all respondents who are expected ever to have a disorder in their lives, will have an onset by age 19 y.

War-Related Traumatic Events

The two most commonly reported war events were being a civilian in war zone (55.2%) and being a refugee (37.7%) (Table3). Almost half of the Lebanese (47%) were exposed to one or two events, almost one-quarter (21.8%) were exposed to three or more events, while almost one-third (31.2%) were not exposed to any event. Males were more likely to have been rescue workers ($\chi^2_{df=1}$ = 6.5, p = 0.01), to have witnessed death or injury ($\chi^2_{df=1}$ = 27.5, $p < 0.001$) and atrocities ($\chi^2_{df=1}$ = 19.5, $p < 0.001$), and to have been kidnapped ($\chi^2_{df=1}$ = *110.4,p<0.001),* or robbed or threatened by a weapon ($\chi^2_{df=1}$ = 13.6, *p 0.001)* than females. Females, on the other hand, were more likely to be civilians in a war zone ($x^{2\ df=1=}$ *6.4,p= 0.01*) and refugees ($x^{2\ df}$ =1=26.4,p < 0.001). Uncontrollable events such as the death of someone close ($\chi^2_{df=1}$ = 1.3, p = 0.3) or trauma to a loved one ($\chi^2_{df=1}$ = 1.9, p = 0.2) were not related to sex. The middle age groups (11–35 y) at the onset of the Lebanon wars were the most exposed to the majority of the war events ($\chi^2_{df=3}$ = 49.3, $p < 0.001$) (Table 3).

Individual War Traumatic Events

Using the discrete-time survival analysis, our study showed that individuals exposed to individual war events were at a higher risk for developing a mental disorder for the first time ever, controlling for age, sex, marital status, and education. Exposure to these events still increased the odds of first onset of mental disorders, even after controlling for the occurrence of other war traumata.

Witnessing death or injury in war time (OR 1.52, 95% CI 1.04-2.23), having a close person die (OR 1.48, 95% CI 1.03-2.12), and being a civilian in a war zone (OR 1.48, 95% CI 1.11-1.97) increased the odds of developing any mood disorder. Witnessing atrocities (OE 6.76, 95% CI 1.47-31.06) and being a refugee (OR 4.03, 95% CI 1.83-8.88) increased the odds of developing any impulse control disorder. Being a civilian in a

Table 1. Lifetime Prevalence of Mental Disorders and Age

Category	Disorder	Total		Sex [a]		Age (y) [b]			
				Female	Male	18–34	35–49	50–64	65+
		No.	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)
Anxiety disorders	Panic disorder	16	0.5 (0.1)	0.7 (0.2)	0.3 (0.1)*	0.2 (0.1)	1.2 (0.4)	0.4 (0.2)	0.4 (0.4)
	Agoraphobia without panic	13	0.5 (0.1)	0.7 (0.2)	0.1 (0.1)	0.5 (0.3)	0.5 (0.2)	0.1 (0.1)	0.8 (0.7)
	Specific phobia	202	7.1 (0.5)	10.2 (0.7)	4.0 (0.8)**	8.4 (0.7)	7.3 (1.1)	5.1 (1.1)	4.3 (1.5)**
	Social phobia	52	1.9 (0.4)	2.1 (0.5)	1.7 (0.5)	2.8 (0.7)	1.5 (0.4)	1.0 (0.5)	0.4 (0.3)**
	Generalized anxiety disorder	61	2.0 (0.3)	2.8 (0.4)	1.1 (0.3)**	1.8 (0.5)	2.3 (0.6)	1.4 (0.5)	2.9 (1.1)
	PTSD[c]	70	3.4 (0.6)	5.8 (1.1)	1.0 (0.3)**	3.4 (1.2)	3.6 (1.0)	3.7 (1.5)	2.5 (0.8)
	Separation anxiety/adult SAD[d]	95	6.1 (1.0)	8.1 (1.4)	4.1 (1.0)**	7.8 (1.5)	6.7 (1.8)	2.2 (0.7)	3.2 (1.7)*
	Any anxiety disorder [e]	282	16.7 (1.6)	24.8 (2.1)	8.6 (1.7)**	19.4 (2.2)	18.8 (2.2)	9.6 (2.5)	10.6 (3.4)**
Mood disorders	MDD	283	9.9 (0.9)	12.8 (1.1)	7.0 (1.0)**	8.5 (1.3)	12.4 (1.1)	10.9 (1.3)	9.1 (2.3)
	Dysthymia	34	1.1 (0.2)	1.6 (0.3)	0.7 (0.3)	0.6 (0.3)	1.8 (0.6)	1.8 (0.5)	1.1 (0.7)
	Bipolar disorders	61	2.4 (0.4)	2.3 (0.5)	2.6 (0.5)	3.9 (0.7)	1.7 (0.4)	0.6 (0.2)	0.2 (0.2)*
	Any mood disorder	352	12.6 (0.9)	15.4 (1.2)	9.8 (0.9)**	12.6 (1.2)	14.4 (1.2)	12.1 (1.4)	9.3 (2.4)
Impulse control disorders	Conduct disorder[d]	13	1.0 (0.4)	0.1 (0.1)	1.9 (0.8)**	0.8 (0.4)	1.7 (0.8)	-	-
	ADHD[d]	20	1.5 (0.4)	1.6 (0.6)	1.4 (0.6)	1.6 (0.5)	1.3 (0.6)	-	-
	Intermittent explosive disorder	43	1.7 (0.5)	1.2 (0.4)	2.2 (0.7)	2.8 (0.9)	1.0 (0.2)	0.2 (0.1)	0.3 (0.3)**
	Any impulse control disorder[e]	53	4.4 (0.9)	3.6 (1.1)	5.1 (1.6)	4.7 (1.2)	3.5 (1.1)	-	-
Substance abuse disorders	Alcohol abuse	38	1.5 (0.3)	0.4 (0.3)	2.7 (0.6)**	2.1 (0.4)	1.2 (0.5)	1.1 (0.5)	0.8 (0.4)
	Alcohol dependence	9	0.4 (0.2)	0.4 (0.3)	0.3 (0.2)	0.6 (0.3)	0.3 (0.2)	0.2 (0.1)	0.0 (0.0)
	Drug abuse[c]	6	0.5 (0.2)	0.1 (0.1)	0.9 (0.5)**	0.1 (0.1)	0.4 (0.2)	2.0 (1.8)	0.0 (0.0)*
	Drug dependence[c]	3	0.1 (0.1)	0.1 (0.1)	0.2 (0.2)	0.1 (0.1)	0.2 (0.2)	0.2 (0.2)	0.0 (0.0)
	Any substance abuse disorder[c]	27	2.2 (0.8)	0.6 (0.3)	3.8 (1.6)**	2.7 (1.6)	1.9 (0.7)	2.5 (1.8)	0.0 (0.0)**
Any disordere		491	25.8 (1.9)	33.1 (2.6)	18.4 (2.4)**	29.1 (3.1)	26.9 (2.5)	21.4 (4.1)	15.2 (3.9)
Two or more disorderse		234	10.5 (1.4)	13.8 (1.8)	7.0 (1.3)**	12.1 (2.2)	11.6 (1.4)	6.8 (1.9)	5.9 (2.2)*
Three or more disorderse		105	4.6 (0.7)	6.0 (1.0)	3.2 (0.7)*	5.5 (1.2)	5.1 (1.0)	2.3 (1.0)	2.3 (1.1)*

DSM-IV organic exclusion rules and diagnosis hierarchy rules were used in making diagnoses, except for substance use disorders, where abuse was defined with or without dependence, in recognition of abuse often being a stage in the progression to dependence.

*Statisitical significance at p< 0.05

**P < 0.01.

a χ^2 with df = 1 for all disorders.
b χ^2 with df = 3 for all disorders except for conduct, attention deficit hyperactivity disorders (ADHD), and any impulse disorder where df = 1.
c Assessed in Part II sample (n = 1.031).
d SAD, conduct, and attention deficit hyperactivity disorders were assessed among Part II respondents in the age range 18-44 (n = 595).
e These summary measures were analyzed in Part II sample (n = 1.031). SAD, conduct, and ADHD were coded as absent among respondents who were not assessed for these disorders.

SE, standard error.

doi: 10.1371/ journal.pmed.0050061.t001

Table2. Ages at Selected Percentiles on the Standardized Age-of-Onset Distributions of Disorders with Projected Lifetime Risk at 75 y

Category	Disorder	Projected Lifetime Risk	Age at Selected Age-of-Onset Percentiles							
			5	10	25	50	75	90	95	99
Anxiety disorders	Panic disorder[a]	—	—	—	—	—	—	—	—	—
	Agoraphobia without panic[a]	—	—	—	—	—	—	—	—	—
	Specific phobia	7.9 (0.7)	5	5	5	11	13	29	48	68
	Social phobia	2.0 (0.4)	6	7	11	14	18	20	26	30
	GAD	3.9 (0.7)	14	18	28	39	55	59	71	71
	PTSD[b]	5.3 (0.7)	10	10	19	30	43	51	56	56
	Separation anxiety/adult SAD[c]	7.6 (1.1)	7	8	13	19	29	41	56	56
	Any anxiety disorder[d]	20.2 (1.8)	5	5	8	13	28	47	56	71
Mood disorders	MDD	17.2 (1.3)	16	18	24	34	48	58	66	75
	Dysthymia	2.1 (0.6)	16	18	21	33	49	66	66	66
	Bipolar disorders	2.9 (0.4)	14	14	16	20	27	39	44	46
	Any mood disorder	20.1 (1.2)	15	17	21	31	45	56	66	75
Impulse control disorders	Conduct disorder[a,c]	—	—	—	—	—	—	—	—	—
	ADHD[a,c]	—	—	—	—	—	—	—	—	—
	Intermittent explosive disorder	1.8 (0.5)	13	13	14	16	19	23	27	31
	Any impulse control disorder[d]	4.6 (1.0)	7	8	9	14	19	26	27	31
Substance abuse disorders	Alcohol abuse	2.1 (0.4)	16	18	20	23	35	43	58	58
	Alcohol dependence[a]	—	—	—	—	—	—	—	—	—
	Drug abuse[a,d]	—	—	—	—	—	—	—	—	—
	Drug dependence[a,d]	—	—	—	—	—	—	—	—	—
	Any substance abuse disorder[a,d]	—	—	—	—	—	—	—	—	—
Any disorder		32.9 (2.1)	5	5	11	19	35	53	58	71

Number of cases too small ($n \leq 30$) to be included in analysis.
[b]PTSD was assessed in Part II sample (n = 1,031).
[c]SAD, conduct, and attention deficit hyperactivity disorders were assessed among Part II respondents in the age range 18–44 y (n = 595).
[d]These summary measures were analyzed in Part II sample (n = 1,031). SAD, conduct, and ADHD were coded as absent among respondents who were not assessed for these disorders.
doi:10.1371/journal. pmed.0050061.t002

Table 3. Differences in Exposure to Individual and Cumulative War Events by Sex and Age at Start of War

*Statistical significance with $p < 0.05$

** $p < 0.01$.

[a] Number of people exposed represents unweighted frequencies and was assessed in Part II sample (n = 1,031).

[b] Significance level was measured using Chi-square for number of war events (as one categorical variable) versus sex and age each as one categorical variable.

SE, standard error.

doi:10.1371/journal.pmed.0050061.t003

Category	Event	People Exposed	Total	Sex		Age at Start of War (y)			
		n[a]		Female	Male	0–10	11–18	19–35	>35
			% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)
Individual war events	Rescue worker	37	3.0 (0.9)	1.2 (0.5)	4.8 (1.8)*	2.9 (1.1)	5.8 (2.5)	2.8 (1.6)	1.0 (0.6)
	Witness death or injury	208	18.0 (1.3)	10.2 (1.6)	26.0 (2.2)**	13.5 (2.0)	27.1 (4.2)	24.0 (3.0)	18.2 (4.2)**
	Witness atrocities	119	10.6 (1.4)	5.5 (1.4)	15.8 (2.1)**	7.2 (1.7)	15.7 (4.3)	16.0 (2.6)	10.8 (3.5)*
	Civilian in war zone	620	55.2 (2.9)	61.2 (3.5)	49.0 (4.0)*	46.8 (3.8)	61.2 (6.8)	68.4 (4.6)	62.5 (4.7)**
	Civilian in terror region	114	8.6 (1.5)	6.5 (1.3)	10.6 (2.4)*	7.9 (2.0)	8.7 (2.3)	9.7 (2.8)	9.1 (2.4)
	Refugee	447	37.7 (3.6)	44.4 (4.0)	30.9 (3.5)**	32.2 (5.0)	55.2 (7.0)	45.3 (4.8)	30.9 (5.1)**
	Death of close one	125	10.2 (1.2)	9.2 (1.3)	11.2 (1.8)	4.6 (1.1)	16.0 (6.0)	21.4 (3.7)	9.2 (2.3)**
	Trauma to close one	92	7.6 (0.8)	5.9 (1.3)	9.4 (1.7)	5.7 (1.0)	10.1 (3.8)	11.8 (2.3)	6.5 (2.6)
	Kidnapped	44	3.0 (0.7)	0.04 (0.0)	6.1 (1.5)**	1.8 (0.6)	4.3 (2.3)	5.0 (2.2)	3.9 (2.2)
	Robbed/threatened by weapon	42	2.2 (0.5)	0.6 (0.2)	3.9 (1.1)**	1.0 (0.4)	4.6 (2.0)	4.4 (1.8)	1.4 (1.0)*
Number of war events[b]	None	268	31.2 (3.2)	27.9 (3.5)	34.6 (4.1)**	41.4 (4.6)	15.4 (4.4)	16.0 (3.4)	28.6 (4.3)**
	One	233	23.6 (2.5)	25.4 (3.6)	21.8 (3.1)	21.7 (3.3)	22.8 (5.3)	25.7 (4.6)	29.3 (6.2)
	Two	252	23.4 (2.2)	29.4 (3.5)	17.4 (2.4)	22.5 (3.9)	29.0 (5.2)	23.6 (4.2)	21.7 (4.6)
	Three	129	10.7 (1.3)	11.6 (2.3)	9.8 (1.6)	5.7 (1.4)	17.2 (4.3)	18.9 (4.1)	11.4 (3.6)
	Four+	149	11.1 (1.2)	5.8 (1.0)	16.5 (1.9)	8.6 (1.2)	15.5 (3.8)	15.8 (3.4)	9.0 (2.5)

terror region (OR 3.87, 95% CI 1.64–9.12) increased the odds of developing any anxiety disorder. Being robbed or threatened by a weapon increased the odds of developing any anxiety (OR 3..58, 95% CI 1.31-9.76) and any impulse control disorder (OR 12.62, 95% CI 1.51–105.33).

Cumulative War Traumatic Events

The discrete-time survival analysis showed that being very young at the start of the Lebanon wars (aged 0–10 y)

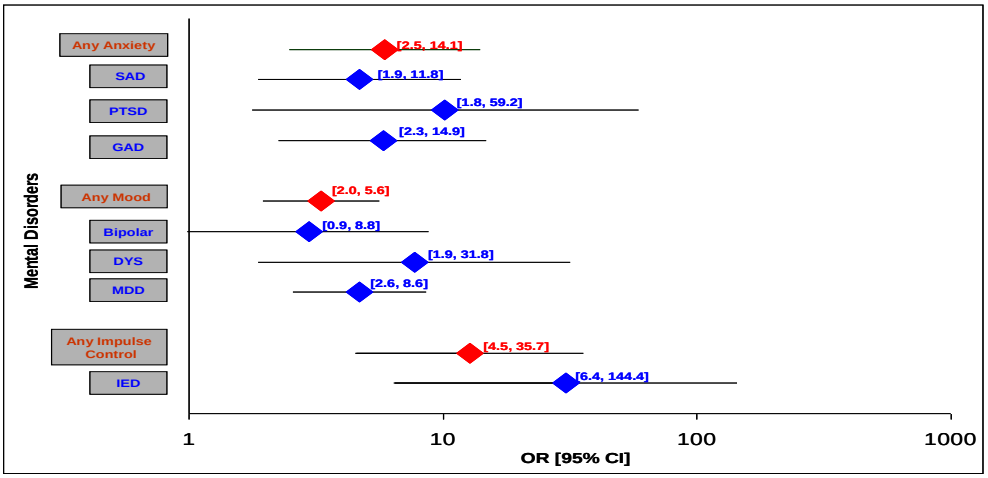

Figure 1. Effect of Cumulative War Trauma on First Onset of Psychiatric Disorders

Disorders with number of cases too small ($n \leq 30$) were not included in this analysis. Odds ratios (diamonds) and 95% confidence intervals are plotted on a logarithmic scale. DYS, dysthymia; GAD, generalized anxiety disorder, intermittent explosive disorder; MDD, major depressive disorder; SAD, separation anxiety disorder; PTSD, post-traumatic stress disorder.

doi:10.1371/journal.pmed.0050061.g001

increased the risk of developing a first onset of anxiety (OR 2.57, 95% CI 1.08–6.12), mood (OR 3.68, 95% CI 1.61–8.44), and impulse control (0–6 y) (OR 2.08, 95% CI 1.08–4.02) disorders. Females again were at a higher risk for a first onset of anxiety (OR 2.92, 95% CI 1.70-5.04) and mood (OR 1.52, 95% CI 1.14-2.02) disorders compared to males. Being a student (compared to low education) and divorced/separated or widowed (ex-married compared to married), predicted the first onset of mood disorders, but not anxiety or impulse control disorders (OR 1.74, 95% CI 1.15–2.63; OR 3.0, 95% CI 1.39–6.47, respectively) (data available upon request).

Furthermore, there was a cumulative effect of war exposure increasing the likelihood of developing anxiety (OR 5.92), mood (OR 3.32), and impulse control disorders (OR 12.72) for the first time. This cumulative effect was also true for individual disorders (within the broader categories mentioned above), the highest ORs being those for intermittent explosive disorder (IED) (OR 30.38), post-traumatic stress disorder (PTSD) (OR 10.24), and dysthymia (OR 7.71) (Figure 1).

Interaction between war exposure and age at onset of wars was significant only for the category "any anxiety disorder," showing an increased risk for respondents who were 35 y or older at the onset of the wars compared to each of the remaining age cohorts (63+ y at interview). The interaction of sex and war exposure, as well as marital status, was not significant for anxiety and mood but could not be carried out for impulse control disorders due to small numbers.

