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Using CBT for Depression: A Case Study of a Patient with Depressive Disorder Due to a Medical Condition (Infertility)

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Abstract

Introduction: Infertility increases the risk for psychopathology more often in women, who can develop symptoms in mood disorders and chronic stress. Depression is one frequent psychological consequence of this medical condition and if it's not being addressed accordingly, depressive symptoms can lead to delays in the onset of medical treatment, impairments in its outcomes and, likewise, poses a risk on the patient's mental health.

Purpose: The purpose of this case study was to disseminate a specific example of how infertility affects mental health, offering a multidisciplinary approach from both traditional CBT and health psychology. In addition to this, the case study presents important cultural aspects regarding psychotherapeutic process and access to health care.

Methodology: This is a descriptive and explanatory case study where multiple quantitative data sources have been used such as self-reported inventories: The Fertility Problem Inventory (FPI), Beck Depression Inventory (BDI) and The Coping Inventory for Stressful Situations (CISS), in addition to a semi-structured clinical interview.

Results: Results showed an improvement in mood, acquisition of a more adaptive thinking style, healthy coping mechanisms and self-help strategies to support the patient post-therapy. The contribution of cultural orientation and wellbeing-centered recommendations are being discussed.

Conclusion: The improvement of healthcare services relies on such presentations of case studies that can shift the focus in new directions of good clinical practices.

Keywords

mental health, depressive disorder, infertility, cognitive restructuring, clinical framing, CBT

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Introduction

Theoretical background

Infertility represents "the failure to establish a clinical pregnancy after 12 months of regular, unprotected sex or an impairment of a person's ability to reproduce either as an individual or with a partner." (Zegers-Hochschild, et al., 2017, p. 1795) and affects about 8-12% of couples of reproductive age globally. Infertility has been described as a disease of the reproductive system, which can lead to disability by impairing reproductive function. Thus, according to the International Classification of Functioning, Disability and Health, it is coded b660, with impaired procreation function (functions associated with fertility, pregnancy, birth and lactation) - b6600 functions related to fertility with impairments such as subfertility and sterility (World Health Organization, 2001). The terms infertility/subfertility are used interchangeably. Infertility is experienced as a crisis situation, being a major stressor in the life of the individual / couple and leading to psychological distress. Often, patients with infertility are at increased risk for psychopathology, most often developing symptoms in the area of anxiety, depression and chronic stress. Women tend to be much more psycho-emotionally affected by this medical condition than men (Maroufizadeh, Navid, Omani-Samani, & Amini, 2019). The main reasons for this are related to the stigma associated with women who cannot have children, especially in cultures that value this aspect as a primary purpose in life and the defining role of a woman. Thus, women with infertility are socially isolated, neglected, more prone to divorce and experience a drastic decrease in self-esteem and self-worth, which can lead to feelings of guilt and lack of meaning in life. Depression can occur as a consequence of infertility affecting the normal functioning of the person and the quality of the couple's relationship (Vioreanu, 2021).

Currently available epidemiological data indicate that depression affects between 39.5% - 42.9% of women with infertility in Nigeria (Awoyinka & Ohaeri, 2014), with even higher rates in Saudi Arabia (53.8%) (Al-Homaidan, 2011) and Ghana (62%) (Alhassan, Ziblim, & Muntaka, 2014). These areas tend to be more affected due to various factors related to cultural beliefs, cultural practices and customs, socio-economic level and access to quality medical services.

However, screening for depression in women diagnosed with infertility should be an implicit method of investigation, as it has been shown that depressive symptoms delay the onset of medical treatment, affect its outcomes and pose a risk to the patient's mental health (Oladeji & OlaOlorun, 2018).

There is a strong and growing body of research on effective psychotherapeutic

interventions in the treatment of depression. A recent and comprehensive meta-analysis (Cuijpers, et al., 2021) examined the effects of several types of psychotherapy on depression, starting with the well-known cognitive-behavioral therapy (CBT) and including individual psychotherapy (IPT), behavioral activation therapy (BAT), problem solving therapy (PST), third wave therapies (3WT), life review therapy (LRT). The results indicate similar effects between these types of therapies, all of which have a considerable efficacy rate. This facilitates patient-centered health care, favoring the patient's preferences for a particular type of psychotherapy. When the patient's preferences and opinions are valued, it is likely that the chosen intervention will fit better with him, and therefore the objectives will be achieved more accurately. This should be controlled through access to up-to-date evidence-based information about treatment options, expected effects, possible risks, and realistic management of expectations regarding the therapeutic process. Moreover, the authors of this study highlight an essential aspect, namely that of maintaining the positive effects of certain psychotherapies, at one year of follow-up. These include CBT, BAT, PST and IPT. Other studies reinforce the efficiency of CBT in lowering anxiety and depression symptomatology in infertile patients. This may happen due to the various range of strategies and techniques that CBT provide for the patients in order for them to restructure irrational thought patterns and acquire healthier and more adaptable beliefs regarding certain adverse life events (e.g. infertility). It has been suggested that prolonged application of CBT in infertile patients results in significant reducing of infertility related stress, which can lead to successful pregnancy in some cases (Golshani et al., 2020; Wang et al., 2022).

CBT interventions are complex and target a wide range of symptoms exploring them cognitively, emotionally and behaviorally. Some of these interventions include behavioral activation, psychoeducation, homework, cognitive restructuring, problem solving and others. Traditional CBT is delivered face-to-face either in an individual or group format, but this type of psychotherapy expanded well in virtual formats too. For example, there are platforms or applications where individuals can learn self-help techniques and they can benefit from psychoeducational programs in terms of basic cognitive-behavioral therapy (López-López, et al., 2019). Moreover, CBT is a practical type of therapy helping the client to acquire life-long skills in order to use self-help in future situations and rely on own internal resources. Generally, CBT is a short-term therapy ranging from about five to twenty sessions.

Case Introduction

Patient E.C., aged 35, lives in Bucharest, Romania where she was born and raised. She graduated from the Faculty of Cybernetics, Statistics and Economic Informatics, working for 8 years as a Web Developer and E-Business specialist at a renowned company. She has been married for 6 years and currently has no children.

Recently, she presented to the therapist with an increase in depressive mood and a decrease in her existential drive. Four years ago, she was diagnosed with unspecified infertility (N97.9; ICD-10-AM) and underwent a series of unsuccessful medical treatments. Last year, she was diagnosed with a depressive disorder due to another medical condition (unspecified infertility) with a major depressive episode (F06.32; ICD-10-CM) and followed a treatment plan consisting of antidepressants and individual psychotherapy. She is currently experiencing a relapse as a result of voluntary discontinuation of both medication and therapy. The patient has no hereditary history of psychiatric disorders.

With respect to patient's psychosocial environment, E.C. lives with her husband for six years and she describes her relationship satisfaction as being very good until the time they started to attempt conceiving. After failed attempts and treatments, the couple's satisfaction dropped significantly (self-reported). She is employed, but recently started to miss work feeling impaired by depressive symptomatology.

Clinical picture

The patient comes with accusations of insomnia, says that she can't sleep and because of that she is absent from work, she has no appetite, she reports feelings of inner emptiness, she doesn't enjoy anything around her anymore, she feels helpless and over-blaming herself for her inability to have a baby. She believes that her husband will leave her at any moment, stating "It would be better for him to leave anyway because I can't offer him anything". She no longer keeps in touch with her friends: "I can't stand the thought that they can have a baby whenever they want, and I can't". She spends a lot of time in the house, locked in her room, trying to avoid contact with her husband by saying that she is ashamed to even look him in the eye. She states that she feels like „nothing in her life is worthy" and that she „will never be able to get over this failure". She has feelings of worthlessness for both her family and society, she has retreated inwardly, she is no longer interested in anything that is happening around her, not even the workplace where she used to make an effort and show commitment: „Even my work colleagues look at me differently, I think they feel sorry for me... that I struggle so much with the treatments and it still doesn't work... I don't even want to go to the office anymore, I can't concentrate on anything anyway".

Regarding the family and the husband, the patient claims that they never reproached her anything, that they supported her throughout the treatment and that the husband is the one who insisted that she go to therapy again. The patient states that no matter how difficult it is for her to leave the house, she does not want to lose her job and "to disappoint my husband even more". All these impairments last for more than two weeks and are experienced daily in relation to almost all activities. The patient has insight into the disorder and is willing to try treatment again.

In summary, the patient's clinical picture is as follows:

- Depressed mood
- Anhedonia
- Fatigue
- Decreased existential drive
- Insomnia
- Loss of appetite
- Decreased ability to concentrate
- Feelings of worthlessness, inadequate excessive guilt
- Social isolation.

All these symptoms cause a clinically significant deterioration in the areas of daily functioning (social, professional, family).

