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Depressive Symptoms Among Palestinian Deaf Adults

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By

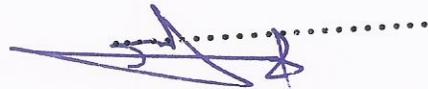
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Dedication

Thanks to Allah the Almighty to make out this thesis.

To my father, my mother, and all my household.

Deepest thanks go to my wife (Nariman) for her help and support.

To all people and friends who assisted me in my study.

To all Palestinian students in their universities in the homeland and abroad.

To my lovely homeland Palestine, I dedicate this nice composition of the work.

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إقرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان:

Depressive Symptoms Among Palestinian Deaf Adults

أقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص باستثناء ما تمت الإشارة إليه حيثما ورد وأن هذه الرسالة ككل أو أي جزء منها لم يقدم من قبل لنيل أية درجة علمية أو بحث علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى.

Declaration

The work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's name:

اسم الطالب

Signature:

التوقيع

Date:

التاريخ

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List of Abbreviations

Abbreviations	
AIHW	Australian Institute for Health and Welfare
APNs	Advance Practice Nurses
ASL	American Sign Language
CDC	The Center for Disease Control
CI	Confidence Interval
CMHP	Community Mental Health Practitioner
DSM-IV	Diagnostic and Statistical Manual for Mental Disorders
ENT	Ear, Nose, Throat
IRB	Institutional Review Board
NIS	New Israeli Shekel
OR	Odd Ratio
PCBS	Palestinian Central Bureau of Stastisics
PHQ	Patient Health Questionnaire
PSL	Palestinian Sign Language
PTSD	Post Traumatic Stress Disorder
S E	Standard Error
SPSS	Statistical Package For Social Sciences
SNAD	Swedish National Association of the Deaf
WHO	World Health Organization

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Abstract

The aim of the Study: The study aims to assess the prevalence of depressive symptoms among Palestinian deaf adults.

Method: A quantitative cross-sectional design was adopted to answer the research question for the study. The framework is based on factors derived from previous studies on the Patient Health Questionnaire PHQ-9 (Robert & Spitzer et al, 2001). The subject population was composed of 217 adults from three representative West Bank Palestinian cities. Participants ranged in age from 15 to 65 years divided as males (n=136) and females (n=81). All participants attend special deaf centers and use the Palestinian Sign Language (PSL).

Results and Data Analysis: The data analyzed using Statistical Package for Social Sciences (SPSS). We used mean, standard deviation, and multivariate logistic regression. According to the multivariate analysis results of the study showed, (OR=2. 0) (95% CI, 1.2-3.4) minimal depression, (OR= 1.7) (95% CI, 1.2-2.3) mild depression, (OR=1. 4) (95% CI, 1.1-1.9) moderate depression, and (OR=0. 9) (95% CI, 0.7-1.2) severe depression.

Conclusion: The concluded result of our study is that more than half of the respondents suffer from depression at varying levels, which is considered significant conclusion. Tendency for depression might be a common health problem among deaf adults attending primary health maintenance installations. Further research on socio-demographic characteristics and the force of depression on their health status is required.

Keywords: Depression, Prevalence, Cross sectional, Deaf, Palestinian.

Chapter One

Introduction

Chapter One

1.1 Introduction:

Depression is the greatest cause of non-fatal burden socially and economically, worldwide (Schotte et al, 2006); it is the most common mental health disorder, affecting millions of people annually. In the primary care setting it is estimated that 13 to 25% of patients are seeking care for depressive symptoms, and 80% of those actually treated for depressive symptoms had previously visited their principal care provider (Booth et al, 2013).

As reported in the literature, the term depression may connote a clinical diagnosis, but is likewise applied to identify an emotional experience. For some, depressive feelings may be a temporary response to an issue or state of affairs. For others, depressive symptoms or feelings are deeper and may live longer (Brink & Stones, 2007).

Symptoms of depression may have physical, emotional, or cognitive manifestations of mood alteration that interferes with everyday life over time. Giving way to discuss depressive symptoms increases the danger of missing signs of clinical depression and even suicide (Murray et al, 2006).

In this study, depressive symptoms refer to physical, emotional, or cognitive manifestations of mood alteration that interferes with everyday life over time.

Hearing loss in young adults accounts for a great proportion of the hearing problems in most societies if left untreated (Smith, 2004).

Seeing the Palestinian region, the result of the Israeli occupation and responding liberation movements (Intifadas) put the Palestinian population

under high psychological stress, which involves the occurrence of many mental health troubles like anxiety, Post Traumatic Stress Disorder (PTSD) and depression (Sarhan, 2008).

1.2 Background:

Mental wellness is a major public health issue because it refers to a broad cluster of natural processes directly or indirectly linked to the mental well-being component included in the World Health Organization report (WHO, 2013).

The Arab world still presents a deficiency of awareness regarding mental health troubles, and subsequently, there is a shortage of mental wellness services and professionals in the region (Al Kernawi, 2005).

Primary care providers such as advance practice nurses (APNs) may be the initial point of contact for individuals experiencing depressive symptoms.

APNs and physicians commonly discuss depressive symptoms with their clients (Fraguas et al, 2006; Tylee, 1999), which can contribute to earlier identification of those at risk for depression. Many health care providers even manage depression or depressive symptoms in the primary care setting, thereby reducing morbidity and mortality (Belnap et al, 2006).

Nevertheless, primary care providers frequently fail to discuss depressive symptoms with their deaf clients (Tamascar et al, 2000) in part because they are not adequately prepared to talk about or assess depressive symptoms among deaf adults (Montoya et al, 2004).

While researchers have historically defined deaf individuals as possessing a disability, most deaf adults see themselves as members of a unique, non-disabled community (Kim, Clarke, & Barton, 2001).

Members of the deaf community accept a common knowledge and a collective memory that is practiced to communicate; this mode of knowing is learned and shared over time, and guides thinking, conduct, and decisions in a vulgar way (Ingrid, 2008). The singularity of the deaf community must be believed in any physical or mental aspect of the main health care assessment.

About 15% of people in the U.S. are deaf or hard of hearing (4.5 million) and 38% of those who lost their hearing before the age of 19 are pre-lingually deaf (approximately 600,000) (Dobie, 2014). There is no evidence in the literature to suggest that deaf adults do not have depressive symptoms, but methods of assessing depressive symptoms among the population are unreliable and inadequate for the primary care context. Most studies exploring depressive symptoms among deaf adults are quantitative in nature, and fail to capture the overall experience of the phenomenon from an insider's view.