Table 4. Proportional Treatment Contact in the Year of Disorder Onset and Median Duration of Delay among Cases That Subsequently Made Treatment Contact[a]

Disorder	Making Treatment Contact in Year of Onset (%)	Ever Making Treatment Contact (%)	Median Duration of Delay (y)	No.
Any anxiety disorder[b]	3.2	37.3	28	299
Any mood disorder	12.3	49.2	6	349
Any impulse control disorder[b]	3.8	15.1	3	53
Any substance disorder	0.9	35.4	9	38

[a]Disorder hierarchy is not used in these diagnoses.

[b]Assessed in the Part II sample (n = 1,031).

doi:10.1371/journal. pmed.0050061.t004

Treatment

About half (49.2%) of those with a lifetime mood disorder had obtained treatment for this disorder (Table 5). However, the median delay between age Of onset and age of first seeking treatment was 6 y. Only 12.3% obtained treatment in the same year as the onset of their mood disorder. Treatment rates were much lower for other disorders. The proportions ever seeking treatment for the remaining disorders were lower (anxiety, 37.2%; substance, 35.4%; and impulse control disorders, 15.1%). However, delays in seeking treatment for anxiety and substance disorder were longer than that of depression. The median delay for substance disorders was 9 y and that for anxiety disorders was 28 y. The lowest treatment delay among all disorders (3 y) was reported for impulse control.

Discussion

This study presents data on national lifetime prevalence of a wide array of psychiatric disorders in an Arab country, to our knowledge for the first time. One-fourth of the Lebanese adult population met criteria for any of the DSM-IV

disorders, and one-third were estimated to do so by age 75 y. Females are at higher risk of developing anxiety and mood disorders than are males. Being separated, divorced, or widowed increased the likelihood of developing a mood disorder. The effect of sex and marital status on the first onset of mental disorders was independent of war exposure.

The high prevalence of mental disorders and the early age of onset during the young, formative, and productive years create a considerable national burden. This burden is compounded by long delays in seeking care for these often chronic and recurrent conditions. Seeking treatment in the first year of onset of disorder and shortly after was very low. The extremely long delay for treatment of anxiety disorders was due to onset of many anxiety disorders occurring in childhood and treatment not occurring until adulthood. Whereas barriers to seeking care could include factors such as financial difficulties, stigma, and lack of awareness; shortage of health care professionals in Lebanon is not expected to be one of the reasons. It is estimated that there are 325 physicians per 100,000 population in Lebanon [29], the highest ratio in the Arab World and equivalent to many industrialized countries. Therefore, increasing awareness about mental health conditions and reducing possible taboos rather than increasing human resources becomes imperative, not only among the general public and health policy makers, but also and most importantly among health care professionals.

In addition, the study examines on a national level the effect of war on developing first-time mental disorders. In our sample, only 31.2% of the Lebanese were not exposed to any war events, whereas 11.1% were exposed to at least four war events. Males were exposed to more war events and to those events that reflect greater mobility in war time, whereas females reported more often being civilians in war regions or refugees. Those who were children at the start of war reported being less exposed to war events, possibly reflecting their lower mobility and lower recall of the war events at that time.

War, analyzed as both individual events and cumulative exposure, increased the risk of developing for the first time, mental disorders in the life of the Lebanese. This increased risk was shown for all anxiety disorders that had enough participants to be analyzed (separation anxiety disorder [SAD], PTSD, and GAD), for mood disorders (major depressive disorder [MDD] and dysthymia, but not for bipolar disorder), and for impulse control disorder (intermittent explosive disorder). This increased risk was highest for impulse

control disorders followed by PTSD and dysthymia. It is important to note here that the age cohort effect we report could be explained by either having been exposed to these events during this specific age or being in this age group per se [17.30].

Three main limitations of this study have to be considered. First, adults reporting on past psychiatric disorders, age of onset, treatment, and exposure to war may be subject to differential recall bias. A number of factors, including current psychiatric status, time to first onset of disorders, older age, and severity of episode, might have contributed to this differential recall bias. Second, the survey population excluded institutionalized respondents. Third, given the taboos surrounding mental illness, respondents in a face-to-face interview may have under-reported relevant symptoms. Taking these limitations into consideration, the results are probably an underestimate of the true lifetime prevalence of psychiatric disorders in Lebanon since all these factors are likely to bias the estimates downwards. Moreover, with regard to war exposure, although we looked at specific war events, exposure to the general war environment and its impact on the respondent's mental health was difficult to assess. Also many of the CIs are very wide; consequently. results may not be reliably extrapolated to the whole population.

In conclusion, there is an urgent need to assess not only the prevalence, but also the determinants, of treatment failure and delays in treatment in a comparative manner to obtain robust evidence for policy making with regard to the burden of mental disorders in the Arab World. Furthermore, in the Middle East, where armed conflicts have been commonplace for decades, it is important to recognize that these conflicts result in mental disorders that are not limited to PTSD but also include mood and impulse control disorders that are likely to have long-term implications for the war-exposed populations.

Acknowledgments

We would like to thank Miss Yasmine Chatila for her work in supervising the field work and data cleaning, Mrs. Caroline Cordahi Tabet and Ms. Lilian Ghandour for their work in training and adaptation of the CIDI 3.0, and Miss Mariana Salamoun for her work in literature review and preparation of the manuscript. The LEBANON survey was carried out in conjunction with the World Health Organization World Mental Health (WMH) Survey Initiative.

We thank the WMH staff for assistance with instrumentation, fieldwork, and data analysis.

الملخص
هذه هي دراسة وبائيه للاضطرابات النفسية في لبنان. وقد بلغت العينة 2857 بالغًا كعينه ممثله للمجتمع اللبناني. وقد أظهرت الدراسة بعد تطبيق المعايير المناسبة وحسب تصنيف الأمريكي الرابع للأمراض النفسية أن الاضطرابات النفسية شكلت 25.8% من العينه وكان أكثرها شيوعا القلق 16.7% الاضطرابات المزاجية 12.6%. اضطراب الإندفاع 4.4% والاعتماد على المؤثرات العقلية 2.2% ولم يتلق المعالجة المناسبة من هذه العينة إلا القليل بالاضافه إلى التأخر الشديد عن بدء المعالجة لمده تراوحت ما بين (6 – 28عاما). وقد كان للحرب أثر في زيادة الخطورة بالنسبة للقلق والكابه واضطراب الإندفاع.
وبالخلاصة فان ربع العينة تعرضت للاضطرابات النفسية في أي وقت من حياتهم. وقد أظهرت الدراسة الحاجة إلى التشخيص والعلاج المبكر لهذه الاضطرابات. كما كان للحرب اثر في بدء ظهور هذه الاضطرابات.

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[1] Department of Psychiatry and Clinical Psychology, Saint George Hospital University Medical Center, Beirut, Lebanon, [2] Department of Psychiatry and Clinical Psychology, Faculty of Medicine, Balamand University Medical School, Beirut, Lebanon, [3] Institute for Development, Research, Advocacy and Applied Care (IDRAAC), Beirut, Lebanon, [4] Survey Methodology Program, Institute for Social Research, University of Michigan, Ann Arbor, Michigan, United States of America, [5] School of Nursing, Faculty of

Medicine, American University of Beirut, Beirut, Lebanon, [6] School of Pharmacy, Lebanese American University, Byblos, Lebanon, [7] World Health Organization (WHO), Geneva, Switzerland, [8] Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts, United States of America

* To whom correspondence should be addressed. E-mail: egkaram@idraac.org
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The Arab Journal of Psychiatry (2009) Vol. 20 No 1 Page (18 -33)

The Psychology of Media Bias and Its Impact on Arab-American and Muslim Psyche

M. K. Hamza[1], Niveen Yaseen[2], Ashraf F. El-Houbi[3], Betty Duncan[4], Carlos Diaz[5]

الأوجه النفسية لتجاوزات الإعلام وأثرها على نفسية العرب والمسلمين الأمريكيين

محمد حمزه، نيفين ياسين، اشرف الحوبي، بيتي دنكن و كارلوس دياز

Abstract

Stereotypical degradation and humiliation of minority ethnic groups have been practiced historically by all forms of U. S. media; however, the devastating aftermath of September 11, 2001, heightened the degree of prejudice, discriminatory behavior and misunderstandings, particularly toward Muslims and Arab-Americans. These groups have continued to experience negative societal reactions that run the gamut from suspicion to phobia. This study attempted to determine the extent to which this has affected all members of Arab-American and Muslim- American communities especially children. A survey was conducted to examine American attitudes toward Muslim and Arab-Americans and their potential impact on children's psyche and well being. Statistical techniques were employed to analyze and summarize responses for each survey question. A chi-square test and logistic regression techniques were used to ascertain if there were significant relationships between response variables and the set of independent variables. The study explored these differences in detail and provides statistical analyses of these findings.

Introduction

In the late eighteenth century, the United States became a republic dedicated to the ideals of religious and political freedom. Since that time, there has been a continuous assimilation of immigrant and minority populations, a melting pot that has never been an automatic or easy intermingling, but has always promised a potential source of newly-infused energies and contributions. The events of September 11, 2001, added a new dimension to this difficulty in blending, particularly for Muslim and Arab-Americans. This occasion brought to the forefront increased concerns for the role of Islam in society and its relationship to American national security and foreign policy. The media focused on Muslims as the cause of the attack, often stereotyping all Muslims as terrorists [1]. As with media coverage of the Gulf War, numerous faces of the Middle East were suddenly brought into American homes, but there was little or no attempt at understanding any of these groups of people or the cultures behind them[2].

According to El-Farra, individuals from the Middle East are often described simply as "Arabs," although those addressed may be from different countries and represent a variety of religions, cultures, and belief systems. Since the mind initially reacts to images more emotionally than intellectually, the media make use of stereotypes to portray common beliefs and gain the confidence of the audience when the stereotypes appear to fit reality and create credibility[3]. Bayoumi noted that Muslims, as a group, are unfairly held responsible for the actions of any other Muslims world-wide. They are treated as "guilty until proven innocent, and their guilt is premised almost exclusively on their birthplace or birth religion"[4]

This is reminiscent of an episode in American history following the bombing of Pearl Harbor in 1941—a time which witnessed the internment of 120,000 Japanese-Americans. This event was pre -cipitated by Executive Order9066, which set into motion the mass evacuation and imprisonment of Japanese-Americans in the U.S., two thirds of whom were U.S. citizens. With total disregard for the Bill of Rights of the U.S. Constitution, these people were forced out of their homes and into relocation centers[5]. Although U.S. military authorities at the time justified the action on the basis of a perceived threat to national security, no evidence of sabotage or espionage committed by any Japanese-American was ever documented. It has been concluded that the only crime these Japanese were guilty of was that of being Japanese[6]. The internment resulted from a history of prejudice and restrictive legislation against Asian-Americans that had been fanned by economic and political motives. Takaki examined the impact of World War II on Asians living in Hawaii and found that Japanese-Americans, constituting 37% of the total island population at the time, were spared being uprooted since interning them would have devastated Hawaii's economy[7].

A comparable situation is exemplified by a 2002 CAIR (Council on American Islamic Relations) report advising FBI agents and other law enforcement authorities conducting raids and interrogations of Muslim-Americans who were legal immigrants or U.S. citizens based solely on profiling criteria. While the U.S. government defended their actions as necessary for national security, none led to the arrest of terrorist suspects. As in the case of the Japanese, it disrupted the lives of thousands of Muslim-Americans and threatened democratic freedoms and the rule of law [8]. While one might think these actions would lessen with the passage of time since 9/11, Lisa Miller, writing for *Newsweek* magazine, reported that the Council on American Islamic Relations counted nearly 2,500

civil-rights complaints by Muslim Americans in 2006, a dramatic increase over the year 2005[9].

According to a *USA Today* report[10], some Muslims and Arab-Americans wonder if internment could happen again—especially if there is another terrorist attack in the U.S. Themes that have repeatedly emerged in *USA Today* interviews with Muslims and Arab-Americans include the following: refusing to travel by air because of continued suspicion and hassles, Anglicizing or completely changing their names, speaking English instead of Arabic, displaying the American flag, trimming their beards, and worrying about government eavesdropping and surveillance[10].

The widespread nature of this continuous suspicion and hateful rhetoric can even be seen in the comments of well-established public figures such as Franklin Graham (son of evangelist Billy Graham), who said during an NBC news program: "The God of Islam is not the same God. He's not the Son of God of the Christian or Judeo-Christian faith. It's a different God and I believe it is a very evil and wicked religion" [8]. Furthermore, Pope Benedict XVI's reference to Muhammad's offerings as being "evil and inhuman" and commanding his followers "to spread by the sword the faith he preached" was not language that was well received by Muslims [11]. Dionne cautioned that Muslims "need to know that non-Muslims are willing to engage with the best and not just the most extreme currents of Islamic thought" [11].

Striking examples of this "unwillingness to engage" can be seen by the U.S. government's refusal to admit into the country distinguished foreign scholars who were in a pivotal position to help Americans better understand not only the sources of international tensions, but also their ongoing potential for further escalation. Although the delays and interminable security checks have lessened since 9/11, scholarly associations in the social sciences say problems persist for their foreign members [12]. Foreign scholars who have been barred by the U.S. from 2004 to 2007 include Tariq Ramadan, a well-known Islamic intellectual from Europe; Karim Meziane, a physicist at the University of New Brunswick and a Canadian citizen; Dora Maria Tellez, a Nicaraguan historian who had to resign from a teaching position she had accepted at Harvard Divinity School; Vicente Verez-Bencomo, a Cuban scientist who was to receive an award at California's Tech Museum of Innovation for his research team's development of a low-cost vaccine for meningitis and pneumonia; Adam Habib, a professor of political science at the University of KwaZulu-Natal in South Africa and their director of the program democracy and governance, who had been scheduled to

meet with the officials of the National Institute of Health, the Center for Disease Control and Prevention, and the World Bank, as well as with scholars at both Columbia University and City University of New York; and Riyadh Lafta, a prominent Iraqi professor of medicine at Al-Mustansiriya University Baghdad who was to give a lecture at the University of Washington and work with colleagues there on a research project concerning increased rates of cancer among children in southern Iraq[12].

Not only have scholars been stymied, but also those attempting to aid needy Muslims through legitimate Muslim charities [13]. Since 9/11, under the Patriot Act the U.S. government has closed down six American-Muslim charities, although there has not been a single terrorism conviction against any of the employees or board members. According to Islamic teachings, it is immoral, unethical, and un-Islamic to engage in illegal activity, and there has been no documentation showing money for charitable works going into the hands of actual terrorists [13].

In the aftermath of the September 11 attacks, the U.S. faces the question of whether Muslims and Arab-Americans have the same opportunity to practice their faith and exercise their rights as other Americans. For them, the commitment of America's Founding Fathers to "liberty and justice for all" is being put to the test daily. In a July/2006 *USA Today* Gallup Poll, 39 percent of Americans admitted to holding prejudice against Muslims and thought Muslims—US citizens included—should carry special IDs. More than 20 percent did not want a Muslim neighbor, and almost 60 percent had never met a Muslim. [4]

Furthermore, offensive advertisements have become more prevalent since the launch of America's war on terrorism, [14]Arab-American groups helped to prevent a billboard ad, designed by the Coalition for a Secure Driver's License, which showed a man in a traditional Arab keffiyeh holding a grenade and a driver's license. The message clearly intended to show that Arabs are dangerous and therefore should not get driver's licenses. Another ad for a car dealership in Columbus, Ohio called for a "jihad on the automotive market," and furthered the theme by the salespeople's wearing of burqas and giving swords to children on "fatwa Friday[14]. Clearly, when misleading concepts are promulgated in a society which knows very little about Muslims and Arab-Americans, the potential for stereotyping is significant. Since 2001, being or being perceived to be Muslim and/or Arab seems to be sufficient grounds for legal or cultural suspicion. Misinformation or the lack of accurate information, engendered by television, radio programs and the influence of

Hollywood, plays a significant role in the American perceptions, attitudes, behavior and misunderstanding of Muslims and Arab-Americans.

Shaheen documented images on American entertainment shows since 1974 and found that the "rogues" were often Arab-Muslims. He noted that fanatical Muslims surfaced in mid-l980s television movies such as *Hostage Flight* (NBC, 1985), *Sword of Gideon* (HBO, 1986), *Under Siege* (NBC, 1986), *The Taking of Flight 847*(NBC, 1988), *Terrorist on Trial:*

The United States vs. Salim Ajami (CBS, 1988), and *Hostages* (HBO, 1993). He pointed out that these and others like them are constantly rebroadcast on cable and network systems. What he considered particularly disturbing was that they effectively showed all Arabs, Muslims, and Arab-Americans as being at war with the United States .[15]The American-Arab Anti-Discrimination Committee (ADC) has received complaints from many parents as a result of this.

From many pervasive stereo-typing, [16.]

These parents have found that their children have become ashamed of their religion and heritage—often the result of taunting from classmates. This has led to Muslim and Arab-American children lying about their heritage and wanting to change their names in order to avoid being targeted, threatened, and accused of being responsible for terrorist activities .[15]In view of this cultural fear, misunderstanding and distrust, the authors of this paper sought to explore the attitudes and feelings of those living in a particular U.S. region, South-east Texas, toward members of the Arab-American and Muslim communities.

Survey Validity

The survey, based on previous work by Hamza, et al.[23] was conducted in the fall of 2006; the sample size was expanded (n = 90). It was designed to explore respondent' attitudes toward Muslims and Arab-Americans in the United States, using the independent variables of *religion*, *age*, *ethnicity*, *vocation*, *area*, and *gender*. The questions posed provided a basis from which to study the attitudinal relationships resulting from each variable.

The data were collected from several Southeast Texas cities. This survey was completed by volunteers and conducted in various settings such as retail stores, hospitals, schools, corporate atmospheres, and restaurants. Thirty questions were answered and each was based on a five-point Likert scale (*strongly agree*, *agree*, *disagree*, *strongly disagree*, and *no opinion*). The survey also covered demographic variables, such as *vocation*, *ethnicity*, *religious affiliation*, *gender*, *age*, and *place of residence*. These responses indicate whether the data show any evidence of bias. To get statistically significant evidence to support the

presence of bias or discrimination, the data were analyzed with statistical techniques such as the chi-square test of independence. Graphs are attached in the appendix.

Ninety-two percent of the respondents were Christian; the other 8% represented other major religions such as Judaism, Buddhism, and Hinduism. By design, there were no Muslims asked to take the survey, in order to prevent the possibility of any extraneous variables that would mix the viewpoints of Muslims with those of non-Muslims. The majority were between 31-50 years old. About 35% were teachers and educators; 20% were businessmen, business-women, or engineers. About 81% of the respondents were Caucasian and 10% were African Americans. The remaining fell under the category of "other," most of these being Hispanic. Forty-seven percent lived in suburban areas, 34% in urban areas, and 19% in rural areas. About 68% were female (see attached graphs).

