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# Schizophrenia : Possible Characteristics of Affective Pattern

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## ABSTRACT

This study was conducted with the aim of investigating possible characteristics of affective pattern in schizophrenic patients. A convenience sample of 20 schizophrenic patients representing different nosological types of schizophrenia was subjected to a rating of affect by multiple raters in a semistructured interview setting.

The judgement of affect according to the developed rating scale was largely based on phenomenological considerations.

The assessment of affect according to this method has produced a satisfactory level of interrater reliability. Analysis of the revealed affective pattern indicates the following :

1 – Affect is not quantitatively lost or severely weakened in schizophrenia. The apparent impoverishment is more probably related to qualitative and functional considerations.

2 – Data from affect profiles point to some possibly significant characteristic features :

a – Some affects are particularly prominent, the most prominent of which is "fear".

b – **Other affects show a consistently low position in the profiles. These are mainly pleasurable affects and love.**

c – **Other affects such as anxiety, depression, hate, shame and shyness occupy a comparatively moderate position in the profiles.**

**Most of these features are explainable in terms of the dynamics of this disorder particularly from an evolutionary perspective.**

## INTRODUCTION :

The importance of affective phenomena in schizophrenia has been recoginzed since the early evolutionary stages of psychiatry. Bleuler was probably the first to emphasize this importance. In his fundamental pathognomonic symptoms of schizophrenia disordered affect came only second in importance to disordered thinking. For him it was of decisive importance for the diagnosis of schizophrenia, either in the advanced stages or at any time in the course of the illness (Oppenheimer, 1971; Andersen, 1979).

On reviewing literature, however, one can notice a marked decline in general interest or actual emperical work directed to affective phenomena in schizophrenia particularly if compared to interest and work devoted to cognitive aspects of this disorder. The reason for this defect may be partly related to the methodological problems that beset research in the field of emotion in general.

Most research works ( as seen in available literature) usually focus on relatively limited or partial aspects of affective phenomcna in schizophrenia. Examples are works concerned with a certain disorder of affective expression particularly blunting of affect (Abrams and Taylor, 1978; Andersen, 1979), a certain mood disorder in schizophrenic patients, particularly depression and anxiety ( Donlon **et al.,** 1979; Serban & Gidynski, 1979) or an affect-related phenomenon

such as "anhedonia" in relation to schizophrenia (Harrow et al., 1977). Apart from phenomenlogical descriptions of disorders of mood and affective expression in schizophrenia which are usually encountered in textbooks, no major emperical work has, to our knowledge, been devoted to an attempt at portraying the pattern of affects in schizophrenic paticnts. Such a work, in our opinion may help in detecting possible significant features characterising this affective pattern. The desired objective is analogous to that successfully obtained through emperical work on the characteristic cognitive pattern in this disorder. This study is meant to be a preliminary attempt in this direction.

## MATERIAL AND METHOD :

### (1) Sample :

The study was conducted on a sample of 20 schizophrenic patients.. The relatively random selection of patients was limited only by an attempt to represent, as much as possible, the different nosological types of schizophrenia, Methodologically speaking this sample may be considered as a "convenience sample" (Lewin, 1979).

Table (1) presents the diagnostic breakdown and duration of illness in the sample. Patients were diagnosed in accordance with the Diagnostic Manual of Psychiatric Disorders – DMP – 1 (Egyptian Psychiatric Association, 1979). The diagnosis of each case was established by the agreement of at least three qualified psychiatrists. Mean duration of illness in the sample was 7.2 years with a standard deviation of 5.9.

Identification data of the sample are presented in table (II).

### (2) Method :

Patients were subjected to a rating of affect by mulitple raters in a semistructured interview setting. A special rating scale was developed for the purposes of this study. It is composed of 24 items to be rated on a seven point scale (0–6) representing quantitative grading of

each item from "absent" to "extreme". The first twenty items comprise a list of affects while the remaining four items represent disorders of affective expression. (For the list of items see tables 3 & 4).

The required judgement of affect in this rating scale is largely based on phenomenlogical considerations. It is holistic judgement guided by such data as the patient's verbal report, facial expressions,

**TABLE ( I )**

**Diagnosis and Duration of Illness**

**( No. = 20 pts )**

| | No. | Precent |
|---|---|---|
| **Type of schizophrenia :** | | |
| Chronic undifferentiated | 6 | 30% |
| Paranoid | 5 | 25% |
| Hebephrenic | 3 | 15% |
| Schizoaffective | 2 | 10% |
| Catatonic | 1 | 5% |
| Simple | 1 | 5% |
| Acute undifferentiated | 1 | 5% |
| Residual | 1 | 5% |
| **Duration of illness** (mean = 7.2 years & S.D. = 5.9) : | | |
| less than 6 months | 2 | 10% |
| 1 – 5 years | 7 | 35% |
| 6 – 15 years | 6 | 30% |
| 11 – 15 years | 3 | 15% |
| 16 – years | 2 | 10% |

**TABLE ( II )**

**Identification Data of the Sample**

**( No . = 20 pts. )**

| Datum | No. | Percent |
|---|---|---|
| **Age** (Mean = 29.4 & Range = 18 – 41 years) : | | |
| 15 – 19 | 3 | 15 % |
| 20 – 24 | 4 | 20 % |
| 25 – 29 | 2 | 10 % |
| 30 – 34 | 4 | 20 % |
| 35 – 39 | 5 | 25 % |
| 40 – 45 | 2 | 10 % |
| **Sex :** | | |
| male | 11 | 55 % |
| female | 9 | 45 % |
| **Marital Status :** | | |
| single | 12 | 60 % |
| married | 4 | 20 % |
| divorced | 4 | 20 % |
| **Educational level :** | | |
| can read & write | 1 | 5 % |
| primary school | 2 | 15 % |
| preparatory school | 7 | 35 % |
| secondary school | 4 | 20 % |
| higher education | 6 | 30 % |
| **Occupation :** | | |
| no work | 4 | 20 % |
| student | 4 | 20 % |
| skilled labour | 2 | 10 % |
| clerical work | 3 | 15 % |
| professional | 6 | 30 % |

vocal tones and inflections, gestures, body movements, general behaviour, situational context as well as the rater's empathy or intuition, all put togther. In order to provide a common background of agreement on a delineating conception of items a list of " guiding definitions" was prepared in which an attempt was made to offer a definition for each item as commonly conceived and agreed upon in literature ( inclnding textbooks and dictionaries ). The definitions were discussed and agreed upon by the raters.

Each of the patients was subjected to a semistructured interview. All interviews were conducted by the same (most senior) psychiatrist in the presence of other raters. The interview consisted of sets of exploring questions probing the 24 items to be rated. However, the interviewer was allowed freedom to adapt his questions and approaches to the individual patients in order to elicit responses to be evaluated by the attending raters. After the interview six experienced raters ( 5 qualified psychiatrists and one clinical psychologist ) independenty rated each patient. The reliability of this assessment was evaluated statistically. The intraclass correlation method which estimates reliability coefficients among multiple raters was utilized for this purpose.

**RESULTS :**

**( A ) Reliability of affect rating :**

As seen in table ( III ) the intraclass correlation coefficients ( corrected for the average or sum of ratings ) reveal a good level of interrater reliability among all six raters. The majority of correlation coefficients (68٪) are 0.80 or more. 72٪ of the correlations are significant at. 01,16٪ are significant at. 05, while only 12٪ (3 correlations) are non significant.

