

Anxiety, Depression, Somatization and Psychiatric Morbidity in Rural Minia

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This work was carried out to determine the prevalence of anxiety, depression and somatization and psychiatric morbidity in a population sample of rural Minia. It also aimed at validation of the GHQ-30.

A random sample of 325 (140 males, 185 females) subjects were approached to be interviewed using anxiety, depression and somatization subscales of SCL-90 and GHQ-30.

Results: One month prevalence rate of psychiatric morbidity according to SCL-90 was 18.7% (15.8% in males and 21 % in females), while it was 31.7% (27% in males & 35.4% in females respectively), according to GHQ-30. Prevalence of anxiety was 18.6% (9.8 & 24.8% in male and female population respectively) , while that of depression was 22.8% of the population (9.7% in males and 33.2% in females). 18.5% suffered high levels of somatization (3% in males and 29.3% in females). Education was negatively correlated with morbidity.

There was an overlap between diagnosis of anxiety and depression. Somatization correlated positively with both anxiety and depression. The somatic symptoms profile in anxiety and depression was not different.

The sensitivity of GHQ-30 was 83.7% and its specificity was 92.3 %. The cut-off score derived from the population studied was found to be 9 in the dichotomous method.

Conclusion: Mental health problems are common in rural areas, with uneducated females being the most affected population.

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INTRODUCTION

The myth that people living in rural areas lead a quiet, stress-free life has been recently challenged. There is growing evidence that people living in rural areas, especially the women, may be at greater risk of anxiety and depressive disorders than in Western societies (Mumford et al, 1997). In a

leading community study by El-Akabawy et al (1982), point prevalence of psychiatric disorders in rural Egypt was found to be as high as 42.4%. A recent report by Eisa et al (1997) estimated psychiatric morbidity in an Egyptian rural community to be 30.5%. Okasha (1992) also found that depressive symptoms are more common in rural (39%) compared to urban (23%) population.

The traditional view of investigating minor disorders in community has always concentrated on anxiety and depression. There is increasing interest, however, in somatoform disorders and somatization as a means of expression of psychological distress.

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Recent epidemiological surveys give estimates of very high prevalence rates of minor psychiatric disorders, reaching 40% (Kessler et al, 1985). Even higher estimates were reported, with 66% and 25% rates in women and men respectively (Mumford et al, 1997). However, such cases are underrecognized by general practitioners (Vazquez-Barquero et al, 1997), or they might even not seek help at all.

Subjective ratings of psychiatric symptoms are widely used in epidemiological studies. However, most of the instruments translated into Arabic that measure such symptoms are not validated. As the sensitivity and specificity estimates derived from one population do not automatically translate to another, that accuracy of prevalence rates based on criteria from other cultures may be questionable (Katz et al, 1995). Cut-off scores should be derived from the data of the population being studied.

The objectives of the present work were:

- 1- To assess psychiatric morbidity, prevalence of anxiety, depression and somatization in a village representative of rural subculture in Minia governorate.
- 2- To study the relationship between anxiety, depression and somatization in a population sample.
- 3- To investigate the difference between somatic symptoms profile in anxiety and depression.
- 4- To assess reliability (internal consistency) and validity of the GHQ-30 in relation to SCL-90, and also to estimate a cut-off score derived from a sample representative of the culture in the studied community.

SUBJECTS AND METHODS

This study was conducted in Damshir village during the period from August to the end of October, 1995. Damshir is about 5 Kms to the west of Minia city, with a population of about 15000. It was randomly selected from villages of Minia governorate as a typical agrarian village. Houses were numbered and a systematic random sampling was adopted in recruitment of cases. Only subjects in the age range between 16 and 65 were included.

Prior to assessment, several meetings were held between the researchers and community leaders in the village in order to overcome any obstacle that might have arisen during screening. A verbal consent was obtained from every participant after explaining the nature and aim of the research and also reassurance that data are confidential.

