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PSYCHOLOGICAL ASPECTS IN THE HYPPOLYTUS BY EURIPIDES

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Abstract: This study provides an example of qualitative analysis of a literary text conducted through the theoretical and methodological means of the Psychology of Art and Literature. The approach adopted for the analysis of the text follows the type of interpretation of the founder of the Psychology of Art and Literature in Italy with Senior Professor Antonio Fusco of the University of Cassino. Aim of this study is to analyze the psychological determinants in the tragedy Hippolytus and in particular the motivations underlying the behavior of the characters.

Key words: Greek tragedy, psychological analysis, Psychology of Literature.

The work of desecration carried out by the Sophistry recognizes Euripides as the tragedian who desecrated the theological world of Homer and Aeschylus and showed gods being on a level with men, often openly criticizing them and giving his tragedy features that only now, after over two thousand years, can be considered as an essential constituent of the contemporary thought.

All Euripides' tragedies take place clearly on a human level as well as the invocation to Zeus by Hecuba in *The Trojan Women*, if well played in its feeling rather than literally, does not at all prove that the poet is getting back to the ancient religion in some way and, first of all, to the world doomed and worked out by the gods (Fusco, Tomassoni, 2013). The tragedy that we are going to examine, *Hippolytus* is concerned with the evils that may arise from a passionate love verging on the limits of an obsessive idea: it begins with a prologue in which, according to the new philosophy of sophistry, the emotional and ethical values are reversed and Aphrodite, the goddess born from the foam of the Aegean Sea and patroness of love[1] becomes a cruel bestower of death. The monologue in which the goddess talks about Hippolytus begins with a categorical statement: «*I am powerful, I am famous in heaven and on earth, I am Cypris the goddess*[2]»[3]. A categorical sentence follows, summarizing the desecration of the divine which we talked about and that turns – as we said - Aphrodite into a goddess capable of killing without mercy: «*I bestow my favours to those who venerate me, but if someone behaves in an insolent way I will destroy him* ». Soon after she says very significant words to understand the world secularization and the belief of Euripides that the gods were mere abstraction or, in any case, they were almost identical to human beings[4]. At this point starts the speech of Hippolytus, the son of Theseus and an Amazon, who is accused by the goddess to be the only one to underestimate her importance. The next sentence states: «*He does not want to know anything about sex, the idea of getting married does not even touch him*» and a psychologist will easily notice how less significant this Aphrodite is as compared to the Aphrodite, the goddess of love, that certainly cannot be reduced to sexuality. The speech goes on and deals with the relationship with the goddess Artemis who, with a clear sense of envy on the part of Aphrodite, Hippolytus considers the greatest deity. So also the rest of the speech he recites: «*but the company of a goddess is too much for only one man, not that I'm jealous, it is not so! However Hippolytus has offended me and today I will avenge myself. Most of the work is to be done now, I will just leave something undone to complete the work*». At this point Phaedra enters the scene, whom Cypris will use to punish Hippolytus with death, and Aphrodite says that as soon as Phaedra saw Hippolytus, she fell obsessively in love with him according to the strong will of the goddess. Phaedra is exactly the opposite of the "frigid" Hippolytus and she even built on the rock of Pallas a temple dedicated to Aphrodite (and here the desecrated goddess becomes cruel and unjust), according to the concept expressed shortly after by Hippolytus himself, who says: «*men are subject to the same laws as gods*». In fact, as an ordinary and cruel woman, the goddess has devised a fraudulent plot to accuse Hippolytus in front of Theseus's father of having tried to seduce Phaedra and, when she has to try to justify this plot which will also lead to Phaedra's death, she categorically states (and, at this point, she is very reminiscent of Medea) that she will not care even for the death of the innocent Phaedra, because what matters is her enemy's punishment. And when Aphrodite saw Hyppolytus on returning from hunting she pronounced the last words of the monologue, categorical and cruel words, worthy of a criminal woman, far away from the theological world of Aeschylus: «*The gates of Hades are already open. Hippolytus does not know it but this is his last day*». Aphrodite not only reveals herself as a jealous and vengeful woman, but, above all, some criminal elements get into her way of thinking and go beyond the deity's desecration making the protagonist almost a personification of evil also for the lack of rational restraints and in-depth critical powers of the Ego, which is absolutely inconceivable for a person who, despite everything, is a deity. On the scene, from which the goddess disappears, enters Hippolytus with a wreath of flowers in his hands. He starts with a long speech in honor of Artemis who, among other things, he considers the most beautiful of all the goddesses of Olympus to whom must be devoted all the very few things on earth that can symbolize purity, devotion and sublimated love: «*My lady, I offer you this wreath: I braided it with flowers of an untouched meadow. Over there the shepherds do not dare graze their flocks and no one has ever gone with the scythe to cut: an untouched meadow where the bees fly in the Spring. Modesty keeps it: as a gardener that wet it with the river waters. Only people who always behave in an honest way – a natural honesty, not learned by anyone - only they can pick the flowers in the meadow. It is prohibited to bad people. My lady, accept by pious hands this wreath for your golden hair. I'm the only man who has the privilege of your company, the only one who can converse with you. I do not see you, sure, but I hear your voice. I would like to continue to live in this way until the end of my days*». There are several further observations to make about the short speech of Hippolytus. The untouched meadow where only bees fly can turn into a symbol of fertility and sweetness related to honey. The water that wets the meadow suggests a clear sense of palingenesis which is related to the meaning of high ethics when we consider that the same meadow, a symbol of purity, as already said, can be reached only by absolutely honest people (a natural honesty, not imposed by any particular law). Only these elected beings are allowed to pick the flowers of the meadow, and finally there is the offer of the wreath to the golden hair. A speech follows in which prevails a rationality attributed to the servant of Hippolytus, who also says: «*we must detest the arrogant and hate extravagance*» (acting as the mad *King Lear* by Shakespeare with reference to such people), as it is implicitly stated in the concept of Sophrosyne (σωφροσύνη), which is also accepted by Hippolytus, who says, among other things, that «*men are subject to the same laws as the gods*». It is then pointed out by the servant that there is a contradiction in the behavior of young people because Hippolytus neglects a goddess worthy of the utmost respect, that is Cypris. Hippolytus, psychologically conditioned to the verge of a disease for his worship of Artemis and also proud of his chastity (in the negative sense of the word), reacts in such a way as to show that the brief period when in his mind rationality (and Semnos) has prevailed has already passed and with a sense of pride that surely touches the *Ybris* he says he does not like a goddess who accepts to be worshipped during the night (with a clear connotation of sexuality). At this point the servant reminds him that he must pay a tribute to all the gods, but the mental dimension of Hippolytus remains on a level of excessive pride and above all that erethistic mental dimension (see Hugo-Dazzan, B., Pariante-Carmine, P., 2006) touches a real insult to Aphrodite, to whom he pronounces the following words: «*a laid table is a pleasure after a hunting party... and so much for your Cypris*». The servant merely absorbs the Ybris of the young boy and tries to avoid a reaction from the goddess with words inspired by a true Sofrosune: «*oh Cypris please forgive if someone said stupid things... pretend not to have heard anything The gods must show they are wiser than men*». The women of the chorus enter and briefly make a comment on the situation of the places just to be able to speak about their lady (Phaedra) who is presented in a quite advanced state of physical and mental illness with a streak of masochism which leads her to even hide her blonde hair under veils (in relation to her deeply depressed mood). The Chorus concludes by saying that Phaedra has not eaten in the two past days and that, for a suffering they know nothing about, the death drive prevails in her and she goes towards a painful end. At this point the most interesting research from the psychological point of view consists in an investigation about the causes of Phaedra's depression. The Chorus is made up of olderly and wise women who try to penetrate the woman's mental dynamics by asking the nourisher a question about what may be the causes of such a serious disturbance. In fact, the women make the most different assumptions and think that may be it is the god Pan who disturbs Phaedra or even the pale Hecate[5]. Soon after there is an unintentional but proper hymn of praise (even if the women are not aware of it) to Artemis, whose power they praise by saying that the goddess exerts her power on the lakes, on earth, and on seas. An assumption follows, which is more properly human and frequent in women's state of anxiety, that is an alleged betrayal by her husband, Theseus, who might betray her with another woman. Another assumption is that from Crete, of which Phaedra is a native, a messenger has been able to bring some sad news to the Queen who suffers from it, torn by grief. The last part of the stasimon is very important because it is detached from the individual case and is about woman's nature so that it could, if interpreted as a specific case, confirm the existence of a certain measure of misogyny as attributed to the poet by many critics (on which we disagree)[6].

The exact words are:

without saying that it is just in the weak
feminine nature a breathless
agitation caused by the pains
of childbirth and by the delirium
once I too knew the excruciating
spasms of the bowels
in myself, and I invoked the protectress
of births, the heavenly invincibile
goddess who loves the bow,
Artemis with the other gods
always honored by me.

The poet, as we have already said, thinks women - in a very vague sense – suffer from a sense of weakness (such as *fragility your name is woman* by Shakespeare) adding immediately after that the pain of childbirth may cause a psychic disturbance and even delirium[7]. Soon after getting to their own personal experience, older women feel again the *excruciating spasm* of childbirth that is almost relived in the words *spasm of the bowels* and we must notice that on that occasion they have invoked Artemis, the protectress of births, stating that they have always honored this goddess along with all the other gods. Euripides, as we have already said several times, does not believe in the existence of gods but he rightly recognizes - for people who do not have a real philosophical background (that he probably has) - the need to believe without critically analyzing the problem of the existence of gods, and especially the possibility to invoke them in difficult times (as a defense mechanism of the Ego)[8]. Let us now consider the first episode in which the door of the Palace is opened and Phaedra herself appears, helped by her nurse while some maids make a small bed on which the Queen will sit down.

The Chorus simply makes a generic diagnosis of the severe disturbance suffered by Phaedra who has *a sort of shade around her eyes, darker than usual* (with a subtle psychological insight, Euripides detects an essential element in the expression of the eyes in order to be able to identify the mood of a subject).

This statement is followed by the expression of a desire to know the cause of such a disturbance.

Then there is a conversation between the nurse and Phaedra, in which the former observes that Phaedra wants a different placing at every moment, but the essential point is that she never finds the peace of mind she wishes in vain. So, either in her bed or outside home, she is always quite anxious and suffering. Soon after the nurse says that it is preferable to be sick rather than have to heal the sick and states that being sick is ultimately a very simple thing, but taking care of a person who is ill causes a real physical and psychological suffering.