A summit in 2010 (A comprehensive national incentive for healthy people-health promotion and disease prevention), specifically identified deaf adults as having inequitable mental and physical health care due to barriers in communication (Department of Health and Human Services, 2000), increasing vulnerability and the associated risk of illness. Deaf adults often leave the primary care setting without having discussed any depressive symptoms with their provider (DeVinney & Murphy, 2002; Pollard & Adams, 2004) and may leave feeling frustrated, discouraged, and believing that care has been substandard (Barnett, 2002).

As depressive symptoms among deaf adults are frequently missed (Sheppard K. & Badger T, 2010), it is estimated that only 2% of deaf adults ever receive the mental health care they need (Leigh & Pollard, 2003).

Advances in care must begin in the primary care setting with clear dialog and reciprocal agreement between providers and their deaf adult clients (Jackson et al, 2004).

Depression screening tools utilized in primary care may be unreliable for deaf adults (Young et al, 2004). Because they have not been adequately translated and validated. Conditions such as "depression" or "self-esteem" are not well translated from Arabic to Palestinian Sign Language (PSL). It is rather common to face language barriers and translation challenges in primary care, and efforts are not constructed to address the demands of Palestinian Sign Language (PSL).

In order to identify deaf adults experiencing depressive symptoms, primary health care providers such as the Community Mental Health Practitioner (CMHP) need an enhanced understanding of how depressive symptoms might be described.

This study will focus on the gap between how Palestinian deaf adults use PSL to describe depressive symptoms and the primary health care providers' understanding of deaf adults' description. Findings from this study will be partaken with the deaf community through publications and presentations, and with those who provide care to Palestinian deaf adults; this may enhance dialogue about depressive symptoms between primary care providers and Palestinian deaf adults.

1.3 Problem Statement:

Depression is more than just a feeling of sadness. People with depression may have a lack of involvement and pleasure in daily actions, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of expiry or suicide (APA, 2014). At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850,000 lives every year (WHO, 2013).

The community of deaf is centered on a unique language. This is the common means of visual communication and the common language (Haynes & Linden, 2012). Members of the deaf community are bound together by the experience of deafness, which provides a distinctly different view of the world (Megan, 2002). The feeling of a deaf community feels best within the heathen or the national cultural paradigm (Mathews & Elizabeth ,2011)

1.4 Significance of the study:

According to Palestine RC, (2012) there is a need in the West Bank to manage such a study due to the absence of special mental evaluation techniques for people with special needs like deafness. The integration of deaf people in the order suggested by Palestine RC, (2012) to help as follows:

- Help the deaf develop their understanding of the universe about them.
- Help the deaf make friends and commit them a sense of belonging to a group.

- Teach the deaf activities that facilitate them to take on an active part in the household and the community.
- Teach the deaf commitment to the principles of the system and learn responsibility.
- Teach the deaf how to handle and be in harmony with others, i.e. how they need close connections with other masses.
- Prepare the deaf to be more independent people.
- Changing society's negative perception towards people with disabilities.

Members of the deaf community do not trust that their deafness necessitates a cure, and most do not think themselves as disabled or broken (Haynes & Linden, 2012). An imperative in culturally competent and holistic care is to see each person's unique experience of illness, which has historically been lacking in health care to members of the deaf culture (Richardson, 2014).

This study will facilitate primary care providers to discuss depressive symptoms with their adult deaf clients in words that are meaningful and culturally relevant to the population, thus increasing identification of community deaf adult patients at risk for depression. The knowledge gathered from this study can contribute to the growth of a culturally sensitive and dependable method to measure depressive symptoms. Such knowledge may enable nurses to collaborate with other members of the research community to reduce the significant disparities in primary health care for community of deaf adults, thereby reducing morbidity and mortality in this underserved population.

1.5 Demography of the Study:

The entire population of the occupied Palestinian territories is 3.761 million; according to the consequences of the population housing establishment censuses in 2007. The Palestinian population is 45.7% youth and 3% elderly (PCBS, 2007). This work was extended out in three Palestinian cities; Nablus in the northerly portion of the West Bank, Ramallah in the midway region of the West Bank, and Hebron in the southerly portion of the West Bank.

Nablus is a Palestinian city located in the northern West Bank approximately 63 kms north of Jerusalem. Nablus had a population of 187,839 inhabitants in 2007 (PCBS, 2007). Ramallah is a Palestinian city in the central West Bank located 10 kms north of Jerusalem, with a population of about 25,500.0 kilometers north of Jerusalem, with a population of nearly 25,500. Hebron is a Palestinian city located in the southern West Bank, 30 kilometers south of Jerusalem. It is the biggest urban center in the West Bank and home to an estimated 250,000 Palestinians (PCBS, 2007).

1.6 Aim of the Study: To assess the prevalence of depressive symptoms among Palestinian deaf adults.

Specific objectives:

To assess depressive symptoms among Palestinian deaf adults.

1.7 Research question:

What is the difference in depression levels in relation to demographic characteristics among Palestinian deaf adults?

Chapter Two
Literature Review

Chapter Two

Literature Review

2.1 Introduction:

Mental health disorders are the major health issues in young adults between the ages 18-24 (Park et al, 2006).

In the United States, one in every 1,000 people are born profoundly deaf, and two to three per 1,000 are born with partial hearing loss. Hearing loss is the number one birth defect in America (Center for Disease Control, 2006).

About 50 to 75% of all childhood deafness stems from hereditary causes; 15 to 30% of hereditary hearing loss is a syndrome in nature. Over 400 such syndromes have been identified (CDC, 2006).

Several surveys concluded that the main mental health problems among deaf adults are depression and anxiety resulting from the challenge of adjustments (Beate et al, 2011).

2.2 Epidemiology of deafness:

Deafness in Palestine are a problem that many households face and it takes place due to many reasons, like some medications given during pregnancy, and some types of antibiotics and meningitis infections and chronic diseases (Zippora et al, 2000).

Richard et al. (2013) found that hereditary hearing loss and deafness may be conductive, sensorineural, or a combination of both; it also may be syndromic (associated with malformations of the external ear or other

organs or with medical problems involving other organ systems) or nonsyndromic (no associated visible abnormalities of the external ear or any related medical problems); and prelingual (before language develops) or postlingual (after language develops).

Another study done by Shahin et al. (2002) found that hearing impairment occurs in the Palestinian population at a frequency of approximately 1.7 per 1,000 and is higher in some villages.

The percent of deafness in Palestine is high because of all the reasons mentioned above. In developed countries the ratio of deafness is 1 out of 1,000, in Palestine close to 1-100 (SNAD, 2008).