**( B ) Affect mean scores and affect profiles :**

Table (IV) shows the mean scores of the 20 patients as obtained after averaging the scores of the six raters on each item for each

**TABLE (III)**

**Interrater Reliability of Affect Rating as Shown by Intraclass Correlation (20 Patients & 6 Raters)**

| Item | r1 | r11 | Significance level (r11) |
|---|---|---|---|
| 1 – Tension | .510 | .863 | ++ |
| 2 – Fear | .530 | .870 | ++ |
| 3 – Anxiety | .570 | .888 | ++ |
| 4 – Panic | .385 | .790 | + |
| 5 – Rage | .515 | .865 | ++ |
| 6 – Anger | .564 | .885 | ++ |
| 7 – Hate | .507 | .861 | ++ |
| 8 – Depression | .290 | .710 | – |
| 9 – Boredom | .281 | .700 | – |
| 10– Joy | .410 | .807 | ++ |
| 11– Elation | .602 | .900 | ++ |
| 12– Exaltation | .392 | .790 | + |
| 13– Ecstasy | .417 | .811 | ++ |
| 14– Shame | .340 | .756 | + |
| 15– Jealousy | .529 | .870 | ++ |
| 16– Envy | .600 | .900 | ++ |
| 17– Suspicion | .587 | .895 | ++ |
| 18– Shyness | .414 | .808 | ++ |
| 19– Surprise | .418 | .812 | ++ |
| 20– Love | .334 | .750 | + |
| 21– Incongruity | .477 | .845 | ++ |
| 22– Lability | .258 | .676 | – |
| 23– Ambivalence | .323 | .740 | + |
| 24– Blunting | .536 | .874 | ++ |

r1 = Intraclass correlation

r11 = " " of the sum or average

++ = Significant at .01

\+ = " " .05

– = Non-significant

**TABLE (IV)**

**Mean Scores of Patients in the Affect Rating Scale (Averege of six raters)**

| Case No. | Tension | Fear | Anx. | Panic | Rage | Anger | Hate | Depr. | Bore. | Joy | Elat. | Exalt. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1.8 | 1.7 | 3 | 0.2 | 0.2 | 0.5 | 0.7 | 1.8 | 2 | 1.2 | 1.2 | 0.5 |
| 2 | 3.2 | 3.3 | 2.7 | 1.5 | 0.8 | 1.5 | 2.3 | 1.2 | 1.5 | 0.8 | 0.8 | 0.2 |
| 3 | 2 | 2.3 | 2 | 1.2 | 0.5 | 2.2 | 1.2 | 1.3 | 0.3 | 1 | 1.7 | 1.3 |
| 4 | 1.5 | 0.8 | 1.5 | 0.5 | 2 | 1.5 | 0.7 | 1.2 | 1.7 | 0.2 | 0.2 | 0.2 |
| 5 | 0.7 | 0.8 | 0.3 | 0.0 | 0.2 | 0.2 | 0.2 | 0.7 | 0.7 | 0.5 | 0.0 | 0.0 |
| 6 | 2.7 | 6.8 | 2.8 | 1.7 | 1.8 | 3 | 3.8 | 2.3 | 2.7 | 0.3 | 0.7 | 0.3 |
| 7 | 2 | 2.3 | 1.3 | 0.5 | 0.5 | 1.2 | 0.7 | 1.5 | 1.7 | 0.5 | 0.2 | 0.0 |
| 8 | 1.7 | 2 | 1.3 | 0.7 | 1.8 | 1.5 | 1.8 | 1.5 | 2.3 | 0.3 | 0.0 | 0.0 |
| 9 | 1.7 | 2.8 | 0.3 | 1.3 | 2.2 | 2.5 | 1.2 | 2.5 | 1.2 | 0 | 0 | 0 |
| 10 | 0.5 | 2.3 | 1.3 | 1 | 2.3 | 2.7 | 2.2 | 1 | 1.5 | 2 | 3.2 | 2.3 |
| 11 | 1.7 | 2.7 | 1.7 | 1.5 | 1.5 | 2.3 | 2 | 1.5 | 1.7 | 0.2 | 0 | 0 |
| 12 | 1 | 1.8 | 1.8 | 1 | 0.8 | 2.2 | 1.7 | 2.8 | 1.3 | 0.2 | 0.3 | 0.3 |
| 13 | 1.5 | 2.3 | 1 | 0.7 | 1 | 1 | 1.7 | 1.2 | 1.8 | 0 | 1 | 0.2 |
| 14 | 1.7 | 2.8 | 2.2 | 1 | 3.2 | 3 | 2.2 | 1.5 | 1 | 0.7 | 2 | 1.7 |
| 15 | 0.7 | 0.8 | 0.5 | 0.2 | 0.5 | 0.8 | 0.7 | 0.8 | 0.8 | 0.3 | 0.3 | 0.2 |
| 16 | 1.5 | 2.3 | 0.5 | 0 | 0.7 | 1.3 | 1.2 | 1.2 | 1.2 | 0 | 0 | 0 |
| 17 | 2.2 | 2.5 | 1.8 | 0.7 | 0.3 | 2 | 1.5 | 1.8 | 2.8 | 0.2 | 0.2 | 0 |
| 18 | 3.3 | 3.3 | 1.5 | 2 | 0.7 | 1.5 | 1.2 | 1.2 | 1.7 | 0.3 | 1 | 0.7 |
| 19 | 2.3 | 2.3 | 1.5 | 0.7 | 1.7 | 2.3 | 2.3 | 1.3 | 2 | 0 | 1.3 | 1 |
| 20 | 1.2 | 2.3 | 1.2 | 1.5 | 0.2 | 1 | 1.5 | 1.5 | 0.8 | 0.2 | 0.3 | 0.7 |
| Mean | 1.8 | 2.3 | 1.5 | 0.9 | 1.1 | 1.7 | 1.5 | 1.5 | 1.5 | 0.4 | 0.7 | 0.5 |

**TABLE (IV) Continued**

| Case No. | Ecst. | Shame | Jeal. | Envy | Susp. | Shyness | Surp. | Love | Incong. | Lebil. | Ambi. | Blunt. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1.2 | 1.3 | 2.8 | 2.7 | 2 | 2 | 1.7 | 1.8 | 1.2 | 0.8 | 0 | 1.7 |
| 2 | 0 | 2 | 1.8 | 1.3 | 1.3 | 2.3 | 0.8 | 1 | 4.3 | 2.8 | 1.7 | 2.3 |
| 3 | 0.7 | 0.3 | 2.8 | 2.8 | 3.5 | 1.3 | 1.3 | 1.3 | 1.7 | 1.5 | 2.2 | 1.8 |
| 4 | 0.3 | 1.5 | 0.7 | 0.3 | 2.8 | 0.8 | 1 | 1 | 0.8 | 0 | 0 | 2.8 |
| 5 | 0 | 0 | 0 | 0 | 0.5 | 0.2 | 0.2 | 0.3 | 1.5 | 0.2 | 0 | 5.3 |
| 6 | 1.7 | 0.3 | 1.8 | 2 | 2.5 | 0.7 | 1 | 0.5 | 1 | 0.8 | 1.7 | 1 |
| 7 | 0.8 | 1.2 | 0.7 | 0.7 | 0.8 | 0.3 | 0.3 | 0.3 | 2.7 | 1.5 | 1.7 | 3.2 |
| 8 | 0.2 | 2.8 | 0 | 0.2 | 1.3 | 2 | 0.7 | 0.5 | 2.8 | 0.8 | 0.3 | 3 |
| 9 | 0.2 | 0.8 | 1.3 | 0 | 0.7 | 1 | 0.7 | 1 | 2.2 | 0.2 | 1.7 | 1.8 |
| 10 | 1.5 | 1.3 | 2.8 | 2.8 | 2.7 | 1 | 1 | 1.3 | 3.5 | 1.2 | 1.3 | 2 |
| 11 | 0.2 | 1.8 | 1.8 | 1.5 | 2.2 | 1.2 | 1.3 | 0.7 | 2 | 0.5 | 0.7 | 2.8 |
| 12 | 1.8 | 0.5 | 2 | 1.5 | 3 | 1.3 | 0.5 | 1 | 0.7 | 0.8 | 0.7 | 1.2 |
| 13 | 0.8 | 1.5 | 2.7 | 1.5 | 1.2 | 1.2 | 2 | 1 | 2.3 | 1 | 1 | 3.2 |
| 14 | 0.7 | 1.8 | 3.3 | 0.8 | 2.7 | 1.7 | 0.7 | 1.2 | 2 | 1.5 | 1.3 | 1.2 |
| 15 | 0.3 | 0.2 | 0.8 | 1.3 | 1.5 | 1 | 0.3 | 0.8 | 1.8 | 0.7 | 0.2 | 3.8 |
| 16 | 0.5 | 0.5 | 1.3 | 0.7 | 0.5 | 1 | 0 | 0.2 | 3.2 | 1.8 | 1 | 3.7 |
| 17 | 0.7 | 1.7 | 0.7 | 1.7 | 3.2 | 1.2 | 0.7 | 1 | 0.7 | 0.2 | 1.7 | 1.3 |
| 18 | 1.2 | 0.8 | 1.3 | 0.7 | 2 | 1.7 | 0.7 | 1.3 | 2 | 1.8 | 0.7 | 1.8 |
| 19 | 0.3 | 0.3 | 2.2 | 1.7 | 2.8 | 1 | 0.7 | 0.7 | 2 | 1 | 0.8 | 2 |
| 20 | 0.2 | 0.5 | 1.8 | 0.7 | 1.8 | 1.7 | 0.5 | 0.5 | 1.3 | 0.5 | 1.2 | 2.8 |
| Mean | 0.7 | 1 | 1.6 | 1.2 | 2 | 1.2 | 0.8 | 0.9 | 2 | 1 | 1.1 | 2.4 |