And this, as always, suggests a general observation: «*man's life is full of sorrows, and no pause to pain is granted*».

Then there is a reflection on a possible life after death about which, however, the mystery of the afterlife is never revealed and Euripides says that about the afterlife only *vain fables* are known[9].

The following dialogue could be defined a real form of delirious expression in which Phaedra, by turning into a symbolic language her unconscious urge of revenge against her own pains and in some ways against herself, expresses the desire to take part in a hunt in order to fulfil, in a somehow paradoxically state of psychic balance and mental well-being, a desire that her nurse has rightly identified as the expression of a mental disease that only an expert soothsayer could understand.

And that is certainly caused by a deity who disturbs and upsets the woman's mind.

At this point Phaedra recovers, the rational Ego regains

1 Just remember the famous De Rerum Natura by Lucretius that begins with the verses: «Aeneadum genetrix, hominum divomque voluptas, per te rident aequora ponti, tibi suavis daedala tellus submittit flores, placatumque nitet diffuso lumine coelum». And Ugo Foscolo, in the poetry A Zacinto celebrates: «Nascea e facea quell'isole feconde del suo primo sorriso»

2 As it is well known Cyprus was sacred to Aphrodite; the bond of the goddess with Cyprus mainly concerns the city of Paphos.

3 As it is usual in the Greek tragedy - and this also refers to Aeschylus, especially in the Prometheus Bound - it tries to expand the geographical terms of its action in relation to the need, typical in the Greek spirit, to push to the extreme limits of the known world. For this reason Cyprus rumored to be known and powerful from the Black Sea to Mount Atlas.

4 In Quo Vadis by Sienkiewicz, Petronius says «The gods now are merely an abstraction» and also adds that if this Christ that seeks to establish himself in the Roman world is so important, he must be hosted in the Pantheon together with all the other gods.

5 Dante also mentions her in the Inferno, canto X.

6 See in Medea by Euripides when he says that it is better to be a thousand times in front of the shield rather than give birth once.

7 Anticipating the studies that are currently being conducted on postpartum mental disorders.

8 Protagoras also says that the question of the gods is difficult to solve for both the brevity of human life, both for the complexity of the problem in itself.

9 Euripides anticipates once again a concept expressed by Hamlet's in the famous soliloquy in which Hamlet talks about that unknown continent where no one ever came back.

10 See: Hugo-Dazzan B, Pariante-Carmine P. (2006).

control of her mind and she asks the nurse to cover her head to hide her plan. But at this point she makes a very interesting comment: she says that «*it is certainly a bad thing to be insane, but it is better to die without realizing it*».

This reflects an essential element for the Ego and for the suffering, of which the rational Ego is a victim and a protagonist. One wonders whether it would be better to stay in the psychotic[10] state until the end. Being excessive in everything, even in friendship and affection, is always to be avoided and the speech ends with a philosophical reflection attributed to wise men, that is «*never be excessive in any human manifestation*».

At this point the Chorus insists on trying to understand what evil afflicts Phaedra, but the nurse simply replies that she does not know the cause and only knows that Phaedra wants to die for her own choice of anorexia. To the observation of the Chorus that Theseus, her husband, should realize the situation of his wife, the nurse explains that Phaedra has always denied being ill and also Theseus at the moment is far from Trezene.

Then the nurse decides to make a last effort to find a truth on which to base even a possible therapy and that, in any case, it is preferable to the pain that she is suffering now, completely unaware of a state of uneasiness that is taking to death a person deeply loved by her.

In a totally casual way the nurse pronounces the name of Hippolytus, warning also Phaedra that this son of the Queen of the Amazons (Penthesilea) could be recognized by Theseus as his legitimate child thus depriving Theseus and Phaedra's children of their inheritance.

After an almost obsessive insistence, the nurse ultimately realizes that Phaedra is sick of love and though Phaedra defines love as a mental dimension, sweet and bitter at the same time, she categorically states she has only experienced its bitterness. To a specific question of the nurse if she loves someone she is forced to reply: «*anyone who is the Amazon's son*».

The nurse is literally astonished and clearly expresses her willingness to die by saying: «*I am no longer of this world*»[11] and immediately follows a direct attack against Cypris who is considered as a dark force (a sort of a demoniac impulse) capable of destroying a woman and all her family with her. The Chorus also regards that love as a possible cause of «*never heard unspeakable pains*» and even the Chorus's women hope they would never have to suffer for an excess of love and therefore avoid having to share Phaedra's unhappy fate[12]. A long monologue of Phaedra follows. The main elements implying a return to rationality and a clear analysis of the real world are various: at first she speaks of the long sleepless nights when she had reflected on human life and the reasons *why it is subject to corruption*. She rules out that it is grounded on an innate evil nature and indeed wise people are not few. She later recognizes that men distinguish and then know the good but they do not behave according to its rules, either out of laziness (which we can define as apathy) or because they prefer other pleasures such as conversation with friends or even just staying idle.

As regards modesty, which is an essential element in human life, there are two types of it: one deserving any sort of praise while the other consists of a *destructive plague of homes*. Phaedra even suggests two different names and tells how she came to this conclusion.

When she felt hurt by love for Hippolytus, even in part with the hegemony of rationality over emotion, she tried possible ways out of this situation clearly extreme dangerous for her. For this reason, she fell silent considering the language, that is the word, useful to give advice to others but dangerous for herself. And there is a new consideration to be made concerning the big difference, still partly existing between the betrayal of a woman and the betrayal of a man and Phaedra rightly says: «*finding myself being a woman at an early age I would have earned the universal contempt ... cursed the woman who first contaminated her thalamus by lying beside a stranger!*».

It is interesting the fact that she says this evil plagued first the nobles and then, logically consistent with the social criteria of his time, Euripides states that common people complied with them and somehow they felt justified by following what noble people believed it was legitimate to do.

Here, too, the poet expresses a psychologically important observation, in the sense that men seek a justification for an immoral action they make and find it when a lot of other people, even of the highest social rank, act in the same way. But Phaedra's inner purity suggests the Ego a consideration that is peculiar of her personality and which leads her to think that her choice to prefer death to ignominy is right, because in this way her husband will never have to complain of her conduct, and her children, she loves with a deep motherly affection, can be proud of their mother[13].

The words: «*there is one thing worth more than life in this world: being just and good. It is time, then, when the hour comes, which cares to unmask the wicked, in front of whom it places, as in front of a virgin, the mirror*». And finally she says: «*may I never be seen among those people*».

At this point the judgment that can be passed on Phaedra is only that if she yielded to an unrestrained sensitiveness to which her reason has not been able to resist, her rational faculty, closely anchored to the dictates of an ethical Super-Ego, leads her not only to consider her situation shameful, but also coherently to wish to get out of a world in which her image in the mirror would be disfigured like Dorian Gray's[14] face, a situation from which only death can save her.

And here begins the long story of the so-called betrayal of Hippolytus, that according to an attitude widely present in the concept of Euripides, brings Aphrodite to kill (exactly with the logic of a criminal woman) the very people she deeply loves.

Thus, we are confronted with to the crucial confession of an alleged love of Hippolytus for Phaedra[15]. Throughout his work the Author actually wants to show that there is no difference between a human and a divine creature and in this sense, with an intentional equalization of the human being to divinity, he says that the latter should be wiser than man.

This is basically the thought of Hippias, who moves along the entire sophistic-atheist vein, that is desecrating of knowledge.

As regards Theseus, he immediately believes in his wife's betrayal also because, being the son of Poseidon, he had received from his father the promise that those who had offended him would be punished with death (as it happens with the other character, who is a son of the same Poseidon, that is the Cyclop Polyphemus).

Artemis - who has been the companion and the silent guarantor of absolute fidelity of Hippolytus and his unconditional devotion to the gods - personally guarantees the exceptional personality of the young man who had devoted himself to her and his entire physical and mental life to the ethical and theological ideals. The tragedy comes to the end; Theseus recognizes his mistake and is almost destroyed by it. Phaedra is aware of her absurd behavior and of the serious consequences arising from it. Artemis, on the other hand, explains that she, as a goddess, though fond of Hippolytus and being his partner in all the festivities in her honor, cannot witness the death of a man because the co-presence on the scene of both the goddess and death (also this one, obviously, a goddess) are incompatible. For this reason, though seriously wounded in her heart, the goddess leaves the scene where a man who has lived strictly according to the theological and moral rules of a society, who has also devoted his life to a vow of chastity (although unrevealed) in honor of a goddess, sees his sacrifices rewarded with a cold-hearted and aseptic death sentence. The only culprit, that is Aphrodite, not only is not in any way punished for her completely unjustified criminal action, but is not even qualified for what she actually represents: a chance for a divine entity to be unjust and criminal without taking upon herself any responsibility. Perhaps this is the crucial focus of the sophistic philosophy developed by Euripides, which is based on two assumptions: first, the non-existence of a divine entity in the atheistic sense of the term, and secondly, the Author's belief and philosophical thought that not only gods do not exist, but if they existed they would be even inferior to the already limited and incomplete creature that is the human being.

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11 Phrase that will be repeated by Mariana Pineda, by F.G. Lorca.

12 In the Museum of Fine Arts in Maria Theresa square in Vienna there is a picture showing a particular kind of prayer of the Roman women who wish not to be a victim of the excesses to which the love can lead.

13 Concept that is also expressed by Mariana Pineda in the cited tragedy.

14 See: Wilde,O., (1891), Il ritratto di Dorian Grey, Milano, Mondadori, 1987.

15 Communication that will prove to be false, but will have time to play the entire tragedy until to hide under a set of elements created with malice and crime the real motivation of this deity, desecrated by the whole sophistic thought and deliberately brought by the Author to the dimension of criminal woman, that practically means the desecration of any element that makes possible an actual difference between the man and what was until then the concept of a divine and transcendent god.

COGNITIVE-BEHAVIORAL THERAPY OF PATIENTS WITH HYPOCHONDRIA

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Abstract: Originally hypochondria was considered as adistinct syndrome usually treatedpharmacologically. It's treatmentwas based on the psychological theories or the dominant theories. The study regarding cognitive-behavioral approach has its origin sprimarily in the areas of obsessions and panic research.