Two instruments were used in the interview:

1- Anxiety, depression and somatization subscales of the Symptom Check List-90 R (Derogatis,). The Arabic version was prepared by Al-Behairy (19).

2- General Health Questionnaire GHQ- 30 (Goldberg, 1972). The Arabic version of GHQ-30 was prepared by El-Akabawy (1983). In this study, two scoring methods were used: the Likert (0, 1, 2, 3) system and the dichotomous method.

As the level of illiteracy is known to be high in the community studied, the questions were read aloud for all subjects by one of four residents in psychiatry trained to conduct the interview. The population interviewed was asked about the presence of symptoms over the last month.

Statistical Analysis:

Since no data are available on cut-off scores for caseness according to the SCL-90 in Egypt, the following procedure was carried out:

Cases were weighted. Means and standard deviations of total score on the three SCL-90 subscales were calculated and standardized values (Z) for each subject were also calculated (mean Z value = 0, SD = +1). Subjects were considered cases, if the Z-value was above 1. The same procedure was carried out to identify cases with high anxiety and depression.

Frequency of individual symptoms in the sample as a whole, and in both sexes was also assessed.

Comparison between female and male subjects on anxiety, depression, somatization and total score on GHQ-30 was carried out using T-test.

Pearson correlation coefficients between anxiety, depression and somatization and levels of significance were calculated.

The internal consistency (reliability) of the GHQ-30 was determined through the calculation of Cronbach's alpha coefficient. The validity of the GHQ-30 was assessed through the ability of its items to identify cases already diagnosed as cases by the above mentioned method. This was carried out using Discriminant analysis method.

The reliability coefficient of the 12 items (GHQ) that showed the highest sensitivity in detecting cases was calculated.

All statistical procedures were carried out using Statistical Package for Social Sciences (SPSS).

RESULTS

Age and sex distribution:

The sample comprised 325 inhabitants of the village (140 males, 185 females in the age range between 18 and 60. (fig 1).



Figure (1)

Mean age was 31.48 (± 10.31) in the whole sample; 30.01 (9.51) in males and 32.43 (10.78) in females. No significant difference in age was found between men and women.

Table 1

Age group	Percent
16 - 25	31.3
26 - 35	32.2
36 - 45	20.4
46 - 55	10.2
> 55	5.9

The distribution of the subjects according to age group is shown in table (1). The majority of the subjects (63.5%) fell in the age range between 16 and 35.

Anxiety, depression, somatization and total GHQ-30 Scores :

Mean scores on anxiety, depression and somatization subscales of SCL-90, and total score of GHQ-30 (Likert system) in the whole sample, as well as in the male and female groups are shown in table (2) In the same table results of comparison between the two groups, using t-test for independent samples, are demonstrated. Female subjects presented significantly more anxiety, depression, somatization and higher score on GHQ-30 than males.

Individual Symptoms:

The frequency of individual symptoms, according to SCL-90, in the whole sample is shown in table (3). Frequency of individual symptoms ranged from 8.5 to 36%. Irritability, tension and palpitation were the highest anxiety symptoms in frequency. Decreased activity, preoccupation, guilt feelings, weeping and difficulty coping were the highest depressive symptoms to be experienced. Frequency of somatic symptoms was high. 35% complained of back pain, 34% of headache at sometime during the last month. Back-pain, muscle aches and chest pain were also common.

Caseness:

According to the definition of caseness by SCL-90 adopted in this

Table 2
Means and Standard Deviations (Anxiety, Depression, Somatization, GHQ - 30)& Comparison between Male and Female

	Whole sample	Male	Female	T	P
Anxiety	20.15 (6.2)	18.86 (5.9)	21.63 (6.1)	- 3.92	0.000
Depression	29.59 (8.9)	27.46 (7.9)	31.54 (10.1)	- 3.46	0.001
Somatization	28.96 (9.3)	25.98 (7.9)	31.15 (8.7)	- 5.2	0.000
GHQ	31.7 (9.89)	30.0 (10.7)	32.87 (9.3)	- 5.6	0.000