2.3 Prevalence of depression and its risk factors:

Depression is the greatest cause of non-fatal burden, socially and economically, worldwide and it is the most common mental health disorder, affecting millions of people annually (Schotte et al, 2006).

In the primary care setting it is estimated that 13 to 25% of patients are seeking care for depressive symptoms, and 80% of those actually treated for depressive symptoms had previously been determined by their principal care provider (Sheppard, 2008).

Brink & Stones (2007) explain that the term depression may connote a clinical diagnosis, but is likewise applied to identify an emotional experience. For some, depressive feelings may be a temporary response to an issue or state of affairs. For others, depressive symptoms or feelings are deeper and may last longer.

Another study by Murray et al. (2006) refers symptoms of depression to many lawsuits which they closed were: physical, emotional, or cognitive

manifestations of mood alteration that interferes with everyday life over time. Giving way to discuss depressive symptoms increases the danger of missing signs of clinical depression and even self-destruction.

A survey to assess prevalence of boredom proneness and depression among profoundly deaf residential school adolescents found that deafness not only increases the person's exposure to mild degrees of depression, but also tends to augment one's tendency towards experiencing boredom (Cambra, 2002).

Likewise, Harvey (2000) found that modest degrees of depressive symptoms are more dominant in the deaf than in hearing students but more severe depression is not. These findings are linked up with socially dependent personality characteristics in the hearing sample only.

Another study done by Turner et al. (2007) indicates that 61% of deaf students recorded scores indicative of significant depressive symptoms. A sum of 35% recorded scores indicating mild to moderate depression, a further 19% recorded scores indicating moderate to severe depression, and 7% scored within the severe depressive symptoms range.

Black & Glickman (2006) found that deaf people have higher rates of psychiatric disorders such as panic disorder and insomnia than those who are hearing, while at the same time encountering difficulties in accessing mental health services. These elements might increase the danger of suicide. However, specifics of the burden of suicidal behavior in deaf people are presently unidentified.

Kushalnagar (2007) found that hearing impairment, if left untreated, causes severe cognitive and developmental delays.

Masud et al. (2008) suggested that decrease in hearing is classified as deafness and with the availability of better diagnostic facilities, management strategies, equipment and infrastructure, it is likely that more and more deaf patients can be picked up ahead of time and with the interest of proper psychiatric evaluation of a deaf patient, the consequent depression can be diluted. It is stressed that it must be a team effort between Ear, Nose, and Throat (ENT) surgeons, audiologists, speech therapists, psychologists and psychiatrists.

Kvam & Tambs (2007) emphasized that early diagnosis serves as a gold standard to verify seriousness and dedication of people affected in the reclamation of the hearing impaired, which, it is emphasized, must include a psychiatrist at least at some level. People with disabilities encounter practical and social problems beyond those experienced by nondisabled people.

Cooper et al. (2013) found that deaf adults are identified as either disabled or members of a unique culture, who are potentially vulnerable within the health care context. The accompanying literature review illustrates the difficulty in identifying a culturally deaf adult with depressive symptoms. Conceptual perspectives that guide these studies are reviewed within the literature, to include vulnerability, culture, and depression. Theories of depression are gone over, with an emphasis on theories that may relate to deaf adults.

Charney & Manji (2004) proved that early childhood stress and stressful life events increase the risk of depression.

Some other study found that risk factors for depression include being female, of minority status, single, unemployed, and of low-income status (Gutiérrez-Lobos et al, 2000; Pratt and Brody, 2008).

Studies conducted at the University of Alabama in the USA, Dakar in Bangladesh and in Brazil found that females have higher depression levels (Mirsa and Mckean, 2000; Khanam and Rahman, 2003; Andrade et al., 2001; Hojat et al., 1999).

Another study conducted in Australia found that depression, anxiousness, and strain are more among females than males (Butler, 2005).

Blay et al. (2007) found that being of minority status is associated with depression and a poorer perception of health, due to fewer resources.

A work done by Tamascar et al. (2000) found that culturally deaf adults rarely ask about depressive symptoms by their primary care provider and fewer treatment options are given and talked over.

Another study done by Haynes (2013) shows that culturally deaf adults have been labeled as psychotic when using American Sign Language (ASL) in health care contexts.

Carvill (2001) found that a lack of assessment skills appropriate for culturally deaf adults, and unsuccessful people in communication and intellect contributed to numerous missed cases of low and inhibited conversations about depressive symptoms.

A study of close to psycho-social characteristics of blind and deaf male students in Abha City, Asir region, Saudi Arabia showed that depression was more prevalent among blinder (14%) than among the deaf (6.5%) students (Abolfotouh and Telmesani, 1993).

Another three studies on this issue were done in the United Arab Emirates. In the first study of behavioral problems with deaf women, Samreen (2003) found that they were sensitive and embarrassed, which led to shyness, withdrawal or resentment of others. More or less of these women became introverted, spiteful, and covetous of others and exhibited signs of irritability and defiance.

In addition, Jaffal (1994) discovered that students with hearing impairments were likely to take away from others and to exhibit externally directed behaviors like aggression. This outcome was similar to Abdullah (1983) which showed that students with hearing impairments were characterized by aggressiveness, introversion, emotional imbalance and low social maturity.

2.4 Summary of literature review:

The lack of literature available that describes depressive symptoms among the deaf community, we cannot reliably meet the primary health maintenance needs for deaf adults.

Holistic primary health care necessitates understanding how deaf adults describe depressive symptoms and how deaf adults experience depressive symptoms. A civilization-specific tool must be developed that enables primary care providers to screen deaf adults for depressive symptoms. But when these steps have been taken can we begin to reduce the substantial health care disparities among deaf adults.

A Biobehavioral understanding of depression and depressive symptoms complements holistic, advanced practice nursing and research.

Chapter two reviewed the literature describing the unique community of the deaf. The concepts of vulnerability and depression were described and explored with regard to the community of the deaf.

Most of the mentioned studies explored the impact of being deaf on the psychological condition of the deaf population. Thither is a negative impact of being deaf on the occurrence of mental health troubles, particularly depression.

Chapter Three

Methodology

Chapter Three

Methodology

3.1 Introduction:

This chapter is devoted to specify the steps and the methodology taken in posting away the research endeavor. The researcher presents research design, study population, setting and sample, instrument and its validity and reliability, data collection procedures, and the statistical analysis.

3.2 Study Design:

A descriptive, cross-sectional design used to answer the research question, data collected using self reported format using structured interview for the aim of data collection, chiefly with reference to face to face structured interviews using questionnaire methodology.