single patient.. In the 20 affects assessed the mean scores range between 0 and 3.8 scale points. The majority of these mean scores (57%) range between 1 (mild) and 3 (marked). Because of averaging 33.7% fall above zero but are less than 1 scale point (i.e just present). 6.5% of the scores are zero (not present) while only 2.8% exceed 3 scale points (i.e. high).

As regards the disorders of affective expression the relatively highest mean scores are seen in relation to blunting of affect: 25% of scores exceed 3 while the rest range between 1 and 3 scale points. Next comes incongruity of affect (only 15% exceed 3). Ambivalence and lability of affect show the lowest mean scores.

In order to obtain a clearer representation of the affect pattern of the sample as a whole the mean score of the 20 patients on each of the items was estimated. Profile (I) illustrates the mean or average scores of the whole sample on the 24 items of the rating scale. This "average profile" of the sample reveals the following:

1 – 13 out of the 20 affects (i.e. 65%) are scored as mildly present or more (one scale point or more).

2 – Affects showing the relatively highest scores (more than 1.5 scale points) are those of fear (2.3), suspicion (2), tension (1.8), anger (1.7) and jealousy ( 1.6).

3 – Affects showing lowest scores (less than 1 scale point) are mainly the "pleasurable affects" including joy (0.4), exaltation (0.5), and ecstasy (0.7) love and panic (0.9) and surprise (0.8) are also to the lower side.

4 – Affects in-between include anxiety, depression, boredom and hate (1.5), envy and shyness (1.2), rage (1.1) and shame (1).

5 – The highest of the disorders of affective expression is blunting of affect (2.4), followed by incongruity (2), ambivalence (1.1) and lability (1).

PROFILE(1): Average Scores of the Whole Sample
( 20 Schizophrenic Patients )

Profiles (2) to (9) illustrate the average scores of patients in terms of different types of schizophrenia represented in the sample. Taking the "average profile" of the sample (profile 1) as a frame of reference it can be noticed that its general characteristics described above are identifiable also in almost all other profiles. However, subtle variations may be observed in relation to different types of schizophrenia illustrated in these profiles : Variations of possible significance may be summarised as follows :

1 – Profile (2) which represents the chronic undiff. type is the closest to the average profile and bears the typical characteristics described above with some variations in scale points.

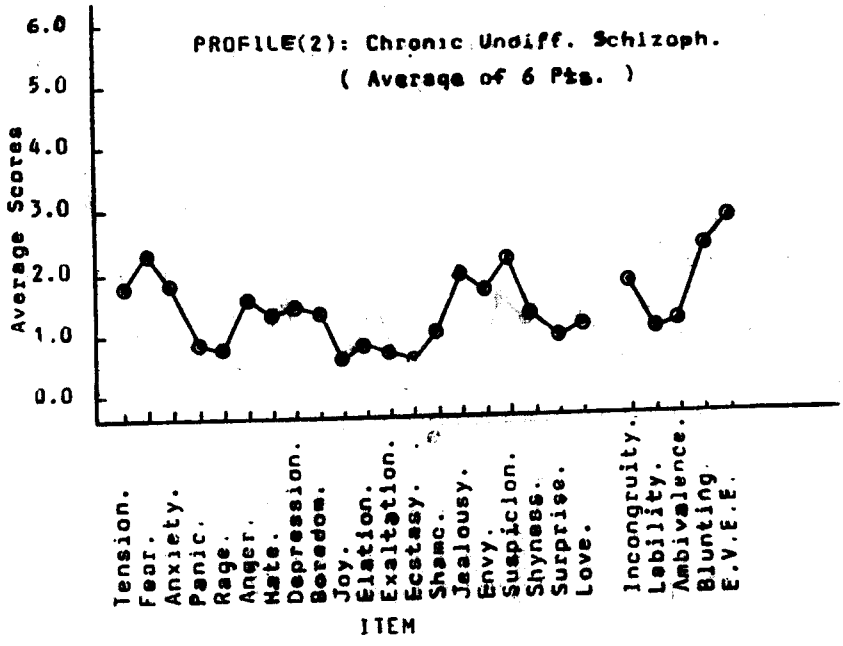
2 – In profile (3) representing the paranoid schizophrenic patients suspicion is highest of all affects (2.5). Anger (1.9) and hate (1.7) are also comparatively high. Disorders of affective expression, particularly incongruity, are generally low.

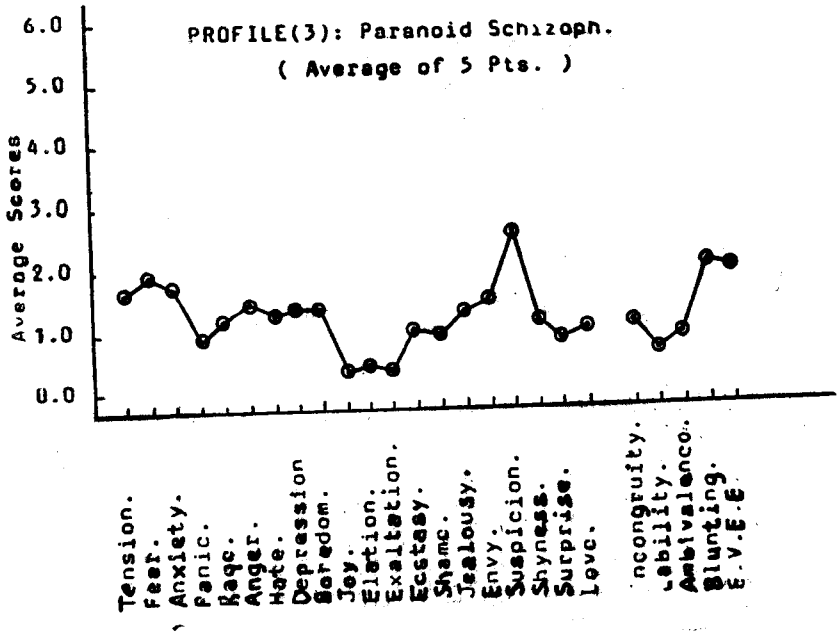
3 – In profile (4) which represents the hebephrenic patients disorders of affective expression are generally high. Incongruity (3.) and lability (1.8) in particular show their highest values in this type.