Table 3
Frequency of Psychiatric Symptoms in the Whole Sample According to the Results of SCL - 90 Subscales

Symptom	Frequency	Symptom	Frequency
Anxiety:		preoccupation	30%
irritability	23%	loss of interest	14%
tremors	12%	hopelessness	11%
feeling panicky	14%	difficulty coping	36%
fear	15%	low self esteem	11%
palpitation	29%		
tension	27%	Somatization :	
panic attacks	13%	headache	34%
restlessness	12%	fainting	27%
compulsion	10%	chest pain	22%
		back pain	35%
Depression :		nausea	24%
decreased libido	8.5%	muscle aches	25%
decreased activity	30%	difficulty breathing	24%
suicidal thoughts	9%	cold sensations	17%
weeping	36%	tingling sensation	21%
retardation	16%	lump in throat	18%
guilt feelings	30%	weakness	23%
loneliness	23%	n u m b n e s s	22%
chest oppression	23%		

Table 4
Frequency of Caseness and Age Group

Age group	Anxiety	Depression	Somatization	GHQ - 30
16-25	19.9%	20.3%	19.9%	26.8%
26 - 35	11.2%	16.3%	11.9%	23.55
36 - 45	23%	29.6%	22.6%	28.45
46 - 55	32.6%	45.7%	47.8%	41.1%
> 55	25.9%	25.9%	12.3%	30.85

study, 18.7% of the population studied were found to be cases (15.8% in males and 21 % in females). Comparison between frequency of cases in both sexes showed a highly significant difference (chi square = 50.8, $p < .000$). Cases of anxiety were 18.6% (9.8 & 24.8% in male and female population respectively) , while 22.8% of the population (9.7% in males and 33.2% in females) had a pathological degree of depression. 18.5% suffered high levels of somatization. The frequency of somatization in females was strikingly higher than males, as only 3% of males and 29.3% of females showed pathologically high somatization.

Caseness and Age:

The frequency of cases in each age group is demonstrated in table (4). It can be noted that the highest level of morbidity was encountered in the middle age group (45-55 years).

Education was also negatively correlated with caseness, as evidenced by regression analysis. The dependent variable was 'caseness' with the independent variable being level of education. T was -1.96 and $p < .05$.

Relationship between Anxiety, Depression and Somatization:

There was an overlap between anxiety and depression, with two thirds of patients with high anxiety having high depression as well. Spearman correlation coefficient between anxiety and depression was .73 ($p = 0.000$). Somatization correlated positively with both anxiety and depression ($r = .61$, $p = 0.000$ and $r = .59$, $p = 0.000$ respectively).

The relationship between somatic, anxiety and depressive symptoms is demonstrated in figure (2). The highest number of somatic symptoms was found in the group that suffered high degree of both depression and anxiety, while the lowest was encountered in the low-anxiety group.

The somatic symptoms profile in patients positive for anxiety caseness and depression caseness is shown in figure (3), showing mean on all somatic symptoms of the SCL-90. The profile in both groups is basically similar. One symptom, muscle aches, was higher in the anxiety group ($p < 0.02$).

Validity and Reliability of the GHQ-30:

Discriminant function analysis showed that GHQ-30 correctly classified

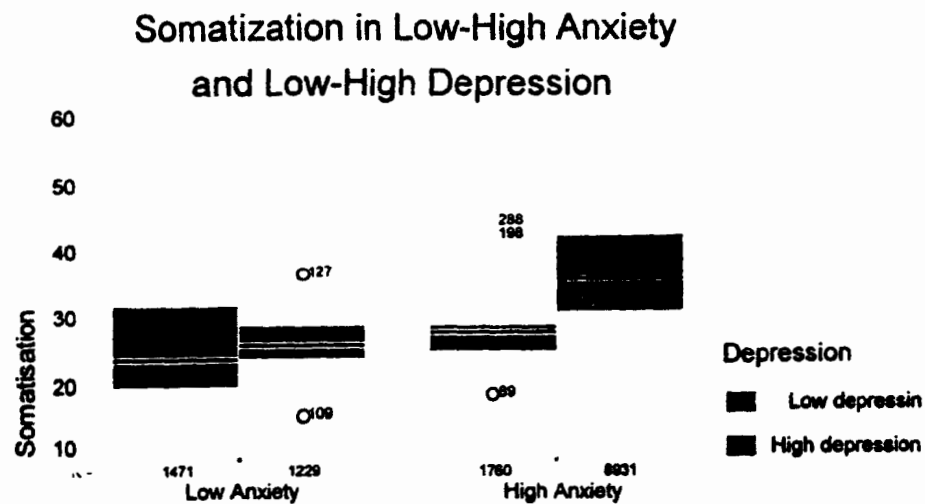


Figure 2

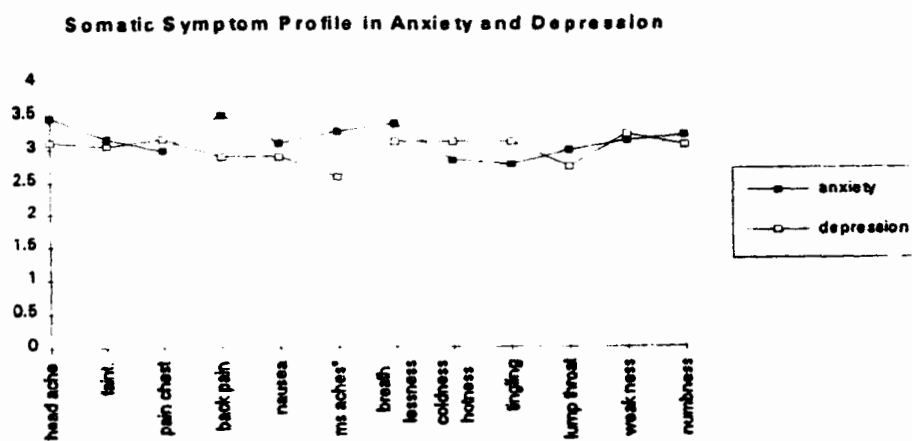


Figure 3

83.7 of the cases and 92.3 % of the non-cases. The minimum value of the GHQ-30 score (yes or no response) was found to be 9. A retrospective analysis of the frequency of subjects scoring 9 or more showed that 31.7% (27% and 35.4% for males and females respectively) exceeded this score, meaning that frequency of cases defined by GHQ-30 is higher than that by SCL-90. The percent of cases in each age group is shown in table (4). The highest rate was encountered in the age group 46-55.

Reliability coefficient of the GHQ-30 was 0.89.

The 12 GHQ-items that had the highest coefficients with the function discriminating cases and non-cases are shown in table 5. The text of those items is presented in appendix 1. The reliability coefficient (Cronbach alpha) of these items was .88.

Usually high reaching 32.2% in a primary-care sample in Spain (Vazquez Barquero et al., 1977) and 36% in a sample of general practice patients (Harris et al, 1996). The same tool was used in a community study in rural Egypt by Eisa et al, (1997) and psychiatric morbidity was estimated to be 30.5%, very close to the present prevalence rate.

DISCUSSION

The prevalence of psychiatric morbidity in population surveys is quite variable. Much of the variability could be accounted for by differences in methodology. Goldberg & Huxley (1992, cited in Mumford et al, 1996) have reviewed 11 studies which used direct assessment of community respondents by standardized research interview. The one month prevalence of