Percentages and Proportions of the Responses

The following results were obtained from the survey (see Table 1).

1. ***Ninety-four percent*** stated that racial problems exist in the United States.
2. ***Fifty-three percent*** thought Arab/Muslim communities suffer prejudice in the United States.
3. ***Sixty-three percent*** said they did not believe much of what is being said about Arabs or Muslims in the media.
4. ***Forty-one percent*** of the respondents indicated that when they think of Arabs/
   a. Muslims, they think of the 9-11 tragedy.
5. ***Fifty-two percent*** of the respondents indicated that they would pay attention to a person's place of origin or religion.
6. ***Fifty-two percent*** of the respondents felt that media bias could cause depression in Arab/Muslim families.
7. ***Sixty-percent*** of the respondents stated that they **have not** studied the cultures and religion of Arab/Muslim people.
8. ***Seventy-six percent*** stated that they would not change the T.V. channel or radio station if it included bias or discriminatory reports about Arab/Muslim people.
9. ***Sixty-two percent*** indicated they would not contribute money or time to social programs to help the Arab/Muslim community.
10. ***Twenty-five percent*** stated that they think Arabs/Muslims are more violent than non-Arab Muslims, ***51%*** said the opposite, and ***24%*** said they did not know.
11. ***Forty-eight percent*** stated that their views of Arabs/Muslims have

a. changed negatively since 9/11.

12. ***Forty-two percent*** indicated they knew of bias against Arabs/Muslims in their own communities.
13. ***Forty-nine percent*** of the respondents stated they would feel uncomfortable when Arab/Muslim people were speaking their own language in their presence.
14. ***Fifty percent*** think Arab/Muslim children are being affected by media bias.
15. ***Thirty-seven percent*** indicated that they would not express their honest opinion without worrying about appearing racist in the presence of an Arab/Muslim.

Materials and Methods

The following Table summarizes all the results from the survey. The questions were organized into three categories: *agree or strongly agree*, *disagree or strongly disagree*, and *don't know*. The authors sought to identify any evidence of bias on the responses of these questions.

Table 1

Survey Questions	Agree or Strongly Agree	Disagree or Strongly Disagree	Don't Know
1)Aware of media broadcast bias against the Arab-Muslim community	56%	31%	13%
2) No race problem in the United States	6%	94%	0%
3) Would contribute money or time to social programs to help the Arab-Muslim community	19%	62%	19%
4) Feel film-making corporations (i.e., Hollywood) portray bad images of the Arab-Muslim	31%	52%	17%
5) White civilization is the most highly developed, sophisticated culture to have ever existed on earth	31%	59%	10%

6) Are aware of bias against Arab-Muslims in their own community	42%	31%	27%
7) Do not pay attention to a person's place of origin or religion	66%	33%	1%
8) Have been in a work or collegial relationship with an Arab-Muslim	48%	39%	13%
9) Think Arab-Muslim children behave just like non Arab-Muslim children	46%	22%	32%
10) Know if Arab-Muslims have been discriminated Against	32%	36%	32%
11) When an Arab-Muslim sits or stands next to them in a public place, they would move away	12%	82%	6%
12) Would listen to the use of Arab-Muslim jokes and derogatory statements when presented the opportunity	36%	53%	11%
13)) Feel uncomfortable when Arab-Muslims use their own language in their presence	49%	48%	3%
14) Their views of Arab-Muslims have negatively changed since 9/11	48%	47%	5%
15) When they think of Arab-Muslims, they think of the 9/11 tragedy	41%	56%	3%
16) Think the United States media are biased toward Arab-Muslim cultures	43%	42%	15%
17) Think Arab-Muslim communities suffer prejudice in the United States	53%	31%	16%

18) Would mind having an Arab-Muslim as their congressman	28%	51%	21%
19) Would not mind having a veiled Arab-Muslim woman as their congresswoman	22%	58%	20%
20) Think Arab-Muslims are more violent than non-Arab Muslims	25%	51%	24%
21) Express their honest opinion when an Arab Muslim is present without worrying about whether they appear racist	51%	37%	12%
22) Think they can do something about discrimination against Arab-Muslims	33%	44%	23%
23) Arab-Muslim children are being affected by media bias	50%	27%	23%
24) Change the T.V. channel or radio station if it includes bias or discriminatory reports about Arab-Muslims	14%	76%	10%
25) Usually tend to believe much of what is being said about Arab-Muslims in the media	28%	63%	9%
26) Have never intensely disliked anyone	52%	45%	3%
27) Believe cultural knowledge affects their expectations	46%	42%	12%
28) Believe they would be uncomfortable with people who have different values from themselves	21%	77%	2%

29) Have studied the culture and religion of Arab-Muslims	33%	60%	7%
30) Media bias can cause depression in Arab-Muslim families	52%	23%	25%

The Pearson chi-square test was computed to study the relationship between the response variables and other independent variables used in the study.

Table 2: Chi-square Test

Comparison	Chi-square Test	DF	p-value
Response vs. Vocation	46.442	16	0.000
Response vs. Ethnicity	90.784	16	0.000
Response vs. Religion	155.584	8	0.000
Response vs. Area	6.720	8	0.567
Response vs. Gender	52.089	4	0.000

The chi-square test of independence (Table 2) was used to check if there were any significant relationships or associations between the response variable (i.e., agree, strongly agree, disagree, etc..) and set of the independent variables (i.e., vocation, religion, area) used in the study. Under the null hypothesis, we assume that the variables are *not* associated. If the null hypothesis is rejected, then we have evidence that the alternative hypothesis (i.e., the variables are associated or dependent) is true. Table 2 reveals that there is statistically significant evidence of a relationship between the response variable and Vocation, Ethnicity, Religion, and Gender at the 0.05 level of significance which led to the rejection of the null hypothesis of independence (since p-value = $0.000<0.05$). This implies that the response does vary by these variables (i.e., there is gender difference in opinion). On the other hand, the authors did not see any significant relationship in area or regional responses (since p-value = $0.567 > 0.05$); that is to be expected since all the information pertains to one particular region. This may not be the case if the study was conducted in different regions in the United States.

We notice that p-values for vocation, religion, and gender are less than 0.05 on the level of significance. There is statistical evidence to conclude that

these variables significantly affect responses. There is insufficient evidence to conclude that the variables of ethnicity and area have a significant effect on responses. The log-likelihood from the maximum likelihood iterations is -4088.086 with statistic G = 34.190 and a p-value= 0.000, indicating that there is significant evidence that at least one of the coefficients is different from zero. For more details about logistic regression and interpretations[17].

Discussion

The negative impact of the media was found to be significant in certain areas. A compelling result was that 94% of those who completed this survey agree that racial problems do exist in the United States, and 43% think that the United States media are biased toward Arab-Americans and/or Muslims. An even larger number, 63%, responded that they tended not to believe much of what was said about Arabs/Muslims in the media. However, 49% of the respondents indicated that they would feel uncomfortable in an environment where Arabs -/Muslims were speaking their own language.

Fifty-two percent mentioned that media bias could cause depression in Arab/Muslim families, but 24% admitted that they did not know about this. This supports Chan's findings that Muslim children often

The logistic regression method was used to study the relationship between the ordinal response variable and set of the explanatory variables used in the study. The coefficients (Coef), p-values, standard errors (SE), and odds ratio are provided in Table3.

Table 3: Logistic Regression Method

Odds Ratio	P-value	Z	SE	Coef	Predictor
	0.000	7.68	0.238	1.829	constant
1.07	0.002	3.11	0.021	0.065	Vocation
1.02	0.555	0.59	0.028	0.016	Ethnicity
0.92	0.006	-2.77	0.030	-0.082	Religion
0.97	0.613	-0.51	0.051	-0.026	Area
1.42	0.000	4.35	0.080	0.349	Gender
1.00	0.535	-0.62	0.003	-0.002	Age

experience discrimination from some of their non-Muslim peers[19]. Furthermore, bigoted behaviors that encourage stereotyping can lead to problems in school for Arab/Muslim children, since they may feel humiliated if viewed in a different light than other students [19]. About a third said they knew of actual instances

of discrimination, but two-thirds had not witnessed any, or were unaware of any situations that had occurred. Interestingly, 51% indicated they would not mind having an Arab-Muslim as their congressman. On the other hand, 58%, indicated they would not accept having a veiled Arab/Muslim woman as their congresswoman. This latter finding begs the question of whether the bias is toward women, Arabs/Muslims, or a combination of both.

Another significant result was the finding that 76% stated they would not change the television channel or radio station if a broadcast included biased or discriminatory reports about Arabs/Muslims. Forty-two percent agreed that they were aware of bias in the collective treatment of Arab-Americans, but 27% said they were not aware of any. More- over, 62% noted they would not contribute money or time to social programs designed to help the Arab/Muslim community. Forty-six percent of the respondents of the survey indicated that they believed that their knowledge of cultures affected their expectations.

Conclusion

The results of the survey reveal there is evidence of bias in the attitudes and behavior of respondents towards Arab-Americans and Muslims. Particular findings compel attention. For example, 53% thought Arab-Muslim communities suffer prejudice in the United States. In addition, 56% of the people were aware of media bias against the Arab-Muslim community. Yet, 76% of the respondents stated they would not change the television channel or radio station, even if it included biased or discriminatory reports about Arabs/Muslims. Thus, the awareness of bias is not matched with any behavior to reduce it. This is also supported by the finding that only 33% felt they could do something about discrimination against Arabs/Muslims (see Table 1).

The greatest weapon in combating this misinformation promulgated by the media toward Arab Americans and Muslims is more education and under -standing. This is supported by the finding that only 33% of the survey respondents indicated that they had studied the cultures and religion of Arabs/Muslims. Similarly, a National Geographic Literacy Survey found that young Americans displayed a weak performance in their knowledge of the Middle East and Asia. Despite these regions' almost daily presence in both U.S. and world news broadcasts, and the potential impact of current conflicts on lives worldwide, the survey found that only 13 percent could find Iraq or Iran on a map of the Middle East/Asia [18].

Teaching about Islam and the treatment of Muslims in America are now central issues in national conversations that are occurring throughout America's major

educational and political institutions [20]. We are increasingly living in a global society that has a new set of challenges, one of which is changing demographics. New immigrants are generating a diversity in U.S. communities which, in turn, makes it incumbent upon the educational system to promote knowledge of, and respect for, other cultures. This respect is revealed in both spoken and unspoken forms. As Hobson wrote in her novel Gentleman's Agreement: "Tone and mood are important; they're the distance between acceptance and rejection"[20]. This acceptance comes only with understanding and allowing others the sense of dignity that relies on the absence of stereotyping or built-in bias. The current focus on the basics, including a strong emphasis on math, science, and technology, is necessary, but to be successful global citizens, workers, and leaders, students will need to be knowledgeable about the world and be able to communicate in languages other than English [22].

Through teaching of the tenets of all major religions, including Islam, students would be more intellectually and emotionally equipped to recognize the use of stereotypes and become citizens who work toward reducing prejudice and discrimination against Arabs/Muslims and other religious minorities. It would be interesting to see if any of this focus on religious and cultural education does affect the responses on future surveys designed to detect bias toward Muslims and Arab-Americans. Additional research might target a larger sampling and compare the attitudes of more formally educated people with those less educated to see if there are any differences in their opinions and attitudes toward Muslims and Arab-Americans. Further insights could be gained by administering surveys in different regions of the United States. Finally, this study has shown that there is some evidence that bias toward Arab Americans and Muslims is perceived by fellow citizens of the U.S. who do not belong to either group. Findings also indicate that perception of this bias does not automatically translate into efforts to reduce it.

ملخص

دأب الإعلام الأمريكي على إهانة وتحقير الأقليات العرقية ، إلا أن أحداث الحادي عشر من أيلول سبتمبر 2001 رفعت من درجة الأحكام المسبقة والسلوك التفريقي وسوء الفهم خصوصاً نحو المسلمين والعرب الأمريكيين .

هذه الدراسة تحاول أن تحدد مدى تأثر الجالية المسلمة والعربية الأمريكية وخصوصاً على صحة الأطفال وحالتهم النفسية، في هذه الدراسة تم تحليل كل إجابة وعلاقتها بعوامل أخرى مستقلة بوسائل إحصائية مختلفة وتم تقديم النتائج ومناقشتها.

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Figure 1

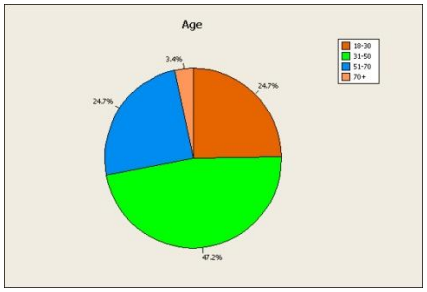


Figure 2

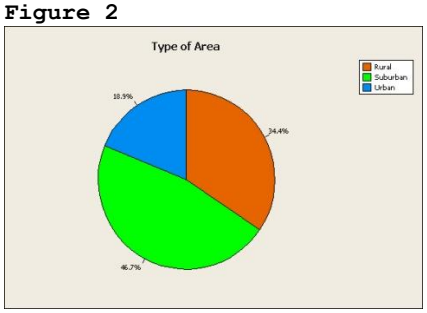
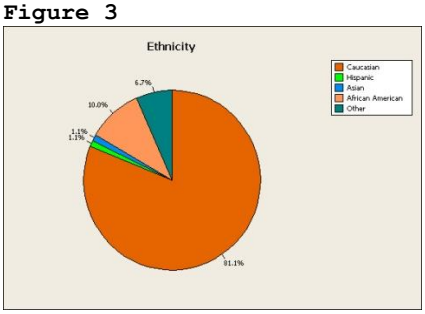


Figure 3



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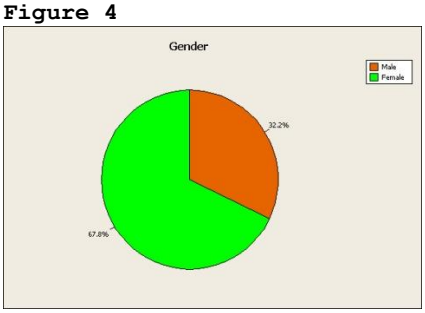


Figure-5

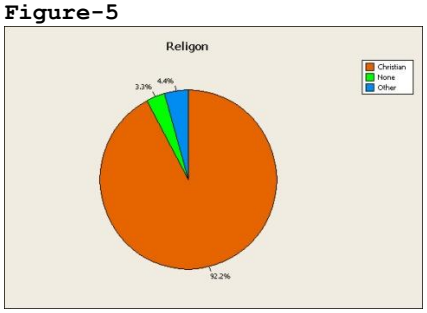


Figure 6

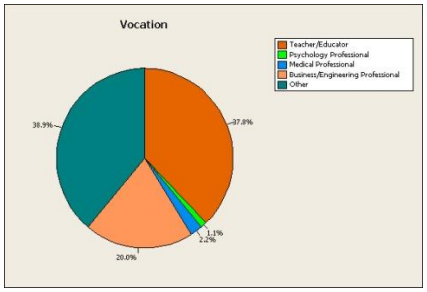
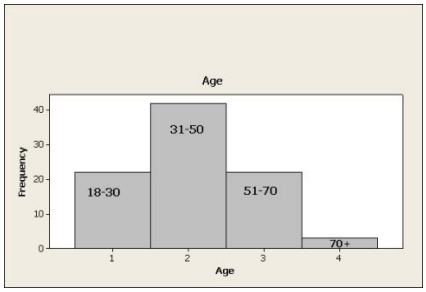


Figure 7



Histogram (Age Distribution)

Correspondence:
Lamar University, Texas[1-4]
Florida Atlantic University[5]
:For publication info to be listed
M. K. Hamza, PhD[1]
Associate Professor
Lamar University
PO Box 1034
Beaumont, TX 77710 409-8808920

The Arab Journal of Psychiatry (2009) Vol.20 NO.1 Page (34 -41)

Evaluation of Community Psychiatric-Home Visit Treatment versus Outpatient Treatment of Chronic Schizophrenic Patients in Bahrain.

Hussain HAA, Tarada M, Redha M, *Sequeira RP.

تقييم العلاج النفسي في المجتمع(الزيارات المنزلية) مقارنة بالعلاج في العيادات الخارجية لمرضى الفصام في مملكة البحرين

حميد حسين، مريم طرادة، منى رضاء، ريجينال سكويرا

Abstract

Background: Schizophrenia has a high rate of relapse. Treatment compliance is challenging in the long-term management of schizophrenia. The outcomes of previous studies on Community Psychiatry Service – Home Visit Treatment (CPS-HVT) are inconclusive.

Aims: To evaluate the effectiveness of CPS-HVT in (a) reducing the number of admissions and (b) duration of admissions of chronic schizophrenic patients.

Methods: A retrospective analysis by auditing files of all cases of adult schizophrenic patients in Bahrain who underwent CPS-HVT treatment. A total of 10 years follow-up (5 years of outpatient treatment before the referral to the community service and 5 years follow-up in the community service after the referral) was carried out. The number of admissions and the duration of admissions were compared.

Results: Of the total number of 232 patients 51 (22%) fulfilled the inclusion criteria. The sum total of 77 admissions during 5 years before the referral to the CPS-HVT was 2577 days (50.5 d/patient). After the referral to the CPS-HVT the sum total of 48 admissions was 1383 days (27.1 d/patient), and no patient had more than 3 admissions. The number of non-hospitalized patients doubled during the 5 years follow-up in the CPS-HVT (n=13; 4 males vs. n=27; 10 males). The proportion of males was 47.1% (n=24).

Conclusions: CPS-HVT is effective and superior to standard outpatient treatment of chronic schizophrenic patients in reducing the number and duration of admissions, in Bahrain. Future studies should evaluate a wide range of other outcomes, including the cost effectiveness of CPS-HVT. Considering the massive impact of community-based care on patients, caregivers, clinicians and the community at large, such studies are urgently needed.

Introduction

Schizophrenia is a relapsing illness, with a high rate of relapse within five years of recovery from the first episode. The cumulative first relapse

rate is 81.9% and the second relapse rate is 78.0%, and after recovery from the second relapse, the cumulative third relapse rate is 86.2% [1].

Discontinuing antipsychotic therapy increases the risk of relapse by almost five-fold for an initial relapse [2].

Some of the factors associated with relapse are non-compliance with medication, stress, inadequate social support and substance abuse [1]. Non-compliance with medication is high in schizophrenic patients. It has been estimated that 40-65% of schizophrenic out-patients stop their regular oral medication within six weeks [3]. Both patient-related and disease-related factors may strongly influence medication compliance [4].