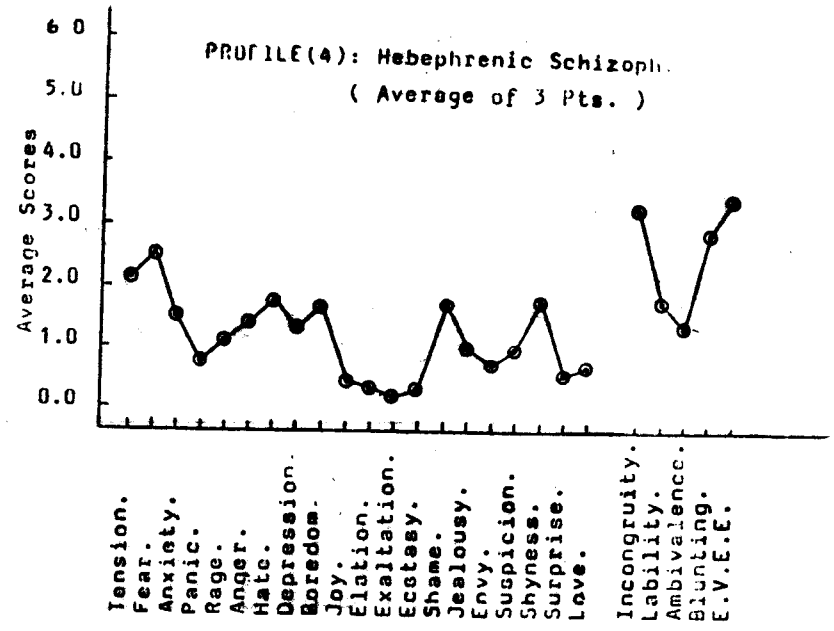
4 – Profile (5) which illustrates the average scores of schizoaffective patients shows an overall higher level of scores. Most varieties of affects including pleasurable, dysphoric and hostile affects reach their highest scores in this profile. On the other hand, blunting of affect shows its lowest score.

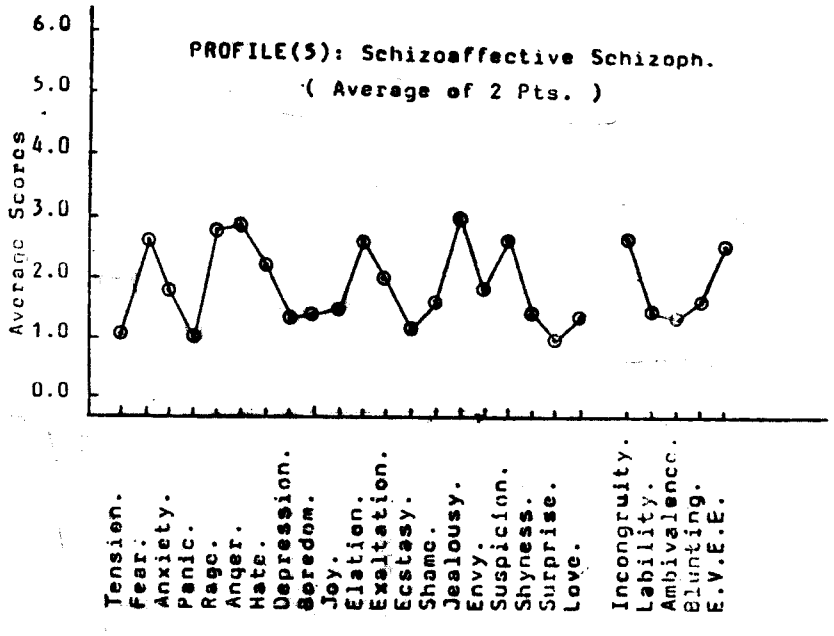
5 – Profile (6) which represents a catatonic patient shows sharp variations between comparatively high and low affects. Depression shows its highest score in this profile while pleasurable affects reach their extremely lowest scores. Ambivalence shows its highest score in this profile while blunting is relatively low.

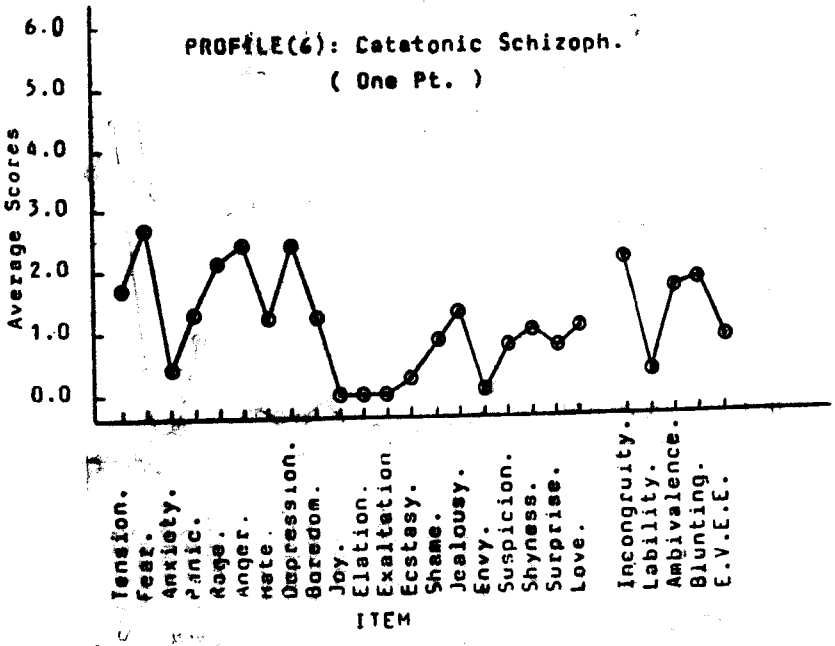
6 – The acute undifferentiated schizophrenic patient represented in profile (7) also shows some sharp variations between high and low affects. However, the relatively high disorder of expression are blunting (3.2) and incongruity (2.3).

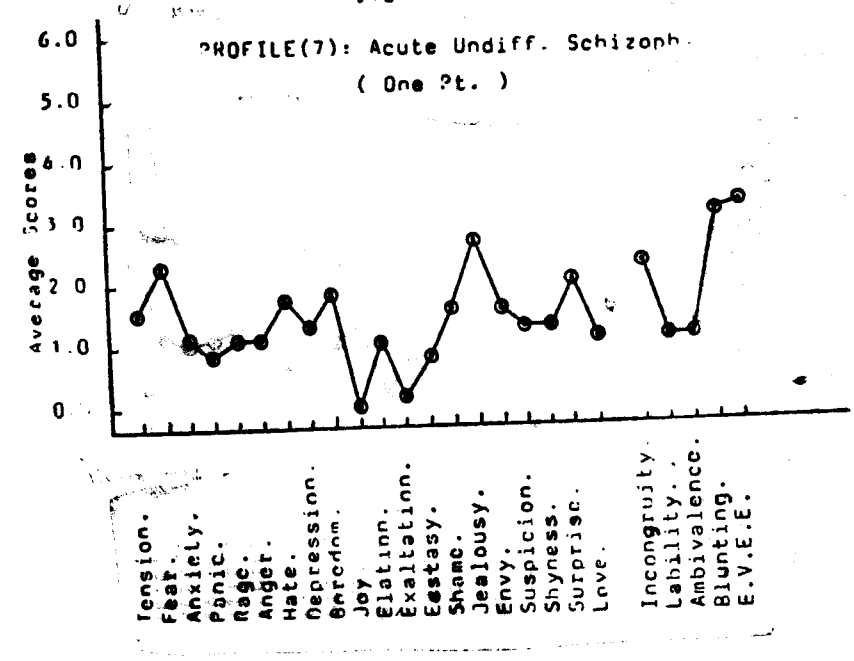

PROFILE(2): Chronic Undiff. Schizoph.
( Average of 6 Pts. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression.
Boredom.
Joy.
Elation.
Exaltation.
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
Incongruity.
Lability.
Ambivalence.
Blunting
E.V.E.E.
ITEM