3.3 Population of the study:

The population of the study was composed of 217 deaf people who available at these three centers during the period from march 2013 – September 2013. The study population included all deaf from the mentioned three centers (table 3-1), a convenient sample of 10% (n=15) was selected for pilot studies in (Charitable Society for the Deaf) in Nablus City which considered the highest center that have registered deaf people approximately 500 deaf from the entire population of deaf 53,000 in the West Bank and Gaza Strip (PCBS, Health Status in Palestine, 2013). All deaf people who are not registered and non competent in using PSL and non competent in (reading and writing) was omitted from the study.

3.4 Sampling:

Convenience sample techniques used to recruit 217 deaf adults residing in three representative Palestinian cities (Nablus in the northern West Bank, Ramallah in the middle, and Hebron in the southern West Bank) made up the sample of this study. Participants ranged in age from 15 to 65 years, with males represented 62.7 % (n=136), while females represented 37.3 % (n=81). All participants attend special deaf centers (table 3-1) and uses PSL.

Table (3-1)

Distribution of the sample according to deaf centers:

Location		
	Center	No (%)
Nablus	Charitable Society for the Deaf	80(37)
Ramallah	Amal Center for the Deaf	77(35)
Hebron	World Deaf Center	60(28)
Total		217(100)

3.5 Study setting:

The work was conducted on three representative Palestinian cities (Nablus in the northern West Bank, Ramallah in the center, and Hebron in the southern West Bank), First I was protruding in the Charitable Society for the Deaf in Nablus city that have 500 registered deaf, Second in Amal Center for the Deaf in Ramallah city that have 380 registered deaf, the last was World Deaf Center in Hebron city that have 310 registered deaf.

3.6 Data Collection Process:

The data collection process started on 4/3/2013 with a pilot study administered by the Charitable Society for the Deaf in Nablus. 15 respondents from this center were taken for the pilot study.

The field-sampling frame was limited to registered deaf people at the three centers in the West Bank. Permit from the manager of every center was packed.

Two licensed and qualified persons in Palestinian Sign Language were paid and trained to gather information and communicate with the interviewer, according to the figure of the deaf in the centers (see ethical consideration p-25).

3.7 The Study Fieldwork Procedure:

Face-to-face interviews using a structured questionnaire were used by deaf people. The questionnaire collected comprehensive information on depression among deaf people and its prevalence. The researcher personally visited the target centers in Nablus, Ramallah, and Hebron.

The researcher sat with the translator and respondents in a structured interview that lasted for 30-45 minutes. Previous to the interview, many initial visits were performed by the researcher to the respondents to reinforce a relationship of trust.

3.8 Selection Criteria:

3.8.1 Inclusion Criteria:

- Being legally deaf.
- Competent and can tolerate interview (using Palestinian Sign Language).

3.8.2 Exclusion Criteria:

- Incompetent clients (can't use Palestinian Sign Language).

3.9 Instrument:

Data were collected via a complementary questionnaire developed in the native language of the respondents (Arabic), and consisting of three parts.

- The first part of the questionnaire included a description of the study and its importance.
- The second part collects demographic information, including (gender, age, level of education, residency and province, income, marital status, kind of job, kinship between parents, family history of mental health problems, and other disability).
- The third part is the scale:

The study adopts a standardized scale (Patient Health Questionnaire (PHQ-9) in order to measure psychological problems (depression and its prevalence among deaf adults people in the West Bank).

The Patient Health Questionnaire (PHQ-9), which is a brief screening tool used to diagnose and measure the severity of depression. The PHQ-9 is shorter than many of the other depression screening instruments and can be self-administered. Adapted from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), the PHQ-9 includes all 9

diagnostic symptom criteria used in the DSM-IV, including the two cardinal signs of depression: anhedonia and depressed mood. The PHQ-9 is widely used by clinicians and can be used with patients with deafness. We employed the Arabic version from Lotfy Alsherbiny (1995), and permission was required from him. (See Appendix 3).

3.9.1 PHQ-9 scoring:

(0 No symptoms) (1-4 minimal) (5-9 mild) (10-14 moderate) (15-19 moderately severe) (20-27 severe).

Depression levels were determined according to the manual of Physical Health Questionnaire (PHQ-9) (scores 0 indicate no depression, (1-4) minimal depression, scores from (5-9) indicate mild depression, scores from (10-14) indicate moderate depression, and scores from (15-19) indicate moderately severe depression, (20-27) indicates severe depression.

3.10 Content Validity:

Content validity deals with how representative and comprehensive the items are in creating the scale. It is assessed by examining the process by which scale items are generated.

The diagnostic validity of the 9-item PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics. PHQ-9 scores > 10 had a sensitivity of 88% and a specificity of 88% for Major Depressive Disorder. Reliability and validity of the tool have indicated it has sound psychometric properties. Internal consistency of the PHQ-9 has been shown to be high. A study involving two different patient populations produced Cronbach alphas of 0.86 and .89. Criterion validity was established by conducting

580 structured interviews by a mental health professional. Outcomes from these interviews showed that people who scored high (≥ 10) on the PHQ-9 were between 7 to 13.6 times more likely to be diagnosed with depression by the mental health professional. On the other hand, individuals scoring low (≤ 4) on the PHQ-9 had a less than a 1 in 25 chance of suffering depression (Kroenke et al, 2001).

The PHQ-9 also has been used in many studies in primary care settings, as well as with older individuals and with those who have physically disabling conditions. It is free to users and available in English and over 30 other languages (Kroenke et al, 2001).

3.11 Questionnaire Reliability:

Reliability analysis allows studying the properties of measurement scales and the items that make them up. The Reliability Analysis procedure calculates a number of commonly used measures of scale reliability and provides information about the relationships between individual items in the scale.

The researcher conducted two reliability tests on the pilot study sample resulting in Cronbach α equal to (0.89), which is considered satisfactory for the use of the study.

3.12 Pilot Study:

A pilot study was conducted to evaluate and to test the questionnaire's reliability and validity, and it was taken out for 15 participants chosen from Nablus (Charitable Society for the Deaf). Pre-testing is an important point

in the questionnaire design process, because the structured questionnaire should be established on a deliberate formulation of questions piloted and refined until the researcher is convinced of their validity. After two weeks, the same questionnaire was administered to the same individuals. It came out that respondents experienced no trouble in understanding the points or the instructions to finish the questionnaire.

The researcher had tested the internal harmony of the questionnaire by calculating the correlation coefficients between each point and the related item fields. Coefficients denoted significance at (0.05) level, which implies that there is a content validity of this segment of the questionnaire for what is being valued.

