

Gender and Other Predictors of Anxiety and Depression in a Sample of People Visiting Primary Care Clinics in an area of political conflict: Gaza Strip.

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Abstract

Objective: this was a quasi-experimental survey that looked at sex difference of mental disorders and the prevalence of mental health problems for people visiting primary health care clinics in the Gaza Strip. **Method:** a survey of 661 randomly selected primary health care patients was completed using the HSCL-25. **Results:** about 73% of patients visiting primary care clinics in the Gaza Strip had mental disorders. The prevalence among females was higher (76.8%) than males (67%); Living in refugee camps was predictive of both anxiety and depression but, for depression, the difference comes from those living in the camps who also define themselves as refugees vs. those who are citizens. Low educational level is a predictor of anxiety and not being married is linked to depression. About 6% of the variance of anxiety can be accounted for in regression by sex, place of residence and education with gender being the most robust predictor. Only about 2.9% of depression can be accounted for sex marital status and education. Again gender is the most important predictor. The results are discussed in the context of Palestinian culture and the ongoing geopolitical conflict.

Introduction

Mental disorders constitute one of the most challenging health problems for primary health care professionals in both developed and developing countries (1, 2). Several epidemiological studies have shown tangible differences in the prevalence rates of mental illness in primary health care clinics. Some studies attribute the differences to difference in the survey tools used; others cite differences in actual morbidity in the population studied (3,4,5, 6). Furthermore, patients screened as psychiatric cases in primary health care clinics have been shown to be more often female, not married, unemployed, and older (7, 8, 9).

Palestinian women often experience especially high stress in Gaza. The frequent absence of men in the Palestinian households burden women with dual responsibilities of both their reproductive family roles and the men's responsibilities as economic providers. Sociopolitical hardships occupy a unique position among the common stressors in the lives of Palestinian women. Not only does the typical Palestinian female live in crowded substandard conditions, she is exposed to the constant strain of the Palestinian/Israeli conflict, either *in vivo* or in the press and on TV. The vulnerability of mental health problems among Palestinian women is high because women are often pass through stressful and negative life experiences. A study carried out by GCMHP, Research Department showed that 63% of Palestinian women in Gaza were exposed to traumatic life events (10). In her study of psychological distress and wellbeing among Palestinian women, Khamis (11) found a significant effect for family roles on the psychological distress and well being, where the study indicated that mothers had higher scores of distress than daughters. Also married and widowed women had higher scores of psychological distress and well being than others, while home-workers had higher scores than students.

The aim of the present study was to investigate the prevalence of mental in the Gaza Strip and its relation to sex difference. In addition, the purpose of the study was to investigate the prevalence of mental disorders among Palestinian refugees' women who live in the camps compared to those who live in different areas in the Gaza Strip.

Hypotheses

1. Refugees who live in the refugee camps will have greater mental disorders than original residence patients, and more than those who live in different parts of the Strip.
2. The prevalence of mental disorders would be higher in female patients, than males.

Research Questions

1. What is the overall level of psychiatric symptoms in a population of Gaza Strip residents who visit an outpatient clinic compared with a normative sample? 2. What demographic variables in addition to gender are predictive of psychiatric symptoms? 3. Were there differences across gender on specific depressive or anxiety symptoms?

Population and Method

Primary health care (PHC) services are mainly offered through two health sectors in the Gaza Strip; the Public Health Services are available in the Gaza Strip both to refugees and original residents who are covered by health insurance. The United Nations Relief and Work Agency (UNRWA) offers free primary health care only to registered refugees.