History

Patient E.C. was born and raised in Bucharest, being the only child of a family of doctors. She reports that the relationship with her parents was a good one, however quite cold and distant. Her parents longed for her to follow the path of medicine, and when E.C. decided that she wanted to choose another path, both her mother and her father tried to make her change her mind by removing any kind of support and making contradictory arguments. E.C. says she always felt pressured to be the best in her chosen field, to prove to her parents that she had made the right choice and to make them proud of her. She is currently in contact with both parents, but conversations and meetings are rare and austere.

Regarding the relationship with her husband, the patient states that this is the only authentic relationship in her life and that he has always supported her in all circumstances. E.C. has no close friends, the only social contacts being at work. She is not used to going on holiday too often because she is busy most of the time. She has been maintaining a leadership position for approximately 4 years, in which she invests many personal resources of time and energy. She considers the job to be her greatest achievement, wanting to add to the list the birth of a child. She considers herself a determined, active, ambitious person, with a desire to lead, emotionally inhibited, chooses to keep her feelings for her. She has no history of somatic or psychological disorders pre-infertility.

The patient's lifestyle was mostly characterized by the inconsistency of a stable schedule, with extra work hours, infrequent breaks, working under time pressure, maintaining a long vicious position on the chair, working at the computer, poor diet characterized by food rich in saturated fats and sugars, eating on the run, without setting a time for meals or sleep. Also, poor sleep hygiene followed by excessive caffeine consumption contributed to the maladaptive lifestyle, a marked maintaining factor for the patient's clinical picture.

The patient's internal resources and strengths consist of intelligence, ambition to succeed, conscientiousness, resilience to challenges and determination. She also declares herself a faithful and family-oriented person, being characterized by stability in life, both personally and professionally.

Purpose

The purpose of this case study was to disseminate a specific example of how infertility affects mental health, offering a multidisciplinary approach from both traditional CBT and health psychology. In addition to this, the case study presents important cultural aspects regarding psychotherapeutic process and access to health care. This case study serves as an academic shaped tool designated to illustrate, as clear as possible, a way of putting theoretical benchmarks into practice.

Methodology

Assessment

For the assessment part, EC completed three questionnaires: The Fertility Problem Inventory (FPI) (Newton et al., 1999) where she scored 160 which indicates moderate infertility-related stress, Beck Depression Inventory (BDI) (Beck et al., 1961) EC scored 31 which indicates severe depression and on The Coping Inventory for Stressful Situations (CISS) (Endler & Parker, 1990a) she obtained 38 on the emotional coping subscale indicating the coping style she uses frequently. The instruments have been translated in Romanian language by a team of specialists using reverse translation.

Case Conceptualization

The approach to this case will be based on cognitive-behavioral therapy, as its success rate in the treatment of depression has been proven (Thimm et al., 2014; Twomey et al., 2017; López-López et al., 2019). Therefore, the models of conceptualization of the case will be detached from the cognitive-behavioral area. According to Beck and Dozois (2008), in general, the depressed person has a negative image of himself, the world and the future (also called the

cognitive triad of depression). The content is negative because it is fueled by distortions in thinking, respectively by distorted automatic thoughts that exacerbate depressive symptoms. Cognitive intervention is therefore an essential step towards improving clinical manifestations.

One of the most used models in conceptualizing depression is the stress-vulnerability model, which is an etiopathogenetic model in the general conceptualization of a case in cognitive-behavioral therapy. Research indicates its effective use in explaining depression (Colodro-Conde, et al., 2018). According to the stress-vulnerability model, life events that come with a certain level of stress (in the case of the E.C. patient the diagnosis of infertility) interacts with the levels of biological or psychological vulnerability of the person (i.e. inability to achieve an important life goal such as having children) and can lead to the onset of psychopathology (depression). The clinical picture is subsequently described multidimensional in terms of emotional state, biological manifestations, dysfunctional behaviors and cognitions (automatic thoughts) (David, 2017).

In order for the intervention plan to be built as efficiently as possible and for the benefit of the client, it is important that after the clinical evaluation, a list of issues be drawn up to be addressed, each problem separately. For the case-specific clinical conceptualization in cognitive-behavioral therapy, the most used model indicated by the literature is the ABC cognitive model (Beck, 1976; Ellis, 1962). The basic assumption of this model is that it is not the life event itself that affects us, but the way we interpret it. The ABC model consists of the following elements:

- The activating event (A) - which can be an external situation (events in everyday life) or an internal situation (emotions, thoughts, behaviors);
- Beliefs (B) - the person's beliefs / cognitions in relation to the activating life event;
- Consequences (C) - the consequences of cognitive processing of the activating event that may manifest at the bio-physiological, emotional and / or behavioral level.

After the start of the therapeutic intervention, to these elements are added two more, learned and practiced in therapy, namely disputing (D), which involves the restructuring of dysfunctional cognitions, and the effective assimilation (E) of adaptive cognitions instead of maladaptive ones (David, 2017).

Therefore, in this case, the activating event is represented by the diagnosis of infertility (A), and the consequences consist in altering the emotional state (C) (depressive symptoms), with response to the physical one (fatigue, social isolation). Beliefs (B) are found in the way in which patient E.C. interpreted the situation, that is through dysfunctional thoughts:

- Global evaluation: "It would be better to leave anyway because I can't offer him anything" - the tendency to evaluate in global terms, starting only from a few isolated behaviors or situations;

- Intolerance of frustration: "I can't stand the thought that they can have a baby whenever they want and I can't" - E.C. considers it unacceptable that she cannot fulfill an important wish, which sets her apart from her friends; this triggered negative emotions and behaviors (C) such as loneliness and exclusion, absenteeism from work, avoidance of social contacts;

- Global assessment and catastrophizing "I feel that nothing in my life is worth it, I will never be able to get over this failure" - maximizing the importance of an event with an emphasis on its negative side; these distortions have led to hopelessness, lack of self-worth and diminished meaning in life;

- Arbitrary inference: "Even my work colleagues look at me differently, I think they feel sorry for me... that I struggle so much with the treatments and it still doesn't work... I don't even want to go to the office anymore, I can't concentrate on anything anyway"- leading to concentration hypoprosexia, slowness in expressing ideas and feelings of alienation generated by self-perceived differentiation between oneself and others;

- Overgeneralization and rigid thinking, in absolutist terms: "I struggled for so many years with IVF treatment and it didn't work, why would this (psychotherapy) work? It's a waste of time, only a child could save me." - E.C. tends to draw a generally valid conclusion based on a single event, which leads to a loss of confidence and positive expectations; E.C. categorizes the experience of having a child as an essential condition for her psychological well-being and meaning in life, failing to consider other possibilities and, therefore, adopting a rigid thinking style that prevents her from adapting to the situation.

With that being said, the way in which the patient perceived the triggering event and the thoughts that she attributed to it were the reason why the depressive symptoms were installed and maintained.

In order to keep a holistic presentation of this case, a clinical classification was also made. This classification may help clinicians analyze the case on multiple levels, hence outlining and improving the intervention plan centered on the patient's psychological needs.

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), depressive disorder due to another medical condition has five diagnostic criteria, as follows:

A. A prominent and persistent period of depressed mood or pleasure / interest significantly diminished for all or almost all activities;

B. There is evidence from history, physical examination or laboratory findings that the disorder is a direct pathophysiological consequence of another medical condition;

C. The disorder is not better explained by another mental disorder (e.g. adjustment disorder, in which the stressor is a serious medical condition);

D. The disturbance does not occur exclusively during a delirium;

E. The disorder causes clinically significant distress or impairment in social, professional, or other important areas of functioning (American Psychiatric Association, 2013).

Patient E.C. meets all the diagnostic criteria listed above.

The diagnostic code of the International Classification of Diseases, tenth edition with clinical modifications (ICD-10-CM) is F06.32 - mood disorder due to a known physiological condition, with major depressive episodes (World Health Organization, 2002).

The classification in the International Classification of Functioning, Disability and Health (ICF) refers to the areas of functionality affected by somatic pathology and psychopathology. Patient E.C. has the following moderate and severe impairments:

- b130 - energy and impulse functions: b1300 energy level (severe impairment); b1301 motivation (severe impairment); b1302 appetite (severe impairment);

- b134 - sleep functions: b1342 sleep maintenance (moderate impairment) and b1343 sleep quality (severe impairment);

- b140 - attention functions: b1400 sustaining attention (moderate impairment);

- b152 - emotional functions: b1521 emotion regulation (severe impairment); b1522 range of emotion (severe impairment);

- b160 - thinking functions: b1600 pace of thought (moderate impairment);

- b660 - procreation functions: b6600 fertility-related functions (severe impairment) (World Health Organization, 2001).

Results

Table 1. Inventories scores pre and post intervention.