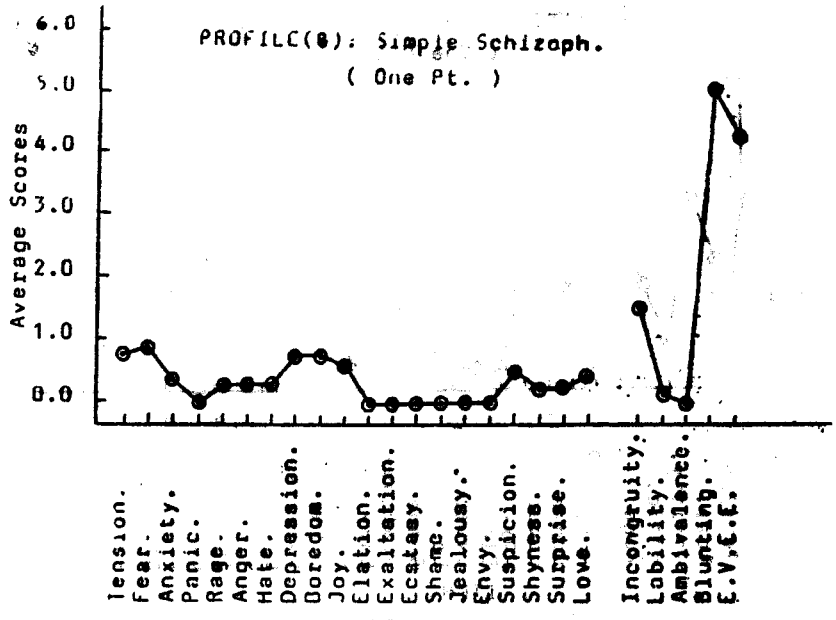

PROFILE(3): Paranoid Schizoph.
( Average of 5 Pts. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression
Boredom.
Joy.
Elation.
Exaltation.
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
ncongruity.
ability.
Ambivalence.
Blunting.
E.V.E.E.

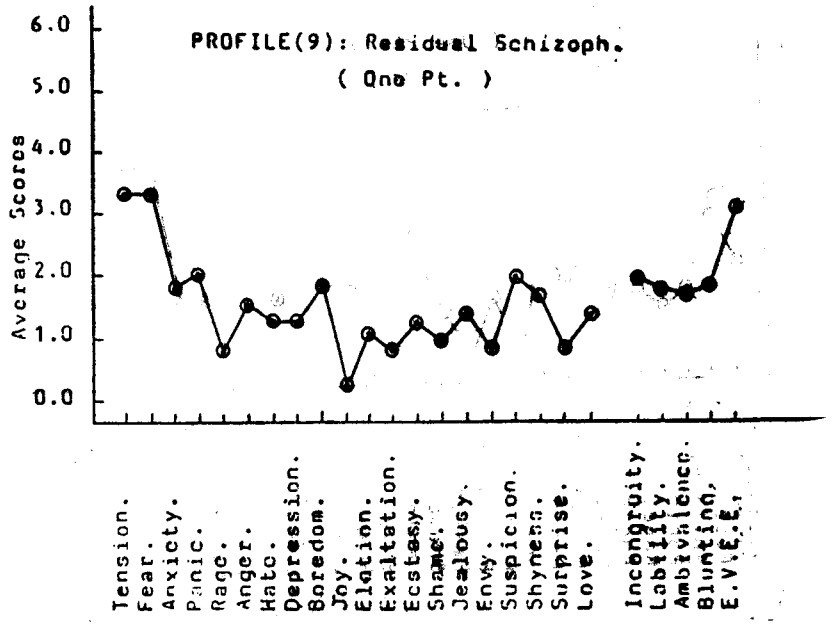

PROFILE(4): Hebephrenic Schizoph.
( Average of 3 Pts. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression.
Boredom.
Joy.
Elation.
Exaltation.
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
Incongruity.
Lability.
Ambivalence.
Blunting.
E.V.E.E.
ITEM


PROFILE(5): Schizoaffective Schizoph.
( Average of 2 Pts. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression.
Boredom.
Joy.
Elation.
Exaltation.
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
Incongruity.
Lability.
Ambivalence.
Blunting.
E.V.E.E.


PROFILE(6): Catatonic Schizoph.
( One Pt. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression.
Boredom.
Joy.
Elation.
Exaltation
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
Incongruity.
Lability.
Ambivalence.
Blunting.
E.V.E.E.
ITEM


PROFILE(7): Acute Undiff. Schizoph.
( One Pt. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression.
Boredom.
Joy
Elation.
Exaltation.
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
Incongruity.
Lability.
Ambivalence.
Blunting.
E.V.E.E.


PROFILE(8): Simple Schizoph.
( One Pt. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression.
Boredom.
Joy.
Elation.
Exaltation.
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
Incongruity.
Lability.
Ambivalence.
Blunting.
E.V.E.E.
ITEM


PROFILE(9): Residual Schizoph.
( One Pt. )
Average Scores
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Tension.
Fear.
Anxiety.
Panic.
Rage.
Anger.
Hate.
Depression.
Boredom.
Joy.
Elation.
Exaltation.
Ecstasy.
Shame.
Jealousy.
Envy.
Suspicion.
Shyness.
Surprise.
Love.
Incongruity.
Lability.
Ambivalence.
Blunting.
E.V.E.E.

7 – The profile of the simple schizophrenic patient (profile 8) is typically the "flattest" among the whole sample. While all affects show their extremely lowest scores blunting shows its extremely highest value.

8 – Profile (9) represents the patient diagnosed as residual type. The general characteristics of the average profile are maintained and fear and tension show their comparatively highest scores among the sample. However, pleasurable affects, particularly ecstasy are comparatively high.

**DISCUSSION :**

The results obtained in this study may stimulate a wide range of topics for discussion in relation to affective phenomena in schizophrenia. However, our present concern will limit the discussion to two main issues :

1 – A brief discussion of the methodological issue related to the reliability of the assessment procedure utilized in this study.

2 – The possible characteristics of affective pattern in schizophrenia as revealed in relation to two dimensions :

(A) Intensity of emotional responsiveness ( a quantitative dimension).

(B) Possible significant features of affect profiles ( a qualitative dimension).

**( I ) Reliability of affect assessment :**

As seen in the results, the assessment of affect according to the rating scale developed in this study has produced a good level of reliability. Comparison with similar studies in literature may provide further illumination in this respect. In a study by Curtis **et al.** (1967), a group of patients ( mostly psychotic ) were rated for affect by multiple raters in a clinical interview setting. However, only four affects were rated, viz. anxiety, depression, cheerfulness and anger.

Using the intraclass correlation method the average reliability for these affects were 0.55, 0.56, 0.57 and 0.76 respectively. The correlations for the corresponding items in our study are 0.88, 0.71, 0.80 and 0.88 respectively, i.e. they are considerably higher. We are probably justified to conclude that the level of reliability in this study provides a reasonably objective basis on which we can proceed to the evaluation of the revealed affective pattern.

**( II ) Affective pattern in schizophrenia :**

(A) **Affective responsiveness** (the quantitative dimension)

The question proposed here is : Is affect lost or severely eroded in schizophrenia ?.

The impression one gets from reviewing many descriptions of schizophrenic patients cited in literature is that these patients suffer from a total or severe loss of affect or capacity for affective responsiveness. Terms like "burnt out affectivity" ( Kolb, 1968 ), "apathy" (Henderson and Gillespie, 1973 ) or "flattness of affect" ( American Psychiatric association, 1980 ) which usually denote a complete lack of emotion or emotional reactivity are frequently encountered in this respect.

The findings of this study do not lend support to such an extreme position. This may be indicated from the following :

1 – The mean scores of most affects assessed show that these affects were at least present in the great majority of assessments (93.5٪) and that their intensity ranged between mild and moderate degrees in a good percentage of cases (57٪) while it was high in another small percentage (2.8٪).