Also, noncompliance and partial compliance with antipsychotic medication are associated with higher rates of relapse and hospitalization of schizophrenic patients [5,6]. Although the use of depot antipsychotic medication makes it clear whether the patient is medication compliant, not all those who are prescribed depot medication keep their injection appointments [3].

Adherence to recommended treatment programs is essential to their effectiveness, but maintaining adherence is particularly challenging in the long-term management of both chronic and episodic disorders among patients, who are often ambivalent about diagnosis or treatment[7].

Secondary prevention is defined as the early identification and prompt treatment of an illness or disorder [8]. Community Psychiatric Service - Home Visit treatment (CPS-HV treatment) provides a significant improvement in reducing the admissions and duration of admission of chronic schizophrenic patients. In Bahrain CPS-HV treatment started in 1977 for severely mentally ill patients, particularly for those who are either noncompliant with the medication and have frequent admissions or noncompliant with the appointment due to transport difficulties. This retrospective study has investigated whether CPS-HV treatment reduced the admission and the duration of admission of chronic schizophrenic patients compared to the previous out-patient treatment (OPD-treatment).

Subjects and Methods

This retrospective study was carried out by reviewing the files of all (n=232) Bahraini adult patients on CPS-HV treatment using pre/post test study design.

After the referral of patient to CPS-HV treatment, a health care team comprising a psychiatrist, a nurse, and a psychiatric social worker visited the patient at his/her home.

Subsequently, the nurse continued visits at least once every two weeks. The frequency of home visits gradually decreased if patients were stable, up to once every 8 weeks. The visits by the psychiatrist depended on the patient's condition and varied between every week to at least once every 6 months. The whole team met regularly to review patient progress assessed by the nurse during the home visit the previous day.

The inclusion criteria were: Chronic schizophrenic patients; 10 years follow-up (five years follow-up while on out-patient treatment before the referral to the community service, five years follow-up in the community service after the referral). The variables analyzed were the number of admissions in each five years of follow-up for each patient and the duration of admission in days, age at the time of this study and gender.

Among a total of 232 patients, 51 (22%) fulfilled the inclusion criteria. The proportion of males was 47.1% (n=24) and the female 52.9% (n=27). Each patient was given a code to ensure confidentiality of the information collected. Data analysis was carried out with SPSS program. Data were checked for accuracy and missing information before performing the statistical analyses. Pre- versus post-CPS-HV treatment differences were analyzed with two-tailed t-test. Patient confidentiality was ensured.

Results

Table 1:

	No of admission before referral to CPN	*Duration of admission before referral to CPN*	*No of admission After referral to CPN*	*Duration of admission after referral to CPN*
Sum	77	2577	48	1383
Std. Deviation	1.332	50.53	1.156	41.49
Mean	1.51	50.53	.94	27.12

During the five years follow-up after the referral to the CPS-HV treatment patients had fewer number of days of hospitalization compared with the

five year follow-up with the OPD treatment before referral to CPS-HV treatment. The sum of days hospitalized was 2577 days (50.5 d/patient) in a total of 77 admissions in the five years before referral to the CPS compared with 1383 days (27.1 d/patient) in total of 48 admissions after the referral to the CPS-HV treatment (P=0.000). No single patient had more than three admissions.

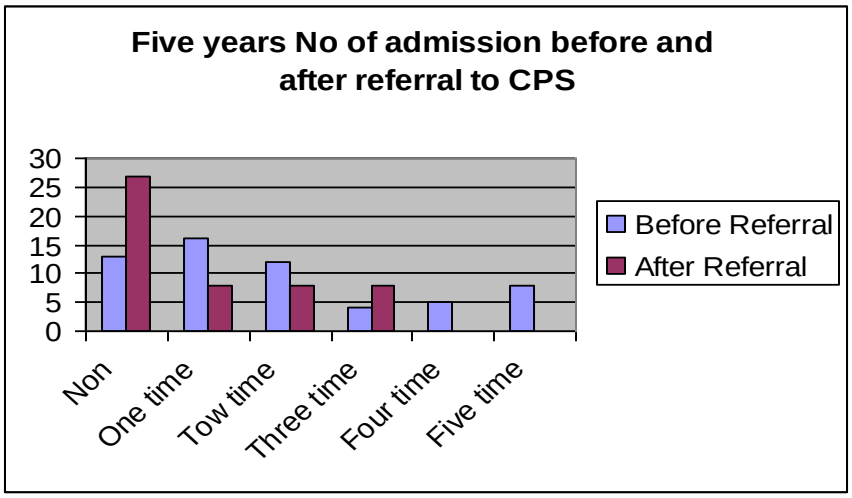
Number of non-hospitalized patients doubled during the five years follow-up in CPS-HV treatment (n=27; 10 males and 17 females vs. n=13; 4 males and 9 females).

Discussion

This study shows the effectiveness and the superiority of the CPS-HV treatment of chronic schizophrenic patients to standard OPD treatment in reducing the admissions and the duration of the admissions. Most of the previous studies have demonstrated that the community psychiatry approach reduces the admission rate and the duration of admission compared to the OPD treatment [9, 10]. However, others have confirmed the efficacy of such intervention only in reducing the admissions but not the duration of admission [11]. A systematic review has concluded that the effectiveness of home treatment remains inconclusive [12]. One of the reasons for such divergent findings is due to variations in community psychiatric programs used in different countries and the study designs used.

We found that the number of admissions declined significantly from 77 to 48 (62% reduction) and the duration of admission from 2577 days to 1383 (47% reduction). Nearly 53% of patients on CPS-HV treatment did not require admission at all. In contrast, Finland Home-Based Psychiatric Treatment study showed a decrease in hospitalization by nearly four-fifths and 50% of patients did not require admissions[9]. The reason for these remarkable improvements in treatment outcomes can be explained on the basis that the CPS-HV treatment ensures compliance with appointments, whereas the visit adherence to the OPD treatment was found to be poor for chronically ill patients with longer inter-visit intervals[7].

Figure 1:
Five years of Admission before and after referral to CPS



Poor drug compliance is associated with greater risk of hospitalization over and above any other risk factors for hospitalization [(5)]. Use of emergency psychiatry services, arrests, violence, victimization, poorer mental functioning, poorer life satisfaction, greater substance use and is associated with poorer functional outcomes [(13)]. On the other hand, the CPS-HV treatment received greater patient acceptance[(9)] which can be attributed to factors such as better therapeutic relationship between the team the patient and the family, better family education to ensure better support and avoid the high or low expression of emotion. Noncompliance with the OPD treatment appointments can be also due to lack of transport facilities, the nature of the schizophrenic in particular the negative symptoms (lack of initiation and motivation) and the lack of full insight, and anti-psychotic adverse effects. On the contrary, during regular home visit the CPS-HV team would have identified and managed the early symptoms of relapse. Further studies are needed to evaluate comparative effectiveness of first and second generation antipsychotics in CPS-HV treatment protocols [(14)].

Conclusions

CPS-HVT is effective and superior to standard outpatient treatment of chronic schizophrenic patients in reducing the number and duration of admissions, in Bahrain. Future studies should evaluate a wide range of other outcomes, including the cost effectiveness of CPS-HVT. Considering the massive impact of community-based care on patients, caregivers, clinicians and community at large, such studies are urgently needed.

الملخص

خلفيه: أن معدل الإنتكاسة لمرض الفصام عالي والتزام المرضى بأخذ الدواء على المدى الطويل تبقى معضلة في علاج مرض الفصام. إن الدراسات السابقة حول العلاج النفسي في المجتمع (الزيارات المنزلية) غير حاسمة في نتائجها

الأهداف: تقييم فعالية العلاج النفسي في المجتمع (الزيارات المنزليه) من حيث:

1. تقليل عدد مرات دخول المستشفى
2. تقليل فترة دخول مرضى الفصام للمستشفى

الطريقة: هذه دراسة ا سترجاعيه, دققت في بيانات ملفات مرضى الفصام البالغين (18-65) في مملكة البحرين ممن يتلقون العلاج عبر فريق العلاج النفسي في المجتمع (الزيارات المنزلية) لفترة عشر سنوات (خمس سنوات من المتابعة في العيادات الخارجية قبل تحويلهم إلى قسم العلاج النفسي في المجتمع وخمس سنوات تاليه بعد التحويل) ومقارنة عدد مرات دخولهم للمستشفى وكذلك طول مدة الدخول.

النتائج: من مجموع 232 مريض ممن يتلقون خدمة العلاج النفسي في المجتمع (الزيارات المنزلية) كان هناك 51 مريض (22%) تنطبق عليهم الإشتراطات الموضوعة. في الخمس سنوات قبل التحويل لقسم العلاج النفسي في المجتمع (الزيارات المنزلية) كان 77 مره دخول للمستشفى ولمدة 2577 يوماً (50.5 يوم/مريض) يقابلها 48 مرة دخول ولمدة 1383 يوماً (27.1 يوم/مريض) في الخمس سنوات التالية بعد التحويل لخدمة العلاج النفسي في المجتمع (الزيارات المنزلية). لم يكن هناك اذخال لمريض أكثر من ثلاث مرات. وتضاعف عدد المرضى الذين لم يتم إدخالهم للمستشفى في السنوات الخمس التالية في خدمة العلاج النفسي في المجتمع (الزيارات المنزلية) من 13 (4 رجال) الى 27 (10 رجال) حيث تشكل نسبة الرجال 47.1%

الخلاصة: إن العلاج النفسي في المجتمع (الزيارات المنزلية) فعال وأكثر تفوق من خدمة العيادات الخارجية في علاج مرض الفصام المزمن من حيث تقليل عدد مرات دخول المستشفى وكذلك مدة الدخول في مستشفى الطب النفسي بمملكة البحرين. إن الدراسات المستقبلية يجب ان تقيم مخرجات كثيرة لخدمة العلاج النفسي في

المجتمع ومن ضمنها الجدوى الإقتصادية مع الوضع في الإعتبار التأثير الكبير لخدمة العلاج النفسي في المجتمع على المرضى ومن يعتني بهم (أهلهم) و الأطباء والمجتمع بشكل عام.

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Correspondence:
Hameed Husain
Psychiatric Hospital, Ministry of Health
Kingdom of Bahrain

The Arab Journal Of Psychiatry (2009), Vol. 20, No .1, Page (42 - 56)

Gelotophobia in the Lebanon: The Arabic Version of a Questionnaire for the Subjective Assessment of the Fear of Being Laughed at

Shahe S. Kazarian, Willibald Ruch and Rene T. Proyer

جيلاتو فوبيا: في لبنان النسخه العربيه لاستبيان التقييم الذاتي للخوف من أن يضحك عليه

شاهي كازريان، ويليبالد روش وريني برويال

Abstract

Objectives: Gelotophobia, a new clinical construct, is defined as the fear of being laughed at and ridiculed and is measured by the GELOPH<15> scale. The present study describes adaptation of the English version of GELOPH<15> to Arabic, using back-translation methodology, and its validation in the Lebanese context.

Method: The Arabic GELOPH<15> is administered to a group of Lebanese university students (n=198) to assess its factor structure and to a second group of 60 university students to assess its relationship to the Arabic Humor Styles Questionnaire (HSQ), the Arabic Center of Epidemiological Studies-Depression (CES-D) scale, the Arabic Satisfaction with Life Scale (SWL).

Results: The findings support the internal consistency of the scale and its factor structure as a one-dimensional individual differences phenomenon. The findings also elucidated the relationship of the Arabic GELOPH<15>, and to life satisfaction as assessed by the Arabic Satisfaction with Life Scale (SWL).

Conclusion: Overall, the results suggest that the Arabic GELOPH<15> items are relevant in the Lebanese context, especially those that pertain to the intention of controlling oneself strongly and disengagement from social activities for self-protection from derision. As importantly, the findings are suggestive that approximately 7% of the scores exceed a cut-off point of ≥ 2.50, indicative of at least a slight expression of gelotophobic symptoms.

Key words: Gelotophobia, Fear of being laughed at, depression, life satisfaction, humor styles, Lebanon.

Introduction

Gelotophobia is defined as the fear of being laughed at[1]. Gelotophobic symptoms are such that gelotophobes do not experience laughter and smiling generally and from their interaction with others particularly, as something positive or relaxing but rather as a means of put down or aggressive acts[1-3] . Gelotophobes tend to be vigilant in social contexts and get suspicious easily while hearing others laugh. In fact, their negative perceptions are accompanied by the conviction of actually being ridiculous and therefore being laughed at for a good reason. A causal and consequential model of gelotophobia is described by M. Titze and

cited in W. Ruch[4]. In this model (see Figure 1), the development of gelotophobia is attributed to parental interactions in which children are shamed, bullied, and/or exposed to the intense, repeated, and traumatic experience of being laughed at or ridiculed. The consequences of the familial trauma of being shamed, bullied and/or laughed at are social withdrawal to avoid the possibility of being laughed at or ridiculed; 'cold as ice' or humorless appearance; poor self liking and self competence; lack of livelihood, spontaneity and joy; diminished ability to appreciate laughter and smiling as joyful social experiences; and somatization of disturbances in the form of blushing, headaches, dizziness, and sleep disturbances[1,4] . The etiological and consequential model of gelotophobia of M. Titze is based on observations from case-studies and provides a useful theoretical perspective for the investigation of the etiology of gelotophobia[5-6]. First evidence on the existence of gelotophobia as a clinical phenomenon with core symptoms distinct from other neurotic conditions stemmed from observations and diagnostic assessments by clinicians in single-case studies[7-8]. While gelotophobia was initially conceptualized as a categorical clinical phenomenon, Ruch and Proyer[9] have suggested a dimensional approach to gelotophobia which considers fear of being laughed at as an individual difference phenomenon ranging on a continuum from low to high fear and of relevance within the range of normality. Ruch & Proyer[5] have also pioneered the development and refinement of scales to measure gelotophobia (GELOPH<15>), gelotophilia or the joy of being laughed at (PhoPhiKat-45 scale) and katagelasticism or the joy of laughing at others (PhoPhiKat-30 scale). GELOPH<15> is a 15-item self report measure of the core symptomatic components of fear of being laughed at. The scale is available in the English and German languages and is used in clinical and non-clinical contexts[10-11].

The reliability and validity of the GELOPH<15> has been examined in a number of studies with good psychometric properties[9]. Gelotophobes, as assessed by GELOPH<15>, are shown to underestimate their abilities regarding general intelligence, vocabulary, and attention[12] ; they tend to recall situations of being laughed at with a higher intensity than people with gelotophilia or people with katagelasticism[13]; they report more anomalies relating to others (experiencing positively motivated laughter as more unpleasant and being more prone to estimate that the laughing person was in a state of negative affect)[14]; and they obtain higher scores on introversion and neuroticism as measured by the Eysenck Personality Questionnaire[15].

The focus of the present study is on gelotophobia in the Lebanese context.

Anxiety and fear associated with being laughed at and ridiculed is of particular relevance to the prevailing parenting styles

in the collectivist Arab culture generally and Lebanese culture in particular[16-17]. The Lebanese tend to be highly motivated to promote personal and collective honor and maintain positive outward appearances and to avoid fear of shame, humiliation and negative judgment caused by public exposure of dishonor. The *Ahel* of Lebanese children, that is, parents and other adult participants in child rearing, socialize their children to value *Adab* (conduct that is becoming of a properly raised person) and social convention to bring *sharaf* or honor (*Aird* in the case of women) to themselves and to their kin, and to avoid the fear of *aib* or shame and humiliation caused by failure to conform to group norms and the resultant social calamities of *bahdaleh* and *tasharshoh*-public exposure of dishonor[18]. As such, children who violate social conventions may be threatened, punished physically and belittled by their *Ahel*, peers and schools with such diminishing labels as *houmar* (donkey), *mouaak* (disabled), and *bala agel* (without a brain). Children exposed to verbal and physical punishment and belittlement tend to develop shy and introverted avoidance of social interactions to escape the problem of being subjected to belittlement or being laughed at and ridiculed (May Awaida, personal communication, October 29, 2008).

Even though gelotophobia is of cultural and clinical relevance, it has not been studied among Lebanese. The lack of systematic research on fear of being laughed at and ridiculed in the case of Lebanon is not surprising in view of the absence of psychometrically sound and culturally-relevant instruments for the assessment of the construct. In the present study, the English version of the GELOPH<15> scale is translated into Arabic for validation purposes in the Lebanese context. As such, the aim of the present study was threefold. Firstly, the reliability and factor structure of the Arabic translation of the GELOPH<15> and the correlation of item scores and total scores with age and sex were examined for comparison purposes with the original scale[9]. The cultural relevance of the Arabic translation of the GELOPH<15> and its single items (i.e., symptoms) in terms of low vs. high agreements and the cut-off scores as suggested by Ruch and Proyer[9] for the estimation of the prevalence of gelotophobes was also examined. On the basis of anecdotal evidence and discussions with indigenous Lebanese professionals, and considering the Lebanese cultural preoccupation with honor and shame, the Arabic GELOPH<15> was expected to show cultural relevance and acceptable psychometric properties.

Thirdly, the relation of GELOPH<15> scores to humor styles[19]; psychologcial distress in the form of depression[20] and subjective well-being[21] were attempted. The original GELOPH<15> has been investigated in relation to humor styles[22] and life satisfaction[23] but not psychological

distress. In the present study, postive correlations between fear of being laughed at and the two maladaptive humor styles of self-defeating humor and aggressive humor and negative correaltions with the two adaptive humor styles of affilitaive humor and self-enhancing humor were expected. These predictions are based on the assumption that people with gelotophobia perceive themeselves as humor inept[22] and as such they are more likely to engage in humor that is detrimental to self and others and less likely to engage in humor that is enhancing of self and others.

Similarly, in the present study a postive correlation between fear of being laughed at and depression was expected. As diminishment of liveliness, spontaneity, and joy is a consequence of gelotophobia[4], a positive correlation between Arabic GELOPH<15> scores and depression scores was hypothesized.

Finally, in the present study, Arabic GELOPH<15> scores were not expected to correlate significantly with overall life satisfaction scores. This prediction was based on the assumption that people with gelotophobia in the shame-oriented collectivist Lebanese culture are dependent more on social, economic, and political contextual factors for overall life satisfaction rather than positive or negative personal attributes such as ability or fear. The prediction of a lack of correlation between gelotophobia scores and life satisfaction scores is in contrast to individualist cultures in which the personal attribute of fear of being laughed at is hypotheisded to be a predictor of life satisfaction, a proposition that is supported empirically[22] .