INSTRUMENT	INITIAL ASSESSMENT	POST-TREATMENT ASSESSMENT
FPI	160	100
BDI	31	19
CISS	38 (emotional coping subscale)	34 (task-oriented coping subscale)

Sessions of treatment

The intervention for patient E.C. was multimodal, starting with individual psychotherapy based on cognitive-behavioral therapy initially with a standard 12-session plan, antidepressive medication (the patient resumed imipramine) and additional couple counseling offered by IVF clinic. This aspect could represent an important aid in the outcomes of treatment. The main objectives of this case study are:

- Drawing up the list of problems and addressing the main emotional issues;
- Normalizing diagnoses (both infertility and depression) and consolidating hope;
- Strengthening self-esteem and psychological flexibility by disputing distorted thoughts;
- Encouraging social reintegration and looking for alternatives;
- Developing and implementing a balanced lifestyle.

Sessions 1-4

The focus in these sessions was on psycho-education about psychological disorder (depression) and somatic condition (infertility) noting essential aspects such as risk factors, maintaining and protective factors, the maladaptive effect of negative and distorted cognitions on mood and, also, goal setting. The main objective for this module was to explore the cognitive and affective valences of the patient, together with the collection of essential data from the life history (personal, professional, medical). The assessment tools were administered and the list of problems was made. The patient was presented with the advantages and disadvantages of the therapeutic process, the possible obstacles she may encounter, the manner in which it is carried out, the expected results and what will happen at the end of psychotherapy. She also found out the benefits of and how therapeutic counseling can enhance the course of medical treatment for infertility. In addition, she learned how to set goals for herself and how homework can facilitate this process. By the end of third sessions, EC was able to: use self-monitoring tools such as Dysfunctional Thought Record (DTR) to assess her thoughts, add her own

tasks for homework and summarize the therapy session.

Sessions 5-8

In this module, the objectives were set around the disputation of negative thought patterns and finding alternatives for them, with the aim of increasing the frequency of positive thoughts. The main techniques used were cognitive restructuring - empirically/pragmatically/ logically disputing central distorted cognitions and automatic thoughts, positive reinforcement techniques and behavioral activation for re-engaging the patient in daily activities, relaxation techniques to reduce insomnia, problem-solving techniques and assertive training to improve social skills, to strengthen self-esteem and to develop healthy coping. During the week, one of the homework EC had to do was to monitor her mood and thoughts daily and discuss this at the beginning of each session, keeping a daily record of the positive and negative thoughts she was experiencing, identifying and addressing persistent dysfunctional cognitions. In addition to this, she also started journaling.

The stress inoculation training procedure (SIT) has been used to manage the acute level of stress related to infertility. This technique is useful in cases where the activating event is imminent and cannot be changed for various reasons (such as in crisis situations). The training is based on a series of techniques aimed at forming adaptive and effective coping strategies, and the techniques used here are problem solving and assertive training, cognitive restructuring, behavior modification techniques (e.g. successive approximations) and relaxation techniques and meditation (e.g. mindfulness) (David, 2017). Taking into account that one of the patient's strong beliefs is religion, spiritual techniques such as prayers have also been inserted.

Also of great importance to patient E.C. is to strengthen her resilience. She is about to face other stressful life events with the resumption of infertility treatment. The treatment itself is a source of stress through its procedures, the uncertainty of a favorable outcome, the possibility of failure, the long waiting time and the associated financial costs

(Maroufizadeh, et al., 2018). Therefore, the patient must be prepared to face the challenges that will follow and also to be able to look for and consider alternative strategies (other possibilities such as adoption, acceptance of a life without a child, etc.). Some of the techniques that have been considered here are finding and highlighting strengths, internal resources, transforming them into general action strategies, metaphorical techniques and role play for practicing the application of strengths, decision-making techniques and process focus, to the detriment of the result. By the end of this module, EC managed to make the transition from identifying and evaluating automatic thoughts to fundamental beliefs, to acquire new restructured thoughts and beliefs and to actually believe them and to set a different routine in her daily life in order to achieve her therapy goals.

Sessions 9-12

The latter module focused on interpersonal relationships and the growth of time spent doing enjoyable activities, time management and goal setting to improve mood. The role-playing technique was used here, and as homework, in addition to the self-monitoring sheets, the patient had to complete tasks focused on daily journaling about activities that she enjoys, weekly planning of what to do and setting clear goals along with steps to achieve them. The patient was taught self-help techniques to apply whenever she needed, such as self-monitoring, self-assessment, and self-management of reinforcements (by preparing the environment to reinforce desirable behavior). Further, the therapist together with the patient worked on therapy closure, progress has been recorded and the patient received validation from the therapist for this. She also received counseling to prevent relapses. The most important aspect here is for the patient to be able to recognize for herself when she needs specialist help, if the symptoms are getting worse, and to act accordingly. After completing the individual psychotherapy, the patient, together with her husband, benefited

from a couple psychological counseling program for infertility problems at the clinic that offers medical treatment.

At the end of this module, EC received again the instruments that she completed in the beginning of therapy (FPI, BDI and CISS) and the after scores supported the progress observed during sessions: FPI - 100 indicating a decrease in infertility-stress level, BDI - 19 mild to moderate depression, CISS - 34 for task-oriented coping strategy, suggesting a switch from using emotional coping strategy. She also began to individually integrate mindfulness exercises into everyday life along with other relaxation techniques such as progressive relaxation and diaphragmatic breathing. EC reported that the skills learned in therapy mostly helped her shape new perspectives in thinking about her medical condition stating that: „Even if IVF treatment won't be successful, that doesn't mean it's the end; I have other possibilities so now I am willing to consider them." She also mentioned that the improvement she was most proud about was the reduction of negative self-talk and returning to work being able to focus on tasks

Discussion

Obstacles in the course of treatment

Even if EC recorded considerable progress during therapy sessions, some complicating factors were present, thus it's important to examine their origins in order to try and overcome them. The therapist decided to extend the psychological analysis on an integrated human-environmental-physiological model for the purpose of observing how a patient's individual characteristics may act as obstacles in the face of therapy objectives.

First, the most relevant literature models for analysis will be selected. By extracting essential information from the patient's personal and professional history, one can note the environments that influence her health. For example, in order to be able to determine which environmental aspects of work are relevant to the patient's health, which may be predisposing / maintaining

factors, it is necessary to refer to models of work psychology.

One such model, which summarizes the necessary information and captures the relationships between internal and external factors is the SWOT analysis (strengths / weaknesses / opportunities / threats). While external analysis focuses on environmental opportunities and threats, internal analysis helps to identify strengths and weaknesses. At the same time, it helps to understand which of one's own resources and capabilities are rather sources of competitive advantage and which are less likely to be sources of such advantages (Gurel & Tat, 2017). In this case, the following can be noted:

- Strengths: ambition, conscientiousness, taking responsibility, leadership skills;
- Weaknesses: hyperactivity, overwork, inhibition, repression of vulnerabilities, negative emotionality;
- Opportunities: leadership positions;
- Threats: stressful working conditions, leadership responsibilities - making decisions for teams of people (marked stressor), health problems (infertility).

Furthermore, it is important to analyze the patient's personality profile, noting the key features that could contribute to maintaining the psychological symptoms. Personality traits contribute to changes in psychological well-being when they interact with stressors. Thus, according to Freiburg's conceptualization model, personality can be divided into 12 dimensions, which when analyzed in context, can provide a better understanding of the person's preferential, attitudinal, and behavioral characteristics (Fahrenberg, Hampel, & Selg, 2010).). Most relevant to patient E.C are:

- Life satisfaction - people with low scores for this trait have a negative view of life events, have low self-efficacy, tend to ruminate, and in unfavorable conditions easily switch to depressive mood;
- Achievement orientation - people with high scores in this trait are characterized by activism, dominance, competitive behavior and tend to devote more time to the profession than to leisure activities (interests, passions);

- Inhibitedness - this dimension refers to hesitant, withdrawn behavior with low desire for verbalization. People with high scores feel socially inhibited, make friends hard, avoid expressing feelings, and tend to stay away from social gatherings;

- Strain - on this dimension we find stress, tension, exhaustion, feelings of overwork, responsibility and time pressure;

- Emotionality - people with high scores on this factor often face internal conflicts, are irritable and feel asthenic or indifferent. They have frequent mood swings, but are most often characterized by depression or anxiety. There is a risk of psychosomatic exacerbations (Biehl et al., 2020).

Therefore, these traits may explain the increased predisposition to both psychological and somatic vulnerabilities (i.e. unspecified infertility). A system is dysregulated if it has certain vulnerabilities that have accumulated, so personality traits are here predisposing and precipitating factors to psychopathology. Moreover, these traits can affect the course of therapy (e.g. EC faced some issues with keeping her journaling routine and doing her homework, that can be partially explained by her strain and emotionality traits).

In addition to this, an important influence in the patient's psychopathology is found in the meaning that she attributes to the significant life event she is going through. Most often, when a person is faced with an unforeseen and imminent situation (with a negative valence), she/he tends to wonder why this happened to him/her. If the person's specific attribution pattern consists of stable beliefs over time, then the person will tend to extend their long-term helplessness. It should be noted that these patterns of helplessness have been formed over time through learned beliefs about helplessness (e.g. "whatever I do will not change anything"). If the pattern of attribution is rather global, the person will tend to extend their helplessness to more than one life situation or context. If the attributions are internal, then the person will feel excessively guilty and his/her self-esteem will be considerably affected (Peterson, Maier, & Seligman, 1993).