3.13 Statistical Analysis:

Basic descriptive statistics (means, frequencies, standard deviations and confidence intervals) were generated for study variables. After conducting recoding, the data was prepared for analysis. The cutoff point for depression status was having scores of depression above 11, so a depression variable was created that discriminated scores less-than-or-equal to 11 as not depressed and above 11 as depressed. The study used the Pearson's chi-square test to compare differences in counts of independent variables by depression status. The study also utilized multivariate logistic regression analyses to calculate unadjusted and adjusted odds ratios and 95% confidence intervals for measures of strength of association between independent variables and depression status.

Multivariate logistic regression analysis was taken to identify variables significantly related to depression status of deaf adults, then applied to

measure the association for each varying on the outcome, while correcting for confounding.

3.14 Study Variables:

1. Dependent variables: Depressive symptoms.
2. Independent variables: Socio demographic variables, which include: gender, age, level of education, residency and province, income, marital status, kind of job, kinship between parents, family history of mental health problems, and other disability.

3.15 Ethical Consideration:

3.15.1 Translators:

The certified translators were a critical component of the work. The translators were identified to the participants prior to sending the first consultation and each participant was told that they could hire away from the subject area if they did not like to go with the selected translators. The expectation was to use the same translator for all interviews.

Ultimately, two certified translators were used during the interviews. Each translator was involved to give the Human Subjects Protection test, as required by Al Najah National University prior to taking part in the survey. Criteria for picking out the translator included PSL- Arabic certification, 5 or more years of experience as a certified translator, available for interviews during times and dates of data accumulation, and willingness to complete human subjects training for Al Najah National University.

Dr. Sarhan provided guidance and oversight with the planning for the translators. Training included review of human subjects protection and research ethics, the translator's role in research (which differed from

traditional translating), treatment of the training regarding conceptual accuracy (e.g., using back-translation exercise), and practicing in-person interviewing and translating with a volunteer deaf adult. Training. Each translator spent approximately five hours with the human subjects training modules.

3.15.2 Procedures for the Protection of Human Subjects:

The researcher took letters of correspondence and permit from the Institutional Review Board (IRB) of Al Najah National University, Nablus and permission letters were mailed to the Charitable Society for the Deaf in Nablus, Amal Center for the Deaf in Ramallah, and the World Deaf Center in Hebron to seek their participation in the current survey.

3.15.3 Human Subjects Protection:

The questions asked during all interviews were defined to the participant's experience of sadness and depressive symptoms. Participants were reminded prior to each interview that they could abstain from resolving any questions that felt uncomfortable, the interview could be terminated at any time, and the participant could take back from the study at any time without repercussion.

Participants were informed that some questions might feel stressful or upsetting, but that inquiry would be restrained to the experience of sadness and depression. Prior to each interview, participants were reminded that they did not have to answer any questions that felt uncomfortable and they could stop the interview at any time. Although the researcher is an Advance Practice Nurse, his role in this study was purely that of the researcher. He repeated that although he is a nurse, his purpose was not to diagnose or

offer any medical advice or counseling. He identified to all participants that he would refer any participant to the primary health care provider if the participant desired; contact data were made available.

The participants will not be personally named in any reports or publications that may result from this study. Only the researcher and his thesis committee have access to the information provided by the participants. The notes taken during the interviews, and the written narrative identified all participants by pseudonyms, and all data sources were stored in a locked cabinet at the researcher's place of employment (i.e., Al Najah National University, Nablus). The narrative (i.e., text) after analysis will be retained in the same locked cabinet at Al Najah National University, Nablus, for 3 years and then destroyed by Ibrahim.

3.15.4 Consent:

There may be varied levels of understanding among deaf adults community, which is especially important when seeking volunteer participation and receiving written consent. Dr. Sarhan supervised the translation of the Al Najah National University Human Subject Protection-approved written Arabic consent form (i.e., consent for interview) into PSL.

The researcher obtained PSL-signed consent of the participants, with the certified translator present to help with inquiries or worries. Written consent was then received as follows:

- All participants were urged to ask questions of the researcher prior to signing consent form;
- A signed written consent was obtained before carrying on any interviews;

- Written consent was obtained in secret, with only the researcher, participant, and translator present.

Consent forms are being stored in the Office of Nursing Research, College of Nursing, Al Najah National University, and Nablus.

Chapter Four

Results

Chapter Four

Results

4.1 Introduction:

The purpose of this chapter was to identify the prevalence of depression among Palestinian deaf adults in the West Bank. Moreover, this chapter will also examine the purpose of the study variables (marital status, nature of household, family income, sponsors job, family history of mental upset, and so forth) on the prevalence of depression among Palestinian deaf adults in the West Bank.

The sample was passed out over many significant and complementary demographic variables, as indicated in Table (4-1).

Table (4-1): Characteristics of deaf adults

Variable	Category	Frequency (%)	P value
Sex	Male	136(62.7)	<0.244
	Female	81(37.3)	
Age (years)	> 20	22(10.1)	<0.066
	20-29	81(37.3)	
	30-39	55(25.3)	
	>39	59(29.2)	
Marital Status	Unmarried	128(59)	<0.008
	Married	85(39.2)	
	Divorced	2(0.9)	
	Widow	2(0.9)	
Parents kinship	Cousins	6(2.8)	<0.317
	Uncle sons	58(26.7)	
	Distant relation	44(20.3)	
	No relation	109(50.2)	
Family Income	<1000 NIS	107(49.3)	<0.001
	1000-2000NIS	80(36.9)	
	>2000 NIS	30(13.8)	
Educational level	Primary	160(73.7)	<0.680
	Basic	50(23)	
	Secondary	7(3.3)	
Residence	City	95(43.8)	<0.370
	Village	103(47.5)	
	Camp	19(8.8)	
House nature	Separated house	59(27.2)	<0.047
	Live with my family	153(70.5)	
	Other	5(2.3)	
Sponsor job	Full duty	92(42.4)	<0.001
	Part time	61(28.1)	
	Student	20(9.2)	
	Without job	44(20.3)	
Family disorder	Schizophrenia	3(1.4)	<0.001
	Mood disorder	1(0.5)	
	Anxiety disorder	29(13.4)	
	Alcohol and drugs addiction	2(0.9)	
	No History	182(83.9)	

Table (4-1) shows the distribution of demographic characteristics of deaf adults; it shows that (59%) of the deaf are unmarried, (70.5%) of deaf live with their families, and (50.2 %) had a family income of < 1000 NIS. The

proportion of sponsors who had a full-time job was (42.4 %). In terms of family mental illness history, (83.9%) had no previous mental illness.