Cognitive conceptualization of hypochondria was created to effectively explain their characteristics and experience. Recentcontrolled studiesof cognitive-behavioral therapy (CBT) of hypochondriasuggest that: -CBTis extremely effectivein relation tofamily therapyand dynamic and forhospitalizedpatients withhypochondria; -patients preferCBTor waiting list group for treatment, - the improvementpersists for atleast 3 months.

The main aim of this article is to present and analyze the possibilities of CBT appliance.It is showed the efficacy of CB Tin the treatment of patients with hypochondria, but the question whetherit will bea future therapy, will depend on whether the results of research carried out under controlled conditions to be confirmed in clinical practice.

Keywords: *cognitive-behavioral therapy, hypochondria, treatment studies.*

Cognitive - behavioral therapy for patients with hypochondria

Recently, the treatment of hypochondriasis was not considered as a significant issue and was interpreted as a disorder secondary todepression or anxiety. Nowadays, hypochondriasis is defined as a persistent false belief in illness accompanied by avoidance, bodily checking, selective attention and preoccupation.

DSM-IVlists the following criteria for a Hypochondria diagnosis: 1.excessive focusing on the anxiety associated with the conviction of a serious illness, based on a misinterpretation of the bodily symptoms; 2. continued focusing despite assurances and lack of medical evidence; 3. maintenance of state for at least six months; 4. the result of existing somatic disease or action of psychoactive substances; and 5. causes significant distress or interferes with the normal functioning of the human being.

ICD-10 (World Health Organization, 1992) suggests that both of the following states should be present: first, a persistent belief in the presence of at least one serious physical illness underlying the presenting symptom or symptoms, even though repeated investigations and examinations have identified no adequate physical explanation, or a persistent preoccupation with a presumed deformity or disfigurement; and second, the persistent refusal to accept the advice and reassurance of several different doctors that there is no physical illness or abnormality underlying the symptoms.

According to DSM-IV, hypochondria is definedas a misinterpretation of bodily symptoms that cause worrying about the presence or imagined presence that there is a serious illness, despite medical evaluation and reassurance (American Psychiatric Association, 2000). The complexity of differentiating diagnosis is observed in the description and evaluation of "hypochondria - disease phobia" because both disorders link anxiety-caused stimuli, and therefore clinicians must rely on the detection of sources of those stimuli in order to distinguish these disorders. In particular, the fear of the disease is caused directly by the external stimuli, and anxiety in hypochondria caused and sustained by internal stimuli (Salkovskis, 1989).

Using factor analysis, Pilowsky (1967) examined the issue and found that there are three dimensions of hypochondria: 1. preoccupation with the body; 2. fear of disease; 3. conviction of having the disease. According to this approach, it is likely to have different terms and conditions consistent with the clinical impression of validity of this difference (Bianchi, 1971; Marks, 1987). There were no attempts to distinguish hypochondria and health anxiety on the basis of the symptoms experienced and the range of demonstrated behavior intended to ensure avoidance (seeking for assurances and avoidance of the situations similar to the disease) (Warwick, Salkovskis, 1991). Hypochondria could be a phenomenon of relatively stable or transient nature.

According to the cognitive approach, misinterpretation is considered as an essential part of the hypochondria definition. The main feature of hypochondria is a continuous focusing on belief or anxiety associated with a serious disease that appears without proper organic pathology and, despite specialist's assurances, in the lack of physical illness. Anxiety is associated with perceiving signals and physical sensations that are misinterpreted as an evidence of the presence of the serious illness. Therefore, hypochondriasis could be defined as the final stage of anxiety, which focuses on the health (Salkovskis, 1989). Patients with hypochondria use all the resources of medical practice (Kellner, 1985). In cognitive-behavioral therapy of hypochondria, it is recognized that the factors triggering anxiety and confusion can reoccur. CBT modifies the importance of physical changes, reducing them to the level of the standard.

PREVIOUS TREATMENT APPROACHES

Experimental evidence shows that patients suffering from hypochondriadiffer from healthy individual sand those with an anxiety disorder in perception and tendencyto misinterpretation of thenormalbodily sensations (Salkovskis & Clark, 1993).

Health anxiety of various types and levels of severity plays a role in maintaining the mostsomaticproblems suchas high blood pres-

sure, dizziness, asthma, psychogenicvomiting, and dysmorfobia(Salkovskis, 1989). More than 90 percent of the population have experiencedsomaticproblems, suchas headachesorinsomnia (Salkovskis, 1989), and above averagenervousnessdueto illness orinjury has been reported byalmostone-quarter ofadults inrandomlyselected studies(Noyes et al., 2000).

One of the firsthypochondriatheories ispsychodynamic, which has not been confirmed empirically. This theory introduced the important concept of "somatization", meaning that not being able to express psychological distress in an acceptable manner, resulted in expressingit assomatic symptoms. For many yearsit wasthought that hypochondria was asecondary disorder, but current studies have proved it is a primary disorder.

According to the theory of learning, the difficulties arise by classical conditioning (symptoms that appear and lead to anxiety are triggered by stimuli causing anxiety) and are maintained by operant conditioning (avoidance behaviour and reassurance resulting in negative reinforcement) and cognitive processing (frightening thoughts, focused attention) (Salkovskis& Warwick 1986).

The cognitive-behavioral approachstudies regarding understandingand treatment of hypochondria their origins origins primarily in the areas of obsessions(OCD), and panic disorder research. Barlow and Craske (1988) considered panic as a pervasive problem in patients with panic disorder and 83 per cent of patients in each diagnostic category had at least one panic attack. Clark(1986) wrote that panic attack sare the result of catastrophic misinterpretation of some certain somatic sensations. A panic attack triggers are almost always internal. Therefore, cognitive behavioral therapy is focused on misinterpretations and their substitution by rational and calmative explanations (Hawtonet al., 1989).

The theory of a spectrum of obsessive-compulsive disorders developed by American scientists (Hollander, 1993) is based on the observation ofthe existence ofsimilarclinical featuresof OCDdisorderandsomeother diseases. A mutual link between hypochondria and obsessionsmay includesuch featuresas the ageof the disease, its clinical progress, comorbidity with other disorders, presumedetiology, and response to pharmacological and psychotherapeutic (Bryńska, 2007). The OCD spectrum includes several interpenetrating disorders, among which are adysmofrofobia, hypochondria, and depersonalization. Hollander (1993) called one of the dimensionsof psychopathological symptoms of OCD "cognitive-motor", where on the one part of a continuum are disorders in the form ofintrusivethoughts, hypochondria, depersonalization, and dysmorphobia, and on another-a child's OCDet al.

There are several therapeutic strategies used for the treatment of hypochondria,mostly based on the prevailing theories of hypochondria: the theory of unconscious motivation, the primary and secondary benefits, and the need to remainsick (Kellner, 1986). The modern studies on CBT methods of treatment have shown that the results achieved are much better than expected (Kellner, 1983; Salkovskis & Warwick, 1986, Warwick &Marks, 1988).

An importantand constant lyrecurring issue in the hypochondria treatmentis the role of recommendations forpatientsto ensurethe absenceof diseaseon the one handandeliminationof avoidance on theother(usingmethodsdevelopedon the basis ofthe exposuretherapyof obsessive-compulsive disorder) (Salkovskis & Warwick, 1986, Warwick & Marks, 1988). Kellner (1992), in an article dedicated this issue, said that the exhibitionisthe best treatment of patients with a phobia about the disease.However, if the patient isconvinced about the disease, it will bemore effective to use the persuasion method, which means attributing the symptoms to other causes, explanation, psycho-educationand use of cognitive techniques. Kellner also stated that the treatment of these patients includes multiplemedical examinations and ensuring the disease absence. Salkovskis and Warwick (1986) showed the similarity between seeking for assurance and obsessive ritualization. Differencesbetweenobsessiveruminationsandmorbidconcern are described by Rachman(1974).

Presently, hypochondria prevalence among the general population is unknown. Most of the studies are based on the continuum. Kellner (1985) estimated that in the various communities the percentage of hypochondria cases is around 3-13 per cent, and worrying about the disease - around 10-20 per cent among normal people. Epidemiological studies indicate that hypochondria affects 1-5 per cent of the general public, and 2-7 per cent of the outpatient population (American Psychiatric Association, 2000; Comer, 2001). Barski and Klerman (1983) indicate that 30-80 per cent of patients who consult doctors have physical symptoms without foundation. Men and women have the same risk of suffering hypochondria. The disease is most commonly diagnosed in early adulthood, and the peak incidence is between 30 and 39 years old (American Psychiatric Association, 2000; Comer, 2001, Iezzi, Duckworth, & Adams, 2001).

Hypochondria symptoms are common in depression (secondary hypochondriasis), and symptoms of depression are common in hypochondria (primary hypochondriasis). There is also evidence which indicates that hypochondria cooccurs with panic disorder and obsessive disorder (Noyes et al., 1986; Salkovskis& Clark, 1993), agoraphobia, as well as personality disorder and psychotic disorder (Iezzi et al., 2001; Margarinos, Zafar, Nissenson et al., 2002; Warwick, 1995). There is evidence that some patients with hypochondria have a personality, not a mental, disorder (Tyrer et al., 1990). There is experimental evidence demonstrating that patients with hypochondria are different from those without mental disorders and anxiety disorders in the perception and tendency to misinterpretation of normal physical symptoms (Salkovskis& Clark, 1993). Despite the differences in the types of symptoms and duration of the disease causing anxiety, formation of certain concepts in a panic and hypochondria is similar to a form of occurrence of the two disorders which partly overlap (Noyes et al., 1986). Of course, the problem of differentiation diagnosis is crucial in diagnosis of hypochondria and other disorders including anxiety about health (Iezzi et al., 2001).

COGNITIVE-BEHAVIORAL THERAPY: Objectives, assumptions and maintenance factors

The main objective ofCBTin hypochondriatreatingis to achieve with the patient acommonunderstandingof the psychologicalbasisoftheir problem, andto help diagnosethe patient's problem, not the exclusion ofphysical illness(Salkovskis& Bass, 2006).

The wide understanding of the objectives of CBT for patients with hypochondria includes patient's involvement in the psychological approach; coping with somatic symptoms in a new different way; and interrupting the mechanism of self-perpetuating worrying.

A cognitive-behavioral approach focuses on "here and now" (Hawton et al., 1989), but early experience is closely related to the hypochondria development. Discussion of these experiences during therapy allows recognition by patient and therapist of the main factors that may have contributed to the development of the disorder. Additionally, analysis of some important events and emotions will help the patient to understand their situation and themselves better, to find cause and effect relationships. That will strengthen the subjective sense of control. The use of CBT in clinical practice includes issues regarding the selection of patients for treatment, duration and frequency of meetings, as well as the integration of CBT with other therapeutic interventions. The duration of CBT and the course of hypochondria are not strictly defined.