This is called the learned helplessness model and was reformulated by Abramson,

Seligman, and Teasdale (1978) as a cognitive model of depression. In other words, patient E.C. presents an attributive style focused on global assessments (“I feel like nothing in my life is worth it, I will never be able to get over this failure”) and excessive self-blame, which goes beyond the situation (“I can’t stand the thought that they can have a child whenever they want and I can’t”) generating feelings of worthlessness and helplessness. In other words, depression results from the patient's tendency to attribute his or her own failure to stable internal qualities (e.g. self-efficacy, personal skills) and not to internal or external situational factors (e.g. biological limitations, lack of treatment compliance). The therapist reported here a difficulty in assessing the patient’s mood flow across sessions as she didn’t show consistency in completing self-monitoring worksheets. The main reason for this inconsistency was that EC did not seem to understand the way these exercises can help her, arguing that her mood is always the same and nothing can help her change it. The therapist worked together with the patient on these self-monitoring worksheets during some therapy sessions, helping her complete them and then challenging the thoughts that she experienced during and after completion. Using past experience as proof that some strategies can actually improve her mood (for example, when she is sharing her thoughts and concerns with her husband who is showing her understanding and support), EC was able to recognize her tendency towards feelings of helplessness and minimization of positive aspects. As a result, she was willing to try again with self-monitoring, this time putting in a good effort.

Access and Barriers to Care

Combining the medical treatment for infertility with psychotherapy can lead to an emphasis on the financial strain. Besides the fact that medical treatment is expensive and long lasting, the access to it depends heavily on the socio-economic status of the person and also of the country she lives in. A barrier for EC consisted of low access to infertility-related clinics, as she lives in Romania, a non-western, still developing country, that doesn’t offer so many opportunities in the healthcare

industry. She found a suitable clinic in another city, now having to bear the transportation costs as well. This aspect can contribute to a time conflict between medical treatment and psychotherapy. As a result, some therapy sessions were held online, the therapist offering this possibility in order for EC to complete her medical appointments which overlapped with therapy.

Another possible barrier to care can be the absence of psychological counseling services in IVF clinics. It has been shown that psychological support for both individual and couple levels offered simultaneously with medical treatment in IVF clinics improves treatment success rates and overall mental health of the patient by reducing depressive symptoms, anxiety and stress levels (Vioreanu, 2021). Some patients do not afford to pay for extra therapeutic services, thus they may struggle with finding help. Fortunately enough, EC managed to maintain both types of treatment, plus a couple counseling module offered by the clinic.

End of therapy sessions and follow-up

CBT intervention has led to a reduction in depressive symptoms as well as a change in dysfunctional attitudes and cognitions. She returned to work, began a reconciliation process, and resumed infertility treatment. Twelve individual psychotherapy sessions were required for partial remission of symptoms and antidepressant (tricyclic) medication, and in the months following treatment, the patient continued to report improvements in depressive symptoms as well as dysfunctional attitudes and self-image (consolidation of progress over time is also accentuated by the couple's psychological counseling). The patient understood how negative thoughts are a barrier that prevents her from enjoying pleasant things and social activities. She internalized her skills learned during therapy sessions (techniques for stopping negative thoughts to avoid rumination). At the same time, she and her husband were able to consider other options in case of failure of infertility treatment, making the decision to adopt a child. To keep a better track of the treatment outcomes, apart from the measures taken at the beginning and

the end of therapy, EC also completed a feedback sheet at the end of each session. She self-reported how she felt during the therapy session, if the therapeutic relationship was optimal, she reflected on what she learned and how well she thinks she can apply the techniques further, in everyday life. The therapeutic relationship followed a consistent pattern where the patient maintained her wellbeing.

To ensure the stability of the balance even further, after psychotherapy, the following was recommended:

- Building a healthy lifestyle, based on exposure to wellbeing factors that lead to the patient's well-being: significant people, spending time in nature, engaging in activities that will please the patient and help health in general (sports, travel, music, eliminating monotony), reducing exposure to stressors / psychotoxic factors (such as reducing overwork); the goal is to spend as much time as possible in well-being;
- Creating a regular sleep schedule (sleep disturbance can maintain mood swings): by controlling the stimulus, relaxation techniques;
- Maintaining the adaptive effort, in order to mobilize energy and the existential drive (through self-challenges, experimenting with new, positive things, ensuring a living environment with various conditions).

The follow-up session scheduled three months after completion of therapy confirmed the lasting effects of improvement over mood and thinking patterns. The patient followed most of the therapist's recommendations and she was able to reach an important decision regarding a possible negative result of the medical treatment (i.e. adopting a child). Her scores on BDI and FPI remained low and showed a slight but, important, increase on CISS task-oriented coping subscale score. The patient requested to continue visiting the therapist, remaining under psychological surveillance with a session once every three months.

Implications of the case

This case study shows that infertility has extensive effects on the bio-psycho-social level, depression being the most common

psychological consequence, especially among women. An effective intervention plan will address all aspects of the patient's life, analyzing key variables from the bio-physiological, environmental and psychosocial level. In this case, too, the environment in which the person lives, the factors of psychological well-being, lifestyle and social support were evaluated. The perspective of approaching this case adds value by combining classical CBT with elements of health psychology and counseling.

The psychotherapeutic intervention itself was the main element in the management of the clinical picture, but the patient benefited from more than that, learning self-help strategies and techniques that would strengthen her long-term progress. Relying on her inner resources such as conscientiousness and determination (which helped her with homework and the integration of skills learned in therapy), faith and family spirit (through which she solidified her resilience by managing the challenges that followed) the patient managed to break the vicious circle of negative cognitions and bring back positive cognitions accompanied by adaptive behaviors. To all this is added the importance of support from her husband and friends.

The effect of social support on psychological well-being and, implicitly, on the reduction of depressive symptoms is well documented. A model in the literature that explains these associations is the model of social causality (Kaniasty & Norris, 2008) according to which social support is even a precedent for psychological well-being, its lack leading to distress. Based on the relationship between social support and stress, the model argues that the presence of an active support network significantly reduces the risk of depression because it helps boost self-esteem and decreases engagement in dysfunctional cognitions (Zhen et al., 2018; Ren et al., 2018). Therefore, the fact that the patient benefited from social support from her family was an important aid in managing depressive symptoms.

The outcomes of this case study are in line with past research. For example, a recent meta-analysis suggested that CBT techniques led to a significant reduction of depression

rates in infertile women and to a successful replacement of dysfunctional behaviors with more adaptive ones (Abdollahpour et al., 2021). Case studies across literature which focused on delivering CBT to infertile patients, even if scarce, suggested that modification of cognitive distortions and faulty core beliefs due to CBT techniques indicated considerable improvements in interpersonal life of the patient (Choudhary et al., 2019). Considering the fact that current guidelines recommend treating severe depression with pharmacotherapy and that research shows that the most efficient way of treating severe depression is through a mix of CBT and ADM (antidepressive medication), this can also explain the favorable outcome in EC case (Vasile, 2020; Nakagawa et al., 2017).

Another important clinical implication that derives from this case is the utility of screening for depression in IVF clinics. Infertility patients should be screened for depression, stress and anxiety before starting any medical treatment in order to assure positive outcomes. That is because psychological wellbeing plays an essential part in treatment compliance and, so, CBT is recommended to those patients who show an altering psychological state.

As a custom note, this case has important implications for Romanian culture and intercultural research. Firstly, because there is a significant paucity of studies contextualized on Romanian society, where psychology was negatively impacted by its outlawing during the communist regime. Consequently, research in this field is quite limited, also due to the lack of validated psychological tools. One way to move things forward is the translation and validation of questionnaires and tests on the Romanian population, aspect that has been remedied in recent years (Ispas et al., 2014).

Secondly, this case study adds on the perspective of how different populations may respond in the face of a similar challenge, if compared with other case studies of infertile patients from different cultural backgrounds. For example, EC's reaction in the face of infertility diagnosis (i.e. negative, distorted thoughts such as catastrophizing, all-or-

nothing thinking) might be partially explained by her cultural-framed tendencies of valuing cohesion, obligation and familism. These values are characteristic to a collectivist culture (Burholt et al., 2017), thus supporting her emphasis on the importance of having children and social comparison (e.g. „I can't stand the thought that they [friends and workmates] can have a child whenever they want and I can't"). If EC would have been raised in a different culture, an individualistic one, values and cultural norms could have shaped a different thinking pattern, therefore, she could have had a different outcome

Limitations and Strengths of the Study

Limitations of the Study

Some limitations can be acknowledge here. For instance, any case study is subject to researchers' own subjective feeling which has been created throughout therapy sessions and therapeutic relationship and it may influence the way the case study is presented. Another example is that case studies as such are difficult to replicate due to specific, individual and cultural characteristics. A third limitation may be connected to the difficulty in generalization of results to the wider population, considering the personal note of the case and cultural shaped influences. This means that the conclusions drawn from this case study may not be transferable to other settings

Future directions

This case study highlights the importance of psychotherapy for infertility patients and indicates that traditional CBT has a positive outcome on managing depression. Sure enough, we must not overlook the fact that this patient followed a mixed treatment plan, combining CBT with ADM and couple psychological counseling, contributing to overall improvement. Changes in thought patterns (e.g. controlling negative thoughts and quitting overgeneralization), behavior modification by adopting adaptive patterns (e.g. returning to work and keeping a healthy sleep schedule) are skills learned through

CBT strategies and techniques that set the patient on the right track to recovery.