4.2 Prevalence of depressive symptoms among Palestinian deaf adults in the West Bank:

In order to answer the question: what is the prevalence of depressive symptoms among Palestinian deaf adults in West Bank? We used the PHQ9 scale and its scoring, which are calculated by assigning scores of 0, 1, 2, and 3, to the response categories of —not at all, several days, more than half the days, and nearly every day, respectively. PHQ-9 total score for the nine items ranges from 0 to 27. The PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe and severe depression, respectively as shown in table (4-2).

Table (4-2) Interpretation of total score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

From the entire results, 26.4 % of participants' scores placed them in the minimal depression category, 16.5% of participants scored in the mild depression category, while 2.3% scored in the moderately severe

depression category and 3.2% scored in the severe depression category as indicated in table (4-3).

Table (4-3): Prevalence of depressive symptoms among Palestinian deaf adults

Depression level	Frequency (%)
No symptoms	89(41%)
Minimal Depression	57(26.4%)
Mild Depression	36(16.5%)
Moderate Depression	23(10.6%)
Moderately severe depression	5(2.3%)
Severe Depression	7(3.2%)
Total	217(100%)

The results of multivariate logistic regression analysis for unadjusted associations between depression status and independent variables with odds ratios (OR), 95% confidence intervals (95% CI), and p-values are presented in Table 4-4, unmarried deaf have 1.759 times higher odds of having depression as compared to married deaf. Having a family income less than 1000 NIS increased the unadjusted odds 2.694 times for depression as compared to those deaf who have family income more than 1000 NIS. Living in separate house produced unadjusted odds of depression of 1.603 times than deaf who lives with their family. Deaf without a job had 1.409 times higher odds of experiencing depression as compared to those deaf working full duty. Those deaf who have Family history of mental disorder (specifically anxiety disorder) had 5.147 times higher unadjusted odds of suffering depression than those with Alcohol and drugs addiction disorder.

Table (4-4) Multivariate logistic regression analysis of factors associated with depressive symptoms among deaf adults

Variable	Level	B	S.E	OR (95% CI)	P Value *
Marital Status	Unmarried	0.565	0.446	1.759 (1.2 – 2.3)	<0.008
	Married (Ref.)				
	Divorced	1.603	0.753	0.201(0.19 – 0.95)	<0.000
	Widow	2.753	1.711	0.77 (0.50 – 1.09)	<0.003
Family Income	<1000 NIS	0.680	1.173	2.694 (1.50 – 6.35)	<0.001
	1000-2000NIS (Ref.)				
	>2000 NIS	0.100	2.113	0.309 (0.23 – 1.09)	<0.000
House nature	Separated house	0.472	0.492	1.603 (1.1 – 1.9)	<0.047
	Live with my family (Ref.)				
	Other	1.511	0.649	0.221 (0.19 – 0.95)	<0.000
Sponsor job	Full duty (Ref.)				
	Part time	0.677	0.501	0.508 (0.23 – 1.09)	<0.000
	Student	2.694	1.173	0.680(0.50 – 1.94)	<0.002
	Without job	0.343	0.196	1.409 (0.83 – 2.34)	<0.001
Family disorder	Schizophrenia	0.490	0.194	0.613 (0.83 – 2.34)	<0.000
	Mood disorder	2.694	1.173	0.680 (0.50 – 1.94)	<0.002
	Anxiety disorder	1.638	0.567	5.147 (1.75 - 6.27)	<0.001
	Alcohol and drug addiction (Ref.)				
	No History	3.200	2.113	0.013(0.16 – 0.85)	<0.000

*Statistically significant difference, $p \leq 0.05$

Chapter Five

Discussion and Recommendations

Chapter Five

Discussion

5.1 Introduction:

Mental health problems are not exclusive to any specific group; mental problems such as depression are found in people of all regions, all nations, and whole orders. Estimates indicate that approximately 450 million people worldwide suffer from mental disorders, and that one person in four will produce single or more mental or behavioral disorders during their lifetime (WHO, 2011).

5.2 Prevalence of depressive symptoms among Palestinian deaf adults of the West Bank:

Our study reported a prevalence rate of depression among Palestinian deaf adults by 16.1%, this is comparable to a cross-sectional study among Norwegian deaf attending Erik Skodvin clinic that reported a prevalence rate of depression by 27.7 % (Kavam H et al, 2011). Another retrospective study of patients with deafness in Germany shows a prevalence rate of 32 % of depression with different degrees (Dalia, 2000).

Other studies reported lower prevalence rates of depression among deaf adults than did our study; they reported a prevalence rate of 5.4% (Woodcock & Pole, 2007) and 8% (Lloyd et al, 2000). Others reported higher prevalence rates than our study, reaching 41.3% (Li et al, 2014) and 32.4% (Bailey, 1996). Among the entire sample of deaf adults, several demographic variables emerged as significant independent predictors of depression. Marital status, the nature of the household, family income, sponsors' job, and family history of mental disorder were all significantly associated with increased depressive symptoms.

According to the Physical Health Questionnaire (PHQ-9) our results can be manifested as: 26.4% minimal depression, 16.5% mild depression, 10.6% moderate depression, 2.3 % moderately severe depression, and 3.2% severe depression. This agrees with Lund et al. (2008) who found that depression affect 18% of students.

In addition, a study done in Japan for first year students they found that 20.7% of students met the Diagnostic and Statistical Manual of Mental Disorders Fourth Ed. (DSM-IV) criteria for a Major Depressive Episode (Tomoda et al, 2000). Also, Collingwood (2010) found in Dublin that 14% of students have depression, but in Germany they found that depression increased among youth (Wittchen, Nilsson & Lachner, 1998).

5.3 Summary of discussion:

The prevalence rate of depression among Palestinian deaf adults in our study, when compared with other studies, shows the same results, which met our aims.

5.4 Discussion of demographic data:

The greatest number of the deaf adults was found in the Charitable Society for the Deaf (Nablus) with 37% of the entire sample population. The bulk of participants were males (136), which represents 62.7% of the entire sample, while the female participants were (81), which represents 37.3% of the entire sample. The difference in the total number of females and males referred to the type of sampling which was a convenience method.

Likewise, the outcomes indicated that there was no substantial relationship between depression and sex ($P= 0.058$), which dissents from the resolutions

of other studies like Sarhan (2008) who found the prevalence of depression in Palestine to be higher among adult males than women because of the difference in time and type of sample.