In Beck's cognitive theory (Beck et al., 1985), it is suggested that thoughts and images relating to a threat of some type are associated with anxiety. In hypochondriasis, the negative thoughts and images are of a threat to health, and anxiety results.Once health anxiety occurs, a number of factors maintain it – e.g. avoidance, checking and reassurance-seeking.

The main assumption of CBT is that hypochondria is based on a key statement that the bodily signs and symptoms are perceived as more dangerous than they are in reality, and the disease is considered to be more serious and probable than it is (Salkovskis, 1989; Salkovskis& Warwick, 1986; Warwick &Salkovskis, 1989). Patients with hypochondria recognize that they have no effective ways to deal with the threat, and have no impact on its course. So, CBT tries to identify automatic dysfunctional attitudes about health and looks for alternative testable explanations of symptoms. Throughout the course of CBT therapy, gradual education about the origin of physical difficulties is provided.

According to the cognitive model of hypochondria this disorder occurs in the following sequence of knowledge and experience of illness (the own and others) leading to the formation of assumptions about symptoms, diseases and health-related behaviors, starting from the early experiences in personal, social, and media spheres. Then, these assumptions lead to a selective perception of information, which confirms beliefs about the disease, and to rejection of the evidence of good health. Finally, increased vigilance will further their noticing of bodily sensations. A critical event is related to these beliefs, and triggers people's dysfunctional assumptions. Physiological, cognitive, emotional and behavioral components of health anxiety correlate with negative automatic thoughts and their interaction with the beliefs (maintained by the patient) substantially affects the level of health anxiety. The presence of bodily changes or symptoms is caused by negative automatic thoughts about the threat or danger. (Scott, Williams, & Beck, 1991). Warwick and Salkovskis (1991) offer the hypothesis that there are three main mechanisms for subsequent increase of the health anxiety: preoccupation with illness; misinterpretation of the physical symptoms (as a result of perseverance and maintenance of anxiety); and preoccupation with health.

Among the factors maintaining the health anxiety and hypochondriasis, Salkovskis and Bass (2006) identify three in particular: misinterpretation of growing symptoms of autonomic arousal as further evidence of physical illness; selective information about the disease (e.g., the perception of normal changes in the body), or physical traits, caused by worrying about the health bring in to awareness some of the physical changes during presence of some thoughts about the disease in mind, and also leads to selective perception of information and to the confirmation of the existing tendency; and behavior tending to avoidance, checking or total exclusion of physical illness symptoms increase their focusing on those symptoms, that may strengthen the symptoms of hypochondria. Selective attention and checking behavior maintain long-term anxiety, as a neutralization in obsessive disorder (Salkovskis& Warwick, 1986).

Warwick and Salkovskis (1991) conclude that the maintaining factors can be divided into three systems: firstly behavioral (seeking assurances, checking the condition of the body, avoiding activities); secondly, cognitive (intentional focusing on the physical sensations, the effects of terrible ideas about the disease, was how specific beliefs lead to misinterpretation of bodily symptoms and bias); and thirdly, physiological (changes in breathing, loss of physical form because of the lack of exercise, or effects of caffeine, alcohol, or other drugs). Psycho-education regarding factors is very helpful for therapeutic intervention.

COGNITIVE - BEHAVIORAL TREATMENT CHARACTERISTICS: style, steps and treatment strategies

The styleand method oftherapeutictreatment arebaseddirectly on the classical CBT approachdeveloped byA.Beck and his colleagues; soCBT of hypochondriais an active, structured and time-limitedform of psychotherapy. The therapeutic work styleincludes the mutualdevelopmentof goals and a treatment plan by the therapistandthe patient. CBTtechniquesfor hypochondriaare to identify thethoughts, assumptions and beliefs, showingthe relationships betweenphysical symptoms, thoughts, emotionsand behavior; to look for evidenceof the validity and invalidity ofdysfunctional beliefs; to carry on behavioralexperiments; and to generate the alternative hypotheses, etc. (Salkovskis, 1989).

Therapeutic intervention focuses primarily on the patient's belief to solve the problem in a different way than treatment, which requiresthe involvement ofthe patient inpsychological work. The therapist focuses on the physical symptoms, and on the how the patientis trying to understand and interpret those symptoms. The maineffect of CBT is focused onerroneous interpretationsandtheir replacement withthe correctandlogicalexplanations(Salkovskis& Bass, 2006).

Salkovskis (1989) offers a CBT approach for the treatment of health anxiety, which is consistent and uses all the elements of a cognitive conceptualization. The cognitive model of health anxiety and hypochondria assumes that in the conceptualization therapist should consider four basic factors: the perceived likelihood of disease; the perceived costs and burden of disease; the perceived ability to cope with the disease; and the perception of the extent to which external factors will be helpful (Warwick &Salkovskis, 1991). The greater the intensity of the first two factors, and the lower the intensity of the latter two factors, the stronger the patient's anxiety.

Salkovskis and Warwick (1986) offer a clear cognitive conceptualization of health anxiety, which implements of six basic functions: preoccupation with health; insufficient organic substrate; selective attention to changes or signs in the body; negative interpretation of physical symptoms; selective attention and lack of faith in the medical and non-medical communication; and the continuation of ensuring searching, or bodily state checking (Warwick &Salkovskis, 1991).

A cognitive-behavioral therapy process starts with the diagnosis of its purpose, as well as verifying the of patient's attitude towards therapy, focusing on the thoughts associated with it. The clinical history examines the physiological characteristics of the problem and patient's beliefs about their physical condition, disease-related thoughts and emotions accompanying them, as well as preventive behavior (Salkovskis& Bass, 2006). There are other possible component orders used in CBT. According to Warwick (1998),the CBT process includes the six steps following:

1. Engagement;
2. Self-monitoring;
3. Cognitive restructuring;
4. Exposure and response prevention;
5. Modification of abnormal illness-related behaviors; and
6. Identification and re-attribution of dysfunctional beliefs and assumptions

According to Salkovskis, Warwick and Deale (2003), therapy consists of engagement, formulation, self-monitoring, questioning belief, behavioral experiments, dealing with rumination, worry and images, persistent reassurance seeking, dealing with medical consultations, identification and reattribution of assumptions, and relapse prevention.

The next step is to introduce the patient to the cognitive model, which includes the specific problem and offers a completely different, less dangerous way of explanation, so it is important that the patient has agreed that therapeutic strategies aimed at reducing worry, and they are not focused on risk reducing. The evidence for and against the both alternative models should be discussed and described in detail, especially how the body monitoring and medical research may produce the opposite effect than intended. In case of need of new information getting, behavioral experiments could be planned. All these activities promote the development of the patient's conceptualization of hypochondria, so it is important to discuss with him whether he can accept the presented conceptualization. At this stage, the goals of therapy have to be agreed (Salkovskis& Bass, 2006).

The next step is to work with the patient'sbasic beliefs regarding the disease. In understanding the patient's anxiety, it is important to emphasize the development of dysfunctional assumptions about health that were shaped during childhood. It is noticed that patients with hypochondria have a higher level of childhood abuse (Barsky, Wool, Barnett et al., 1994). Hypochondria deals with misinterpretation of sensations and physical changes, and medical informa-

tion as being more threatening than they actually are. The therapist knows that patient beliefs are based on evidence, considered by him to be convincing, which is why the therapy should start from the observation and analysis of the function of these beliefs. In a case where the background of the disorder is strong anxiety, the therapist will focus on changing the way of assessing the significance of physical symptoms. If the patient is afraid of the disease consequences, the questioning of patient's beliefs about how hard it will be, fostering the reduction of negative automatic thoughts and remaking the conceptualization should be deeper. It is essential to check the patient understanding of everything discussed during each session, and what conclusions are reached. It should be noted that some beliefs become dysfunctional in combination with other similar belief (Salkovskis& Bass, 2006).

The important role of the patient is self-monitoring and completing a questionnaire or diary. Self-monitoring can be customized or standard, and include essential variables. At a later stage, it is useful to record the techniques used to improve their effectiveness (Salkovskis& Bass, 2006).

Another important component of CBT is to change the behavior of patients with hypochondria. The patient sees most of their behaviors related to physical health problems as necessary to prevent serious illness. In a case when the behavior associations with the disease are visible, CBT strategies aim to explore and demonstrate their role in sustaining drug and disturbed physiology using targeted discovery, direct demonstration and behavioral experiments. Avoidant behaviors support the patient's preoccupation with the disease and prevent their access to information contradicting their interpretation of symptoms (Salkovskis& Bass, 2006). Examples of specific application techniques aimed at changing the behavior and beliefs of the patient are described in detail by Philips (1988).

Particularly significant is discussion of the behavior, which means obtaining assurance about the absence of disease. This behavior has focused attention on the patient's fears, reduces anxiety for a short time, but increases the absorption and other aspects of the problem in the long term perspective (Salkovskis& Warwick, 1986, Warwick &Salkowskis, 1985). Such behaviors include requests for medical examinations and a detailed discussion of symptoms to rule out a possible disease. Patients with hypochondria undergo numerous studies, and operations, which can cause secondary physiological problems resulting from the large number of tests, and treatments. Irritation of part of the body and internal organs, makes it even more concerning for the patient and confirms the assumption that there is something wrong with him. There are ruminations, arbitrary inference, and selective attention - patients capture negative elements of their health that are consistent with their beliefs and focus on them (Clark & Fairburn, 2006). The patient's response for the information to ensure the absence of disease is perceived by the patient with hypochondria differently: the patient listens selectively, and incorrectly interprets the same assurance. As a result, the repeated assurances increase the patient's anxiety (Salkovskis& Westbrook, 1987). If the patient's main difficulty is to look for proof, effective behavioral experiment preparation shows the effects of assurance (Salkovskis& Warwick, 1986). Self-monitoring of health anxiety, belief in specific thoughts associated with the disease and the need to ensure they are regularly evaluated on a scale of 0-100 should be carried out before , during and after the experiment.