In order to reach all population levels, 10 primary health care clinics in the Gaza Strip were randomly selected from the five regions that form the Strip (Southern Region, Gaza City, Middle Region, Khan Younis Region and Rafah Region). Five of these clinics belong to UNRWA health services and 5 clinics to public sector. Participation was entirely voluntary and was requested through direct contact, where the purpose of the study was explained.

study was conducted during the months of June to December 1998. The sample was drawn among patients coming to the primary health care centres to be seen by primary health care physicians. All patients aged between 16 to 55 years were included in the study; those for reasons such as for a referral, vaccination, insurance or driver's license examinations, prenatal care, and medical reports were excluded from the study. People with emergencies who come to the health centres were excluded from the study. Every second patient in each clinic was approached and invited to participate in the study. After the medical consultation by the GP, the selected patients were asked fill in a 25 items of HSCL in addition to different sociodemographic factors.

Of the total of 670 patients eligible for inclusion criteria, 661 patients agreed to participate in the study. Of 661 patients who completed the HSCL-25 questionnaire, 112 (17%) patients were excluded because they did not respond to all items in the questionnaire leaving 549 responses for analysis.

The instrument

The Hopkins Symptom Checklist-25 (HSCL-25) was used as the screening instrument to detect neurotic psychiatric symptom (12). It has been used in several versions of different lengths (90-16 items) and in a wide range of primary health care settings (13). The HSCL-25 has been shown to be satisfactorily valid and reliable as a measure of mental symptoms and able to differentiate between normal and subjects and neurotic patient population (14). Translated versions of the HSCL-25 have been widely used screen mental disorders, in particular, anxiety and depression experienced during the preceding week (15). It is suitable for psychiatric assessment in primary health care settings and it shows high correlation with clinically assessed depression (16,17).

In this study SCL-25 was used where patients record their own estimates of symptom severity, present during the past week, on a 4-point scale ranging from 1 “not at all” to 4, “extremely”. Responses are summed and divided by the number of the answers. The patient was considered a psychiatric case if the mean rating score over 1.75 (18,19). The patients were also asked for information about demographic background data such as age, sex, marital and civil status, living places and educational level

In order to minimize misunderstanding of the SCL-25 questionnaire a back translation technique was used. The questionnaire was translated into Arabic and second person is asked to translate the questionnaire back to English. The back-translated questionnaire was compared to the original material and discrepancies in terminology and phrasing are ironed out. An expert panel was used, where the Questionnaires were discussed with 5 local experts to see the relevancy of the questionnaire items to the Arab culture. A pilot testing was carried out, the alpha Cronbach indicated that reliability correlation coefficient is 0.77

The HSCL-25 is suitable for psychiatric assessment in primary health care settings and this assessment tool generally shows high correlation with clinically assessed depression. Lavik et al (17) did a validation study comparing the results of HCSL-25 with the Global Assessment of Function (GAF) and the Global Rating on the BPRS in a refugee population in Norway (the majority were from the Middle East). They reported that the HCSL-25 predicted mental health problems in the multicultural subject population. In the present study, a panel of experts evaluated the validity of HCSL-25. The questionnaires were discussed with 5 local

experts to assess its relevance to Arab culture. The only difficulty in applying the questionnaire was that the patients felt embarrassed to answer the item about sex.

Data analysis

The basic design was a quasi-experimental correlation study. Of interest was the difference between the psychiatric symptomatology of males and females in the study and what demographic factors might also be associated with these symptoms. The analysis strategy consisted of ANOVA or T-tests, in which the mean value of the symptom was compared across gender and level of demographic variable. Each variable, in which statistical significance was found, became an independent variable to use in a linear regression, in which the value of the Depression and Anxiety scales respectively, were regressed on the IVs. Partial correlations were run to ascertain the importance and uniqueness of each IV in predicting the symptom.

Item by item responses to the HSCL-25 was analyzed descriptively using cross tabulations. For each of the twenty-five questions, extreme responses to each question (“not at all” or “extremely”) were selected and cross-tabulated by gender. Did men or women tend to endorse extreme responses disproportionately on any of the 25 questions. Standardize residuals were used to compare the extent of this disproportionality across the 25 questions of the instrument.