Table 5
GHQ - 30 Items with Highest Discrimination Power

Item number	Coefficient	Item number	Coefficient
21	.598	28	.385
27	.512	22	.356
14	.466	3	.355
13	.434	7	.322
20	.428	2	.309
16	.417	25	.306

psychiatric morbidity ranged from 9% to 24.1%, the highest score coming from Ugandan city. In the present work, two instruments were used leading to different prevalence rates of psychiatric morbidity. The one month prevalence rate obtained through the SCL-90 was 18.7%. This is similar to 18% prevalence rate in rural India (Harding et al, 1980). On the other hand, the prevalence rate of psychiatric morbidity according to GHQ-30 was 28%. The rate of psychiatric morbidity determined by the GHQ is usually high reaching 32.2% in a primary-care sample in Spain (Vazquez-Barquero et al, 1997) and 36% in a sample of general practice patients (Harris et al, 1996). The same tool was used in a community study in rural Egypt by Eisa et al (1997) and psychiatric morbidity was estimated to be 30.5%. However, irrespective of the instrument applied, the prevalence rate of psychiatric morbidity is relatively high, suggesting that minor psychiatric disorders are common in rural areas. They also indicate a stressful life style in those areas. A major change has taken place in our rural community, with emigration of the younger generation to cities, changing social values, the tendency to individualization and urbanization being risk factors for

increase in psychiatric morbidity in the village (Okasha et al, 1988).

The present study showed that psychiatric morbidity is higher in middle-aged subjects suggesting that they suffer a high degree of stressors. Such a trend towards increase in psychiatric morbidity after the age of 40 was reported by Mumford et al (1979) in rural Pakistan. However, this contradicts EL-Akabawy et al's (1982) findings that nonpsychotic disorders were more prevalent in the younger population. A similar trend has been reported in Western studies of major depressive disorders (Klerman & Weissman, 1989).

Data on the prevalence of depression in general population are also contradictory. US National Institute of Mental Health Epidemiologic Catchment Area Program data base revealed that 19.6% of the general population reported one or more depressive symptoms in the previous month (Judd et al, 1994) and the one year prevalence exceeded the 9.5% 1-year prevalence for all the DSM-III mood disorders combined. The authors labelled this potential clinical condition as subsyndromal symptomatic depression (SSD), defining it as any two or more simultaneous symptoms of depression, present for most or all of the time, at least 2 weeks in duration, associated with evidence of social dysfunction, occurring in individuals who do not meet criteria for diagnoses of minor depression, major depression, and/or dysthymia. In the present investigation the frequency of depressive symptoms in the previous month ranged from 8.5 to 36%, while those defined as cases comprised 9.7% of the male and 33.2% of the female population, the rate being 22.8% in the sample as a whole. This is higher than the 15.3% estimate of depressive

disorders in Egypt (Okasha, 1990). In a study using Center for Epidemiologic Studies Depression Scale (CES-D), 31% exceeded the cut-off score of , while interview method revealed less prevalent rates (Kirmayer et al., 1993). The high prevalence rate of depression in women is in accordance with the results of Hauenstein & Boyd (1994) who found that the prevalence of depression exceeding cutoff scores of CES-D in rural women was 41.4%. These findings suggest that many rural women are at-risk for depression and also show that women with fewer educational and economic resources report more depressive symptoms.

Psychiatric morbidity was very high in women as compared to men. Mood disorders are known to be more prevalent in females. A marked difference was found especially between the level of caseness of somatization in both sexes: 29.3% in females and 3% in males. Population based studies also showed consistently higher somatic symptoms in females (Kirmayer & Robbins, 1991; Katon et al, 1991). High levels of emotional stress and psychiatric morbidity in women as compared to men point to the powerful social factors at work (Mumford et al, 1996). Desjaralis et al (1995) found that, in spite of the fact that women experience higher levels of psychiatric morbidity than men, this gap appears greater in poorer countries.

Evidence for an association between anxiety disorder and major depression comes from several sources, including clinical studies, biological parameters, treatment response, and more recently epidemiological surveys investigating the association between these disorders (Kessler et al., 1994; Merikangas et al., 1996). Correlation between anxiety and depressive symptoms is consistently

high in epidemiological studies, being +.68 according to Goldberg (1996), which is close to the .73 level of correlation between the two groups of symptoms in the present investigation. The overlap between anxiety and depression is also demonstrated by the finding that two thirds of those who scored high on anxiety having high scores on depression as well. Such an overlap, sometimes referred to as comorbidity, is more and more being interpreted by many authors (e.g., Goldberg, 1996; Merikangas, 1996) as an artifact of the syndromal (categorical) approach to diagnostic classification.