Method

Participants**:**

Two independent samples were used in the present study. The first sample consisted of 198 single university students (98 males and 100 females) with a mean age of 19.42 (SD = 1.24). The second sample comprised 60 non-married university students (30 males and 30 females) with a mean age of 19.45 years (SD=1.23).

Instrumentation

Arabic GELOPH<15>[9]. The GELOPH<15> is a 15-item questionnaire for the subjective assessment of gelotophobia. All items are positively keyed and the 4-point answer format ranges from 1 = "strongly disagree" to 4 = "strongly agree". The GELOPH<15> is the standard instrument for the subjective assessment of gelotophobia and is widely used in research[1,3,9,10-11]. The Arabic version is provided in Appendix I.

Arabic Center for Epidemiologic Studies-Depression Scale[20] (Arabic CES-D). The CES-D is a 20-item measure of depressive symptoms in the general population. Each item requires a rating from 1 to 4, higher scores indicating more depressive symptoms. In the present study,

the internal consistency of the Arabic CES-D scale was .82.

Arabic Humor Styles Questionnaire[19,24] (Arabic HSQ). The HSQ is a 32-item measure comprising four 8-item scales assessing four styles of humor: Affiliative (e.g., "I laugh and joke a lot with my friends"); Self-enhancing (e.g., "My humorous outlook on life keeps me from getting overly upset or depressed about things"); Aggressive (e.g., "If someone makes a mistake, I will often tease them about it"); and Self-Defeating humor (e.g., "I often try to make people like or accept me more by saying something funny about my own weaknesses, blunders, or faults"). Respondents indicate the degree to which they agree with each item using a 7-point Likert scale. The four humor styles were scored following Martin et al. [19] to ensure comparability with results reported by Ruch et al. [22] who also used the HSQ and followed Martin et al.'s [10] scoring system. The internal consistencies (Cronbach α) of the four humor styles in the present study were as follows: .77 for Affiliative, .73 for Self-Enhancing, .68 for Aggressive, and .76 for Self-Defeating humor.

Arabic Life Satisfaction Scale[21] (Arabic LSS). The Arabic LSS is a five-item measure of overall satisfaction with life. Each item requires a rating from 1 to 7, higher scores indicating more overall satisfaction with life. In the present study, the internal consistency of the Arabic LSS was .73.

Procedure

The GELOPH<15> was translated from English to Arabic and an independent bilingual person translated this version to English. The two English versions were compared and modifications were applied. The authors of the original version helped in critical cases. This procedure ensured that the original version was correctly translated but also that cultural specifications were taken into account. Before the questionnaire was distributed it was given to graduate students in psychology for testing its understandability and readability. The Arabic GELOPH<15> was adminstered to particpants in the first sample (n=198), all Lebanese students at the American University of Beirut whereas the Arabic GELOPH<15>, the Arabic CES-D, the Arabic HSQ and the Arabic LSS were adminsitered to particpants in the second sample (n=60), all Lebanese students at the same university. The three measures were administred in a random order to minimize potential order effects. The Arabic CES-D and the Arabic HSQ did not require translation as they had already been translated into Arabic[24] . On the other hand, the LSS was translated into Arabic following back-translation methodoogy. The data collection took place between May 2nd and May 8th 2007.

Results

Internal Consistency of Arabic GELOPH<15>

The Arabic GELOPH<15> yielded high

internal consistency (α = .85 for the first sample and α = .82 for the second sample). We also computed for the first sample mean scores and standard deviations for each item separately and a total score, and correlated them with age and sex. As can be seen in Table 1, the corrected item-total correlations ranged between .24 and .64 ($\underline{M}$ = .49) and gelotophobia scores were not related to age or sex.

Factor Strcture of Arabic GELOPH<15>

For examination of the factor structure (unidimensionality) of the scale we computed a principal components analysis for the 15 items. The analysis revealed one strong first factor. The eigenvalues were 5.04, 1.25, and 1.12, respectively. The first factor explained 33.62% of the variance. The loadings of the items on the first factor ranged between .29 (item 7; "I believe that I involuntarily make a funny impression on others") and .72 (item 46; "When I have made a fool of myself in front of others I grow completely stiff and lose my ability to behave adequately"). The median of the loadings on the first factor was .57. Overall, a one-dimensional solution did fit the data best.

Prevalence of Gelotophobia

The answer categories of the items of the Arabic GELOPH<15> provided a possibility of estimating the relative importance of individual gelotophobia symptoms. Therefore, we computed a total score of the two answer categories indicating agreement to an item (i.e., "agree" and "strongly agree") and the frequency of the endorsement to each item was computed. The average item

endorsement was 22.03% and the range was between 5.50% (item 8; "Although I frequently feel lonely, I have the tendency not to share social activities in order to protect myself from derision") and 39% (item 6; "I control myself strongly in order not to attract negative attention so I do not make a ridiculous impression").

The categorical analyses of the Arabic GELOPH<15> showed that there were single items that were highly endorsed in Lebanon. Application of previously established cut-off scores for gelotophobia[9] (i.e., a mean score $\geq$ 2.50) resulted in 7.07% of the scores exceeding the score indicative of gelotophobic symptoms: 6.06% were characterized with slight and 0.51% with pronounced expressions, and 0.51% yielded extreme expressions of the fear of being laughed at.

Arabic GELOPH<15>, Depression, Humor Styles and Life Satisfaction

The correlations of Arabic GELOPH<15> scores to depression scores, humor style scores and life satisfaction scores are provided in Table 2. As can be seen, Arabic GELOPH<15> scores correlated significantly with Arabic CES-D scores ($r=.47$, $p<.0001$) but not with humor styles ($r=-.08$ for Affiliative humor, $r=-.21$ for Self-Enhancing humor, $r=-.08$ for Aggressive humor, and $r=.14$ for

Self-Defeating humor) or life satisfaction scores (r=-.09).

Discussion

The purpose of the present study was to validate the Arabic GELOPH<15> in the Lebanese context as the availability of psychometrically sound and culturally relevant assessment tools is a prerequisite for the systematic study of gelotophobia in Lebanon and other Arabic speaking groups in the Arab world and the Arab diaspora. The present study supports the cultural relevance of the Arabic GELOPH<15> in Lebanon in that the factor structure of the Arabic GELOPH<15> is comparable to the original GELOPH<15>, as is its acceptable internal consistency.

Gelotophobia scores as assessed by the Arabic GELOPH<15> seem independent of age and sex; findings that are in line with data from the German-speaking world where gelotophobia scores also existed independently from demographic variables[9,11]. However, it has to be noted that the age range was limited in the present university student sample. As such, the independence of Arabic GELOPH<15> scores from age is considered tentative and subject to continued investigation. Also, Arabic GELOPH<15> scores in the present study were not related to marital status as all participants in the sample were single. As such, the relationship of Arabic GELOPH<15> with marital status needs to be examined in samples more representative of the Lebanese population.

In the present study, the Arabic GELOPH<15> was also examined in the Lebanese context in relation to humor styles, depression, and overall life satisfaction. Arabic GELOPH<15> scores were hypothesized to correlate positively with the two maladaptive humor styles (aggressive humor and self-defeating humor) and negatively with the two adaptive humor styles (affiliative humor and self-enhancing humor). Arabic GELOPH<15> scores in the present study failed to correlate with any of the four humor styles. The lack of positive correlations between Arabic GELOPH<15> scores and the two maladaptive humor styles are consistent with findings reporetd by Ruch et al. [22] whereas the lack of negative correaltions between Arabic GELOPH<15> scores and the two adaptive humor styles are inconsistent with findings reporetd by the same authors. While the discrepancy in findings needs to be elucidated, the findings in the present study suggest that humor styles as assessed by the Arabic HSQ appear unrelated to gelotophobia. As HSQ-derived humor styles are construed as individual difference attributes, it is tempting to suggest that the lack of indulgence of gelotophobes in any of the four humor styles is reflective of humorlessness, a consequence of gelotophobia identified by M. Titze[4] in his causal and consequential model of gelotophobia.

In the present study, Arabic

GELOPH<15> scores were expected to correlate significantly with CES-D scores in that fear of being laughed at, ridicule and humiliation are important sources of psychological distress to the individual. While the present study supports the hypothesized relationship between gelotophobia and depression, the findings are correlational, and as such, directionality is a limitation. It is possible that gelotophobia symptoms contribute to depression but it is equally likely that depression contributes to gelotophobia symptoms. Nevertheless, the correlation between gelotophobia and depression provides support to the causal and consequential model of gelotophobia advanced by M. Titze[4] in which lack of liveliness is identified as one of the important consequences of gelotophobia.

In the present study, Arabic GELOPH<15> scores, as hypothesized, failed to correlate with overall life satisfaction scores, a finding inconsistent with the significant negative correlations reported by Proyer et al.[23] for samples from Austria, China, and Switzerland (r's between -.29 and -.40, $p < .01$). A likely explanation for the discrepancy in findings is that predictors of overall life satisfaction are partly culture-bound rather than totally universal. In the present study, Arabic GELOPH<15> scores were not expected to correlate with overall life satisfaction as for the collectivist Lebanese satisfaction with life is likely to be determined by contextual factors such as family, economy and political stability more so than internal attributes such as fear and anxiety.

Finally, slightly more than 7% of respondents to the Arabic GELOPH<15> exceeded the cut-off scores for at least slight expressions of the fear of being laughed at. The prevalence rate of 7% obtained in the present study is lower than the one reported for Germany by Ruch and Proyer[9], and perhaps is an underestimate of the true prevalence in the general Lebanese population as the present sample constituted a Western-acculturated and a socio-economically advantaged group.

In summary, the Arabic GELOPH<15> yielded good psychometric properties and the factorial structure was highly comparable to the one reported for the original scale[9]. It seems to be a useful instrument for the assessment of the fear of being laughed at in the Lebanese context, and perhaps in other Arab speaking people in the Arab world and the Arab diaspora.

However, one of the aims of this article was also to stimulate research interests among researchers in Lebanon and the Arab world. As the scientific study of gelotophobia has only recently begun, there are a lot of open questions that should be addressed in the future.

Figure 1

A model of the putative causes and consequences of Gelotophobia as proposed by M. Titze (as cited in Ruch, 2004).

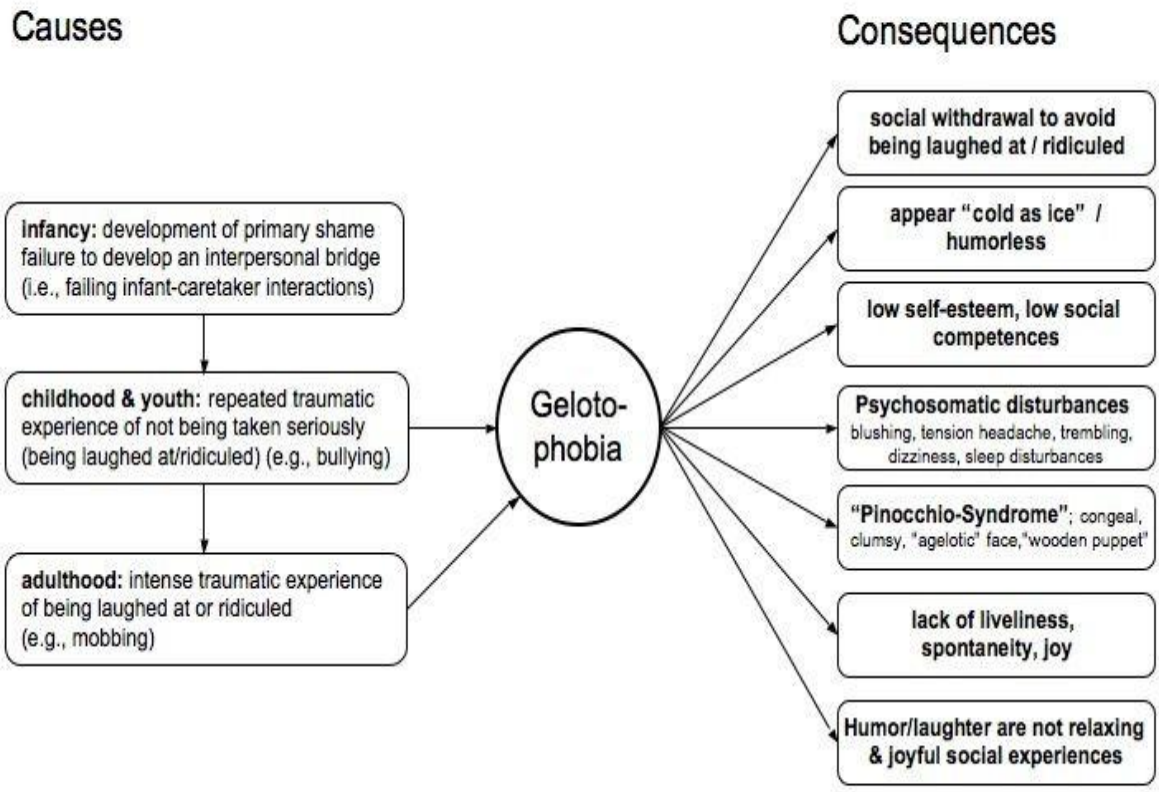

Figure 1. A model of the putative causes and consequences of Gelotophobia as proposed by Titze (Ruch, 2004)

Table (1) Descriptive Statistics, Corrected Item Total Correlations, and Correlations with Age and Gender for the Arabic GELOPH<15>.

	M	SD	CITC	Age	Sex
Item 1	1.93	0.79	.40	-.02	.05
Item 2	1.55	0.68	.42	.02	-.05

Item 3	1.86	0.80	.43	.02	-.09
Item 4	1.77	0.80	.59	-.09	.08
Item 5	1.90	0.83	.57	.00	.11
Item 6	2.20	0.98	.53	-.07	.06
Item 7	2.03	0.87	.24	-.09	-.15*
Item 8	1.48	0.65	.35	-.05	-.05
Item 9	1.98	0.82	.52	.15*	.07
Item 10	1.79	0.84	.51	.07	.01
Item 11	2.08	0.89	.54	.01	.22**
Item 12	1.91	0.87	.58	.03	.20**
Item 13	1.73	0.82	.42	.00	.08
Item 14	1.67	0.75	.55	-.07	-.05
Item 15	2.08	0.83	.64	.02	.10
Total	1.86	0.46	.49	-.01	.08

Note. *N* = 219-220. *M* = mean, *SD* = standard deviation; *CITC* = corrected item-total correlation (total = median CITC); *Age* = correlation with age, *Sex* = correlation with *sex* (1 = males, 2 = females).

*$p < .05$; **$p < .01$.

Table (2) Correlations between Arabic GELOPH‹15› scores (n=60), depression, humor styles and life satisfaction**.**

	SWLS	Depression	Affiliative Humor	Self-Enhancing	Agressive Humor	Self-Defeating
Geloph	-.09	.47**	-.08	-.21	-.08	.14
SWLS	-	-.14	.32*	.20	.16	.05
Depression	-.14	-	-.18	-.30*	-.11	-.02
Affiliative Humor	.32*	-.18	-	.27*	.24	.34**
Self-Enhancing	.20	-.30*	.27*	-	.10	.25
Aggressive Humor	.16	-.11	.24	.10	-	.37**
Self-Defeating	.05	-.02	.34**	.25	.37**	-

*$p < .05$; **$p < .01$.

Appendix I : Arabic GELOPH_

التعليمات: تشير العبارات التالية إلى مشاعرك وأفعالك وإدراكك **بصفة عامة**، لذا يرجى محاولة تحري الدقة القصوى عند وصف ردود أفعالك وأنماط سلوكك المعتادة من خلال وضع علامة X على أحد الخيارات الأربعة. يرجى استخدام المعيار التالي: (1) أعارض بشدة (2) أعارض (3) أوافق (4) أوافق بشدة

على سبيل المثال:

أنا شخص مرح

.....

..... (1) (2) (3) (4)

إذا كنت توافق بشدة على هذه العبارة، بمعنى إذا كنت **بصفة عامة** شخصاً مرحا، **ضع علامة X أمام (4)**. أما إذا كنت تعارض هذه العبارة بشدة، بمعنى أنك **عادة *لست*** مرحاً *على الإطلاق*، **ضع علامة X أمام (1)**. وإذا واجهت صعوبة في الإجابة على أحد الأسئلة، اختر الإجابة المناسبة **أكثر**. **يرجى الإجابة عن *كل* الأسئلة، ولا تحذف أي سؤال**

1	عندما يضحك الناس في وجودي، أشعر بالارتياب.	(1) (2) (3) (4)
2	أتفادى الظهور على الملأ لأنني أخشى أن يدرك الناس شعوري بعدم الأمان وبالتالي قد يسخرون مني.	(1) (2) (3) (4)
3	عندما يضحك الغرباء في وجودي، غالباً ما أربط بين هذا وبين شخصيتي.	(1) (2) (3) (4)
4	من الصعب على أن أستمر في النظر في عين شخص آخر لأنني أخشى أن يتم تقييمي بشكل يحط من قدري.	(1) (2) (3) (4)
5	عندما يقوم الآخرون بإطلاق النكات علي، أشعر بالشلل.	(1) (2) (3) (4)
6	أتحكم في نفسي بشدة حتى لا ألفت الانتباه إلي بشكل سلبي ويأخذ الآخرون عني انطباعاً سخيفاً.	(1) (2) (3) (4)
7	أعتقد أنني عفوياً أترك انطباعاً لدى الآخرين بأن شخصيتي هزلية.	(1) (2) (3) (4)
8	بالرغم من أنني أشعر كثيراً بالوحدة، فإن لدي النزعة لعدم مشاركة الأنشطة الاجتماعية مع الآخرين لأحمي نفسي من السخرية.	(1) (2) (3) (4)
9	عندما يظهر عني انطباعاً محرجاً في مكان ما، أتفادى الذهاب إلى هذا المكان مستقبلاً.	(1) (2) (3) (4)
10	لو لم أكن أخشى أن يسخر مني الناس، لكنت قد تحدثت أكثر على الملأ.	(1) (2) (3) (4)

11	إذا قام أحد الأشخاص مرة بالسخرية مني، لا يمكنني التعامل معه بعد ذلك أبداً بغير تحفظ.	(1) (2) (3) (4)
12	يستغرق الأمر مني فترة طويلة حتى أتمكن من التغلب على الإحساس بأن الآخرين سخروا مني.	(1) (2) (3) (4)
13	عند الرقص أشعر بعدم الارتياح لأنني مقتنع بأن الذين يشاهدوني يرون أنني سخيف.	(1) (2) (3) (4)
14	عندما أشعر بأنني غير معني نسبياً بالموضوع، يزيد الخطر بأن أجذب نحوي الانتباه سلبياً وأظهر كأنني غريب الأطوار للآخرين.	(1) (2) (3) (4)
15	عندما أقوم بتصرف أحمق أمام الآخرين، أصبح متوتراً تماماً وأفقد القدرة على التصرف بشكل مناسب.	(1) (2) (3) (4)

يرجى التحقق من أنك أجبت على **كافة** الأسئلة.