The Results

Table (1), breaks down the sample by patient characteristics across residential categories. Females predominated in the sample. There were 314 female respondents (57.2%) compared with 235 males (42.8%). The vast majority claimed refugee status (378, 69.1%) although less than half actually lived in a refugee camp at the time of the survey (232, 42.3%). About a quarter each lived in villages and in cities and a smaller number (43, 7.8%) in new residential areas. As expected, the large majority of those designating themselves refugees lived in camps. Although there are more women in the sample, men and women appear to be fairly evenly distributed across places of residence. Overall, it is a young sample, with the younger respondents tending to live in the camps. Surprisingly, unemployment did not seem to be concentrated in the camps, and office workers and laborers could live in the camps as well as the village or city.

Educational level was mixed. Over 96% had at least some formal education, but only 210 (38.3%) had finished secondary school or had more than a secondary education. Educational level seemed to be independent of place of residence. Neither those with no education or those with secondary education or greater were disproportionally represented in the camps. The sample was largely either unemployed (111, 20.2%) or listed housewife as their occupation (222, 40.4%). About one-fifth was office workers and one-tenth students. The mean age of the sample was 30.29 (SD 10.34).

Table (1) is around here

The sub-scales of the HSCL-25 each had adequate reliability on this sample. The Depression and Anxiety scales showed a Chronbach alpha of .7875 and .7560, respectively. Mean scores for the sample on the two scales were 20.85 (SD 6.46) for Anxiety and 31.030 (SD 8.30) for Depression. Both scales evidenced normal distributions as indicated by skewness and kurtosis statistics close to zero.

Hypothesis (1); Refugees who live in the refugee camps will have greater mental disorders than original residence patients, and more than those who live in different parts of the Strip.

Camp residents showed the highest mean anxiety level of the four residential groups (21.63, $f = 2.85$, $p = .036$, Camp and Villiage dwellers significantly different on post-hoc test using Tukey-B). When non-camp residents are lumped together in to a single group, the camp residents still exhibit a greater anxiety level (21.63 vs. 20.30, $f = 5.86$, $p = .018$). Those merely identifying themselves as refugees regardless of place of residence show no significant from those identifying themselves as refugees for either anxiety or depression. Although camp dwellers were more depressed than the other three types of residence (Table 2) differences were non-significant. However, when the other three groups were lumped together into one, a significant difference did emerge ($t = xx$, $p = .004$). Although camp dwellers show the highest level of depression of the four groups, the difference is not significant. However, when the non-camp groups are collapsed into one, a significant difference does emerge ($f = 7.54$, $p = .006$).

Table (2) is around here

For anxiety, the interaction of residence (camps vs. non-camps) and civic status (refugee vs. non-refugee) is non-significant. The controlling factor for anxiety seems to be where the respondent lives and not the civic status. However, the interaction between these two factors for depression is significant ($f = 3.58$, $p = .014$). Refugees who live in the camps are the most depressed (32.32) but, surprisingly, self-described refugees who do not live in the camps are the least depressed (29.55). Citizens, whether camp dwellers or not, fall in between and are similar to each other (citizen camp dwellers, 30.0, vs. citizen non-camp dwellers, 30.89).

Hypothesis (2); The prevalence of mental disorders would be higher in female patients, than males.

Female respondents had a mean anxiety score of 21.92 vs. 19.42 for males ($t = -4.57$, $p = <.0005$). Similarly, females mean depression score was 31.80 vs. 30.01 for males. ($t = -2.51$, $p = .012$).

Research Question 1. What is the overall level of psychiatric symptoms compared with a normative sample?

As a whole, the entire sample was quite depressed and anxious, compared to standard clinical norms. Sixty-five percent was above the clinically significant cutoff of 1.75 for the Anxiety Subscale and 69% were above the cutoff for depression. Clinically significant anxiety and depression was over represented in the female part of the sample for both anxiety and depression ($F = 8.76$, $df 1$, $p = <.01$ for anxiety; $F = 6.37$, $df 1$, $p > .05$ for depression).

Research Question 2. What demographic variables, in addition to gender, are predictive of psychiatric symptoms?