This study is comparable to our study in that there is no significant relationship between depression and sex. However, Padesky & Hammen (1999) conducted two other studies to clarify these issues. The first study attempted to duplicate the findings on a similar larger sample of college students using a discriminate function analysis of male and female reactions.

Depressed women are characterized by a lack of trust, a lack of fear for what occurs to them, and being hurt by criticism. The second study examined possible sex differences in the self-labeling of depression, attitudes toward seeking help for depression, and actually help-seeking behaviors.

The above-cited effects of different studies prove that human behavior can be varied according to different factors such as space, time, culture, religion, rules, biological agents, and social or political factors. The prevalence of depression among different genders may have altered from the time of Sarhan's study until the time of the current study because of the past effect of checkpoints, socioeconomic problems and other factors that used to increase the prevalence of depression among males more than females. As well, the student population is different from other populations regarding a person's duty to his or herself and family.

The results also showed a significant relationship between depression and the nature of the household. Deaf adults who live with family have the highest odds ratio (OR=2. 694). Most homes in Palestinian cities are few in number, of rooms and space to run. Additionally, Palestinian families have between 6-8 kids. In this study, we found that Palestinian houses of participants had small areas to move and to do many activities, which would lead to increased stress in deaf living with their families.

Khurshid et al. (2012) found that students and parents living in the same house suffer stress to a greater extent than those who live independently.

Furthermore, the results depict a significant relationship between depression and family income (OR= 1.603). 49.3% of participants' families earn <1000 NIS per month, 36.9% of the deaf adults and their families earn between 1,000-2,000 NIS per month, and 13.8% of the deaf and their families earn >2000 NIS each month. These numbers of family income are very low, especially if the number of the family members is from 6-8 members. Everyday life in the West Bank is expensive and financial problems only increase if they take in more than one member studying in the universities (PCBS, 2007).

Considering the variables of age, gender, level of education, residence, and family kinship there are no significant relationships between these factors and depression.

Our study is not comparable to a study performed in Nigeria that found that (8.3%) of students met the criteria for depressive disorder having a minor depressive disorder due to problems with accommodation in a very big family (Adewuya et al, 2006).

5.5. The conclusion of the study:

The study found that deaf adults suffer from different levels of depression. On that point are some variables that affect depression, like marital status, nature of the household, family income, and a family history of mental disorder. Depressive symptoms appear to manifest similarly deaf and hearing people.

The deaf adult's feelings and experiences must be considered as intensified by the communication barriers. Further isolation from household members, peers, fellow workers, and health care providers exacerbates the lack of social reinforcement and may prolong the symptoms of depression.

Membership in the deaf culture reduces the sense of being different and provides improved self-esteem. This may ultimately be the vehicle that helps a deaf individual pull through his or her depressive symptoms.

Relying on depression screening instruments as a way to assess depression among community deaf adults is inadequate, and additional methods of eliciting symptomatology must be used. Earlier and more exact way of assessment can enable more prompt treatment, thereby reducing mental health disparities to this underserved population.

5.6. Limitation of the study:

There were many obstacles faced by the researcher during this study:

- The sample did not admit the non-registered deaf people.
- Mailing letters and getting approval from the university took two months due to bureaucratic issues.
- Transportation between Nablus, Ramallah and Hebron was costly and time-consuming.
- It was hard to get a suitable scale for depression of deaf people.
- This study is restricted due to budgetary restraints, because this study is personally financed.

5.7. Recommendations:

1. Membership in the deaf culture reduces the sense of being different and provides improved self-esteem.
2. Relying on depression screening instruments as a way to assess depression among deaf adults is inadequate, and additional methods of eliciting symptomatology must be used.
3. Establish counseling sessions for all health care workers (psychiatrists, mental health nurses, health workers, psychologists and general mental health counselor) about sign language and the barriers which affect communication with deaf people.

Chapter six

References and Appendixes

6.1. References:

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6.2. Appendices

Appendix (1)

نموذج معلومات المشترك:

عنوان الدراسة:

الاعراض الاكتئابية لدى فئة الصم البالغين الفلسطينيين.

معلومات الباحث:

انا الطالب ابراهيم فخري ابراهيم اقطم - كلية الدراسات العليا ، قسم تمرير الصحة النفسية والمجتمعية في جامعة النجاح الوطنية ،

المشرف على البحث : الدكتور عدنان سرحان .

عن ماذا تتحدث الدراسة :

لإعداد رسالتي العلمية سأقوم بعمل بحث عن الاعراض الاكتئابية لدى فئة الصم البالغين الفلسطينيين ، حيث انه من الممكن ان يؤثر الاكتئاب على جميع جوانب حياة الصم وأسر هؤلاء الناس لذا تتطلب هذه الدراسة اهتماما خاصا بهؤلاء الناس، ولهذا، سيقوم الباحث بدراسة أعراض الاكتئابيين فئة الصم البالغين في فلسطين وكيف يمكن لهؤلاء الناس الحد من هذه الاعراض.

الهدف من الدراسة:

الغرض من هذه الدراسة هو تقييم أعراض الاكتئاب ومدى انتشاره لدى فئة الصم البالغين في فلسطين .

ماذا يتوقع منك فعله:

كمشارك في هذه لدراسة لديك دور مهم يتمثل بالإجابة عن اسئلة الاستبيان بأمانة.

الخصوصية:

كل المعلومات سوف تستخدم لأغراض هذه الدراسة فقط.

الرفض للمشاركة في هذه الدراسة:

ليس هناك ما يلزمك للمشاركة في هذه الدراسة بإمكانك رفض ذلك.

الضرر:

بعد الاطلاع على الجانب الاخلاقي لاجراءات حماية حقوق الانسان في حالة الاعاقات الخاصة والتدرب عليها وتنفيذها من خلال الباحث و مترجمي لغة الاشارة وبإشراف من د. عدنان سرحان والطايم الاكاديمي لكلية العلوم الصحية في جامعة النجاح الوطنية- نابلس ، تم اتباع كافة الشروط الخاصة لحقوق الانسان في هذا المجال، بحيث لا تتعرض لأي ضرر او اذية لإجابتك هذه الاستبيان.

شكرا لمشاركتكم.

الطالب: ابراهيم فخري ابراهيم اقطم.

Appendix (2)

نموذج موافقة عامة:

انا الموقع أدناه.....، والمولود في.....