For this case study, an analysis concerning the impact of CBT and the impact of medication was not performed. It would have been useful to see under what percentage did the therapy help alone, compared to medication. Future works can add this dimension into their assessment. Clinicians are encouraged to use the screening of infertility patients for depression, but also for anxiety and stress, as these are the most documented psychopathological consequences of infertility (Galst, 2017). To assure a good practice, the psychological interventions should be applied at the beginning, during and at the end of IVF treatment, as it has been shown that infertility treatment can worsen the psychological state of the patients (cost, duration and uncertainty of success rate) (Chu et al., 2017).

It would also be useful to look into mixed CBT techniques and if their impact on depressive mood can be more conclusive. Because this case study only focused on traditional CBT strategies, future research could mix ACT with CBT in order to control for any added value this might have.

Ultimately, clinicians and students could investigate infertility patients with different backgrounds such as other cultural origins. This case focused on a patient born and raised in a non-western, collectivistic country that is considerably distinct in cultural orientation compared to western countries. Some cultural aspects such as rules of society, the characteristic way of adapting, the meaning and significance of life, traditions and beliefs contribute to the way of evaluating and responding in a certain life situation (for example, coping with infertility).

To illustrate this, one study that focused on establishing personality typologies in a specific culture found that, in Romanian culture, there are five types that can be identified: the sub-controlled type (with insufficient impulse control), the overcontrolled type (with excessive impulse control), the resilient type, the passive type, and the tense type that is most prone to irrational cognitions and maladaptive thought patterns that could lead to psychopathology

(Sava et al., 2011). Therefore, emic personality traits predispose an individual to different outcomes in the face of an important life event, changing the prognosis of a disorder.

Conclusions

To ensure the stability of the balance even further, after psychotherapy, it is recommended to maintain an adaptive effort, in order to mobilize energy and the existential drive (through self-challenges, experimenting with new, positive things, ensuring a living environment with various conditions).

Concluding, the improvement of healthcare services relies on such presentations of case studies that can shift the focus in new directions of good clinical practices.

Conflict of interest

The author declares that she has no conflicts of interest.

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A Theoretical, Historical, and Socio-Economic Case for Saving Lives through Strategic Improvement of Mental Health Systems around the World

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Abstract

Introduction: Comparing mental health systems between different countries illuminates the potential for change by showing us different approaches exist in the global here and now. Globally, people are suffering and dying daily from untreated mental health conditions and those working in these systems have to live in this reality.

Purpose: The purpose of this paper is to examine how stigma, underfunding, deficits in best practices, confusing systems, and failed strategic planning are all variables causing systems' deficits that have people unnecessarily suffering and dying around the world.

Methodology: To make the case for change, we use critical analysis to examine mental health systems through an analytic framework that includes history, systems investment, and general treatment approaches. We review mental health care systems through theories of structural functionalism, conflict, social dynamics, and socio-economic asset development.

Results: The historical examination provides vital systems-development insight while the systems investment examination delves into the overall funding structures and strategies of each country. Theoretical analysis reveals how problems seem intractable, but also how progress is always possible.

Conclusion: This examination informs critically thinking advocates, through historical and theoretical lenses, to generate precise calls for win-win strategies that can be individualized per World Health Organization and other advancing treatment recommendations.

Keywords

mental health, mental health treatment, national mental health evaluation, mental health problems, mental health administration, mental health system history, mental health practice approaches, and international mental health recommendations

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Introduction

The World Health Organization's (WHO, 2020) best practice approach, adopted by most European countries, includes robust inpatient, intensive outpatient, and outpatient services that address all levels of need. Though it may seem obvious, it must be stated that these recommendations necessitate adequate resourcing that create a sustainable relationship with quality communications between patients (clients) and mental health practitioners. How societies and governments view this resourcing, as investment or as poorly utilized limited funding, largely dictates mental health outcomes. This paper argues for a substantiated positive investments attitude that leads to a win-win for those suffering from mental problems and the broader societies in which they live.

Mental illnesses, including psychological and emotional struggles, occur across a wide and complex spectrum, and for a treatment system to be effective it has to precisely reflect that complexity. Especially with advances in neuroscience (Shapiro, 2012; van der Kolk, 2014) we have increasingly effective treatments for every area of defined mental health condition. In the Mental Health Action Plan 2013-2020 (which has been extended to 2030), the World Health Organization (WHO, 2013) states,

"Health systems have not yet adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%. A further compounding problem is the poor quality of care for those receiving treatment."

An optimized mental health system requires particular characteristics for both practitioners and clients. First, in terms of capacity, practitioners need access to affordable and high-quality education and training followed by clear career options with user-friendly and adequately remunerating pay. The World Health Organization (2020) emphasizes prioritizing mental well-being, eradicating stigma, discrimination, and social exclusion, providing effective and comprehensive care with choice for those in need. The obvious impediment is funding, which includes both societal and governmental willingness and financial capacity. In any case, nothing changes until such funding is committed.

Purpose

This paper examines mental health systems in three countries, which vary across a spectrum of mental health systems and outcomes, in order to

provide historical, theoretical, and socio-economic analyses for problems and the critical need for change. Important contrasts can be drawn between the largely private and profit-oriented United States, more robust and universal systems of Western Europe (e.g., Germany), and countries with limited resources and still in early developmental phases, such as in Eastern Europe (e.g., Lithuania). Population and GDP per capita estimates provide context for the size and relative prosperity of people in each country (The Organization for Economic Cooperation and Development [2022]). The World Health Organization's (WHO, 2020) Mental Health Action Plan 2013-2020 (extended to 2030) recommends a guiding framework for best practices. The systems, historical and theoretical analyses work together to make a case for vital, complete, and sustainable change, especially emphasizing theories of functionalism, social-dynamics, and the socio-economic asset development perspective (Dolgoft & Feldstein, 2007).

Methodology

This critical analysis includes historical research, systems examination, and theory-based analysis. Critical analysis was selected because of how it guides a logical deconstruction that makes way for criticisms and recommendations for progress in mental health care (Browne & Keeley, 2012). For this study, 86 scholarly sources were examined and 54 were included in the article. There were 19 for Germany, 21 for Lithuania, and 27 for the United States. The remaining sources for this article provided comparisons and important context, such as World Health Organization (2020) accounts of best practice recommendations. Key search terms include each country's name with mental health, mental health treatment, national mental health evaluation, mental health problems, mental health administration, mental health system history, mental health practice approaches, and international mental health recommendations.

The authors also scanned the literature for comparisons of any of these countries' mental health systems to others. The order of examination for each country was current mental health conditions (e.g., suicide rates), type of system and administration (health care and mental health care), investment in context of overall economy, specifics of types and depth of mental health treatment, and outcomes evaluation. This critical analysis deconstructs systems, especially focusing on historical context and specific systems evolutions. Theory is used to evaluate the relevance of these historical and systems development findings and provides frameworks through which to guide important questions for continued advocacy and research.

Results

Multinational Comparison

Table 1: Comparison of Countries' Mental Health Systems (History, Systems Investment, General Treatment Approaches)

Country	Population (GDP per Capita)	Historical Development	Systems Investment	General Treatment Approaches
Germany	83.1 million (58,386 USD)	Public funded through the two major churches; cost-regulated private insurance market	4% GDP (cost saving measures)	- Medication - Inpatient psychiatric - Comprehensive psychotherapy
Lithuania	2.8 million (42,551 USD))	Public funded, government administered	.125% GDP	- Emphasize medication - Limited Psychotherapy
United States	331.9 million (69,558 USD)	Private for-profit with selective government non-profit (disabled, elderly, veterans)	3.5% GDP (no cost saving measures in private market)	- Emphasize medication - Inpatient psychiatric - Comprehensive psychotherapy
Note. - Population and GDP per Capita (The Organization for Economic Cooperation and Development [OECD] [2022]) - Citations for all other information are in the text of the article. - Systems Investment Column - Estimates do not reflect indirect costs of untreated mental health problems. - Estimates do not reflect cost saving measures which, for example, do exist for Germany but do not for the United States (i.e., Germany getting more for their investment).				