Table 2, displays the results of comparing the total score of the Hopkins Symptoms Checklist and the two subscales, Anxiety and Depression across selected demographic categories. The 4 categories of "Address" were collapsed into two as a comparison of people living in the camps with all other residents was of theoretical interest. Although the category of occupation was statistically significant, it was redundant with the Gender category. Every housewife was female, so this occupational category just repeated the significant difference found for gender.

As can be seen, marital status was predictive of depression but not anxiety. Educational level was predictive of anxiety but not depression. Age was also captured in the survey but it showed no association with the Hopkins total score or with either subscale.

The statistically significant demographic variables were used as Independent variables in linear regressions predicting anxiety and depression. Neither regression produced a standardized residual larger than 3.42 suggesting no outliers in the analysis. Histograms of standardized residuals appeared roughly normal and normal probability plots of standardized residuals indicated no sign of heteroscedasticity. As can be seen in Table (3), the prediction of anxiety was more powerful than that for depression. It appears that being female, having less than secondary education, and living in the camps is a fairly robust predictor of anxiety, regardless of one's civic status. Gender appears to be the most powerful predictor having a unique correlation with anxiety of .180. Demographics could only predict about half the variance in depression compared to anxiety. Here, being female, with less than a secondary education and being unmarried were the important factors and all three seemed of equal importance as predictors.

Table (3) is around here

The individual questions on the Hopkins Symptoms Checklist were examined to ascertain gender differences in responding. A 2 x 4 cross tabulation was run by gender for each of the 25 questions. Only the extreme responses, either "Not at all" or "Extremely" are displayed in the Table (4) below along with the standardized residual. A high-standardized residual indicates that men or women were disproportionately represented in that cell in proportion to the number of respondents in the cell. Positive numbers signal overrepresentation, negative number under representation. In the case of a few questions, responses were overwhelmingly in the "Not at all" category. For example, 74% of the respondents responded "Not at all" to the question about ending their life, probably due to religious and ideological taboos about suicide. But, most of the questions had adequate responses across all four categories.

Table (4) is around here

As can be seen the largest standardized residuals occur in the questions dealing with anxiety, and somatic complaints (headache), and with crying. Women over-endorse these categories in every case, and men under-endorse them. The question on crying is probably confounded with cultural prohibitions about men crying, especially powerful in Arab culture. In only three questions were men significantly over represented in the “Extremely” category: insomnia, worries about the future, and having no interest in things. The latter two may be related to worries about work and the role of breadwinner for the family, in an environment of underemployment and economic uncertainty.

Discussion

The study general confirms a high level of both reported depression and anxiety from patients visiting clinics in the Gaza Strip. Some but not all of the factors found in previous studies were found to contribute to anxiety or depression. Gender, low educational level, being single (for anxiety) and place of residence were all predictive. Unlike prior studies, age was not associated with either anxiety or depression. This is not surprising given the current political climate. The majority of Palestinians feel trapped in the Gaza Strip and face an ever-deteriorating economic situation making it difficult for wage earners to support their families. Unemployment is high and those who do work have no assurance that their work will provide steady income. Rather, they know that their source of income may be cut off at any time by Israeli restrictions. Crowding is common, especially in the camps, and there is limited opportunity for either social or geographic mobility.

Consistent with prior epidemiological studies (20, 21, 22), sex is highly predictive of both anxiety and depression and in fact has the highest unique correlation with both. A cross-cultural study showed that 62% of primary care patients are females, around 50% of them were at the age of 15-24 years. In Jordan, women have a significant higher prevalence of psychiatric disorders 69% than men 52% (6). The Nordic study (4) showed that 64.2% of the patients visiting primary care centres are females. Overall, the study indicated that there was no significant difference in mental illness prevalence regarding gender. However, there was a tendency of female patients being mentally ill.