الخلاصة:
الأهداف: الجلاتوفوبيا Gelotophobia مفهوم سريري جديد، يعرّف بالخوف من أن يضحك على الفرد أو أن يسخر منه ويقاس بمقياس كالوف <15> Geloph . تصف الدراسة الحالية تكيّف النسخة الإنجليزية لكالوف <15> Gelophإلى العربية، بإستعمال منهجية الترجمة الخلفية، وباسقاطه على السياق اللبناني.
المنهج: تم اختبار كالوف <15> العربي عن طريق مسح باستمارة اعطي لمجموعة من طلاب الجامعات اللبنانيين (n =198)لتقييم بنية العامل (factor) ولمجموعة ثانية من 60 طالب جامعة لتقييم علاقته باستمارة المرح العربي (Arabic Humor Styles Questionnaire) و بمقياس المركز العربي للدراسات المرضية للكآبة (Arabic Center of Epidemiological Studies-Depression)، وبمقياس الرضاء بالحياة العربي (Satisfaction with Life Scale).
النتائج: تدعم النتائج الإتساق الداخلي للمقياس ولبنية عامله كظاهرة إختلافات فردية أحادية البعد. وضّحت النتائج علاقة كالوف <15> Geloph العربي أيضًا، وإلى الرضاء بالحياة كما يقيّمه من قبل مقياس الرضاء العربي.
الخاتمة: عموما، تقترح النتائج بأنّ اسئلة كالوف Geloph<15> العربي ذات علاقة في السياق اللبناني، خصوصا تلك التي تخصّ نية سيطرة على الذات بقوة والتحرر من النشاطات الإجتماعية للحماية الذاتية من السخرية. بنفس الأهمية، توحي النتائج بأن 7 % منهم قد تجاوز نقطة الفصل 2.50، التي تعتبر مؤشّر تعبير طفيف على الأقل من أعراض كالوتيفوبية.
الكلمات المفتاحية: الكالوتيفوبيا Gelotophobia، الخوف من السخرية وضحك الأخرين على الفرد، رضاء بالحياة، الكآبة، لبنان

Acknowledgments

The authors would like to thank Dr. Nahwat El-Arousy (Helwan University, Cairo) for translating the English version of the GELOPH scale into Arabic, and Sari Hanafi (American University of Beirut) for translating the English Abstract into Arabic. Thank you also to Dr. May Awaida (American University of Beirut) for her useful comments on Lebanese child rearing practices and their consequences.

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Correspondence:
Shahe S. Kazarian
Professor of Psychology, Department of Social and Behavioral Sciences, American University of Beirut,
Beirut 1107-2020, Lebanon
Willibald Ruch
Professor of Psychology, Universität Zürich, Psychologisches Institut,
Persönlichkeitspsychologie und Diagnostik
Binzmühlestrasse 14/7, CH-8050 Zürich
Rene T. Proyer
Professor of Psychology, Universität Zürich, Psychologisches Institut,
Persönlichkeitspsychologie und Diagnostik
Binzmühlestrasse 14/7, CH-8050 Zürich
Address for Correspondence: Shahe S. Kazarian, American University of Beirut, Beirut 1107-2020, Lebanon. Tel 961 1 350,000 ext 4374; Fax: 961-1-739973, e-mail:sk29@aub.edu.lb.

The Arab Journal of Psychiatry (2009). Vol.20. No. 1 Page (57-65)

Medical Ethics

The WPA position statement on the ethics of the use of unmodified electroconvulsive therapy

Mohammed T Abou-Saleh, George Christodoulou

تقرير عن موقف الجمعية العالمية للاطباء النفسانيين من اخلاقيات العلاج الكهربائي الغير معدل

محمد ابوصالح و جورج كريستو دولو

Abstract

This position statement is an addendum to the one on the use and safety of electroconvulsive therapy that was prepared by the Section of Biological Psychiatry in 2004 and was eventually approved by the WPA General Assembly in 2005[1].

Introduction

The WPA position statement on the use and safety of ECT has referred to ethical considerations in its use; the need to obtain informed consent from those with capacity to consent; to ensure that the patients' relatives and carers are consulted in the case of patients with impaired capacity to consent and to seek a second opinion from an appropriately trained professional. However, the statement has not referred to the use and safety of unmodified ECT or the ethics of its practice. It is to be noted in this context that most national guidelines on the use of ECT have not referred to the use of unmodified ECT. This may be related to the notion that unmodified ECT is hardly ever used in Western Europe, North America and Australasia, countries that have produced these national guidelines. The WPA, as a global health professional organisation needs to provide guidance on the use of unmodified ECT in view of the continued use of this method in many countries.

The use of unmodified ECT

Electroconvulsive therapy, which was introduced in 1938, was originally unmodified and involved the administration of electrical current resulting in a generalised convulsion. Injuries resulting from violent convulsions were prevented by applying physical restraint and holding of the patient. ECT induces

a central seizure detected by electroencephalogram and a visible convulsion. All along, it was conceived that the central seizure and the peripheral convulsion were the effective ingredients in ECT. The ECT procedure was modified in 1950s with the introduction of anaesthesia and muscle relaxation prior to the administration of ECT. In addition, patients were premedicated with atropine administered subcutaneously 30-60 minutes before the ECT to reduce bronchial secretions and inhibit the vagal discharge which accompanies the convulsion and thus minimise the occurrence of arrhythmias. In view of the cerebral effects of atropine it was replaced by methylscopolamine, which does not cross the blood-brain barrier.

For anaesthesia, short acting barbiturates such as methylhexitone or thiopentone are used at the minimal dose so that the seizure threshold is not raised. The dose should be sufficient to induce unconsciousness to prevent the terrifying experience of total paralysis, including paralysis of respiratory muscles, induced by the muscle relaxant.

Once the patient is rendered unconscious, the muscle relaxant (suxamethonium), the modifying agent with the effect of abolishing the peripheral convulsion is introduced. Once the anaesthetic and the muscle relaxant are given, 100% oxygen is administered by mask before and after the convulsion and continued until spontaneous respiration has returned. The safe administration of ECT requires the involvement of an anaesthetist or other appropriately trained health practitioners such as psychiatrists or nurses.

Current use of unmodified ECT

The use of unmodified ECT has been variously described as barbaric, inhumane and unethical, labels that have also been used to describe ECT whether modified or unmodified. In the case of unmodified ECT, this derives from the impression of the onlookers witnessing the patient whilst having a generalised convulsion and being physically held and restrained to prevent physical injury. With the introduction of modified ECT in the 1950s the use of unmodified ECT was gradually phased out over the next two decades. Modified ECT has become the standard practice in Western Europe, North America and Australia. However, reports and surveys have shown that unmodified ECT is still used in

Japan, Russia, China, India, Thailand, Turkey and in many low and middle – income countries.

Concerns were expressed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment on the use of unmodified ECT in Turkey (http://www.cpt.coe.int/en/states/tur.htm).

The Turkish Government has responded to the report indicating that it has taken corrective action (http://www.cpt.coe.int/documents/tur/2006-30-inf-eng.htm).

A recent survey of ECT practice in Japan reported the use of unmodified ECT in 60 institutions[2.] and in 37 of these 60 institutions unmodified ECT was used exclusively, less in University than in non – University psychiatric hospitals. The reasons for using unmodified ECT included emergency, lack of anaesthetist and equipment, being "safer than modified ECT" and being reserved for young people. Particular side effects of unmodified ECT included incidence of teeth injury, arrhythmia and fracture/dislocation. No cases of ECT – related death were reported.

A national survey of ECT use in the Russian Federation reported that fewer than 20% of ECTs were modified with anaesthesia.

Anaesthesia and muscle relaxants were never used in 31 out of the 42 responding institutions estimating that 21% of institutions used modified ECT at least sometimes [3]**.** It was noted in the report that there was no system or expectation for ECT training and no national organisation to advance ECT practice despite the respondents' enthusiasm and positive attitudes towards ECT and for adopting modern ECT methods.

The national Survey of ECT Practice in Thailand [4]**,** showed that unmodified ECT was used always in 9 psychiatric and 5 general hospitals and occasionally in two university hospitals comprising 94% of all ECT use. Respondents gave reasons for their use of unmodified ECT: lack of funds, convenience, lack of personnel, lack of equipment, lack of anaesthesia and economic reasons. This was related to the poor infrastructure and resourcing of mental health services and specifically to the psychiatrists' attitudes and lack of training in the practice of ECT.

A survey of the practice of ECT

in 188 teaching institutions and psychiatric hospitals in India showed that more than 70% of ECT administrations were performed in psychiatric hospitals and approximately half of ECT use was on unmodified ECT[5] **.**

However, there are very few reports on the use of unmodified ECT from low income countries except for earlier studies from Nigeria indicating that unmodified ECT was the main method of administration[6, 7]**.** This is likely to be the case in many low income countries in view of the poor infrastructure and funding for psychiatric services and the lack of trained mental health professionals.

The efficacy and safety of unmodified ECT

There have been few controlled studies on the comparative efficacy of modified and unmodified ECT.[8] Kendell reviewed the few controlled studies and concluded that modified and unmodified ECT were equally effective, as shown in the studies by havens (1958) and Seager (1959)[9,10] which both involved substantial numbers of patients who were randomly allocated to the two treatments. Further studies specifically evaluating the therapeutic effects of the convulsion confirmed it as the therapeutic ingredient[11, 12.13.] The role of the convulsion in mediating the therapeutic effects of ECT has, of course, been strongly supported by the controlled studies of real and simulated ECT reviewed in the WPA consensus statement on its use[1].

The controversy over the use of unmodified ECT, however, has been mainly related to its risks and adverse effects. Not withstanding the recognised and well documented adverse effects of ECT as reviewed in the WPA consensus statement, unmodified ECT has been associated with physical injuries produced by the uncontrolled convulsive movements which cause fractures in the mid thoracic vertebrae and dislocations particularly of the jaw, occurring in 30% of patients in some studies[8,14] They highlighted the disadvantages of unmodified ECT with reference to Western research conducted in the 1940s and 1950s which suggested that convulsions were associated with 20-40% risk of multiple subclinical vertebral body compression fractures mostly affecting the middle thoracic vertebrae observed

mainly in males, in young and in old subjects. However, these fractures were not associated with pain or other symptoms and did not require orthopaedic intervention.

Andrade et al (2003)[14] have reported new research on the adverse effects of unmodified ECT conducted in India between 1980 and 1990, reporting that only 0.7 % of patients had fractures with unmodified ECT, the majority of whom suffered no pain or disability or other musculoskeletal complications . A further study with radiological evidence showed 2% rate of vertebral injury[16.] Unmodified ECT does not appear to cause internal tissue damage expressed in a number of metabolic changes[17].

It must be noted that unmodified ECT is essentially unmonitored ECT as well, meaning that all acquired knowledge as to the monitoring of the seizure and the related physiological parameters cannot be used.

Ethical considerations

The principal ethical concern about the use of unmodified ECT is related to the risk of suffering the aforementioned adverse effects that do not occur when modified ECT is used. However, such risks should be set against the benefits of administration of unmodified ECT in cases where ECT is strongly indicated and can not be given in its modified form. Such a case is psychotic depression with high suicidal risk which requires rapid intervention with ECT, the most effective treatment in such a condition.

The pros and cons of administering unmodified ECT should be carefully considered. Informed consent, including consent of the patient's relatives and carers should be secured. Moreover, there needs to be an appreciation of the realities of practice of ECT in low income countries with poor service infrastructure and limited availability of anaesthetists and medication for the administration of modified ECT. It must be noted that there is no guidance on the use of unmodified ECT by the American Psychiatric Association, the Royal College of Psychiatrists and other authoritative bodies catering for ECT practice in high income and well resourced countries. The WPA as a global association of national psychiatric organisations strongly advocates the use of modified ECT as

standard and optimal practice. However, it is recognised that there are cases in which psychiatrists are faced with the situation where ECT is strongly indicated but there are no facilities and skilled staff to administer it in its modified form. In these cases unmodified ECT should be considered as an option after full consultation with the patients and their relatives and ensuring informed consent is obtained. Such considerations are no different from considerations of urgent medical and surgical interventions that may be associated with greater risks and more serious adverse effects.

Andrade et al (2003)[18] in their commentary on the dilemma of unmodified ECT referred to the civil rights activities in India which culminated in a non - governmental organisation for the rights of the mentally ill filing a writ petition to the supreme court of India in 2001 seeking a blanket prohibition of the practice of unmodified ECT. In relation to this, it is noted that the national psychiatric associations in India have advocated that whilst the practice of modified ECT should be the rule, consideration should be given to exceptions when unmodified ECT should be considered. The verdict of the Supreme Court is still awaited.

Andrade et al (2003) regretted that the Indian Psychiatric Society had not taken an official position on the use of unmodified ECT or produced guidelines to that effect and have advocated that "there are extenuating circumstances in which unmodified ECT may be better than no ECT …. and that the decision to administer unmodified ECT must be made in exceptional circumstances and on a case by case basis, and never as a routine practice …… "

Conclusions and Recommendations

Whilst unmodified ECT is as effective as modified ECT (administered with an anaesthetic and a muscle relaxant), it is associated with significant risk and adverse effects (fractures and dislocation), which do not occur with modified ECT. This has rendered the use of unmodified ECT more controversial than modified ECT and raised ethical concerns over its continued use. Recent reviews of the practice of ECT has indicated that unmodified ECT is still in use in countries like Japan, the Russian Federation, India, Thailand , Turkey and most

probably in many developing and low income countries with poor infrastructure and funding for mental health services and few professional human resources.

Understandably, the guidance from National Professional Associations in Western Europe and the US have not tackled the issue of the use of unmodified ECT as it is no longer in use in these countries.

Regrettably the national psychiatric associations in countries where unmodified ECT is still in use have not provided guidance on its use. The WPA as a global professional association and following the recent international congress in Istanbul has issued this addendum statement on the use, safety and ethics of unmodified ECT and makes the following recommendation:

The National Member Societies of the WPA, in collaboration with their governments are asked to implement the WPA declarations, statements and guidelines on ethics and consider the recommendations of the WHO resource book on mental health, human rights and legislation, with the following aims:-

- To support ethical practices and observe human rights in all clinical, research, educational and policy activities;
- To implement modified ECT as standard practice for every person who needs this treatment.
- To cease the use of unmodified ECT in view of evidence indicating that this method has no difference in effectiveness from modified ECT but has more adverse effects.
- In settings where the current choice in the field is unmodified ECT or no ECT, to make decisions on the basis of the clinical condition of the patient, current evidence - based information, the informed consent of patient and relatives and the consideration of possible equally effective alternative treatments.
- To urgently make every effort for the creation of the necessary infrastructure for the provision of modified ECT. This is an ethical obligation on the part of Governments professional organizations and individual practitioners.

This statement was prepared by Mohammed T Abou-Saleh, revised by George Christodoulou and reviewed by the members of the WPA Standing Committee on Ethics and the WPA Section on Biological Psychiatry and has

incorporated the comments of the WPA Member Societies and other WPA components. Special mention must be made of the contribution of Eliot Sorel and the WPA Section on Conflict Management and Resolution which raised this matter of concern in the WPA.

الملخص :
هذه ورقه اضافه للورقه السابقه التي بينت استعمال وأمان العلاج بالإختلاج الكهربائي والتي تم تحضيرها من قبل قسم الطب النفسي البيولوجي عام 2004. وتمت المصادقه عليها من الجمعيه العالميه للطب النفسي في الهيئه العموميه عام 2005.

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Correspondence:
Mohammed T Abou-Saleh
Professor of Psychiatry & Honorary Consultant in Addiction Psychiatry
Head of Addiction Research Group
Deputy Head, Division of Mental Health
St George's, University of London
Cranmer Terrace
London SW17 ORE
UK
Professor Mohammed T Abou-Saleh On behalf of the WPA Section on Biological psychiatry
Professor George Christodoulou On behalf of the WPA Standing Committee on Ethics

The Arab Journal Of Psychiatry (2009) Vol 20, No 1 Page (66 - 77)

Point of view

Is George Kelly's constructs system (Loosening – Tightening) related to his perspective in Psychotherapy?

Saad Almoshawah

نظام التنافر والترابط البنائي المعرفي لجورج كيلي ومدى ارتباطه باستراتيجيات العلاج البنائي

سعد بن عبداللة المشوح

Abstract

George Kelly developed a theoretical position which is extended from ontological and epistemological arguments to practical applications in psychotherapy [1;2;3;4] .He presents and elaborates his position at all levels of theoretical discourse in his two volume book, "The Psychology of Personal Constructs". He calls his philosophical position "Constructive Alternativism". The personality theory he formulated is called "Personal Construct Theory". The most popular part of his work is the technique he developed for elicitation of personal constructs, which is called the "Repertory Grid Technique".

Kelly rejects the notion that human psychology can be divided into separate realms. He suggests that personal construct psychology covers both consciousness and unconsciousness. Moreover, he rejects the classical tricotomy of psychology, that is cognition (intellect), affection (emotion) and conation (action). Although his theory is considered by some others as being in the realm of cognitive psychology but he does not accept that, and consider his theory as a theory of personality which is a whole.

Indeed, Kelly suggests that there are sub-systems in a person's psychological space. These sub-systems can be relatively autonomous from each other as the fragmentation corollary suggests. They also evolve through experience as the experience corollary suggests.

The purpose of this paper is to examine Gorge Kelly's theoretical perspective, especially his constructs system (Loosening – Tightening). The article begins with an outline of Kelly's perspective, and then it discusses constructive alternatives and the loosening – tightening system.

George Kelly's Theoretical Perspective

Kelly's theoretical position has some uniqueness, and its relations with other philosophical positions and psychological theories have been subjects of controversy. However, it should be noted that Kelly's Repertory Grid Technique has been used widely not only by the followers of his theoretical line, but also many others who ignore his theory [5]. It appears that the Repertory Grid Technique is separable from its theoretical roots. This is conceivable, because it provides highly sophisticated mathematical and

statistical tools that are attractive even for those who do not understand or do not care to consider Kelly's theoretical position. These tools can be particularly attractive for statistically inclined behaviourists [6].