In spite of the well-documented overlap between the two disorders, it might be the case that they overlap in community samples, more than they do in psychiatric population. Gurley. et al. (1996) found that anxiety and depression are discriminable among youth who meet criteria for a specific emotional disorder but more highly associated among youths without such a diagnosis. The authors suggested that in youth, as has been shown in adults, depression and anxiety become increasingly discriminable as emotional psychopathology becomes more severe.

On the other hand, somatic symptoms correlated positively with both anxiety and depression, the correlation being stronger with the former. This finding is in accordance with the results of the WHO collaborative study of psychological problems which were consistent for all sites. Anxiety symptoms also showed a slightly stronger correlation with somatic symptoms than did depressive symptom (Simon et al, 1996).

The most frequent somatic symptoms, apart from headache, were back-pain, chest pain and muscle aches. In a cross-cultural study by Janca et al

(1995), those were reported to be among the most useful somatic symptoms suggesting somatization, with patients insisting on a physical rather than a psychological cause. The number of somatic symptoms showed increase with increase in severity of either anxiety or depression and was maximal in cases with high scores on both. This is in accordance with a previous report, where patients with mixed anxiety-depression disorder had higher somatic symptoms than patients with anxiety or depression alone (Soliman, 1997).

In spite of the fact that characteristic somatic symptoms are believed to be associated with depression and others with anxiety, no difference in the somatic symptoms profile between the two groups. Only muscle aches, that are related to high tension, were higher in patients with high anxiety. Simon et al (1996) also found that symptoms known to be characteristic of anxiety showed similarly strong association with depression, and symptoms typically described with depression were also correlated with anxiety. Similarly, Brawman-Mintzer et al (1993) compared the distribution of somatic symptoms associated with generalized anxiety disorders in patients with pure form of this disorder and those with also one comorbid disorder. The authors concluded that the pattern of somatic symptoms was similar in both groups.

The reliability coefficient of the GHQ-30 in the present study is comparable with that of the GHQ-28 found in a cross-national study (Simon et al, 1996). However, the cut-off score of 9 is relatively high. A high threshold was also obtained by El-Rufaie & Dradkeh (1996) in a validation study of the Arabic version of GHQ-30 in a sample of primary health care patients in

Al Ain that used stringent criteria for caseness assessed by a semistructured interview.

According to the principle of cultural relativism (Fabrega, 1989), some, if not all, of the parameters of psychiatric illness among a people are variable, different, and more or less unique precisely as a function of their culture. The 12 factors that were strongest in discriminating cases were slightly different from the 12-item version of GHQ. However, its reliability was the same as that of the 30-item version. We suggest the use of proposed short version in further screening for psychiatric morbidity in different populations in Egypt.

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Appendix I:

The proposed 12- item GHQ

- ١ - هل كنت تشعر بأنك غير سعيد ومكتئب .
- ٢ - هل كنت تشعر بأنك عصبي ومشدود طول الوقت.
- ٣ - هل شعرت بأنك لا تستطيع التغلب على الصعوبات التي تواجهك.
- ٤ - هل كنت تشعر بأنك تحت ضغط.
- ٥ - هل كنت تشعر بأن كل شيء متراكم عليك.
- ٦ - هل كنت قادرا على الاستمتاع بأنشطتك اليومية
- ٧ - هل كنت تشعر بأن الحياة ميثوس منها تماما.
- ٨ - هل كنت تفتقد الثقة في نفسك.
- ٩ - هل قضيت ليالى طويلة فى قلق واضطراب.
- ١٠ - هل كنت تشعر بالرضا عن الأعمال التي تقوم بها.
- ١١ - هل ضيعت كثيراً من وقت نومك بسبب انشغال بالك.
- ١٢ - هل كنت تشعر بالأمل فى المستقبل.