A possible explanation could, however, be that Palestinian women have a unique cultural and environmental situation. They are living in an authoritarian community where men are the power and the authority (23). A study by Research Department of the GCMHP (24) indicated

that 25% of women in Gaza exposed to domestic abuse once in their childhood. During the Intifada women were very active and participated jointly with men in the political struggle against the Israeli occupation. Their role were changed from the traditional housewife, only taking care of the children, to a women who have a role in the struggle and development, taking care of the family members. As indicated by FAFO study, 10% of the females participated in their study, were the household (23). This was clear among families, mainly refugees, when the father is arrested, imprisoned or killed in the struggle. This new role raises Women's self-esteem and self-confidence. During the Intifada, there was a 'collectivistic style' of relationship between the individuals and the community; the individual put aside the self-interest and obeys the will of the group norm ad values. (23,25). They renounce the losses of their beloved objects such as sons, husbands, brothers and fathers. When the Intifada subsided and terminated by the Declaration of Peace Principles between Palestinians and Israelis, the high expectations and the hope that people put on the peace process were not brought about. This output opened the wound of beloved losses such as husband, fathers, and any other love object.

The analysis of the survey reveals higher level of anxiety and depression in women generally, and higher levels of anxiety and depression for camp dwellers. In the case of the camp dwellers, only those self describing themselves as refugees report more depression. Why should being a refugee have no effect of the different anxiety levels between the camps and non-camps but be a factor in depression? We believe that the reason is economic. Those identifying themselves as citizens living in the area of the camp prior to its creation and probably had established jobs and some measure of economic security as well as family support. These factors may mitigate against depression by allowing the resident to feel less helpless. As indicated in FAFO study, the refugees in the Gaza Strip camps showed that 70% of refugee people live in homes with "average amainties", 18% have poor infra-structural services, and 12% live "above average" (23). Another explanation may, however, be attributed to the Palestinian culture which, have a role in the patient presentation of mental symptoms. Such culture indicate a general tendency of individuals to present emotional distress in somatic forms which allows them to occupy the sick role avoiding the blame and stigma (26). Therefore, people tend to present their psychological suffering in the form of physical symptoms which considers a factor that contributes to the high frequency of physical symptoms of depression and anxiety among Palestinians in particular and Arabs in general (25).

Conclusion

In Palestine as in many developing countries, the most frequent health indicators used in planning health services are linked to physical health problems. These indicators are mostly based on the magnitude and distributions of physical health problems such as infant mortality rate. These indicators are essential in planning any health services, however, any comprehensive health service plan has to consider the mental health indicators.

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Table (1) Socio-demographic characteristics of patients in each residential area.

	Total		Camp		Village		City		New areas	
	N.	%	N.	%	N.	%	N.	%	N.	%
Civic status										
Native	31.2		8.8		46.2		41.5		3.5	
Refugees	377	68.8	7.6	5	52	13.8	71	18.8	37	9.8
Gender										
Male				4	50	21.4	61	26.1	23	9.8
Female	42.7		2.7		81	25.8	81	25.8	20	6.4
	314	57.3	132	42.0						
Age										
16-24				4						
25-34	37.5		9.0		21.1		19.1		10.8	
35 +	26.8		41.1		17.1		34.9		6.8	
	194	35.7	71	36.6	61	31.4	51	26.3	11	5.7
Marital Status										
Married	64.6		38.7		26.3		28		7.1	
Single	31.6		49.1		20.8		20.2		9.8	
Prev. marriage.	21	3.8	10	47.6	2	9.5	8	38.1	1	4.8
Occupation										
Housewife	221	40.5		4						
Unemployed		2	1.2		25.8		29.0		4.1	
Laborers	0.3			4						
Office work			9.5		15.3		24.3		10.8	
Student	11.4		24	38.7						
	92	16.8		4	32.3		22.6		6.5	
	60	11.0	5.7		19	31.7	25.0		9.8	
					14	23.3	19.6		8	13.3
							19	31.7		
Education										
No school							2			
Primary	6.8		43.2		29.7		4.3		2.7	
Preparatory										
Secondary and higher	20.6		32.7		26.5		34.5		6.2	
	34.3		44.1		44	23.9			7.9	
	210	38.3	86	45.1	45	21.4	24.5			
							48	22.9	10.0	

Table (2). Summary of Hopkins Checklist Totals By Demographic Characteristics, Broken Down by Depression and Anxiety.