Salkovskis distinguished eight principles in the treatment of health anxiety, which are significant in the treatment of somatic symptoms: 1. to determine what the problem is, not what the problem is not; 2. to confirm the authentic presence of the symptoms (the main goal of treatment is to explain their presence in detail); 3. important information may help the patient, and irrelevant or repetitive may increase his distress; 4. treatment of a co-operative character, not confrontation; 5. instead of rejecting the patient's unrealistic beliefs, to help the patient to determine which signals are the evidence of the disease, and which factors are maintaining the issue and worrying; 6. to create a short-term contract to see an alternative explanation of physical symptoms; 7. to educate patients on the interaction of four anxiety aspects and health; and 8. consistent elicitation of the patient's feedback to ensure their understanding of treatments and to prevent the possible increasing of anxiety.

TREATMENT STUDIES

Studies on the efficacy of CBT treatment of patients with hypochondria were presented in the form of case descriptions, and experiments with a single case and a series of cases, to indicate that in some cases the treatment can be effective. Salkovskis and Warwick (1986) presented a description of cognitive-behavioral therapy of two patients who thought that they suffered from life-threatening diseases. The therapist has set a benchmark in which evidencewas collected in the form of log (providing medical induced anxiety), which was presented to patients as a result of behavioral experiments. The role and importance of seeking assurances and associated checking behavior was discussed in detail. Then it agreed with the patient's description of cognitive problems.

Warwick and Marks (1988) conducted a larger study on patients with a disease phobia and what patients believed about the disease. They used a strategy based on exposure and response prevention to change beliefs.

The positive forecast of hypochondria treatment is associated with the following features: acute onset, short duration, mild or low number of symptoms, low dependence on the health care system, the presence of true disease and no co-occurring mental illness (Comer, 2001; Hiller, Leibbrand, Rief et al., 2002). However, taking into account factors such as mediation, chronicity and hypochondria, symptoms overlap with other conditions such as reinforced dysfunctional psychological and behavioral responses, it is unlikely that more than one or two positive prognostic indicators are present. In this situation, the forecast recovery is generally low (Warwick &Salkovskis, 1991). However, the implementation of cognitive-behavioral therapy of hypochondria has increased over the last decade, and relatively recent results of empirical research gave some support. Recent CBT controlled studies in the treatment of anxiety about health associated with a number of somatic symptoms (chronic fatigue syndrome, chest pain, chest pain, cardiac without reason), suggest that CBT is effective treatment (Looper&Kirmayer, 2002; Margarinos et al., 2002). Furthermore, there is evidence of a superior performance compared to CBT family therapy and dynamic in the treatment of hypochondria in the international population (Rodriguez & Martinez, 2001). In relation to drug treatment, patients prefer CBT or awaiting treatment group to achieve a higher level of improvement (Walker, Vincent, Furer et al., 1999).

There is evidence of the effectiveness of intensive CBT in the treatment of hospitalized patients with hypochondria (Hiller et al., 2002). There is evidence to suggest that patients with hypochondria treated with CBT show significantly greater improvement, as shown by their own self-observation, therapist, evaluative studies and the continued improvement three months later (Warwick, Clark, Cobb et al., 1996). Other studies have documented improvements, lasting from seven months to one year, but also suggest that cognitive therapy can be effective in maintaining the improvements (Clark et al., 1998).

Finally, there is evidence on the effectiveness of group CBT in the treatment of anxiety about health (Looper&Kirmayer, 2002; Margarinos et al., 2002). Stern and Fernandez (date; Salkovskis& Bass, 2006) have demonstrated efficacy in the treatment using behavioral group therapy in an uncontrolled study of general hospital patients. There is evidence that the CBT can be effective in the hypochondria treatment among a limited population, for example, in patients who have survived the brain trauma. It is a new direction for future research (Williams, Evans, &Fleminger, 2003).

As a result of the few studies conducted and a comparative analysis regarding the effectiveness of CBT, it is not difficult to describe the effectiveness of the cognitive behavioral therapy for patients with health anxiety / hypochondria, and how, in combination with other forms of psychological therapy or medication, it gives optimum results.

The results suggest that cognitive variables may actually significantly mitigate the effects of the processes that cause extreme anxiety about health. It should be noted that the cognitive model of hypochondria has several problems: it is difficult to verify the theoretical assumptions of this approach; morbidity differences and phenomenology of anxiety about health and hypochondria among subgroups of men are not explained; and CBT success needs to be proven in many controlled studies (Reinecke& Clark, 2005).

Now the effectiveness of CBT in treating hypochondria has been proven, its development can take place in two related areas. The first is to identify effective elements of CBT, especially in terms of the effectiveness of behavioral therapy, stress management, which results in shorter and more effective development interventions. The second is development of CBT in the understanding and treatment of anxiety as a response to medical research, screening and the development of genetic studies of common diseases (Salkovskis& Bass, 2006).

Ratios derived from the cognitive-behavioral approach in the future must allow the prediction of negative psychological reactions. Transfer of a cognitive-behavioral approach to research allows for specific and targeted counseling before testing in order to prevent negative reactions and acceptance of cognitive therapy for health anxiety and hypochondria in order to reduce psychological distress after studies (Salkovskis& Bass, 2006).

In summary, the cognitive approach to hypochondria is one of the most important achievements of modern clinical psychology, which has developed the effective cognitive-behavioral approach and offered it to the patient's medical alternatives. Cognitive theory has its advantages: it is consistent, refers to the cognitive psychology, dysfunctional behavior and experience, has a practical application, and allows the inclusion of the main information about hypochondria. The cognitive approach is based on how the individual understands their problem and the process of cognitive-behavioral therapy, and also takes into account their expectations.

Many studies should be conducted to clarify the psychological processes occurring in the fear of health, which will correctly classify and identify problems and syndromes associated with hypochondria. The efficacy of CBT in the treatment of patients with anxiety about the health and hypochondria has been demonstrated, but the question of whether the use of CBT treatment for this disorder therapy proves to be the most effective in the future, will depend on whether the results of research carried out under controlled conditions can be confirmed in clinical practice.

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ΕΝΑ ΜΟΝΤΕΛΟ ΠΡΟΒΛΕΨΗΣ ΤΗΣ ΕΞΑΡΤΗΣΗΣ ΑΠΟ ΤΟ ΔΙΑΔΙΚΤΥΟ: Ο ΡΟΛΟΣ ΤΩΝ ΣΥΝΑΙΣΘΗΜΑΤΩΝ ΚΑΙ ΤΩΝ ΔΙΑΠΡΟΣΩΠΙΚΩΝ ΣΧΕΣΕΩΝ
A PREDICTIVE MODEL OF INTERNET ADDICTION: THE ROLE OF EMOTIONS AND NEGATIVE RELATING TO OTHERS

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Περίληψη Σκοπός: Σκοπός της παρούσας εργασίας ήταν η διερεύνηση των αρνητικών διαπροσωπικών σχέσεων και των αντιλαμβανόμενων συναισθημάτων μοναξιάς, θλίψης και άγχους στην εξάρτηση από το διαδίκτυο.

Υλικό – Μέθοδος: Το δείγμα ήταν 774 μαθητές επαγγελματικών Λυκείων και φοιτητών του ΤΕΙ Κρήτης. Το Internet Addiction Test (IAT) και η σύντομη έκδοση του Person's Relating to Others Questionnaire (PROQ3) χρησιμοποιήθηκαν για την μέτρηση της προβληματικής χρήσης του διαδικτύου και των αρνητικών σχέσεων με τους άλλους ανθρώπους, αντίστοιχα.

Αποτελέσματα: Οι εξαρτημένοι από το διαδίκτυο είχαν στατιστικά σημαντικά πιο αρνητικές σχέσεις από αυτούς που έκαναν ήπια και μέτρια χρήση του διαδικτύου. Στο δομικό μοντέλο εξισώσεων (Structural Equation Modeling; SEM) όλοι οι δείκτες έδειξαν ικανοποιητική προσαρμογή. Οι αρνητικές διαπροσωπικές σχέσεις και η θλίψη προέβλεψαν την εξάρτηση από το διαδίκτυο.

Συμπεράσματα: Η πρόληψη και παρέμβασης της υπερβολικής χρήσης του διαδικτύου θα μπορούσε να επικεντρωθεί στη βελτίωση των διαπροσωπικών σχέσεων και στην αντιμετώπιση των συναισθημάτων θλίψης και μοναξιάς.

Λέξεις-κλειδιά: Υπερβολική χρήση διαδικτύου, διαπροσωπικές σχέσεις, θλίψη, μοναξιά, Δομικό Μοντέλο Εξισώσεων.

** Μέρος της παρούσας εργασίας έχει παρουσιαστεί στο 3ο Πανελλήνιο Συνέδριο της Ελληνικής Εταιρείας Μελέτης της Διαταραχής Εθισμού στο Διαδίκτυο: E-LIFE 2013 – Πρόληψη και αντιμετώπιση διαδικτυακών συμπεριφορών υψηλού κινδύνου.*

Summary Aim: The aim of the present study is the investigation of the potential role of negative relating to others, perceived loneliness, sadness, and anxiety in adult Internet addiction (IA).

Material - Method: A sample of 774 participants were recruited from high school technical schools and from a Technological Education Institute. The Internet Addiction Test (IAT) and the shortened Person's Relating to Others Questionnaire (PROQ3) were used to measure the degree of problematic Internet use behaviors and one's negative (i.e. maladaptive) relating to others, respectively.

Results: Internet addicts had significantly more negative relating than mild and moderate users. The Structural Equation Modeling (SEM) showed adequate fit across all indices. Negative relating to others and sadness were found to predict Internet addiction.

Conclusions: Internet addiction could be both prevented and ameliorated through the intervention in negative relating and sadness.

Key words: excessive internet use, interpersonal relationships, depression, loneliness, Structural Equation Modeling (SEM).

** Part of this study has been presented in the 3rd Panhellenic Conference of Hellenic Association for the Study of Internet Addiction Disorder: E-LIFE 2013.*

Εισαγωγή

Είναι ευρέως αποδεκτό ότι το διαδίκτυο αποτελεί ένα χρήσιμο εργαλείο ενημέρωσης και επικοινωνίας στην καθημερινή μας ζωή. Ωστόσο, η εξάρτηση από το διαδίκτυο αποτελεί ένα ραγδαία αναπτυσσόμενο πρόβλημα για τους νέους. Η Young, βασιζόμενη σε κριτήρια του DSM για τις άλλες διαταραχές εξάρτησης, όρισε την εξάρτηση από το διαδίκτυο (internet addiction) ως την υπερβολική, ψυχαναγκαστική-καταναγκαστική, μη ελεγχόμενη χρήση του διαδικτύου που προκαλεί ανοχή, σημαντικό στρες και ελλείμματα στην καθημερινή λειτουργικότητα (Young, 1998, 1999). Παρά την εκτεταμένη έρευνα, στο DSM-5 συμπεριελήφθη στις καταστάσεις για περαιτέρω μελέτη και όχι στις επίσημες διαγνωστικές κατηγορίες (Holden, 2010).