2 – Though blunting of affect was the most prominent among disorders of affective expression assessed its overall level does not reflect a severe reduction of emotional responsiveness or affective intensity (average score was 2.4 scale points with a higher limit

not exceeding 3 scale points in the great majority of cases). The only conspicuous exception in this respect was the simple schizophrenic patient who showed an extreme degree of blunting.

The above findings acquire greater significance if we take into consideration that the great majority of patients were chronic established cases (mean duration of illness was 7.2 years).

Other disorders of affective expression were demonstrated in our sample. Incongruity showed a moderate average score (2 scale points) while ambivalence and lability showed a mild average score (1.1 and 1 scale points respectively). However, such disorders — by their definitions — reflect disturbances in the functional regulation and control of emotional responses and do not indicate a quantitative reduction or loss of affect or affective responsiveness.

Our findings are more consistent with another line of thinking expressed by an increasing number of authors. Henderson and Gillespie (1973) see that even in advanced cases of schizophrenia there is sometimes more evidence pointing to affective activity than would, on the surface, be suspected. Freeman (1969) suggests that there is no permenant or irreversible weakening or impairment of affect in schizophrenia. It is rather the likelihood and manner of expression which is disturbed.

Arieti (1974) suggests that schizophrenic patients do not actually lose emotions but they cannot experience or express them as they should. As a consequence of their cognitive deterioration they do not show the adequate or usual response to common social symbols. When in their own symbolic (paleosymbolic) world, however, they may react with deep emotions. Rakhawy (1979) also sees that emotions are not really lost in schizophrenia. What is lost is their functional efficacy as means of communication and motives for action.

**(B) Possible significant features of affect profiles** (the qualitative dimension)

As seen in the results, the assessed affects may be differentiated into three groups according to their relative intensity :

1 – Some affects are particularly prominent and show the comparatively highest scores in the average profile and a more or less corresponding level in the other profiles representing different types of schizophrenia. Ranked from highest to lowest these affects are : Fear, suspicion tension, anger and jealousy.

2 – A second group of affects show comparatively lowest scores in the average profile as well as the majority of other profiles. These include all pleasurable affects as well as love, surprise and panic.

3 – The third group of affects lie in-between and show a comparatively moderate level in the average profile as well as the profiles of most types. These include anxiety, depression, boredom, hate, rage, envy, shyness and shame.

As demonstrated in the results subtle variations between profiles representing different types of schizophrenia do exist but they are generally consistent with the conventional characteristics of these types, e.g. the relatively higher levels of hostile affects in the paranoid type, the overall higher level of scores in the schizoaffective type, the extreme degree of blunting in the simple type ... etc.

It is of interest, however, that variations do not significantly mask or contradict the general trends described above.

This global differentiation of the assessed affects into comparatively highest, moderate and lowest probably gives a rough indicator of the degree of prominence of each of these affects within the studied group of schizophrenic patients. The relative position of some of the affects according to this comparative differentiation may be of some particular significance. This will be explored in the following discussion and evaluation of separate affects or groups of related affects.

**1 – Fear and anxiety :**

As seen in the results fear is the most prominent affect. It is the

highest in the average profile and it consistently shows the highest score in almost all other profiles (the only exceptions are the profiles of the paranoid and acute undiff.Types where it ranks second, and the schizoaffective type where it ranks fifth). Anxiety, on the other hand, is one of the affects that occupy a comparatively moderate position within the assessed group.

Although fear and anxiety appear to be very much related (both experientially and physiologically) attempts have always been made to differentiate between them. Most definitions make a distinction by relating anxiety to the anticipation of danger, the source of which is largely unknown (illdefined or unconscious), whereas fear is the response to a consciously recognized and usually external threat or danger (Davis, 1957, Linn, 1980, Kaplan and Sadock 1980, ...). Another important and more elaborate distinction, however, is based on an evolutionary prespective. It has been well elaborated by Arieti (1976) who contende that the difference between the two affects is not simply the appraisal of a definite external danger but is rather related to the evolutionary level of cognitive mechanisms involved. In fear, the cognitive element is more primitive (presymbolic) and consists of the appraisal of concrete perceptual data indicating danger while in anxiety the cognitive element depends on higher symbolic or conceptual processes that allow the anticipation of danger that is not immediate or concrete. Moreover, the appraised dangers are not only those threatening physical existence but will also include moral dangers related to self esteem, values and meanings given to one's existence.

Developmental data do confirm this point of view; studies conclucted by Bridges and Buler on the development of emotion in children demonstrate that fear is more primitive than anxiety. For while fear appears around the third month of life, anxiety manifests around the seventh month.

As a conclusion, the basic distinction between fear and anxiety

lies in the fact that fear is the more primitive affect. It may be considered the primitive prototype of anxiety (Arieti, 1976).

At a dynamic level, most theories or conceptions of schizophrenia view it as a regression to earlier primitive levels of development, both ontogenetically and phylogenetically ( Arieti, 1974 & Shean, 1978). This may generally explain why fear (as well as similar primitive affects) may be prominent in the affective profiles of schizophrenic patients.

But the question remains : why is fear "the most" prominent affect in the profiles ?

Most dynamic theories or conceptions stress the central dynamic role of anxiety as leading to the schizophrenic transformation. Arieti (1978) maintains that the whole schizophrenic process can be viewed as a mechanism used to diminish or transform anxiety. Also, clinical observation indicates that in potential and early schizophrenic patients morbid and devastating anxiety is the most prominent affect (Fish, 1962, Kolb 1968, Willis, 1976....). On the other hand, the findings of this study indicate that it is fear, rather than anxiety, that is (phenomenologically) the most prominent affect in established schizophrenic patients. Putting these data together, it may be reasonable to speculate that with the increasing schizophrenic regression anxiety gives its way to its primitive prototype, i.e. fear.

**2 – Tension :**

Tension is generally considered a primitive and undifferentiated affect. According to Arieti (1976) it may be defined as a protoemotional (presymbolic level) category that includes "several relatively simple states of discomfort which tend toward relief or discharge". In this sense it is an undifferentiated state provoked by many unfavourable stimuli (physical or psychological) and it may evolve into other more differentiated affects (e.g. anxiety, anger, depression ...).

As seen in the results tension ranks third, among affects showing highest average scores. In the light of the above conception. this prominent position may be explained in terms of the mechanism of regression as was the case with fear.

As a consequence of the schizophrenic regression and dedifferentiation of functions this primitive and undifferentiated affect reemerges and becomes prominent substituting (to different degrees) the more differentiated unpleasant forms of affect.

**3 – Suspicion, anger, hate and rage :**

These affects may be grouped together as representing "hostile affects" .

As noticed in the results, suspicion is the most prominent affect of this group (it ranks only second to fear in the average profile). This comparatively high level probably reflects a significant paranoid element in a majority of schizophrenic patients. Dynamically speaking, this phenomenon is probably a reflection of the extremely insecure and threatened schizophrenic existence (Arieti, 1974).

Anger is among the five comparatively highest affects in the average profile while hate and rage fall among the moderately represented affects. The difference between the average scores of anger and hate is not apparently significant (1.7 and 1.5 scale points respectively). The average score of rage, however, is relatively low.*

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* An important methodological issue should be considered in evaluating the results concerning " rage" as well as "panic". These two affects share a special nature that limits their proper assessment in the context of the present study. Both affects are known to manifest in episodic short-lived outbursts that are less likely to be encountered in the limited interview situation. What was rated was probably mainly a potentiality sensed from the patients' verbal reports rather than the properly manifesting affect. This factor limits the significance of their results and provides uncertain basis for their discussion.

The prominent position of anger revealed here is not a totally new finding. Commenting on affect in schizophrenia Freeman (1969) remarks : "It is of some interest that anger is the most commonly observed affect, particularly in patients who are for the most part withdrawn and inaccessible".