Variable	Category	Anxiety Subscale		Depress. Subscale		Hopkins Total	
		Mean	Sig.	Mean	Sig.	Mean	Sig.
Gender	Male	19.42	<.0005	30.01	.012	49.44	<.0005
	Female	21.92		31.80		53.73	
Marital Status	Married	21.01	ns	30.59	.017	51.60	ns
	Not Mar.	20.57		31.85		52.42	
Occupation	Housewife	22.65	<.0005	32.01	<.002	54.65	<.0001
	Unemployed	19.97		31.05		51.02	
	Laborer	19.05		28.43		47.48	
	Office Worker	20.13		32.26		52.39	
	Student	18.87		28.48		47.25	
Education	< Secondary	21.51	.003	31.55	ns	53.06	.008
	Secondary +	19.81		30.20		50.01	
Address (4 categories)	Camp	21.63	.036	32.17	ns	53.80	.024
	Village	19.80		29.99		49.79	
	City	20.97		30.46		51.43	
	New Res. Area	19.58		30.05		49.62	
Address (2 categories)	Camp	21.63	.018	32.17	.005	53.79	.004
	All Other	20.30		30.21		50.51	
Civic Status	Citizen	20.66	ns	30.81	ns	51.47	ns
	Refugee	20.95		31.14		52.40	

Table (3) Comparison of Linear Regression Predicting Anxiety and Depression From Demographic Characteristics

Anxiety					Depression				
		IVs	T	Par. r			IVs	T	Par. r
R	.245	Education	.007	-.115	R	.170	Mar. Stat.	.030	.063
R2	.060	Address	.009	-.112	R2	.029	Education	.009	-.120
F	.0000	Sex	.000	.181	F	.001	Sex	.009	.110

Table (4). Standardized residuals for males and females for the individualized questions on the Hopkins Symptoms Checklist

Question	Standardized Residual			
	Males		Females	
Hopkins Question	Not at all	Extremely	Not at all	Extremely
Suddenly scared for no reason	1.7	-2.0	-1.5	1.7
Feeling fearful	2.6	.3.2	-2.2	2.8
Faintness, dizziness, weakness	1.6	-1.8	-1.3	1.5
Nervousness or shakiness inside	1.7	-1.6	-1.5	1.4
Heart pounding or racing	1.7	-1.8	-1.5	1.6
Trembling	.4	-.8	-.3	.7
Feeling tense or keyed up	.6	-.7	-.6	.6
Headaches	2.7	-2.7	-2.3	2.3
Spells of terror or panic	.9	-1.3	-.8	1.1
Feeling restless, can't sit still	-.2	.5	.1	-.4
Feeling low in energy, slowed down	1.2	-.7	-1.0	.6
Blaming self for things	.2	-1.0	-.2	.9
Crying easily	5.2	-5.4	-4.5	4.7
Loss of sexual interest or pleasure	1.6	-2.0	-1.4	1.8
Poor Appetite	.2	.1	-.1	-.1
Difficulty falling, staying asleep	.8	1.3	-.7	-1.2
Feeling hopeless about the future	-.9	1.1	.8	-.9
Feeling blue	-.9	.5	.8	-.4
Feeling lonely	-.3	-1.7	.2	1.5
Thoughts of ending life	.2	-.1	-.2	.1
Feeling of being trapped or caught	.4	-.2	-.3	.1
Worrying too much about things	.4	-.7	-.3	.6
Feeling no interest in things	-.1	1.3	.1	-1.2
Feeling everything is an effort	.2	-.2	-.1	.2
Feelings of worthlessness	.4	-.3	-.4	.2