Οι έφηβοι και οι νεαροί ενήλικες (π.χ. φοιτητές) έχουν μεγαλύτερο κίνδυνο εξάρτησης από το διαδίκτυο (Tsai & Lin, 2003) σε σχέση με άλλες ηλικιακές ομάδες. Το ποσοστό εξάρτησης από το διαδίκτυο διαφέρει σημαντικά ανά χώρα. Στην Ευρώπη το ποσοστό για τους εφήβους κυμαίνεται από 1% έως 9% (Siomos, Dafouli, Braimiotis, Mouzas, & Angelopoulos, 2008), ενώ για την Ελλάδα το ποσοστό κυμαίνεται από 0% (Tripodaki et al., 2008) έως 11% (Floros, Fisoun, & Siomos, 2010). Το ποσοστό εξάρτησης είναι πολύ υψηλότερο στις Ασιατικές χώρες και κυμαίνεται από 2% έως 18% (π.χ. Yang & Tung, 2004). Οι φοιτητές εμφανίζουν εξάρτηση από το διαδίκτυο σε υψηλότερο ποσοστό από τους εφήβους. Διεθνώς, το ποσοστό κυμαίνεται από 6% έως 35% (Frangos, Frangos, & Sotiropoulos, 2011; Ni, Yan, Chen, & Liu, 2009). Ωστόσο, υπάρχει συμφωνία ως προς το ότι οι εξαρτημένοι από το διαδίκτυο είναι κυρίως άντρες (Stavropoulos, Alexandraki, Motti-Stefanidi, 2013; Siomos et al., 2008; Widyanto & Griffiths, 2006). Ένας από τους σκοπούς της παρούσας εργασίας είναι η μελέτη του ποσοστού εξάρτησης σε ένα μεγάλο Ελληνικό δείγμα μαθητών και φοιτητών.

Δεν είναι σαφές εάν τα ποσοστά επικράτησης του φαινομένου της εξάρτησης από το διαδίκτυο, τόσο στην Ελλάδα, όσο και διεθνώς, οφείλονται σε πολιτισμικές διαφορές ή στο είδος του εργαλείου αξιολόγησης που χρησιμοποιείται. Το Internet Addiction Test (IAT) είναι το πιο διαδεδομένο εργαλείο. Οι ψυχομετρικές του ιδιότητες έχουν επιβεβαιωθεί τόσο στην πρωτότυπη Αγγλική του έκδοση (Widyanto & McMurran, 2004), όσο και σε άλλες γλώσσες (π.χ. Κινέζικα, Γαλλικά, Ιταλικά, Πορτογαλικά, Φινλανδικά, Γερμανικά κ.άλ.). Η προσαρμογή του στην Ελληνική γλώσσα δεν έχει συστηματικά μελετηθεί. Για το λόγο αυτό ένας ακόμα σκοπός της παρούσας εργασίας είναι η μελέτη των ψυχομετρικών ιδιοτήτων του IAS σε ένα δείγμα Ελλήνων μαθητών και φοιτητών.

Οι παράγοντες πρόβλεψης (κυρίως διαπροσωπικοί) της εξάρτησης από το διαδίκτυο έχουν ευρέως διερευνηθεί. Το μοντέλο κοινωνικών δεξιοτήτων της προβληματικής χρήσης του διαδικτύου (social skill model of problematic internet use) υποστηρίζει ότι η προτίμηση διαδικτυακών (online) κοινωνικών αλληλεπιδράσεων, αντί των δια ζώσης (face to face), είναι συνέπεια της αυτοαντίληψης του ατόμου για κοινωνική ανεπάρκεια / αδεξιότητα (Caplan, 2003, 2005). Τα αποτελέσματα διεθνών ερευνών έχουν δείξει ότι οι έφηβοι που έχουν φτωχή ποιότητα διαπροσωπικών σχέσεων έχουν αυξημένο κίνδυνο ανάπτυξης προβληματικής χρήσης του διαδικτύου (Milani, Osualdella, & Di Blasio, 2009a,b). Θετική σχέση έχει επίσης βρεθεί μεταξύ της εξάρτησης από το διαδίκτυο και της κοινωνικής απόσυρσης/ απομόνωσης (Douglas et al., 2008) και χαμηλής κοινωνικής αυτο-επάρκειας/ αποτελεσματικότητας (Iskender & Akin, 2010). Χαρακτηριστικά, όπως η εσωστρέφεια (Xiuqin et al., 2010), η χαμηλή αυτο-εκτίμηση και η ντροπαλότητα σχετίζονται θετικά με την προβληματική χρήση του διαδικτύου και αυξάνουν τον κίνδυνο ανάπτυξης εθισμού από αυτό (Casale & Fioravanti, 2011. Iskender & Akin, 2010. Kim & Davis, 2009. Mottram & Fleming, 2009. Odaci & Çelik, 2013. Odaci & Kalkan, 2010. Saunders & Chester, 2008. Yang & Tung, 2007).

Όσον αφορά στην μοναξιά, υπάρχουν αντιφατικά αποτελέσματα. Άλλες έρευνες δείχνουν ότι αυξάνει τον κίνδυνο εξάρτησης από το διαδίκτυο (Bozoglan, Demirer, & Sahin, 2013. Xiuqin et al., 2010) και άλλες ότι τον μειώνει (Morahan-Martin & Schumacher, 2003. Whitty & McLaughlin, 2007). Συναισθήματα άγχους (Shepherd & Edelmann, 2005) και κατάθλιψης (Andreou & Svoli, 2013. Cho, Sung, Shin, Lim, & Shin, 2013) έχουν επίσης συσχετιστεί με αύξηση του ποσοστού εξάρτησης από το διαδίκτυο. Η σχέση της θλίψης / κατάθλιψης και της εξάρτησης από το διαδίκτυο έχει επιβεβαιωθεί στη διεθνή βιβλιογραφία (Dalbudak et al., 2013). Ωστόσο, Κάποιες μελέτες έχουν δείξει ότι η χρήση του διαδικτύου αυξάνει την πιθανότητα εμφάνισης κατάθλιψης στους εφήβους (Masoudnia, 2013; Park, Hong, Park, Ha, & Yoo, 2013), ενώ άλλες μελέτες έχουν δείξει ότι η κατάθλιψη μπορεί να αποτελέσει προδιαθεσιακό παράγοντα της εξάρτησης από το διαδίκτυο (Cho et al., 2013. Jafari & Fatehizadeh, 2012).

Βάσει των παραπάνω ευρημάτων, ένας ακόμα σκοπός της παρούσας μελέτης είναι να διερευνήσει το ρόλο των αρνητικών διαπροσωπικών σχέσεων και των αρνητικών συναισθημάτων (άγχος, μοναξιά και θλίψη) στο φαινόμενο του εθισμού από το διαδίκτυο. Από όσο γνωρίζουν οι ερευνητές, καμία μελέτη έως τώρα, ούτε στην Ελλάδα ούτε διεθνώς, δεν έχει μελετήσει ταυτόχρονα τις διαπροσωπικές σχέσεις και τα συναισθήματα σε ένα μοντέλο πρόβλεψης της εξάρτησης από το διαδίκτυο.

Μεθοδολογία

Δείγμα

Συνολικά ένα δείγμα 774 νέων συμμετείχε στην έρευνα. Το 62,9% ήταν φοιτητές του ΤΕΙ Κρήτης (27,5% άντρες και 72,5% γυναίκες, με μέση ηλικία τα 20,2 έτη, Τ.Α. = 2,8) και το 37,1% ήταν μαθητές επαγγελματικών Λυκείων (32,7% άντρες και 67,3% γυναίκες, με μέση ηλικία τα 19.9 έτη, Τ.Α. = 7.4). Περισσότεροι φοιτητές παρά μαθητές ανέφεραν συναισθήματα μοναξιάς (31,1% έναντι 23,8%, χ2(1)=4.79, p=.032) και οριακά υψηλότερες βαθμολογίες στην κλίμακα εξάρτησης από το διαδίκτυο (βλ. παρακάτω) (41,2 έναντι 39,3, t = 1.961, p = .050), ενώ το ποσοστό ήπιας, μέτριας και σοβαρής χρήσης δεν διέφερε σημαντικά. Καμία άλλη διαφορά δεν βρέθηκε μεταξύ των δύο ομάδων (π.χ. φύλο, ηλικία, άγχος).

Εργαλεία

Χορηγήθηκε ερωτηματολόγιο το οποίο περιελάμβανε ερωτήσεις για το φύλο, την ηλικία και τα αυτο-αντιλαμβανόμενα συναισθήματα μοναξιάς, θλίψης και άγχους των ερωτώμενων. Επίσης περιελάμβανε ερωτήσεις για γνωστούς προγνωστικούς παράγοντες (π.χ. ηλικία έναρξης χρήσης του Η/Υ, ύπαρξη Η/Υ στο σπίτι ή/και στο δωμάτιο κ.άλ.) και βασικά συμπτώματα της εξάρτησης (π.χ. πονοκέφαλοι, δυσκολία συγκέντρωσης κ.άλ.). Τέλος, χορηγήθηκαν τα ακόλουθα εργαλεία:

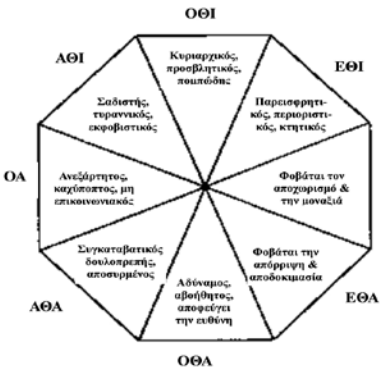
Internet Addiction Test (IAT; Young, 1998). Αποτελείται από 20 ερωτήσεις για την αξιολόγηση των παθολογικών συμπεριφορών χρήσης του διαδικτύου, οι οποίες απαντώνται σε μία 5/βάθμια κλίμακα (Καθόλου, Σπάνια, Περιστασιακά, Συχνά, Πάντα). Ενδεικτικές ερωτήσεις είναι: «Πόσο συχνά διαπιστώνετε ότι παραμένετε σε σύνδεση με τον Υπολογιστή, περισσότερο από ό,τι αρχικά σκοπεύατε;» και «Πόσο συχνά συλλαμβάνετε τον εαυτό σας να ανυπομονεί να ασχοληθεί και πάλι με τον Υπολογιστή;». Από το άθροισμα των βαθμολογιών προκύπτουν 3 επίπεδα εξάρτησης από το διαδίκτυο (Young, 1998): ήπια (20 – 49), μέτρια (50 – 79) και σοβαρή (80 – 100). Χρησιμοποιήθηκε η Ελληνική μετάφραση για την οποία έχουν αναφερθεί ικανοποιητικές ψυχομετρικές ιδιότητες (Siomos, Floros, Mouzas, & Angelopoulos, 2009).