L'Anxiété, La Depression, La Somatization et La Morbidité Psyciatrique dans un Village de Minia

Le but de cette recherche était d'évaluer la prevalence de L'Anxiété, la depression, la somatization et al morbidité psychiatrique dans un village representatif de la subculture agricole. On a conduit un interview avec 325 subjects en utilisant la version Arabe de GHQ-30 et celle-ci de l'eschelle de l'anxiété, la depression, la somatization (SCL-90).

La prevalence des troubles psychiatriques était 31.7% selon GHQ-30, cependant qu'elle était 18.7% selon SCL-90. La prevalence de l'anxiété, la depression, la somatization était 18.5%, 22.8% et 18.6%. La prevalence des tous les troubles étudiés était haute chez les femmes.

On a trouvé une correlation significative entre l'anxiété et la depression. D'un autre côté, les symptomes somatiques étaient associés aux tous les deux formes des troubles.

On a correctement différencié les cas positifs (83.7%) selon le GHQ-30. La spécificité était 92.3%. On a établi la validité de cette methode.

La prevalence des troubles psychiatriques est haute dans la subculture agricole.

القلق والإكتئاب والجسدية، والمرض النفسي

فى ريف المنيا

أجريت هذه الدراسة لتحديد نسبة إنتشار القلق والإكتئاب والجسدية، والأمراض النفسية الصغرى بشكل عام فى ريف المنيا، كما استهدفت الدراسة أيضاً تقنين النسخة العربية لإستبار الصحة العامة - ٣٠ .

وقد تكونت عينة البحث من ٣٢٥ شخصاً (١٤٠ من الذكور و١٨٥ من الإناث البالغين) واستخدم فى المقابلة النسخة العربية لإستبار الصحة العامة - ٣٠ ومقاييس القلق والإكتئاب والجسدية من قائمة الأعراض - ٩٠ .

وأظهرت الدراسة أن نسبة انتشار الأمراض النفسية الصغرى خلال الشهر السابق على الدراسة تتراوح بين ١٨,٧ ٪ (وفقاً لمقياس الأعراض - ٩٠) و ٣١,٧ ٪ (وفقاً لإستبار الصحة العامة - ٣٠). وكانت نسبة انتشار القلق والإكتئاب والجسدية هى على التوالى ١٨,٦ ٪ و ٢٢,٨ ٪ و ١٨,٥ ٪، وكانت معدلات انتشار هذه الاضطرابات مرتفعة فى الإناث مقارنة بالذكور على نحو دال إحصائياً، وارتبط إزدياد نسبة المرض النفسى بنقص مستوى التعليم.

وأظهر البحث ارتباط الإكتئاب والقلق على مستوى الأعراض والزملة المرضية، بينما ارتبط كل منهما بظاهرة الجسدية، ومن ناحية أخرى لم يكن هناك اختلاف بين صورة الأعراض الجسدية فى كل من الإكتئاب والقلق.

وقد بلغت حساسية إستبار الصحة العامة - ٧,٨٣٣٠ (نسبة التشخيص الصحيح للحالات الموجبة)، بينما كانت نسبة التشخيص الصحيحة للحالات السالبة ٣,٩٢ ٪، وإتضح أن عينة المرض أعلى فى هذه العينة منها فى التراث المنشور، حيث بلغت ٩ درجات. واقترح الباحثون نسخة مصغرة لإستبار الصحة العامة - ٣٠ من إثني عشر عرضاً مستمدة من الصورة المرضية السائدة والأعراض الأكثر إنتشاراً فى هذه العينة التمثيلية.

ويخلص البحث إلى أن الأمراض النفسية الصغرى شائعة فى الريف، وبخاصة فى النساء الأقل تعليماً، كما يشير إلى أن الأعراض الجسدية تشكل نوعاً من التعبير العام عن الضغوط، بصرف النظر عن التشخيص.