On the other hand, there are some theoretical arguments against taking his theory seriously. [7,8,9] argued that Kelly did not recognise his theoretical ancestry in psychology e.g. Lewin, Piaget, Allport, Werner and Sullivan who were theoretically on his side. Therefore, he hardly deserves consideration for his theoretical work. [10,11] argues that the widespread disregard of his philosophy and theory in the literature is because of its inherent weaknesses. Moreover, he also demonstrates that Kelly's self positioning vis-a-vis Existentialism, phenomenology and Marxism was based on the stereotyped American view of these philosophies.

Although I tend to agree with Holland [10]. That Kelly's evaluations of other philosophical positions are stereotypical ones, and in that sense his philosophy is weak, I do not think that his whole philosophy and theory can be labelled inherently weak. There are two crucial points to be considered when evaluating Kelly's philosophy. First, he tries to formulate his position in the context of his contemporaneous theories, particularly behaviourism in psychology. As Warren[12] argues , Kelly's philosophical position is at odds with the philosophies of his time, and it is better alignable with the contemporary developments in philosophy. This created some difficulties for Kelly in articulating his theory. Second, Kelly formulates his position in such a way that it is consistent with the main argument of his philosophy. He formulates his philosophy in a loose way. He thinks that the loosening of a person's construct system is a necessary component of creativity[6]. He also theorises that any theoretical construct is subject to change, and makes his theory amenable to such a change. As **11** suggests that George Kelly invites us to go beyond him in one of retrospective evaluations of his position. Kelly states, "Indeed our theory is frankly designed to contribute effectively to its own eventual overthrow and displacement" [13].

I am arguing for an elaboration of Kelly's philosophy and theory, not because I completely agree with him, nor that I think his position from the philosophical to operational is consistent throughout. However, there is an important premise of his approach that I totally agree with that any scientific inquiry (perspective, theory, research and etc.) should be conducted with the awareness that it is operating at all levels of knowledge process, and the inquirer should try to raise this to his consciousness and try to be consistent at

all levels. This is the message of Kelly's Personal Construct Theory.

Constructive Alternativism

Kelly[14] declares himself as being "against realism". Indeed, this self-positioning is questionable. His self – declared position vis-à-vis phenomenology is not a clear one either. He both criticises phenomenology [13] , and says that his position is a combination of the "neo–phenomenological approaches" and more conventional methodology.

According to Kelly [3, 14,15,16,17,] the universe (physical reality) exists. Is the reality of nature independent from man's knowledge of it? Is this reality orderly and lawful? He accepts the existence of reality independent from its knowledge. However, he tends to argue against the self-orderliness and self-lawfulness of the universe. He says that the universe is essentially active and ever changing [1, 18.] The reality of the universe is not divided into independent events, it is an essential continuity. Kelly aligns himself with Heraclitus's notion of an active universe and argues against Aristotle for putting science in pigeonholes (i.e., construing reality as discrete events of phenomena).

One following argument is that since reality is not discrete or composed of independent events, lawfulness and determinism are not essential to the analogy of the universe. Lawfulness and determinism are defined by mainstream science as observed repetitions in phenomena. However, no event actually doubles back on itself. Therefore, concretely, the new events are unique; it is only by abstracting them that a person finds what is replicated. In other words, repetition is nothing but a construct. Then why does man use this construct called "repetition"? Because, it is convenient and gives man a capacity to manage his world. Man has gained this construct through his experience.

One can argue that Kelly's position on the existence of the universe is a contradictory one. It can be said that the argument against the existence of discrete events or phenomena and the notion that orderliness and repetitions are nothing but construct, eventually boil down to the rejection of an independent existence of reality. On the other hand, Kelly says that he accepts the existence of reality, and recognises the manageability of reality. How would reality be manageable if repetition and orderliness were mere constructs? How could those mental tools (constructs) be of use if they did not correspond to anything? However, he does not answer these questions.

They are difficulties in Kelly's ontological position. However, it should be kept in mind that he was in a dialogue with the positivist behaviourists of this time. As Warren and others [12; 6;19]; remind us, Kelly was at odds with these theories. However, he could not develop

a sound alternative to them. I think Kelly's arguments will become more meaningful and consistent in themselves if they are related to the ontological implications of the chaos perspective.

Kelly argues against putting science in pigeonholes, which is an approach based on the assumption that the events in the external reality are discrete. His position contrary to this is that reality is an essential continuity. He is against the notion of orderliness and lawfulness of phenomena, because he is in a dialogue with naïve realism, which argues that there are iron laws in reality which are expressed in linear causalities. Those linear causalities were supposed to assure perfect predictability. Kelly was not comfortable with such a deterministic notion of science. Chaos changes the meaning of orderliness and predictability and suggests that most natural phenomena are non-linear and only partially predictable. Kelly would have been more comfortable with this notion of orderliness and predictability. He also would have found compatibility between his notion of essentially active and ever-changing universe and these ontological implications of Chaos.

According to [21], who is one of the most prominent developers of the personal construct theory after Kelly, the persistent dialectic between a man who engages in intentional action, yet whose behaviour is lawfully locked into an integral universe permeates construct theory. This tension can be observed, sometimes, in the form of contradictions in Kelly's notion of personal constructs and their relations to reality and his self-positioning vis-à-vis phenomenology and Existentialism.

According to Kelly, "the universe is existing and man is coming to know it" [(1, p.170)]. However, knowing is not simply a reflection of reality on the human mind." The universe is real, but is not inexorable unless man chooses to construct it that way" **(1. p8).** In the knowing process, man is a proactive being.

However, in the process of man's relationship with reality, Kelly argues that constructions of those realities by man play an important role. Man looks at his world through transparent patterns or templates which Kelly calls constructs. Man creates his own ways of seeing the world by imposing structure on it. Obviously, for Kelly, the superordinating view of the theorist, not the information coming from reality, determines the nature of constructing. Therefore, reality is subject to many alternative constructions. However, among the various ways in which the world is construed, some of them are undoubtedly better than others. The question of which can be better determined by testing them in terms of their predictive efficiencies.

These points may seem to contradict each other.Oliver[22], however, does not see a contradiction in his interpretations of Kelly's philosophy." Reality has that much structure enough to exclude some perceptions or interpretations of it, but it is tolerant of variety of construal and an individual in constructing freshly is exhibiting his creativity" [(22,p.188)]. Kelly places special emphasis on man responsibility in the creation of constructs. In fact, his usage of the word construct has a special meaning. He deliberately does not use the word concept because a concept it too likely to be presumed a latent category of nature – something for man's diligence to discover rather than for his ingenuity to contrive [13]. As Holland and Landfield [10; 23], Suggests, Kelly's clear distinction between concept and construct introduces the criterion of responsibility. We are responsible for our constructing, since this is the formative structure of our choosing. This is a notion; Holland argues that Kelly shares with Existentialists. Holland sees Kelly's criticism of phenomenology as a result of his not knowing much about European phenomenology and existentialism, and he argues that Kelly was a naïve existentialist. However, Holland suggests that there are two similarities between Kelly's and Existentialism; Kelly's attitude toward labels in general, and the importance he gives to a person's unique structuring of the world by impressing upon it.

A basic problem with Kelly's philosophy is, as Holland points out, his conception of man as a utopian creature, an abstract, a historic being. In his writings, it never becomes clear whether he means an individual man or a species. As Holland points out, there is no place for social forces in Kelly's philosophy and theory . Although the change, action and flow of universe are basic postulates in his philosophy, he does not mention any concrete history. In fact, he admits that his theory is historical.

This is understandable when his primary emphasis on the individual person and his construction is considered. Any mentioning of history and society would be recognition of constraints imposed upon the individual and a possibility of construction being determined by some external forces. That would not have been Kelly's position. However, Kelly does not close the door to effects of social processes in the constructing process. He states that the construction systems of an individual person can be communicated and widely shared.

The Fundamental Postulate and Its Corollaries

Kelly formulated his personal construct theory as a fundamental postulate and its eleven corollaries. Kelly's fundamental postulate says "A person's processes are psychologically channelled by the ways

he anticipates events" [1,p.46]. We can see the two key notions of Kelly's philosophy in the fundamental postulate: individual responsibility and change. However, by person, Kelly means individual person. This abstract individual person is at the core of his theory. He does not see the person as an object that is temporarily in a moving state, but rather as a form of motion. By "channelled", he means a network of pathways which both facilitate and restricts a person range of psychological action. First of all, these pathways guide a person's interpretation of external realities. His construction corollary says: "A person anticipates events by constructing their replications"**(1,p.50)**. These replications are the bases for predictions. Once events have been given beginning and endings, and their similarities and contrasts construed, it becomes feasible to try to predict them.

There are two instruments used in the construing process, construct and elements. A construct is a bipolar dimension (e.g. good – bad, inclined – not inclined, etc). Constructs are reference frames, templates through which a person sees the continuous reality and brackets it, frames it. Constructs are abstractions of reality. Elements are more concrete; they can be placed on construct dimensions. "Elements are things or events which are abstracted by a construct" [1, p.137]. Thus, elements are constructs themselves; being an element of another construct, they are also abstractions, but abstractions of a lesser degree.

Characterisation of Construction System

In Kelly's theory, constructs are not independent dimensions. They are related to each other, and constitute a whole, which is the person's construction system [14;15;16;24;18]. His organisation corollary says, "Each person characteristically evolves for his convenience in anticipating events, a construction system embracing ordinal relationship between constructs" [1,p.56].

The first important point here is that constructs of a person are organised, that is they are related to each other in a relatively stable set of relationships. This corollary suggests more than systemic relationships. It also says that there is a hierarchical relationship among constructs. Some constructs are superordinate in this systemic hierarchy, whereas others are subordinate. Kelly also uses the analogy of centrality of constructs and considers superordinate constructs as more central to the construction system of the person.

According to Kelly, a person is in need of setting up a consistent hierarchy of constructs. However, this is not for consistency's sake, unlike [25], the notion of an inherent tendency toward cognitive consonance. It is rather "to anticipate the

whole world of events and thus relate himself to them that best explains his psychological processes. If he acts to preserve the system, it is because the system in an essential chart for his personal adventures, not because it is a self–contained island of meaning in an ocean of inconsequentiality" [1,p.59].

A person's construction system is a dynamic one; it changes as the person construes his experiences. The experience corollary suggests: "A person's construction system varies as he successively construes the replication of events" [1,p.72]. Personal constructs change as one continues having experience. This implies an interaction with the environment. However, that does not mean simple reflection of external reality into a person's construct system .A person has an active role in the change of his constructs.

This corollary countervails the organisation corollary. It leaves open the possibility of inconsistencies in a person's construct system. However, according to Kelly, what one man sees as inconsistent another may see as consistent; consistency is a construct, and a personal one.

Loosening – Tightening Construct

Complexity and differentiation of a personal construct system are not stable states. The construct system changes as a person interacts with his environment. One of the dimensions of change is loosening and tightening of constructs. Loosening is defined as characteristic of those constructs leading to varying predictions, while a tight construct holds its elements firmly in their prescribed constructs. Under loose construction, an element classifies at one pole of a construct on one occasion is envisioned at the contrast pole on the other. Thus a loose construct tends to be elastic,

relating itself to its elements only tenuously; yet it retains its identity as a personal construct in the clients' system."[1, pp.1020-1030]. This definition by Kelly makes it looks as if loosening and tightening refer the relationship between a construct and its elements. However, some other parts of Kelly's works can be interpreted to mean that loosening and tightening define the relationship between the constructs. Thus, it can be said that Kelly did not make him clear on this issue. His followers picked up the issue and usually suggested that both the construct–element and construct–construct relationship are subject to loosening and tightening. However, both elements would be abstractions at varying degrees. Such a conceptualisation renders the distinction between element– construct and construct–construct relationships obsolete. Conceptualisation of both element and construct as forms of abstraction also will be more meaningful in the context of Kelly's

conceptualisation that a construct system is a whole. In his system of construct and element, we can talk about the loosening and tightening of the relationship among theses components (i.e. elements and constructs).

However, when does loosening occur? **26,** Suggests that cognitive complexity or simplicity has something to do with a person's ability to loosen his construction system. A person with relatively monolithic conceptual structures will tend to resist change in the face of ambiguity in order to avoid further confusion and anxiety. Even minor change in a tightly organised construct system can present a prospect of impending chaos. On the other hand, the explanation of Bannister etal [27], is that a person loosens his construction of events in the face of repeated predictive failure. He calls this phenomenon, serial invalidation. A person loosens the relationships between his constructs in order to minimise the reverbatory impact of further invalidation. Although this loosening of construct relationships is presumably undertaken to conserve the system, progressive loosening, without corresponding integration, eventually would lead to the collapse of the entire conceptual structure. The corresponding integration process is what Kelly calls "tightening" [14;15;16;17].

However, according to Kelly, in the loosening phase, a person may recall some events neglected before; new elements come into his field of attention. This makes constructs more permeable, i.e. more ready to change through accepting new elements on their dimensions. A person may shuffle some ideas into new combinations. Tightening, on the other hand, stabilises construction and facilitates the organisation of the ordinal relationship in a construct system. In other words, both the reconstruction of reality in a person's mind and his preferences pertinent to that reality becomes clear in the tightening process.

Kelly defines another cycle in the constructing process. That is the "Circumspection Pre-emption Control Cycle" and he calls the first cycle, the creativity cycle, which starts with loose construction rather than prepositional construction. In that case, there is a single construct shaping up. In the proposition phase of the Circumspection Preemption Control Cycle, however, this may be an array of constructs.

It is arguable that Kelly's concept - ualisation of two separate cycles is justified and related in his perspective because his distinction is based on his element construct differentiation, which he did not explain very well. But [21], dissolved this unnecessary distinction between element and constructs**[28]**, does not agree with Kelly's differentiation between the two cycles, and sees the

phases of Circumspection Preemption Control Cycle as more elaborate forms of loosening and tightening.

I agree with Bannister's view that because constructs are essentially personal, there are some constructs or some areas of construction which are shared with others. Loosening occurs due to the need for validation of construction, and validation can take place in a social context.If this validation is in relation to the constructions of others, then we may see this cycle as one of creating shared meaning.

Conclusion

In this essay I have tried to outline Kelly's perspective and his technique (loosening – tightening) constructs and to consider whether Kelly's constructs system is consistent with his philosophy and ideas about a person. It is not my aim to prove those techniques, but rather to focus in Kelly's Perspective. It has been shown, however, that despite the ambiguities and lack of clarity in Kelly's system, it is consistent with his theoretical perspective.

As a psychotherapist I believe that the constructs system has a complexity which has not been resolved. However, even with this complexity, a person may be capable of constricting broader as - pects of reality and reconstructing concrete reality in more creative ways. Indeed, I do not think that Kelly is very well in explanation about the system of loosening–tightening constructs, or his distinction between the two parts of his system and another system which he called "the Circumspection Preemption Control Cycle". Moreover, the users have not taken Kelly's theory very seriously. More importantly, the loose construction of the theory did not appear to be a strong alternative to behaviourism, even among the followers of Kelly.

ملخص

يعتبر التطور التاريخي و الرئيسي للعلاج البنائي كان علم نفس **personal construct psychology** الذي وضعه أصلاً جورج كيلي **G. Kelly** (*1955*) وطوره بعد ذلك بانيستر، فرانسيلا وزملائهم. حيث تقترح هذه النظرية أن الأشخاص البناءات الشخصية يفهمون أو "يؤولون"، العالم من خلال أنظمة البناءات الشخصية. على سبيل المثال هناك نموذج على البناء الشخصي هو "ودود-غير ودود". ذلك البناء يُمكّن الشخص من التمييز بين الأشخاص الذين يتم إدراكهم "كودودين" وأولئك "غير الوديين فهو سيتصرف بشكل
مختلف تجاه شخص مؤول على أنه "ودود" وتجاه شخص "غير ودود" ويتجسد البناء داخل نظام اعتقادي خاص بالفرد، فكل بناء لديه مداه الخاص من الملائمة. وقد ابتكر كيلي وزملائه تقنية عُرفت باسم "شبكة ذخيرة المعلومات **repertory grid** لتقييم البناء الفريد ومحتوى أنظمة البناء الخاصة بالأفراد، كما وضع عدد من الفنيات الفلسفية والنظرية لتطبيق مبادئ البناءات الشخصية في الممارسة العلاجية الاكلينيكة النفسية والتي اشتهرت باسم التنافر

والترابط البنائي المعرفي **Loosening – Tightening system** ، حيث يُطلب من العملاء أن يصفوا أنفسهم كما هي، ومن ثم يبتكروا وصف لدور بديل اعتماداً على مجموعة مختلفة من البناءات حيث يتم تشجيعهم ليقوموا بهذا الدور لفترات محددة.

وقد ذكر كيلي (*1950*)ان البنائية تتسم بأنها تعتمد على ثلاثة افتراضات أساسية أولاً، يُعتبر الفرد عارف نشط **active knower**، أنه منخرط بشكل هادف في فهم عالمه. ثانياً، تعمل اللغة كوسيلة أولية من خلالها يبني الشخص فهمه للعالم. ولهذا يهتم المعالجين البنائيين على وجه التحديد بالمنتجات اللغوية مثل القصص والاستعارات، التي تُرى كطرق لبناء الخبرة. ثالثاً، هناك بُعد تنموي لقدرة الفرد على بناء عالمه. هذه الافتراضات الرئيسية الثلاثة تميز اختلاف ذو دلالة بين العلاج المعرفي والعلاج السلوكي المعرفي القدامى وبين البديل البنائي الأحدث، وقد قدم كيلي أفكاره كنظرية رسمية، مع فرضيات ونتائج طبيعية. أهم هذه العبارات كانت فرضيته الأساسية أن عمليات الشخص المعرفية تُوجه من خلال الطريقة التي يتوقع بها الأحداث من خلال النظام البنائي المعرفي الخاص به. ويحاول الباحث من خلال هذا البحث أن يلقى الضوء على التصور العلاجي البنائي لجورج كيلي ومن ثم التعرف على مدى ملائمة أشهر الاستراتيجيات والفنيات العلاجية في نظرية البناء المعرفي للفرد والتي أطلق عليها كيلي اسم ، والتي يستخدمها العديد من المعالجين النفسيين في الوقت الحاضر. ومدى الفاعلية التطبيقية لهذه الاستراتيجيات لدى المعالجين النفسين والأطباء. وقد خرج الباحث بتصور إن العلاج النفسي البنائي لجورج كيلي ليس من الممكن تطبيق استراتيجيات الترابط وعدم الترابط المعرفي للفرد كوسيلة تطبيقية علاجية ذات جدوى وفاعلية والسبب ان العلاج البنائي يرتبط ويرتكز على أسس فلسفية بحتة بدلا من استراتيجيات قابلة للتطبيق خلال الجلسة العلاجية النفسية.