Η σύντομη έκδοση του Person's Relating to Others Questionnaire (PROQ3. Birtchnell, Hammond, Horn, De Jong & Kalaitzaki, 2013). Αξιολογεί τις αρνητικές – δυσλειτουργικές διαπροσωπικές σχέσεις με τους άλλους ανθρώπους στα πλαίσια της θεωρίας του Διαπροσωπικού Οκταγώνου (Birtchnell, 1994, 1996). Αποτελείται από 48 ερωτήσεις, οι οποίες κατατάσσονται σε 8 κλίμακες και απαντώνται σε μία 4/βάθμια κλίμακα. Βάσει της θεωρίας, οι διαπροσωπικές σχέσεις των ανθρώπων αναπαρίστανται στους τέσσερις πόλους δύο κάθετα τεμνόμενων αξόνων («Ουδέτερη Εγγύτητα», «Ουδέτερη Απόσταση», «Ουδέτερη Θέση ισχύος» και «Ουδέτερη Θέση αδυναμίας») και στους τέσσερις ενδιάμεσους πόλους, οι οποίοι προέρχονται από τον συνδυασμό των τεσσάρων βασικών («Εγγύτητα από θέση ισχύος», «Εγγύτητα από θέση αδυναμίας», «Απόσταση από θέση ισχύος» και «Απόσταση από θέση αδυναμίας»). Ενδεικτικές ερωτήσεις για τις οκτώ κλίμακες του PROQ3 είναι:

- ΟΘΙ: «Προσπαθώ να κανονίζω τα πράγματα έτσι ώστε οι άλλοι να κάνουν αυτό που θέλω».
- ΕΘΙ: «Γαντζώνομαι δυνατά σε κάποιον που είναι κοντά μου».
- ΟΕ: «Έχω την τάση να προσκολλώμαι στους άλλους».
- ΕΘΑ: «Φοβάμαι την απόρριψη».
- ΟΘΑ: «Το προτιμώ όταν κάποιος άλλος έχει τον έλεγχο».
- ΑΘΑ: «Εύκολα υποχωρώ στους άλλους».
- ΟΑ: «Δεν αφήνω τους άλλους να με πλησιάζουν πολύ».
- ΑΘΙ: «Έχω την τάση να εκδικούμαι τους ανθρώπους που με προσβάλλουν».

Παραδείγματα αρνητικών σχέσεων για κάθε μία από τις 8 κλίμακες παρουσιάζονται στο Σχήμα 1.

Σχήμα 1. *Χαρακτηριστικά παραδείγματα αρνητικών σχέσεων από κάθε μία θέση του Οκταγώνου.*



Σημείωση: *ΟΘΙ: Ουδέτερη θέση ισχύος, ΕΘΙ: Εγγύτητα από θέση ισχύος, ΟΕ: Ουδέτερη εγγύτητα, ΕΘΑ: Εγγύτητα από θέση αδυναμίας, ΟΘΑ: Ουδέτερη θέση αδυναμίας, ΑΘΑ: Απόσταση από θέση αδυναμίας, ΟΑ: Ουδέτερη αδυναμία, ΑΘΙ: Απόσταση από θέση ισχύος.*

Αποτελέσματα

Συνολικά 25,6% των συμμετεχόντων έκαναν φυσιολογική χρήση του διαδικτύου, 51,0% ήπια χρήση (βαθμολογίες < 49 στο IAS), 22,4% μέτρια χρήση (βαθμολογίες 50 – 79 στο IAS) και 1,0% σοβαρή χρήση (εξάρτηση) (βαθμολογίες 80 – 100 στο IAS). Οι άντρες είχαν σημαντικά υψηλότερες μέσες τιμές εξάρτησης από το διαδίκτυο (όπως μετρήθηκε με το IAT) από τις γυναίκες (43,1 έναντι 39,4, t(760) = 3.611, p < .0001) και σημαντικά περισσότεροι άντρες (1,8%) από γυναίκες (0,6%) είχαν πρόβλημα εξάρτησης από το διαδίκτυο (χ2(3) = 14.960, p = .002).

Στον Πίνακα 1 παρουσιάζεται το προφίλ των συμμετεχόντων όσον αφορά μία σειρά μεταβλητών σχετικά με τη χρήση του Η/Υ και του διαδικτύου. Όσοι εμφανίζουν προβλήματα χρήσης (δηλαδή λαμβάνουν βαθμολογίες από 50 και πάνω στο IAS) είναι μικρότεροι σε ηλικία σε σχέση με όσους κάνουν φυσιολογική – ήπια χρήση (δηλαδή λαμβάνουν βαθμολογίες έως 49 στο IAS) (Μ.Ο. = 19,1 έτη έναντι Μ.Ο. = 20,3 έτη), έχουν Η/Υ στο σπίτι τους (99,5% έναντι 94,7%), αισθάνονται περισσότερο μοναξιά (37,2% έναντι 25,5%) και θλίψη (50,6% έναντι 32,0%), συγκεντρώνονται λιγότερο εύκολα (36,3% έναντι 56,4%), έχουν συχνότερα πονοκεφάλους ή ενοχλήσεις στα μάτια (48,1% έναντι 29,2%) και τους ευχαριστούν λιγότερο συχνά τα πράγματα που τους ευχαριστούσαν παλιά (43,7% έναντι 52,3%).

Οι διαφορές στις διαπροσωπικές σχέσεις σε σχέση με τα τρία επίπεδα εξάρτησης από το διαδίκτυο (ήπια: < 49, μέτρια: 50 – 79 και σοβαρή: 80 – 100) διερευνήθηκαν με την ανάλυση διακύμανσης (Analysis of variance – ANOVA). Επιλέχθηκαν τα τρία επίπεδα εξάρτησης (αντί των δύο) για μία λεπτομερέστερη διερεύνηση των διαφορών στις διαπροσωπικές σχέσεις. Τα αποτελέσματα έδειξαν ότι οι εξαρτημένοι από το διαδίκτυο είχαν στατιστικά σημαντικά υψηλότερες μέσες τιμές σε σχέση με αυτούς που κάνουν ήπια και μέτρια χρήση, σε όλες σχεδόν τις κλίμακες του PROQ3, με υψηλότερες τιμές (9,29) στην κλίμακα «Ουδέτερη απόσταση». Η κλίμακα αυτή περιλαμβάνει σχέσεις που χαρακτηρίζονται από συναισθηματική απομάκρυνση,

Πίνακας 1. *Το ψυχοκοινωνικό προφίλ των συμμετεχόντων που κάνουν φυσιολογική – ήπια χρήση του Η/Υ και του διαδικτύου σε σύγκριση με εκείνων που εμφανίζουν προβλήματα χρήσης. Τα ποσοστά αφορούν στις θετικές απαντήσεις.*

Χαρακτηριστικά	Σύνολο (n=774)	Φυσιολογική χρήση (n=593)	Προβλήματα χρήσης (n=181)	χ^2(p) / t(p)
Φύλο (%)				2,19 (,084)
Άντρας	29,7	28,3%	34,1%	
Γυναίκα	70,3	71,7%	65,9%	
Μέση ηλικία	20,11	20,34	19,11	2,99 (,003)
Έχεις Η/Υ στο σπίτι σου	95,5	94,7	99,5	7,98 (,001)
Έχεις Η/Υ στο δωμάτιο σου	69,6	68,4	73,8	1,88 (,099)
Κάνεις χρήση αλκοόλ	46,3	46,6	46,4	,00 (,516)
Κυκνίζες	22,3	22,2	21,9	,01 (,501)
Γυμνάζεσαι τακτικά	50,7	51,3	50,3	,05 (,441)
Πιστεύεις ότι έχεις φίλους που σε καταλαβαίνουν και νοιάζονται για σένα	90,2	90,5	89,1	,31 (,334)
Αισθάνεσαι μοναξιά	28,4	25,5	37,2	9,39 (,002)
Αισθάνεσαι ότι έχεις περισσότερο άγχος από τους συνομηλίκους	44,2	43,5	46,7	,60 (,25)
Κοιμάσαι λιγότερες ώρες τον τελευταίο καιρό	48,4	46,7	53,8	2,83 (,055)
Αισθάνεσαι συχνά θλιμμένος/η	36,6	32,0	50,6	20,61 (,000)
Προσέχεις τη διατροφή σου	57,3	58,7	53,0	1,86 (,101)
Η επίδοσή σου στο σχολείο είναι όπως παλιά	54,1	55,9	48,6	2,97 (,051)
Συγκεντρώνεσαι εύκολα	51,6	56,4	36,3	22,76 (,000)
Σε ευχαριστούν το ίδιο τα πράγματα που σε ευχαριστούσαν παλιά	50,4	52,3	43,7	4,17 (,025)
Έχεις συχνά πονοκεφάλους ή ενοχλήσεις στα μάτια	33,7	29,2	48,1	22,39 (,000)

αποστασιοποίηση, απομόνωση, κοινωνική απόσυρση και από δυσκολίες επικοινωνίας με τους άλλους ανθρώπους (Πίνακας 2).