Germany

WHO (2011b) reports that Germany (population 83.1 million; GDP per Capita 58,386 USD [OECD, 2022]) has a quite robust mental health care delivery system, considering it a top public health priority, including authorizations at the level of primary care. Perhaps their largest impediment to mental health care is stigma, which reduces mental health help-seeking (Kessler, Agines, & Bowen, 2014).

History of Mental Health System- Germany

The timing of medical advancement and post-World War II reconstruction led to many western European countries reforming their health care systems. It took a couple of decades post-World War II for this change to occur; during the 1950s and 1960s there was widespread shame and neglect and thus care was "restricted to large, old-fashioned institutions in remote areas" (Salize, Rossler, & Becker, 2007). Germany experienced a deinstitutionalization of chronic and severely mentally ill people in the 1970s, leading to an increased need for community mental health. Later, the reorganization of East and West Germany "required dramatic changes in the structure and quality of the mental health system

of the former German Democratic Republic (GDR)" (Salize, Rossler, & Becker, 2007). A big and expensive effort, but federal law from the 1970s set very high standards for access to high quality and affordable services. Also, in the 1970s Germany's system of subsidiarity was born (Göçmen, 2013). Subsidiarity stipulates decisions about services should be made as close to those in need as possible, so the German government sends funding through the two major churches (Diakonisches Werk der Evangelischen Kirche in Deutschland [Diakonie] and Deutscher Caritas Verband [Caritas]) in Germany to provide all health and human services.

Systems Investment- Germany

Germany is among the nations with highest GDP dedicated to health care (11.43%) (WHO, 2021) and mental health (~4%) and has been growing consistently in recent years (Schwarz, et al., 2020). The German system has Statutory Health Insurance (SHI) known in German as Krankenkasse. The government requires that all German citizens (and actually many non-German citizens) have market access to any insurance provider they choose at what the government sets as a reasonable rate. More recently, Germany shifted to a Global Treatment Budget approach.

Schwarz, et al. (2020) state that this change, popular among practitioners and patients, shifts from a daily performance-based approach to a “lump-sum GTB”, shifting from in- to outpatient settings. Savings can then be reinvested along the full spectrum of care. While there are strong federal policies there still is a struggle to systematize mental health services across 16 German states. In particular, differences can be found between actual number of psychiatric beds (Salize, Rössler, & Becker, 2007).

General Treatment Approaches- Germany

Germany's treatment approaches span a wide spectrum of services deeply steeped in expert tradition and backed by a robust economy and heavy regulations that ensure there is accessibility and outreach. Germany designates three theory-based psychotherapeutic approaches: Behavioral, Depth, and (Psycho) Analytic (PubMed Health, 2016). Concepts frequently enunciated within the German mental health care system are social education, mental health consulting, assessment, and case management, in addition to those providing deep, intensive psychoanalytic approaches. Germany produced and hosted some of the world's most influential psychoanalysts, including Karen Horney, Erich Fromm, Erik Erikson, and Gustav Kafka. German was also the language of Sigmund Freud and thus the early field of psychoanalysis (Ermann, 2010). They also track utilization through what they call a Point of Contact system (National Library of Medicine, 2016). This requires health care professionals throughout the system to intentionally perform exploratory examination along with psychoeducation to ensure people understand the availability of mental health services.

Lithuania

Lithuania (population 2.8 million; GDP per Capita 42,551 USD [OECD, 2022]) has a triad of problems related to mental health care, including troubling behavioral trends (i.e., addiction, suicide), under-resourced mental health care delivery system (WHO, 2011c), and profound culture-based avoidance to mental health care. Perceptions of soviet era institutionalization magnifies stigma toward mental illness (Pūras, 2019). In spite of these challenges, there remains a growing push for increased funding and investment in WHO oriented best practices (Skvernelis & Veryga, 2017).

History of Mental Health System- Lithuania

Lithuania struggles with some of the highest rates of suicide and alcoholism, all while attempting to revise their health care systems, since 1991, after 100+ years of occupation (Pūras et al., 2004). Mental health clinics started in 1996 and grew to ~115 clinics by 2016 (Skvernelis & Veryga, 2017). In 2007 the Lithuanian parliament

voted to adopt the European mental health principles recommended by the World Health Organization (WHO) (Muntianas, 2007). They hoped to ensure human rights of patients and to integrate modern services to address mental health needs through a biopsychosocial method.

Systems Investment- Lithuania

Records on financing of the Lithuanian mental health system can be hard to find, but financing for the overall health care system increased from 45.7 to 57.5 million Euros (~\$56 to \$70 million USD) between 2012-2016 (Skvernelis & Veryga, 2017). The amount of mental health clinics and professionals have increased, but there are still deficits, particularly in child and adolescent psychiatry). There is a lack of diversified and prioritized financing in Lithuanian mental health care, which obscures and limits innovative services that could benefit the system in the long run (Šumskienė, 2017; Šumskienė & Petružytė, 2017). Ironically, the current financing approach most resembles the soviet model, denying innovation and advancement. Becoming a European Union (EU) member in 2004 did not bring essential systemic changes (Pūras et al., 2013). Certain institutions have stable financing and no competition. Experts further argue that inadequate financing hurts non-governmental organizations, which seek alternative approaches, a wider range of specialized interventions, innovative service models, and current mental health care system reform (Pūras et al., 2013).

General Treatment Approaches- Lithuania

Lithuania has both inpatient and outpatient psychiatric services that utilize a blend of counseling, psychopharmacology, and social supports (often referred to as case management or psychosocial support) (Dembinskas, 2003). Lithuanians may more commonly be able to access mental health care that reflects a psychosocial paradigm (Šumskienė & Petružytė, 2017). These services focus on sustaining independent living for those struggling with mental health issues (Šukys, 2012). While this is likely done with sensitivity and compassion for the mental health struggle the person is experiencing, the level of funding indicates that this psychosocial approach does not necessarily include deep and effective psychotherapeutic treatment (Šumskienė & Petružytė, 2017). There are discussions in the ministry of health to make psychotherapy a part of the system, but for now psychotherapy is primarily attainable only through private practices (LPS, 2021). There is a government supported emotional mental hotline and a complex services packet.

Addiction and suicide continue to plague Lithuania as rates are among the highest in the world. Funding and prevention programs have been inadequate thus far (Skruibis & Žemaitienė,

2015; Šumskienė & Petružytė, 2017). There have been proactive efforts on both of these issues. Strategic planning includes capacity building in areas of recruitment, education, training, professional development, and prevention programs, all of which would increase the quality and availability of mental health services.

United States of America

The mental health care system in the United States (population 83.1 million; GDP per Capita 58,386 USD [OECD, 2022]) is in a state of emergency, especially considering both mental health and addiction problems. The National Alliance on Mental Illness (NAMI) is “the nation’s [United States] largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness... started as a small group of families... blossomed into the nation’s leading voice on mental health. (NAMI, 2022)” NAMI gives the United States a grade of D, stating “Mental health care in America is in crisis. Even states that have worked hard to build life-saving, recovery-oriented systems of care stand to see their progress wiped out. (2009)” Advances in health care along with the AMA’s lock on a private entrepreneurial model for medicine making the U.S. health care system exorbitantly expensive, far beyond most American’s ability to sustain. As a strength in the United States, medical training and expertise are world class (Garson & Engelhard, 2008), but millions are shunned (50 million prior to the Patient Protection and Affordable Care Act of 2010 [PPACA] and 31.6 million now [National Center for Health Statistics, 2022]). The United States is also the only industrialized country that bankrupts citizens for catastrophic medical debt; two-thirds of people who file for bankruptcy in the United States cite medical issues as the primary cause (Konish, 2019).

History of Mental Health System- United States

The United States mental health system is a study in contradiction and ambivalence, mostly an extension of the profit-driven medical system with also an underfunded and inconsistent government-based system (i.e., Medicaid, Medicare, and Veterans Administration) primarily for the poor, disabled, elderly, and veterans. The profit driven private health care system, created by the American Medical Association (AMA) and amplified through an evolution of private health insurance and pharmaceutical industries, necessarily creates scarcity while passing along high and ever-escalating costs to clients and patients.

The AMA began in 1845 with a stated purpose, “Scientific advancement, standards for medical education, launching a program of medical ethics, improved public health” (AMA, 2021). But the

AMA evolved as a wealthy and powerful lobbying group and its most prominent impact is that it ensured the field of medicine would remain a private, entrepreneurial, and for-profit system (Rosenthal, 2018). Hospitals, clinics, and health insurance companies followed the for-profit model.

Health insurance companies started as nonprofits in the 1890s to stabilize doctor and hospital revenue over the course of a year to avoid sharp financial peaks and valleys. Rosenthal (2018) states,

“They intended it to help the sick. And in the beginning, it did. A hundred years ago medical treatments were basic, cheap, and not terribly effective. Often run by religious charities, hospitals were places where people mostly went to die. ‘Care,’ such as it was, was delivered at dispensaries by doctors or quacks for minimal fees.”