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Address correspondence:

Dr. Saad Almoshawah,

Associate Professor, King Khaled Academy, National Guard, Department of Psychiatry, College of Medicine, King Saud University, P.O Box 100466, Riyadh 11635 Saudi Arabia, Tel+966555516090, Fax +996(1)2520243

Book Review

1- THE MIND WITHIN THE NET
Models of learning, Thinking and acting
Manfred Spitzer
A Bradford Book 1999
The MIT press
Cambridge, Massachusetts
London, England

How does the brain work? How do billions of neurons bring about ideas, sensations, emotions, and actions? Why do children learn faster than elderly people? What can go wrong in perception, thinking, learning, and acting? Scientists now use computer models to help us understand the most private and human experiences. In The Mind within the Net.
Manfred Spitzer shows how these models can fundamentally change how we think about learning, creativity, thinking, and acting, as well as about such matters as schools, retirement homes, politics, and mental disorders.

Neurophysiology has told us a lot about how neurons work, neural network theory is about how neurons work together to process information. In this highly readable book, Spitzer provides a basic, nonmathematical introduction to neural networks and their clinical applications. Part 1 explains the fundamental theory of neural and how neural network models work. Part II covers the principles of network functioning and how computer simulations of neural networks have profound consequences for our understanding of how the brain works. Part III covers applications of network models (e.g., to knowledge representation, language, and mental disorders such as schizophrenia and Alzheimer's disease) that shed new light on normal and abnormal states of mind. Finally, Spitzer concludes with his thoughts on the ramifications of neural networks for the understanding of neuropsychology and human nature.
Manfred Spitzer is Professor and Chairman of the Psychiatric Hospital at the University of Ulm, Germany.

Adnan Takriti

The Arab Journal of Psychiatry (2009) Vol.20 NO.1 Page (78- 83)

تاريخ الطب النفسي

بدايات الطب النفسي المعاصر في العراق ,قراءة في سيرة ذاتيه

مها سليمان يونس

The Foundation of Modern Psychiatry in Iraq, Exploring Personal Archives

Maha Suliaman Younis

Abstract

This report aims to explore the beginnings of modern psychiatric services through scrutinizing the life profile of the pioneer psychiatrists in The Kingdom of Iraq.

Data was collected from the personal archive primarily together with personal interviews with some contemporary physicians and patients and scares documents.

Its realized by this study that the pioneer psychiatrists were the cornerstones of mental health establishments around the twentieth century through their contributions in government and private health centers ,also it showed that the personal archives can be helpful in analyzing the cultural atmosphere through historical facts .

المقدمة

أرتبط المرض النفسي في العراق كشأن المجتمعات العربية الأخرى بالمفاهيم الروحية والغيبيات كموامل مسببه وطريقة للشفاء في ان واحد ولعل معظم هذه المفاهيم قد استمدت جذورها من الموروثات إلثقافية و الإجتماعية الضاربة في القدم أكثر من التصاقها بجوهر و تعاليم الدين الأسلامي الذي يمثل الدين الرئيسي للسكان وعليه ساد الإعتقاد بالإستعانه بالمعالجين الروحيين ممثلين برجال الدين من المعممين (الشيوخ و السادة), عند ظهور الإضطرابات النفسية وبالأخص الذهانية منها لما يعزى لهم من قدرة على السيطرة على المسبب لها كالجن أو الشياطين التي تتلبس المريض وتقلب تفكيره وسلوكه السوي وأحيانا عوامل الحسد(العين) وتأثير السحر (العمل) من قبل المعالجين الشعبيين [1]،اتبعت أساليب متعددة لطلب الشفاء منها تلاوة آيات من القرأن الكريم أو بعض التعاويذ مع لمس المريض (التعزيم) أو شرب أعشابًا معينه (السقوة) يرافقها على الغالب أو بشكل رئيسي , التبرك بالأضرحة المقدسة (الزيارة) أو المبيت فيها برعاية أحد القائمين عليها لأيام عدة (الربط عند الأمام) كما هي التسميات باللهجة الدارجة لنيل شفاعته في الشفاء , و لم تخلو هذه الممارسات من إيقاع الأذى بالضرب

الشديد أحيانًا وما زالت قائمة حتى اليوم في القرى الفلاحية و المدن الصغيرة النائية على وجه الخصوص [2].

المؤسسات الصحية الرائدة في الطب النفسي شهدت بداية القرن العشرين محاولات بسيطة لعلاج الأمراض العقلية و العصبية من قبل بعض أطباء الصحة العامة من العراقيين و البريطانيين العاملين في سلطة الإنتداب الإ أنها لم توثق وتبرمج كتخصص قائم بحد ذاته ومورست ضمن المستشفى العام الواقع في بغداد (المجيدي) نسبة إلى السلطان العثماني (عبد المجيد) و الذي سمي لاحقًا بالمستشفى الملكي بعد تأسيس الدولة العراقية .

غير أن البداية الحقيقية للطبابة العقلية الحديثة تمثلت بانشاء أول مستشفى للأمراض العقلية و العصبية أطلق عليها اسم دار الشفاء بعد تحوير بناية قديمة يعتقدبكونها اصطبلاً للحيوانات أصلاً كائنة في منطقة باب المعظم إلى يمين المستشفى الملكي العام في بغداد عام 1921 م إشتمل المبنى على ساحة وسطية كبيرة مكشوفة و قاعات صغيرة مسقفة مع أثاث بسيط وعددمحدود من الأسرة خصصت للمرضى العاجزين , رغم ارتباطها و قربها من المستشفى المركزي إلأ أنها عدت بمثابة دار (حجر) لحجز و إيواء المعتوهين و المختلين عقليا و بالأخص ممن يشكلون خطورة في المجتمع والمصابين بحالات الهياج الشديد والقادمين من خارج العاصمة وكانت إجراءات إدخال المرضى تتم عن طريق الشرطة المحلية و بأمر قضائي من المحكمة الشرعية ويعتقد أن المراقبة التمريضيه لزوال النوبة الحادة كان هو المعيار الأساسي للتحسن السريري للمرضى ومن ثم إخراجهم ومما يثبت صحة هذه النظرية أن الأحصاء الشهري لعدد المرضى الداخلين يقارب عدد المرضى الخارجين والذين يدخل في ضمنهم عدد المرضى المتوفين حيث لم يحتوي المستشفى على سجل خاص بعدد و أسباب الوفيات رغم تكرارها و بالأخص في أيام البرد الشديد , وقد أشارت الوثائق إلى استعمال علاج احداث الصدمات بحقن الوريدي للأنسولين الذي استبدل لاحقا بالعلاج عن طريق احداث الصدمات الكهربائية بالجهاز الخاص بذلك حوالي العام 1940 مع بعض العقاقير الدوائية المتوفرة انذاك .

كان المستشفى ملحقًا اداريًا بوزارة الأشغال العامة وباشراف مديرية الصحة العامة التابعة لها من الناحية الطبية و الخدمية والعلاج كاملاً بالمجان وكما اسلفناسابقا أسهم بعض الأطباء العامين و الممرضين المؤهلين في إدارة شوونها ولم تكن فيها عيادة خارجية لفحص المرضى الجدد والمزمنين منذ تأسيسها وحتى زوالها, مما يدل على اكتسابها لصفة (الحجر) أكثر من دورها في التشخيص و العلاج وقد جرت بعض المحاولات لإجراء اصلاحات إدارية وخدمية إبان الأربعينيات ولكنها كانت عاجزة عن الإيفاء بمتطلبات الأعداد المتزايدة للمرضى و اكتظاظ البناية المتهالكة بهم حيث كان عدد المرضى 795(628من الذكورو 167من الإناث) يعاني جلهم من أنتشارالأمراض الجلدية المعدية و انعدام وسائل الراحة كالنظافة و التدفئة ولربما ساهمت هذه الصورة الكئيبة في ترسيخ مفهوم الوصمة الإجتماعية المرتبطة بالمرض النفسي .

وقد ورد في تقرير الخبير الدولي في الصحة النفسية الذي تفقدها ضمن زيارته

التفتيشية لمؤسسات الصحة النفسية في العراق عام 1950 (الدكتور كراوس) وجوب إبدالها بمستشفى واسع وجديد وعلى اسس علمية حديثة ولم تمضي ثلاثة اعوام حتى تحقق هذا الهدف بأفتتاح مستشفى (الشماعية) للأمراض العقليةعام 1953 في ضاحية شرق بغداد بسعة 400سرير ابتداءًا ثم أستمرت في التوسع و التطوير لتصل إلى 1300 سرير مع عيادة خارجية وعدة اقسام متخصصة و في عام 1960 تم هدم بناية مستشفى دار الشفاء بالكامل و نقل جميع النزلاء إلى مستشفى الشماعية الجديد[3].

أخذ الوعي بالطب النفسي يتزايد مع تأسيس عيادة خارجية للأمراض العصبية ملحقة بالمستشفى التعليمي الملكي ليومي السبت و الخميس بأشراف المرحوم الدكتور هاشم الوتري الذي تولى عمادة كلية الطب لاحقا و التي بدأت بواقع يومين في الأسبوع لتتوسع إلى عيادة مزدحمة بالمرضى للحالات العقلية و العصبية على حد سواء طيلة ايام الأسبوع مع كونها مركزًا لتدريب طلبة الصف الخامس (المنتهي) عام 1936 و قيل أن عدد المراجعين اليومي كان يتجاوز المائة ,علمًا أن التدريس النظري لمادة الصحة العقلية كان مدرجًا ضمن المنهاج التدريسي للكلية عام 1929 باشراف المحاضر البريطاني لطب الجملة العصبية [4].

إضافه إلى هذا اشتملت بناية المستشفى العسكري الملكي على عيادة خارجية للأمراض العقلية و العصبية و ردهة لإدخال المرضى من أفراد القوات المسلحة مطلع الأربعينيات [5] .

بعد إنشاء مستشفى الشماعية لإيواء المرضى المزمنين بالدرجة الأولى ظلت الحاجة مستمرة لأنشاء وحدة تعليمية و علاجية للأمراض النفسية الحادة ونظرًا لغياب التخصيصات المالية لإنشاء مبنى خاص فقد تم تحوير الردهة الثالثة في المستشفى التعليمي الملكي إلى قسم خاص لرقود المرضى العقليين اشتمل على 22 سرير و على أسس علمية و خدمية لائقة بقرارصادر من لجنة تنسيقات التدريسات السريريةفي المستشفى الملكي الطبي المكونه من العميدومدير المستشفى وبإدارة الأطباء الإختصاصيين ,الدكتور جاك عبودي والدكتور صفاء الدين حامد و الدكتور علي كمال (الفلسطيني الجنسية) عام 1953[5] .

الى جانب المراكز الحكومية المجانية أنفة الذكر ساهمت العيادات الخاصة في خدمة المرضى النفسيي وأولهاهي عيادة الدكتور جاك عبودي المتخصصة لعلاج الأمراض العقلية و العصبية و التي افتتحها في مايس 1934 في منطقة رأس القرية وسط بغداد ثم توسعت فيما بعد لتشتمل على حوالي 10 اسرة لرقود الحالات الحادة وقد تطورت هذه العيادة إلى مستشفى خاص للأمراض العقليةلأول مرة في العراق عام 1944 مزود بأسرة وكادر تمريضي وقسم للعلاج بالصدمات الكهربائية وسيارة اسعاف لنقل المرضى الطارئين سمي ب(دار الرشيد) ويعتقد أنه أغلق نهائياً في نهاية الستينيات و سنستعرض أدناه السيرة الذاتيه لمؤسسه .

رائد الطب النفسي في العراق

ولد المرحوم الدكتور جاك عبودي شابي عام 1908 من عائلة يهودية عراقية في البصرة ودرس الأعدادية في كلية الملكة

فكتوريا في الإسكندرية –مصر وتخرج منها عام 1925بتفوق ثم عمل موظفًا حكوميًا بعنوان في مديرية المساحة العامة ثم استقال لينضم إلى كلية الطب الملكية العراقية في بغداد عام 1927 ليتخرج بعدها في الدورة الأولى 28–7 1932 بالترتيب الثاني ضمن ثمانية ناجحين من اليهود و النصارى و المسلمين تم تسجيلهم ونيلهم إذن الممارسة الطبية وفقًا للمادة 13 من قانون ممارسة الطب ما لبث أن التحق بالبعثة الدراسية على نفقة الحكومة العراقية إلى بريطانيا لنيل شهادة الاختصاص في الأمراض النفسية (D.P.M), ليعود بعدها في 16–2–1934مباشرًا وظيفته في مستشفى الأمراض العقلية (دار الشفاء) كأول أختصاصي في الطب النفسي في القطر وكلف باقيام بالتدريب السريري لطلبة كلية الطب بلقب (معاون محاضر) بعد منحه لقب الأختصاص من قبل مدير الصحة العام وافتتح عيادته في نفس العام وفق ضوابط ادارية في ضرورة ممارسة المهنة في حدود التخصص وبعد الظهر تحديدًا ويعد أول من استعمل العلاج بالصدمات الكهربائية في عيادته الخاصة عام 1944 حسب الوثيقة الصادرة من دائرة الإستيراد.

انتدب للعمل في تدريس مادة الصحة العقلية في كلية الطب بعد منحه لقب (محاضر) في 1939 رفع بعدها إلى لقب (استاذ مساعد)عام 1942 ثم كلف رسميا بتولي إدارة مستشفى دار الشفاء عام 1942بأمر من وزير الشؤون الإجتماعية وبعد قيام اسرائيل عام 1948 , رفض الهجرة وتمسك بجنسيته العراقية وحصل على جواز سفر خدمه وتسهيلاً حكوميًا بسفره وعائلته تقديرًا لمكانته العلمية ,مثل العراق في مؤتمر للطب النفسي في لندن ومؤتمر للجراحة العصبية في لشبونه عام 1948.

في 3–4– 1954 أحيل إلى التقاعد حسب طلبه لأصابته بمرض تصلب الشرايين وورد في تقريره السري الصادر من عمادة كلية الطب أشاده بحسن سلوكه وانضباطه الوظيفي وتولى الدكتور معمر الشابندر بعده إدارة مستشفى دار الشفاء حتى زوالها عام 1960 .

تفرغ تماما للعمل في عيادته ومستشفاه المزدحمة دائما بالمرضى من كافة أرجاء القطر وبعد نكسة حزيران عام 1967 اختزل ممارسته الطبية إلى أضيق الحدود وانكفأ في داره معظم الأحيان ولم تشير المعلومات المتوفرة إلى تعرضه لمضايقة سياسية أو قانونية أو من قبل الناس , حتى غادر القطر نهائيا بموافقة من مدير الأمن العام آنذاك إلى بريطانيا عام 1972 حيث عمل كطبيب نفسي في سجن (بركستون) في لندن حتى وفاته هناك عام 1981 .

الأستنتاج

دلت هذه الدراسة على جملة من الأستنتاجات منها :

1–أن المؤسسات الصحية الرائدة في مطلع القرن العشرين , قد نجحت في استقطاب المرضى على الرغم تدني مستواها العلمي و الخدمي وانتشار الجهل بطبيعة الأمراض النفسية و بذلك تكون قد ساهمت في نشر الوعي الصحي لدى العامة وخلق ثقتهم بها كونها حكومية ومجانية ويمكننا اعتبارها الركيزة الأساسية لنظام الطب النفسي في العراق .

2 –أن إنشاء برنامج تعليمي و تدريبي حكومي في الطب النفسي داخل وخارج القطر ومنذ الثلاثينيات قد ساهم إلى حد كبير في تشجيع أجيالاً عديدة من الأطباء للتخصص في هذا المجال .

3–أشارت الوثائق الأرشيفية إلى وجود الضوابط الإدارية و الرقابية على السلوك المهني للأطباء في الممارسة الوظيفية و العمل لخاص رغم ندرتهم وحداثة النظام الصحي مما يدل على قيام وجود نوع من الرقي و العصرنه في الآداب المهنيه قبل تأسيس النقابات و الجمعيات .

4–أضطلع أول الأطباء المتخصصين بالطب النفسي بدور رئيسي في تحسين صورة المرض العقلي واخراجه من دائرة الشعوذة عن طريق اصلاحاته الأدارية و التزامه بممارسه تخصصه حصرًا في أول عيادة طورت لاحقًا إلى أول مستشفى أهلي وعلى أسس عصرية ولا يغفل دورها في إسناد الجهد الطبي الحكومي في وقت مبكر قياسًا إلى الوضع العام في العديد من المجتمعات العربية المشابهة .

5–يستشف من تلك السيرة الذاتية لرائد الطب النفسي صورة عن جو التسامح الديني المتأصل في نفسية الفرد العراقي و تعايشه مع الأقليات الدينية و العرقية حيث لم تقف حقيقة انتماءه إلى الطائفة اليهودية عائقاً أمام بزوغه في المجتمع واكتسابه لحب واحترام السلطة و الجمهورفي عهد شهد تقلبات سياسية عديدة .

توصي هذه الورقة بأعداد قاعدة معلومات لسير الأطباء الرواد في الوطن العربي وتوظيف المعلومات المستحصله منها في تحليل المناخ الثقافي و الإجتماعي المحيط بمفاهيم الطب النفسي .

الخلاصة

تهدف هذه الورقة إلى توثيق تاريخي لبدايات منظومة الطب النفسي المعاصر من خلال دراسة السيرة الذاتية لأول طبيب نفسي في المملكة العراقية .

استخدمت المضيرة الشخصية للطبيب الرائد كمصدر أساسي للمعلومات مع المقابلات المباشرة لبعض الأطباء و المرضى ممن عاصرو ا تلك الفترة وقلة من التقارير المعنية

أوضحت هذه الدراسة الدور الرئيسي الذي قام به الأطباء الرواد في تكريس مفهوم عصري للصحة النفسية في بدايات القرن العشرين من خلال عملهم في إنشاء مراكز علاجية وتدريبية حكومية و إسهامهم في خدمة المريض النفسي في القطاع الخاص أيضا كما أشارت إلى ضرورة الأستعانه بالوثائق الشخصية من أجل دراسة و تحليل الوقائع التاريخية المتعلقة بالطب النفسي ومحاولة فهم المناخ الإجتماعي و الثقافي المحيط بها .

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Correspondence:
Dr. Maha Suliaman Younis
F.I.C.M.S ,C.A.B.P
Assistant professor in psychiatry-Faculty of Medicine –Baghdad University
Baghdad-Iraq
Maha.younis@gmail.com