The overall picture as discussed above points to the possibility that hostile affects occupy a significant position in the affective profile of schizophrenic patients.

**4 – Jealousy :**

This affect ranks fifth among affects showing highest average scores. This relatively prominent position may be explainable dynamically in terms of the mechanism of regression to earlier stages of development. According to Hadfield (1962) jealousy is a prominent affect in children. It is related to the dependent child's insecurity and fear of losing the love of a significant person (mother). If he sees this love passing to another he is thrown into a state of panic which gives rise to jealousy. It is possible that in the course of schizophrenic regression the patient's increasing insecurity and dependency again reproduce jealousy to a prominent degree.

**5 – Joy, elation, exaltation and ecstasy :**

"Pleasurable affects" represented in this group were consistently lowest in almost all profiles (the only exception was the schizoaffective profile). Of these affects, joy (which shows the lowest average score) is considered a within normal positive affect. The other three affects are to some degrees within the limits of normal life experiences. However, they indicate pathology when they occur in inappropriate degrees in relation to inappropriate circumstances (Linn, 1980).

The marked impoverishment of these affects as noticed in our study is consistent with observations reported in literature. Elevated mood, in general, is considered to be uncommon in schizophrenia

(Fish, 1962). It is dysphoric mood, rather than elevated mood, which is more common in schizophrenia (American Psychiatric association, 1980).

Our findings also lend support to the validity of the phenomenon of "anhedonia" (i.e. marked defect in pleasure capacity) as described by several authors in relation to schizophrenia. This anhedonia is manifested clinically by a general weakening of positive or pleasurable affects and it was reported to be particularly prominent in chronic schizophrenic patients (Harrow et al., 1977; Lehmann, 1980). The consistently lowest scores of pleasurable affect, in our sample (mostly chronic established cases) may represent a typical demonstration of this phenomenon.

**6 – Love :**

Like pleasurable affects, love was among the comparatively lowest affects in the profiles.Dynamically speaking, this finding may be related to a major aspect of the schizophrenic psychopathology, namely the marked disturbance and deterioration of object relations (Steiner, 1979). Object relation is mainly based on the ability to form and sustain a mature loving bond with others ( Moore and Fine, 1968). The low position of love revealed in our schizophrenic patients is probably a significant indicator of the degree of deterioration of object relations in these patients.

**6 – Depression and boredom :**

These two affects are very much related since boredom, though commonly considered a differentiated affect (Linn, 1980), is hardly separable from the general mood of depression. In a way it may be considered to represent a form or quality of depression.

Both affects are among affects occupying a comparatively moderate position in the average profile and in the majority of other profiles their scores range between mild and moderate degrees. According to Fish (1962), depressive moods are met with in chronic schizophrenia.

However, this depression is frequently described as being "on the surface, mild and associated with a feeling of failure" (Henderson and Gillespie, 1973). In early stages or acute episodes of schizophrenia, on the other hand, depression is reported as particularly common and prominent (Fish, 1962; Mayer-Gross et al., 1977). Our results are generally consistent with such observations. The majority of our patients (who are mostly chronic) show mild to moderate degree of this affect. Also, the most prominent degree of depression can be noticed in the profile of the catatonic patient who had the most recent and acute onset.

**7 – Other affects :**

Other affects rated in this study include shame, shyness, envy and surprise. Except for "surprise" they all fall among affects showing a comparatively moderate position in the average profile.

Space limitations will not allow a detailed discussion in relation to these affects. However, as a general comment it may be stated that such affects represent different qualitative aspects of the rich and complex human emotional repertoire. Their presence to such degrees in the profiles probably denotes that the affective life of the assessed schizophrenic patients has not lost much of its richness and variability although most of them are chronic and established cases. The presence of shame and shyness in particular, probably indicates that such patients are not as callous and insensitive as they are commonly conceived to be.

This discussion of the qualitative dimension provides some illuminating data that may be integrated with our previous discussion of the quantitative dimension. Instead of speaking of a general qualitative reduction or loss of affects or affectivaty in schizophrenis quantitative reduction or loss of affects or affectivity in schizophrenia ted above, some affects (generally the higher affects) may become reduced or less manifest, but at the same time other affects (generally the more primitive affects) may become prominent.

In other words emotion is not actually lost or weakened in schizophrenia. What happpens is more likely to be a shift from one order or level of emotion to another. What appears to be lost or weakened is a higher level of emotion or emotional functioning. But at the same time a lower or more primitive level of emotion or emotional functioning emerges and becomes prominent.

This viewpoint has been expressed and elaborately discussed by some authors. Arieti (1974) contends that this change can be meaningfully explained in relation to cognitive deterioration. In the course of their regressive process patients cannot effectively use higher emotions that involve higher cognitive forms and process. They do not show the " usual " expected emotional reaction to common social symbols. However, their affective life is maintained in relation to a lower cognitive forms and process (paleosymbolic or preconceptual). In a parallel line, Rakhawy (1979) sees that the basic affective disturbance in schizophrenia is neither the absence nor the withdrawal of emotion. It is a result of the separation between the symbol and its meaning with a reactivation of primitive clumsy emotions. Emotions, in general, though existing become useless as motives for relatedness and action. In other words they are not lost, but rather lose their function.

**CONCLUSIONS :**

1 – Assessment of affect based on phenomenological considerations which focus on experiential rather than external behavioral aspects of phenomena can produce a satisfactory degree of reliability.

2 – The results of this study do not lend support to the assumption that affect is quantitatively lost or grossly weakened in schizophrenia. The Affective change is more probably related to a qualitative shift from higher to lower orders of emotional functioning with a resultant apparant impoverishment of conventional or socially expected emotions or emotional responsiveness.

3 – Analysis of affect profiles indicates some possibly significant charcteristics of schizophrenic affective pattern :

a. Some affects occupy a prominent position. "Fear" in particular is consistently highest of all affects assessed. Other prominent affects include suspicion, tension, anger and jealousy.

b – Other affects occupy a consistently low position. These are mainly pleasurable affects (joy, elation, exaltation, ecstasy) and love. This may support the validity of the phenomenon of "anhedonia" previously reported in relation to schizophrenia.

c – Other affects such as anxiety, depression, hate, shame and shyness constitute a third group which occupies a comparatively moderate position.

4 – Most of the above findings are cogently explainable in terms of accepted psychodynamic hypotheses of schizophrenia. The evolutionary perspective is particularly relevant in this respect.

As a last comment, it must be stated that generalization from these findings and conclusions is limited by certain factors that should be taken into consideration. These include the relatively small size of the sample studied, the lack of comparison with normal subjects or other types of psychiatric patients and the fact that assessment was restricted to a limited cross-section of the patients' affective life. However, they are worthy of consideration as initial tentative results that may provide illuminating guidelines for further replication and verification.

## REFERENCES

Abrams, A. and Taylor, M.A. (1978) A rating scale for emotional blunting. **American Journal of Psychiatry**, 135 : 2, 226 – 229.

American Psychiatric Association (1980) **Diagnostic and Statistical Manual of Mental Disorders (DSM-III).** Washington D.C.: American Psychiatric Association.

Andreasen; N.C. (1979) Affective flattening and the criteria for schizophrenia. **American Journal of Psychiatry,** 136 : 7, 944-947.

Arieti, S. (1974) **Interpretation of Schizophrenia.** Second edition. New York : Basic Books.

———— (1976) **The Intrapsychic Self : Feeling and Cognition in Health and Mental Illness.** New York : Basic Books.

———— (1978) Anxiety and beyond in schizophrenia and psychotic depression. In Arieti, S. (Ed.), **On Schizophrenia, Phobia, Depression, Psychotherapy and the Further Shores of Psychiatry** (Selected Papers). New York : Brunner/Mazel, Publishers.