Eventually insurance companies followed the AMA’s for-profit approach and between the 1920s and the 1960s, progressively engaged in discriminatory practices, in particular denying coverage to those with pre-existing conditions. There is evidence that the early health insurance companies (e.g., Blue Cross) held out as exclusively nonprofits but could not compete with newer for-profit insurance companies (e.g., Aetna and Cigna), and caved to economic pressures to gain access to the stock market (Rosenthal, 2018).

The government-based programs of Medicare, Medicaid, and military-affiliated health care (e.g., Veterans Administration [VA]) developed between the 1940s and 1960s to protect vulnerable populations and to take care of veterans (Tikkanen, Osborn, Mossialos, Djordjevic, & Wharton, 2020). These resources, though often inadequate, are critical for those meeting eligibility requirements (e.g., poverty, disability, old age, and veteran status).

President Obama’s Patient Protection and Affordable Care Act of 2010 (PPACA) was the most significant health care legislation since the 1960s. It has its strengths, but it was actually implemented without a core component, the Public Option, which would have been a government-based nonprofit health insurance plan that any American could purchase. The Congressional Budget Office (CBO), the strictly nonpartisan budget analyst for the U.S. Congress, estimated 6 million Americans would have opted for the public option in the roll-out of PPACA (CBO, 2009). That number likely would have grown exponentially by now since it has been shown that overall satisfaction is significantly higher for Americans with government-based health insurance (e.g., Medicare) than in the private market (McCarthy, 2012). It also could have generated market pressures for the private

insurance system to lower prices while improving coverage.

Systems Investment- United States

The National Institute of Mental Health (NIMH, 2011) cites a cost of \$57.8 billion in 2006, 163 billion in 2011, and \$238 billion in 2020. US GDP leads the world in percentage of investment in health care and is ever-growing at 17.7% in 2019 (Centers for Medicaid and Medicare Services [CMMS], 2019). But estimates on mental health, which also include certain aspects of indirect costs, put mental health GDP at 3.5%. Estimates on cost rise dramatically when including indirect costs of untreated mental health problems, which include those who could work but will remain on disability, those turning to addictions as coping mechanisms and ending up with catastrophic treatment costs or in the criminal justice system (Insel, 2008). "It goes without saying that the excess costs of untreated or poorly treated mental illness in the disability system, in prison, and on the streets are part of the mental health care crisis. We are spending too much on mental illness in all the wrong places. And the consequences for consumers are worse than the costs for taxpayers" (Hogan, 2002).

General Treatment Approaches- United States

Most mental disorders are treated solely with medication, even though more than 50% call for psychotherapy (Arean, Renn, & Ratzliff, 2020). Most mental health practitioners in the U.S. espouse a general cognitive-behavioral therapy approach, but for many of them that mostly means they simply talk with their clients about general thought and emotional disturbances. There is a significant population of practitioners with deep and high-quality proficiencies in specialized areas, including Psychodynamic, Motivational Interviewing, Attachment Theory, and, more recently, the neurobiological approaches, such as Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 2012). For the percentage able to gain access to psychotherapy, it is very difficult to discern which practitioners will provide the best and most specialized services.

Community Mental Health

The vision behind Kennedy's Community Mental Health Act of 1963 was to deinstitutionalize chronic and severely mentally ill people into a wide-reaching network of community-based outpatient centers. The agenda was broad and administration across presidential terms (e.g., from Carter to Reagan) varied and ultimately weakened outcomes (Drake & Latimer, 2012). The two biggest problems with community mental health are the lower prevalence of experienced and competent practitioners (owing mostly to low pay) and hyper-focus on case

management (basic resources for independent living) and psychopharmacology, in lieu of psychotherapeutic treatment. In truth, there are most excellent services provided through community mental health; here and there pockets of particularly good treatment teams arise. But this is a widely varying and unpredictable phenomenon. For those with Medicaid, they can expect their care to be mostly in the areas of psychopharmacology (e.g., anti-depressants) and case management. They may also receive individual and/or group therapy, but availability and quality also vary widely.

Private Health Insurance (Uninsured/Private Fee)

Most Americans have private health insurance that covers a percentage of mental health care costs. A typical copay to cover a \$125 outpatient psychotherapy fee is between \$30 and \$60. Insurance plans are not required to cover mental health, and many do not. A person seeking weekly psychotherapy for a year could pay as much as \$3000 for copays on top of expensive health insurance premiums. Increasingly, psychiatrists and psychotherapists opt out of insurance altogether, citing issues with low reimbursement and a disorganized, unreliable, and cumbersome billing system. 34% of people with private insurance seeking mental health care had difficulty finding a practitioner accepting their insurance (NAMI, 2016). And with increasing demand, mental health providers can charge higher rates and find plenty of financially able people to pay out of pocket. Yalom (2009) states:

"So I worry about psychotherapy—about how it may be deformed by economic pressures and impoverished by radically abbreviated training programs. Nonetheless, I am confident that, in the future, a cohort of therapists coming from a variety of educational disciplines (psychology, counseling, social work, pastoral counseling, clinical philosophy) will continue to pursue rigorous postgraduate training and, even in the crush of HMO reality, will find patients desiring extensive growth and change willing to make an open-ended commitment to therapy."

This epitomizes a mental health systems status quo in the United States that includes no plan for affordable access to quality services to all in need.

Discussion and Theoretical Examination

History and theory are powerful teachers for understanding the present and making plans for the future. Lives and human well-being are at stake, so for our purposes we assume that we need to go no further in making the case that mental health systems improvements are vital,

even if in varying degrees between nations. Social dynamics (or sociodynamic theory) proposes that all systems are in a state of dynamic change through positive and negative feedback (Durlauf & Young, 2001). From this, we could deduce that when an argument for change does not appear to be winning in the public domain, enough feedback (frequency and intensity) eventually causes change to occur. This can explain how dramatic change often does seem to suddenly occur after decades of debate that seemed to go nowhere. Although aspects of certain systems may appear quite fixed, policy history shows that change can happen dramatically when there are motivated electorates and government officials (e.g., Advance Child Tax Credit and Economic Impact Payments in the United States [USA.gov, 2022]).

The Past

The reality is that in various ways most nations have not adequately responded to mental health needs of their societies, whether by underfunding (and thus de-prioritizing), ill-informed strategies, inadequate expertise, or stigma causing reluctance to seek professional help. WHO (2020) states, "Mental health is one of the most neglected areas of public health." They further estimate an inadequate average of 2% of health budgets going toward mental health globally. And then where services are available, there tend to remain major impediments to help-seeking for those most in need. The weight and consequences of untreated mental illness on the health care, mental health care, and criminal justice systems, and most importantly on families and communities, are incalculable. Dedicating appropriate resources and expertise would equally bring about inestimable societal benefits.

A central tenet of conflict theory states that money interests win out at the expense of vulnerable populations (Marx, 1848; Turner, 1975). But conflict theory is not necessarily about how the rich and powerful victimize the vulnerable, per se; it is an indication of what naturally happens as humans look out for themselves and close others, rather than ways to mitigate the negative outcomes that might occur when marginalized groups suffer. The Socio-Economic Asset Developmental perspective (Dolgoﬀ & Feldstein, 2008) illuminates just such a mitigating approach. Robust longitudinal economic data demonstrate the financial wisdom of resolving social and health problems as early and thoroughly as possible (Centers for Disease Control [2022]). This reinforces the age-old wisdom, "an ounce of prevention is worth a pound of cure". There is a win-win phenomenon when we avoid the cost of crisis care and also have many more people productively functioning at all levels of society.

The Present

A fundamental principle of governmental policy is that sweeping legislation is difficult, expensive, and always yields unintended consequences (Dolgoﬀ & Feldstein, 2007). There is no way for a country with millions in population to adopt sweeping legislation that immediately and universally works effectively for all. Change along with changing needs assures that there will always be complications that include some people struggling and suffering in the interim. It should be an axiom of every nation that aspires to principles of freedom and liberty to stay ever vigilant and committed to addressing and resolving these struggles and suffering as fast as humanly possible. But how does change really happen? And why can it be so slow in coming?

The human capacity to adapt to dysfunction is immensely influential. In short, people adopt an "it is what it is" attitude, believing there would be no way to change large, problematic systems. Regardless of how we find ourselves in failing systems, we understand through a theory such as structural functionalism (Durkheim & Halls, 1894) that we can expect that there will always be resistance to change from the status quo, even when that change is clearly superior. Structural functionalism reveals how complex mental health systems have shifted, adapted, and evolved to become a sustainable general strategy aimed at alleviating mental health problems. Since the environment in which this system exists is a human construction, it does not necessarily follow laws of nature (Durkheim & Halls, 1894). Thus, if there was anything faulty about the overall system, for example an unbalanced ratio that prefers profit to human health, then subsystems seeking to adapt within this system, might necessarily only function as an extension of these imbalances. In that case you will have sometimes quite altruistic and developed resources (e.g., grant funded faith-based clinics in inner-cities) that would cease to exist if the system, as a whole, was rectified. This can lead to those with a heart for the vulnerable unwittingly arguing for strategies that prevent the greater-good for those they serve.

