

## Psycho-Demographic Study of Anxiety in Egypt: The PSE in its Arabic Version

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**Summary:** This is the first attempt to study the socio-demographic aspects of anxiety disorders in Egypt and to apply the Arabic version of the PSE in evaluating the profiles of clusters and symptoms of anxiety in a sample of 120 patients with anxiety. There were significant differences in some presentations between males and females, between illiterate and educated groups, and between those exposed to mild and severe crowding. Structured interviews like PSE will help in transcultural comparisons of clinical psychiatric disorders.

Wing and his colleagues (1967) developed the Present State Examination (PSE) based on a comprehensive list of questions, brief symptom definitions and a guide to the conduct of the interview. The PSE was originally constructed in English and studies on its reliability were carried out (Wing *et al.*, 1967; Kendell *et al.*, 1968; Sartorius *et al.*, 1970). The original English version has been translated into Arabic by Okasha and Ashour (Egyptian Psychiatric Association, in press). This translation was given to a third person who translated it back into English, which in turn was assessed by an English speaking psychiatrist who compared the original version with the back-translated one and removed any inconsistencies.

The centre in Ain Shams University in Cairo consisted of six psychiatrists who had undergone a period of training in the use of PSE before contributing patients to the study. Regular checks were made on the inter-rater reliability. The PSE aims to cover the full range of symptoms and is divided into a number of different areas for convenience. That of anxiety was of particular interest for the purpose of this study.

A structured interview like the PSE is an important advance over the questionnaire technique. However the interview schedules developed to date suffer from some obvious shortcomings (Kapur *et al.*, 1974):

- (1) None of the interview schedules is designed to tap information from a near relative or a friend to obtain a complete picture of the psychopathology.
- (2) None of the schedules has a section for systematic recording of historical information, so important in reaching a diagnosis.
- (3) The schedules developed for use in the West appear less and less satisfactory as one moves away from the socio-cultural context in which

they were developed. For example, none of the schedules pays special attention to possession states, symptoms of sexual inadequacy and somatic overconcern, so commonly encountered in developing countries (Kapur *et al.*, 1974). The authors added four questions to the PSE to suit the Egyptian setting in future studies (on possession or witchcraft, traditional healing efforts, sexual inadequacy and praying).

### Method

One hundred and twenty patients suffering from anxiety states were collected at random from Ain Shams University out-patient clinic (representing low social classes) and those attending private clinics of the authors (representing middle and high social strata) during the first six months of 1980. The diagnosis of anxiety was agreed upon by two psychiatrists and based on the Egyptian Diagnostic Manual of Psychiatric Disorders (1979). This is derived mainly from ICD (WHO, 1978), DSM-III (American Psychiatric Association, 1980) and the French classification, also taking into consideration the socio-cultural context. 'Anxiety State' refers to a condition of predominant tension and apprehension experienced mentally and physically, persisting independently of external factors and not secondary to other medical or psychiatric illnesses. The physiological basis lies in increased activity of the autonomic nervous system.

### Results

Our sample consisted of 77 males and 43 females. Anxiety states were highest in the age group between 20-29 years, this high representation being noticed in both males and females; (males: below 20, 8; 20-29,

40; 30–39, 20; above 40, 9 cases; females: below 20, 5; 20–29, 18; 30–39, 12; above 40, 8). The 20–29 age group (18.7 per cent of the population in the Egyptian census) is faced with all the stresses of marriage, finding and maintaining suitable employment, frustrated expectations, housing difficulties, economic inflation, political sanctions in developing countries, and the dilemma between following local traditions and culture and adjusting to westernized life styles. Females in the age group from 20–29 years are more vulnerable to anxiety states because of the above factors, and in addition, the burden on the emancipated females who have to work and continue to perform their marital duties in the traditional fashion. The postponement of marriage until the late twenties because of a housing shortage, economic difficulties etc. can add to sexual frustration, as premarital intercourse and other sexual outlets contradict the conformity of the society to the religious codes. It is a popular belief that people who move from the countryside to the city are more susceptible to anxiety symptoms because of a lack of adaptation, difficult adjustment and the feeling of alienation. In our sample of 120 anxiety patients, only 27 had moved from the village to the city, 64 were natives of the city, and of the remaining 29 no moves were known.

With regard to marital status, single males were more frequent among anxiety patients; while among the females, the married ones were commoner (males: married 25, single 52, divorced 1; females: married 22, single 18, divorced 1). This can be interpreted that the married Egyptian female is exposed to more stress than the single female because of the male dependency on his wife in all household activities, in spite of the fact that she may be emancipated and pursue her own career outside the home. In contrast the single male is more prone to anxiety, as he is continuously concerned with his expectations regarding marriage, housing, finances and future career more than the established married man.

The living conditions of 118 cases where details were recorded showed that 92 were not economically responsible for their families, while only 26 (including 4 females) were fully supporting their families. This can be explained by the traditions of the Egyptian family where the member's social status is not equivalent to his financial resources. Regarding the effect of crowding in the home on anxiety, it was scored that if one person was living in one room, there was no crowding, 2 persons would be mild crowding and more than 2 persons severe crowding. Owing to the housing difficulties and the country having the highest birth rate in the world (with a one million increase every ten months), crowding to this extent is common in Egypt. We found that out of 118 cases of

anxiety, 58 were not living in crowded conditions, 34 in crowding and 26 in severe crowding, a distribution which makes it seem as if crowding as a factor does not play a major role in the initiation or maintenance of anxiety in our culture (although we cannot be certain of the rates of these degrees of crowding in the base population as the census does not record them).