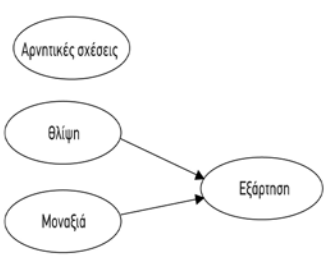
Πίνακας 2. *Διαφορές στις διαπροσωπικές σχέσεις ανά επίπεδο εξάρτησης από το διαδίκτυο.*

	ΟΘΙ	ΕΘΙ	ΟΕ	ΕΘΑ	ΟΘΑ	ΑΘΑ	ΟΑ	ΑΘΙ	Σύνολο
<49	6,1	4,5	6,2	6,2	5,0	5,2	6,2	6,7	46,1
50-79	7,9	5,8	7,3	7,6	5,3	6,1	7,0	7,4	54,6
80 >	8,1	5,7	6,7	8,0	6,9	5,3	9,3	7,1	57,1
F	24,28	15,02	8,69	12,60	2,18	7,73	8,32	3,79	28,14
p	.000	.000	.000	.000	.114	.000	.000	.023	.000

Σημείωση: *ΟΘΙ: Ουδέτερη θέση ισχύος, ΕΘΙ: Εγγύτητα από θέση ισχύος, ΟΕ: Ουδέτερη εγγύτητα, ΕΘΑ: Εγγύτητα από θέση αδυναμίας, ΟΘΑ: Ουδέτερη θέση αδυναμίας, ΑΘΑ: Απόσταση από θέση αδυναμίας, ΟΑ: Ουδέτερη αδυναμία, ΑΘΙ: Απόσταση από θέση ισχύος.*

Στη συνέχεια έγινε έλεγχος ενός δομικού μοντέλου εξισώσεων (Structural Equation Modeling; SEM) με την μέθοδο της Μέγιστης Πιθανοφάνειας (Maximum Likelihood), με τις διαπροσωπικές σχέσεις, το άγχος, την μοναξιά και τη θλίψη ως μεταβλητές πρόβλεψης της υπερβολικής χρήσης του διαδικτύου. Χρησιμοποιήθηκε το Stata 12 και οι εξής δείκτες προσαρμογής: χ2/d.f. (CMIN/DF) τιμή μικρότε¬ρη του 3 (Kline, 2005), SRMSR (Root mean square error of approximation) μεταξύ 0,06 - 0,08 ή λιγότερο, CFI (Comparative Fit Index) μεταξύ 0,90 – 0,95 ή παραπάνω, CD (Coefficient of determination) πάνω από 0,90 και RMSEA (Root Mean Square Error of Approximation) λιγότερο από 0,06 (Hu & Bentler, 1999). Μετά τη συσχέτιση των σφαλμάτων συνδιακύμανσης (error covariances) μεταξύ των ερωτήσεων 6 - 8 και 3 - 19 του IAS, όλοι οι δείκτες έδειξαν ικανοποιητική προσαρμογή (χ2/df = 2.62, CFI = 0.916, RMSEA = 0.050, SRMR = 0.040). Βρέθηκε ότι όλες οι μεταβλητές πρόβλεψης σχετίζονταν θετικά μεταξύ τους. Ωστόσο, μόνο οι αρνητικές διαπροσωπικές σχέσεις (όπως αξιολογήθηκε με το PROQ3) και η θλίψη προέβλεψαν την εξάρτηση από το διαδίκτυο (Σχήμα 2). Εκ των δύο μεταβλητών, σημαντικότερη ήταν η συμβολή των δυσλειτουργικών – αρνητικών διαπροσωπικών σχέσεων με τους άλλους ανθρώπους στο φαινόμενο της εξάρτησης από το διαδίκτυο.

Σχήμα 2. *Αιτιώδεις διαδρομές των μεταβλητών πρόβλεψης της εξάρτησης από το διαδίκτυο. Οι τιμές είναι οι τυποποιημένες τιμές Βήτα (standardized beta coefficients).*



Συζήτηση και συμπεράσματα

Από τον Πίνακα 1 είναι φανερό ότι το προφίλ των συμμετεχόντων στο δείγμα της παρούσας έρευνας είναι σχετικά ικανοποιητικό: μικρό ποσοστό κάνει χρήση αλκοόλ και καπνού, αισθάνεται μοναξιά, θλίψη και άγχος, ενώ η πλειοψηφία έχει φίλους, προσέχει τη διατροφή του, και η επίδοση στο σχολείο, η συγκέντρωση και η ευχαρίστηση που λαμβάνει από δραστηριότητες είναι ικανοποιητική. Τα ευρήματα αυτά είναι απολύτως κατανοητά αν λάβουμε υπόψη μας ότι στο δείγμα της παρούσας έρευνας βρέθηκε μικρό ποσοστό εξάρτησης από το διαδίκτυο (1%). Επομένως, οι προδιαθεσιακοί παράγοντες για την πλειοψηφία του δείγματος βρίσκονται σε χαμηλά σχετικά επίπεδα, ενώ οι παράγοντες προφύλαξης σχετικά σε υψηλά.

Ωστόσο, βρέθηκαν διαφορές σε κάποιους προδιαθεσιακούς / αιτιολογικούς παράγοντες ανάλογα με τη συχνότητα χρήσης. Όσοι ήδη εμφάνιζαν προβλήματα χρήσης ήταν νεότεροι σε ηλικία και είχαν Η/Υ στο σπίτι τους σχέση με αυτούς που έκαναν φυσιολογική - ήπια χρήση. Επίσης αισθάνονταν σε μεγαλύτερο ποσοστό μοναξιά και θλίψη. Τα ευρήματα αυτά συνάδουν με εκείνα της διεθνούς βιβλιογραφίας (Caplan, 2003; Pezoa-Jares, Espinoza-Luna, & Vasquez-Medina, 2012). Επίσης επιβεβαιώθηκαν μερικά από κλασσικά συμπτώματα της εξάρτησης, όπως η δυσκολία συγκέντρωσης, οι συχνοί πονοκέφαλοι και η έλλειψη ευχαρίστησης με δραστηριότητες που παλιότερα πρόσφεραν ευχαρίστηση.

Το σχετικά χαμηλό ποσοστό σοβαρής εξάρτησης από το διαδίκτυο (1%) που βρέθηκε στην παρούσα μελέτη έρχεται σε αντίθεση με άλλα Ελληνικά δεδομένα (Siomos et al., 2008), ενώ είναι συγκρίσιμο με το ποσοστό (1,5%) της μελέτης των Kormas, Critselis, Janikian, Kafetzis, & Tsitsika (2011). Η διαφορά ενδέχεται να οφείλεται σε διαφορές στο δείγμα και τα χαρακτηριστικά του, στις κλίμακες μέτρησης κ.άλ. Ωστόσο, το υψηλό ποσοστό μέτρια εξαρτημένων (22,4%) που βρέθηκε, δυνητικά μπορεί να εμφανίσει σοβαρή εξάρτηση από το διαδίκτυο στο μέλλον. Σε συμφωνία με τα δεδομένα άλλων ερευνών (Stavropoulos, Alexandraki, Motti-Stefanidi, 2013; Siomos et al., 2008), περισσότεροι άντρες παρά γυναίκες ήταν εξαρτημένοι. Αυτό μπορεί να οφείλεται στις προσδοκίες από τους άντρες να ασχολούνται με τους Η/Υ και το διαδίκτυο, όσο και με το αυξημένο ποσοστό των αντρών που ασχολούνται με ηλεκτρονικά και διαδικτυακά παιχνίδια και επισκέπτονται πορνογραφικές σελίδες (Young, 1998).

Ένα σημαντικό εύρημα της παρούσας έρευνας είναι ότι οι αρνητικές / δυσλειτουργικές διαπροσωπικές σχέσεις με τους άλλους ανθρώπους και η θλίψη αποτελούν σημαντικούς προγνωστικούς παράγοντες της υπερβολικής χρήσης του διαδικτύου. Δηλαδή, οι Έλληνες έφηβοι και νεαροί ενήλικες που έχουν αρνητικές διαπροσωπικές σχέσεις και αναφέρουν συναισθήματα θλίψης, έχουν μεγαλύτερη πιθανότητα εξάρτησης από το διαδίκτυο. Το εύρημα αυτό συνάδει με το μοντέλο κοινωνικών δεξιοτήτων της προβληματικής χρήσης του διαδικτύου (Caplan, 2003, 2005). Δηλαδή, τα άτομα που αισθάνονται αμηχανία στις δια ζώσης κοινωνικές συναλλαγές είναι πιθανό να καταφεύγουν στις διαδικτυακές. Επομένως, ενδέχεται το διαδίκτυο να αποτελεί έναν τρόπο κοινωνικής δικτύωσης για άτομα με περιορισμένες διαπροσωπικές δεξιότητες. Στην παρούσα μελέτη επίσης βρέθηκε ότι η θλίψη προδιαθέτει στην εξάρτηση από το διαδίκτυο. Το εύρημα αυτό συμφωνεί με τα αποτελέσματα διεθνών (Cho et al., 2013. Jafari & Fatehizadeh, 2012) και άλλων Ελληνικών μελετών (Andreou & Svoli, 2013).

Η μελέτη αυτή έχει αρκετούς περιορισμούς. Οι αιτιώδεις σχέσεις που περιγράφονται στην παρούσα «διατμηματική - συγχρονική» (cross - sectional) μελέτη δεν μπορούν να επιβεβαιωθούν χωρίς διαχρονικές - διαμήκεις μελέτες (longitudinal). Υπάρχει περίπτωση τα ποσοστά να έχουν υποτιμηθεί λόγω της τάσης των συμμετεχόντων για κοινωνικά αποδεκτές απαντήσεις (social desirability responding). Ενδεχομένως τα αποτελέσματα να ήταν διαφορετικά σε άλλα δείγματα (π.χ. σε μαθητές άλλων Λυκείων ή φοιτητές άλλων σχολών ή σε άλλες ηλικιακές ομάδες). Τέλος, περισσότερη έρευνα χρειάζεται για τη διερεύνηση και άλλων παραγόντων που ενδεχομένως επηρεάζουν την εξάρτηση από το διαδίκτυο.

Παρά τους περιορισμούς, τα ευρήματα της παρούσας έρευνας μπορούν να συμβάλλουν στην κατανόηση του φαινομένου της εξάρτησης από το διαδίκτυο και στο σχεδιασμό προγραμμάτων πρόληψης και παρέμβασης. Τα προγράμματα πρόληψης και παρέμβασης θα μπορούσαν, επιπροσθέτως των άλλων δράσεων, να επικεντρωθούν στη βελτίωση των ελλειμμάτων στις διαπροσωπικές σχέσεις και στην αντιμετώπιση των συναισθημάτων θλίψης που ενδεχομένως εμφανίζουν τα άτομα που είναι επιρρεπείς ή εξαρτημένοι από το διαδίκτυο.

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