أؤكد انه تم قراءة وتوضيح طلب المشاركة في هذه الدراسة التي تحمل عنوان الاعراض
الاكتئابية لدى فئة الصم البالغين الفلسطينيين

وقد اعطيت نموذج من طلب الموافقة وعلى استعداد للمشاركة في البحث. وتلقيت كافة المعلومات
التي تتعلق بالبحث سواء كانت شفوية(بلغة اشارة الصم الفلسطينية) او خطيه وأنا مدرك تماما
مشاركتي في هذا البحث طوعية.

توقيع المشارك:

التاريخ

ويؤكد الموقع ادناه انه قدم كافة المعلومات اللازمة حول البحث وقد سلم المذكور اعلاه نسخة من
الطلب المقدم ونموذج الموافقة.

توقيع الباحث:

التاريخ

Appendix (3)

البيانات الديموغرافية

				ضع اشارة على مكان الاجابة
		أنثى	ذكر	1.الجنس
أكثر من 35	34-30	29-24	اقل من 24	2.الفئة العمرية
بكالوريوس فأكثر	ثانوية عامة	اعدادي	ابتدائي	3. المستوى التعليمي
غير ذلك	مخيم	قرية	مدينة	4. السكن
	متدني	متوسط	عالي	5. مستوى المعيشة
أرمل	مطلق	متزوج	اعزب	6) الحالة الاجتماعية
لا أعمل	طالب	أعمل في دوام جزئي	اعمل في دوام كامل	7. نوع العمل
غير ذلك حدد.....	مع شخص لا تقربه	مع الاهل(او اقارب اخرين)	بيت منفصل (زوج / زوجة او شريك)	8. مكان سكنك
لا يوجد صلة قرابة الأفراط في تناول الكحول والمخدرات	قرابة بعيدة	ابناء خال	ابناء عم	9.صلة القرابة بين الوالدين
	الاكتئاب	الهوس والاكتئاب / الهوس الاكتئابي	الفصام الذهاني	10.هل يعاني احد أفراد عائلتك او أقربائك من أي من الامراض التالية:
		غير ذلك حدد.....	القلق	
				11) هل تعاني من أي اعاقه اخرى حدد.(1) نعم (2)لا

Appendix (4)

الاستبيان

تعتبر هذه الاسئلة جزءا مهما من مساعينا لتوفير افضل رعاية صحية ممكنة لك وستساعدنا اجوبتك على فهم بعض المشكلات التي قد تعاني منها ، الرجاء الاجابة عن كل سؤال بدقة. هل عانيت يوما من المشاكل التالية خلال الاسبوعين الماضيين:

طوال الفترة(كل يوم تقريبا)	اكثر من اسبوع	اقل من اسبوع	ولا مرة	
3	2	1	0	
				1. قلة الاهتمام او الاستمتاع بممارسة الاعمال اليومية مثل الاعمال المنزلية او مشاهدة التلفاز.
				2. الشعور بالحزن او ضيق الصدر او اليأس.
				3. صعوبة في النوم او نوم متقطع او نوم اكثر من المعتاد.
				4. الشعور بالتعب او الارهاق حتى من اقل مجهود.
				5. قلة الشهية او الزيادة في الاكل عن المعتاد.
				6. الشعور بعدم الرضا عن النفس او الشعور بالفشل او الاحباط.
				7. صعوبة التركيز او قلة الاستيعاب او كثرة النسيان .
				8. بطء في الحركة او قلة في الكلام عن المعتاد بدرجة ملحوظة من الاخرين / او على العكس من ذلك التحدث بسرعة وكثرة في الحركة.
				9. هل شعرت بالحزن لدرجة تفضيل الموت عن الحياة او راودتك افكار لإيذاء النفس.

جامعة النجاح الوطنية
كلية الدراسات العليا

الاعراض الاكتئابية لدى فئة الصم البالغين الفلسطينيين

إعداد

ابراهيم فخري ابراهيم اقطم

إشراف

الدكتور عدنان سرحان

قدمت هذه الأطروحة استكمالاً لمتطلبات الحصول درجة الماجستير في ترميض الصحة النفسية المجتمعية بكلية الدراسات العليا في جامعة النجاح الوطنية في نابلس، فلسطين.

2014

ب

الاعراض الاكتئابية لدى فئة الصم البالغين الفلسطينيين

اعداد

ابراهيم فخري ابراهيم اقطم

اشراف

د. عدنان سرحان

المخلص

الهدف من الدراسة: هذه الدراسة تهدف لتقييم انتشار الاعراض الاكتئابية لدى فئة الصم البالغين الفلسطينيين.

الطريقة: اعتمد التصميم الدراسة المقطعية الكمية لغرض جمع البيانات، واستند الإطار على عوامل مستمدة من دراسات

سابقة على استبيان الصحة المريض (PHQ9) ، وقمنا باستخدام النسخة العربية من لطفي الشربيني

(1995). مجتمع الدراسة يتكون من (217) شخصاً من ثلاث مدن فلسطينية في الضفة الغربية ممثلة للمناطق

جغرافياً، وتراوحت أعمار المشاركين فيها من 15-65 مقسمة على النحو التالي الذكور (n=136)، الإناث (n=81)

كل منهم يحضر مراكز الصم ويستخدم لغة الإشارة الفلسطينية (PSL).

النتائج وتحليل البيانات: توزيع البيانات، التي تم جمعها، وتحليلها باستخدام الحزمة الإحصائية للعلوم الاجتماعية (SPSS).

قمنا باستعمال المتوسط والانحراف المعياري ، والانحدار اللوجستي متعدد المتغيرات .نتائج الدراسة تبين من مجموع

العينة، اكتئاب الحد الأدنى ، (OR=2.0) (95% CI, 1.2-3.4) ، الاكتئاب البسيط

، (OR=1.7) (95% CI, 1.2-2.3) ، الاكتئاب المعتدل ، (OR=1.4) (95% CI, 1.1-1.9) ،

والاكتئاب الحاد (OR=0.9) (95% CI, 0.7-1.2).

إلا أن الدراسة لم تظهر وجود علاقة بين العمر والجنس و مستوى التعليم، والإقامة، والقرب العائلي و الاعراض

الاكتئابية.

ت

الاستنتاج: 42.2% من اجمالي العينة لدى فئة الصم البالغين الفلسطينيين لا يوجد لديهم اعراض اكتئابية ، بينما

10.6% اكتئاب متوسط ، و 5.5% كان لديهم اكتئاب شديد . نتيجة ملخص دراستنا انه اشتكى حوالي أكثر من

نصف المستطلعين من الاعراض الاكتئابية على مستويات مختلفة وهذا يعتبر استنتاج هام.

الكلمات الرئيسية: الاكتئاب وانتشاره، والدراسة المقطعية، الصم، الفلسطينيين.