Curtis, G. C., Smith, W.G., Kordasz, F. and Fogel, M.L. (1967) The influence of amount and type of information on the rating of affect. **Journal of Mental and Nervous Disease, 144 :** 124 – 132.

Davis, D.R. (1957) **An Introduction to Psychopathology.** London : Oxford University Press.

Donlon, P.T., Rada, R.T. and Arora, K (1976) Depression and the reintegration phase of acute schizophrenia. **American Journal Psychiatry,** 133 : 11, 1265 – 1268.

Egyptian Psychiatric Association (1975) **The Diagnostic Manual of Psychiatric Disorders ( DMP–I ).** Cairo : Egyptian Psychiatric Association.

Fish, F.J. (1962) **Schizophrenia.** Bristol : John Wright & Sons Ltd.

Freeman, T. (1969) Schizophrenia : Symptomatology, diagnosis and clinical course. In Bellak, L. and Loeb, L. (Eds.), **The**

**Schizophrenic Syndrome.** New York – London : Gruns & Stratton.

Hadfield, J. A. (1962) **Childhood and Adolescence.** Baltimore : Penguin Books.

Harrow, M., Grinker, R., Holzman, P. and Kayton, L. (1977) Anhedonia and Schizophrenia. **American Journal of Psychiatry, 137 : 794 – 797.**

Henderson, S.D. and Gillespie, R.D. (1973) **A Textbook of Psychiatry.** Tenth Edition. **London : Oxford University Press.**

Kaplan, H. I. and Sadock, B.J. (1980) Typical signs and symptoms of psychiatric illness. In Kaplan, H.I., Freedman, A.M. and Sadock, B.J. (Eds.), **Comprehensive Textbook of Psychiatry.** Third Edition. Vol. I. Baltimore : Williams & Wilkins.

Kolb, L.C. (1968) **Noyes' Modern Clinical Psychiatry** Seventh Edition. Philadelphia : Saunders.

Lehmann, H. E. (1980) Schizophrenia : Clinical features. In Kaplan, H.I., Freedman, A.M. and Sadock, B.J. (Eds), **Comprehensive Textbook of Psychiatry** Third Edition. Vol. II. Baltimore : Williams & Wilkins.

Lewin, M. (1979) **Understanding Psychological Research.** New York : John Wiley & Sons.

Linn, L. (1980) Clinical manifestations of psychiatric disorders. In Kaplan, H.I., Freedman, A.M. and Sadock, B.J. (Eds.) **Comprehensive Textbook of Psychiatry.** Third Edition. Vol. I. Baltimore : Williams & Wilkins.

Mayer – Gross, W., Slater, E. and Roth, M. (1977) **Clinical Psychiatry.** Third Edition. London : Bailliére Tindall.

Moore, B. and Fine, B. (1968) **A Glossary of Psychoanalytic Terms and Concepts.** New York : American Psychoanalytic Association.

Oppenheimer, H. (1971) **Clinical Psychiatry.** New York : Harper and Row, Publishers.

Rakhawy, Y.T. (1979) **A Study in Psychopathology : The Secret of the Game.** Cario : Dar El-Ghad (In Arabic).

Serban, G. and Gidynski, C. (1979) Relationship between cognitive defect, affect response and community adjustment in chronic schizophrenics. **British Journal of Psychiatry, 134 :** 602 – 608.

Shean, G. (1978) **Schizophrenia : An Introduction to Research and Theory.** Cambridge, Massachusetts : Wintrop Publishers, Inc.

Steiner, J. (1979) Holistic group therapy with schizophrenic patients. **International Journal of Group Psychotherapy, 29 :** 3, 195 – 210.

Willis, J. (1976) **Clinical Psychiatry.** London : Blackwell Scientific Publications.

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## الموجـــــــز

### نمط محتمل للظاهرة الوجدانية فى مرض الفصام

أجريت هذه الدراسة بهدف بحث الخصائص الممكنة لنمط الوجـــدان لدى مرضى الفصام . وقد تم اختيار عينة ملائمة من عشرين فصامى يمثلون أنواع تشخيصية مختلفة وقد طبق عليهم مقياس للعواطف بواسطة مقومين فى مقابلة شبه منظمة . وكان الحكم على العواطف طبقا لهذا المقياس — مبنيا على اعتبارات فينومينولوجية . وقد نتج عن التقويم بهذه الطريقـــة مستوى مرتفع من الثبات — بين المقومين .

وقد كشف تحليل النمط الوجدانى عما يلى :

١ — لا يبدو أن الوجدان يفقد كميا أو يضعف بشـــكل حاد فى مرض الفصام ويمكن ارجاع الفقر الظاهرى فى المشـــــاعر الى اعتبارات كيفية ووظيفية .

٢ — أوضحت الدراسة الجانبية ( بروفيل ) لخصائص قد تكون دالة :

( أ ) هناك بعض العواطف الظاهرة وبخاصـــــة « الخوف » وكذلك التوتر والشك والغضب والغيرة .

( ب ) بعض العواطف شـغـلت الجزء الأدنى من البروفيل وهذه هى هى أكثرها متعة : الفرح والمرح والنشوة والحب .

( جـ ) تشغل بعض العواطف كالقلق والاكتئاب والكره والخجل موقعا وسطيا فى البروفيل .

ويمكن تفسير هذه المظاهر وفقا لديناميات هذا المرض وبخاصـــة من منطلق تطورى .

## ABSTRAIT

### La Schizophrénie : Caractéristiques possible D'un Modèle Affectif.

Cette étude a été conduite dans le but d'éxaminer la possibilité

de caractériser un modèle affectif chez les patients schizophrènes. Un échantillon de convenance de patients représentant les différents types nosologiques de la schizophrénie a été assujéti à une évaluation de l'affect par plusieurs évaluateurs dans le context d'un interview semi-structuré.

Le jugement de l'affectivité, suivant l'échelle développée, était largement basé sur des considérations phenomenologiques. L'évaluation de l'affect suivant cette methode a produit un degré satisfaisant de réliabilité entre les juges.

L'analyse du modèle affectif ainsi révélé indique le suivant :

1 – L'affect n'est pas quantativement perdu ou sévèrement affaibli dans la schizophrénie. L'appauvrissement apparent a trait plutôt à des considérations qualitatives et fonctionnelles.

2 – Les profiles affectits indiquent quelques caractéristiques significatives :

a – Quelques sentiments sont particulièrement prononcés, parmi lesquels la peur était la plus remarquable. Les autres sentiments prononcés comprenaient : La tension, le soupçon, la colère et la jalousie.

b – D,autres sentiments occupent une position moins importante dans les profiles, ceci sont surtout les sentiments de plaisir (la joie, l'éxaltation, la gaieté, l'extase et l'amour).

b – D'autres sentiments comme l'anxiété, la dépression, la haine, la honte, et la timidité occupent une position intermédiaire dans les profiles.

La plupart de ces caractéristiques sont explicables en termes des dynamiques de cette maladie, vue particulièrement d'une perspective evolutionnelle.

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# Effect of Amputation on Patient's Self Concept

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Layla I. Kamel and Fatma Abdou Hosni

## ABSTRACT

**This study focuses upon the alteration of self concept as a result of amputation. Studied were sixty individuals, 30 amputees and 30 controls. These were interviewed. The Self Concept Scale by Ismail 1957 was the tool used.**

**Results showed a significantly lower self concept among amputee group. Age and marital status were found to affect significantly patient's self concept while sex and occupation did not have any statistical significant effect.**

**These findings indicate the psychological stress that accompany alteration in body function and appearence and point to the importance of taking this into consideration in providing nursing care for these patients.**

## INTRODUCTION :

Patients suffering from loss of body function undergo psychological stress which stems from the loss of a real object. This is specially significant if the loss affects the individual's social status, occupation, if it interferes with a valued skill or talent (Severyn, 1978). A means to estimate the psychologioal effect of the loss is through the determination of the patients' self concept. In fact, every person posse-