### Discussion

In the DSM-III, anxiety disorders are estimated to range from 2–4 per cent of the general population. Anxiety states represent about 18 per cent of the psychiatric out-patient clinic in a selective Egyptian sample (Okasha *et al*, 1968). In another study on psychiatric morbidity among university students in Egypt, anxiety states represented 36 per cent of the total sample (Okasha *et al*, 1977).

We summarize the interesting points in our present findings as follows (see also the Table). (Full tables and figures are available on application to the authors.)

The commonest symptoms were worrying (83 per cent), irritability (73 per cent), free-floating anxiety (70 per cent), depressed mood (65 per cent), tiredness (64 per cent), restlessness (63 per cent), anergia and retardation (61 per cent). The rarest were alcohol abuse (2 per cent) and drug abuse (5 per cent). Suicidal plans were uncommon (9 per cent). Delayed sleep (49 per cent) was commoner than early waking (22 per cent). Panic attacks were represented in 30 per cent, situational anxiety in 35 per cent, specific phobias in 37 per cent, and avoidance of anxiety in 53 per cent (which was the highest phobic symptom).

Applying chi square tests, significant differences in symptoms were found between males and females. Males showed highly significant differences ( $P < 0.01$ ) in increased hypochondriasis and anxiety on meeting people. This can be explained by the fact that males in our culture tend to somatise their psychological symptoms, as the latter may lower their prestige and degrade their pride, because the belief is that 'real' men should not have psychological symptoms. The man is required to play a superior, confident, dignified role, which may challenge his power of adaptation and accentuate his anxiety on meeting people. Females showed highly significant differences in increased free-floating anxiety, loss of weight and conversion symptoms. The inferior social role of the female favours emotional immaturity, which may explain the prevalence of the above symptoms. We have no explanation for the surprising difference in organic impairment of memory.

There were highly significant differences between illiterates and high school graduates. Poor concentration, loss of weight, delayed sleep, anergia, retardation, obsessional checking, fugues and amnesia

TABLE  
*Association of symptoms with sex, education and crowding*

Symptom	Males vs. females		Illiterates vs. high school graduates		Mildly crowded vs. severely crowded pop.	
	Male	Female	Illiterate	HS Grad.	Mild	Severe
4 Worrying						P < 0.01
5 Tension pains						P < 0.05
6 Tiredness				P < 0.05		P < 0.05
8 Restlessness						P < 0.01
9 Hypochondriasis	P < 0.01					P < 0.05
11 Free-floating anxiety		P < 0.01				P < 0.01
12 Anxious forboding				P < 0.05		
14 Panic attacks						P < 0.05
16 Anxiety on meeting people	P < 0.01					
17 Specific phobias	P < 0.05					P < 0.01
18 Avoidance of anxiety				P < 0.05		P < 0.05
20 Poor concentration				P < 0.01		
21 Neglect due to brooding				P < 0.05		P < 0.01
23 Depressed mood	P < 0.05			P < 0.05		
28 Social withdrawal						P < 0.05
34 Loss of weight		P < 0.01		P < 0.01		
35 Delayed sleep				P < 0.01		
36 Anergia/retardation				P < 0.01		
37 Early waking						P < 0.05
41 Expansive mood				P < 0.05		P < 0.01
42 Ideomotor pressure				P < 0.05		P < 0.01
43 Grandiose ideas/actions						P < 0.01
44 Obsessional checking				P < 0.01		
48 Depersonalization			P < 0.01			
97 Fugues/amnesia				P < 0.01		P < 0.01
100 Dissociative			P < 0.01			
101 Conversion symptoms		P < 0.01	P < 0.01			P < 0.01
103 Organic impairment of memory		P < 0.01				P < 0.01
106 Social impairment				P < 0.05		

were commoner in the educated group, while the illiterates more often suffered from depersonalization, dissociative and conversion symptoms. This agrees with the familiar clinical observation that hysterical symptoms are more frequent among the uneducated population with average and below average intelligence.

Statistical analysis showed significant variation in the profile of anxiety symptoms as regards crowding. Patients living in severely crowded places exhibited highly significant differences from those living in mildly crowded areas. Symptoms like worrying, restlessness, free-floating anxiety, specific phobias, neglect due to brooding, expansive mood, ideomotor pressure, grandiose ideas, fugues, amnesia and conversion symptoms, were more manifest in severe crowding.

On the other hand when we applied the chi square tests between patients living in mild crowding and those with no crowding, we found no highly signi-

ficant differences in anxiety symptoms except in one item from the 52 symptoms, namely panic attacks. If we apply the same with severe crowding, a highly significant score ( $P < 0.01$ ) was manifest in morning depression, expansive mood, ideomotor pressure, obsessional checking, depersonalization and conversion symptoms.

The use of the Arabic version of the PSE has thus enabled us to evaluate the different clusters and symptoms of anxiety in relation to sex, educational status and crowding. A structured interview like PSE will allow better comparison of the clinical symptoms of different psychiatric disorders in different cultures. A plea is made to use structured interviews in future clinical researches, taking the local syndromes and cultural aspects into consideration (Kapur *et al.*, 1974).

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