The Future

Since the global mental health community has ever-increasing clarity about maximally beneficial mental health systems (WHO, 2020), and it has been shown that investment in mental health systems is beneficial to both those in need and the broader society, there is no reasonable excuse for delay. According to Dolgoﬀ and Feldstein (2007), "The socio-economic asset development perspective evolved through attempts to harmonize social welfare with efforts directed at economic development that focuses on ways in which social welfare can contribute efficiently and effectively to economic

development through social investment." Getting away from a liberal vs conservative struggle, there is political-theoretical middle ground. The socio-economic asset development perspective asserts a win-win scenario that it benefits society, both in social and economic terms, to ensure people have mental health needs affordably and effectively met. It is less expensive to prevent or catch problems early, and it is better to have people socially and occupationally functioning, as this is an economic and tax-base generator. Thus, it is a fiscally wise thing to aggressively treat all health conditions, mental and physical, that prevent people from thriving

Limitations and Strengths of the Study

Limitations of the Study

Limitations of this study include a small sample size of countries analyzed, a strong preference by the authors to see mental health systems improved (i.e., potential bias), and assumptions that such analysis and comparisons generate substantive guiding insights. There are no globally enforceable guiding regulations for mental health systems and numerous societal, economic, and cultural factors, beyond the scope of this article, also go into if and how a mental health system is developed and utilized. In an effort to promote progress, the authors also acknowledge that these theoretical interpretations could be affected by bias. The authors also acknowledge that many of the important socio-economic variables involved in mental health care systems are beyond the scope of this study.

Strengths of the Study

The strengths of this study include an elaborate analytic approach (history, systems, and theory-based analysis), unifying information about the global struggle toward effective mental health services, and substantial contribution to salient advocacy declarations. This article is a concise blend of examination and analysis that efficiently enhances advocate messaging and future research foci. Additionally, this format of analysis provides a framework for examining and comparing additional countries' mental health systems

Conclusions

This article compares and contrasts these countries' systems while also making the case for the inevitability of change. Nations vary in terms of stress, levels of mental struggles, mental health infrastructure, prevalence of stigma, and funding willingness and capacity, but there is still an international standard to evaluate each system against. The authors hope this article serves to

educate and bring clarity to people so they can, in turn, do their part to advocate for change in their home countries. Change is inevitable, but it serves all when it comes with strategic and resourced planning. Most countries can estimate numbers and types of mental struggles and develop local quotas for practitioners and resources. And this yields a multifaceted return on investment (i.e., socio-economic asset development [Dolgoft & Feldstein, 2008]). To continue this work, the authors recommend qualitative studies focusing in varying countries on front-line mental health providers, health care administrators, and economists familiar with funding and strategies in areas of health and mental health care. It is equally important that recommendations keep pace with constantly evolving data on best practices across the mental health continuum.

Conflict of interest

The authors declare that they have no conflicts of interest.

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FAMILY BONDING IN CONFINEMENT OF THE COVID-19 PANDEMIC: A SYSTEMATIC REVIEW

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Abstract

Introduction: Due to the demands of the COVID-19 pandemic, the family became the primary setting in which people were confined. As a result, the family bond during confinement is an important phenomenon to study.

Purpose: The purpose of this systematic review was to determine if the family bond would influence the changes in mental health brought on by confinement and the COVID-19 pandemic.

Methodology: The methodological were a Systematic Review using the PRISMA model in the search engines Web of Science, Scopus, PubMed, PSYINFO, Taylor and Francis, Sciendo, Academic Search Ultimate, and Medline between September 2021 and April 2022. NOS (Newcastle-Ottawa Scale) was utilized.

Results: Concerning the search results, it was possible to identify seven relevant studies for analysis: four on the variables associated with psychological well-being during the pandemic and two on the perceived changes in emotional state during the pandemic.

Conclusions: the effects of confinement on mental health are characterized by an increase in negative emotions, heightened perceptions of stress, anxiety, and depression, and altered sleep patterns. Concerning the influence of the family bond on mental health, it was discovered that when the bond is perceived as positive and strong, that is, the individual perceives that their basic, social, and affective needs are covered, it becomes a protective factor for mental health, regulating the manifestation of stress, favoring the manifestation of positive emotions over negative ones, and becoming emotionally supportive.

Keywords

mental health, family bonding, family relationships, confinement, pandemic, COVID-19

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Introduction

The COVID-19 pandemic is the most dangerous threat to global health since the 1918 H1N1 pandemic, which caused millions of deaths worldwide (Asmundson et al., 2020). In November 2019, the first outbreak would begin in Wuhan, followed by the first case in Chile in March 2020 (Godoy Echibur & Badillo Vargas, 2021); eight days later, the World Health Organization declared a pandemic (Bendersky, 2020). This new disease exhibits various unpredictable behaviors, high levels of lethality, variations in the level of contagion, and different strains throughout its duration (Arteaga Herrera, 2020), which would generate uncertainty and different problems in the stability of the various social areas, primarily in health, which would have resulted in the implementation of multiple health measures (Prada et al., 2021).

Primarily, Chile would have imparted all the recommended sanitary measures, adopting in the first instance the State of Constitutional Exception of Catastrophe; additionally, it implements the confinement based on the epidemiological behavior of the various municipalities (Colihuinca & Alejandra, 2021). The confinement caused by the virus's contagion has had a significant impact on various aspects of global stability, including the economic situation. Considering the closure of small and medium-sized businesses, the reduction of employment and the time devoted to working, the unemployment rates among informal workers would have skyrocketed, resulting in increases in poverty, food insecurity, or decreases in family income, particularly among the most vulnerable groups (Lizondo-Valencia et al., 2021; Velasco, 2021).

Social isolation and confinement work as a measure to prevent the spread of COVID-19 (Gonzalez-Bernal et al., 2021; Rodríguez-Fernández et al., 2021; Seo, 2021) and its variants, however it would have some effects, as mentioned above, but they would also have affected other areas, such as mental health, since individuals mention experiencing adverse effects on a psychological level (Martínez-Líbano, 2020; Martínez-Líbano & Yeomans Cabrera, 2021; Martínez-Líbano & Yeomans, 2021), due directly to the conditions of this confinement, and also to the threat of contagion (Kirk & Rifkin, 2022); this impact can produce psychological and psychiatric disorders such as post-traumatic stress (Ashby et al., 2022a; Nagarajan et al., 2022; Yunitri et al., 2022), depression, anxiety (Ashby et al., 2022b; Choi et al., 2020), frustration (Jayabalan, 2020; Muñoz-Fernández & Rodríguez-Meirinhos, 2021), panic disorders (Muñoz-Navarro et al., 2021; Nami et al., 2020) due to factors such as family separation (McAdams, 2021; Montauk & Kuhl, 2020), pain, grief, loneliness, shame, guilt, anger, fear, xenophobia, mass hysteria (Muorah, 2020;

Whitehead & Whitehead, 2010), misinformation on social media (Buzzell, 2020; Tagliabue et al., 2020), financial insecurity (Cheng et al., 2021), stigmatization and other problems that would affect psychological well-being (Fernández-Abascal & Martín-Díaz, 2021; Nguyen et al., 2021). Other research details that such unprecedented isolation measures on social distancing, which prevent access to social support systems such as extended family, friends, acquaintances, and community ties, can affect mental well-being and cause a feeling of loneliness, anxiety, and depression (Alfawaz et al., 2021; Bzdok & Dunbar, 2020; García et al., 2002; Long et al., 2022).

Family bonding is the inclusion of a member within the family, with all that this encompasses: admission, accommodation, and incorporation; this inclusion implies the acceptance that this member is part of the family structure; It is relevant that all family members can turn to others for support and support, especially in risky situations such as the current context (Mateo et al., 2018; Rodríguez Mateo et al., 2018). The universal and characteristic concept of the family is one of union, coexistence, and attachment among its members; however, there are circumstances in which these are not the main factors that characterize any family going through moments of stability and instability (Gough, 1959; Seltzer, 2000; Tomaney, 2022; Traina, 2022). From the systemic model, the different relationships established within the family system create relevance in the current context (Jamali & Mirshak, 2007; Patterson, 2002), since depending on the links formed, the effects mentioned above could be more or less profound (Walsh, 2003); a strong family leadership, defined by its upbringing, guidance, and protection, would be essential for the maintenance of stability (Committee, 2004; Walsh, 2015), however, in times of stress and uncertainty, the emotional affection and exhaustion, exhaust the caregiver resources, modifying parenting styles and weakening positive leadership, triggering a strain on the parent-child relationship (Prime et al., 2020; Wade et al., 2020).

Purpose

The purpose of this systematic review was to determine if the family bond would influence the changes in mental health brought on by confinement and the COVID-19 pandemic.

Methodology

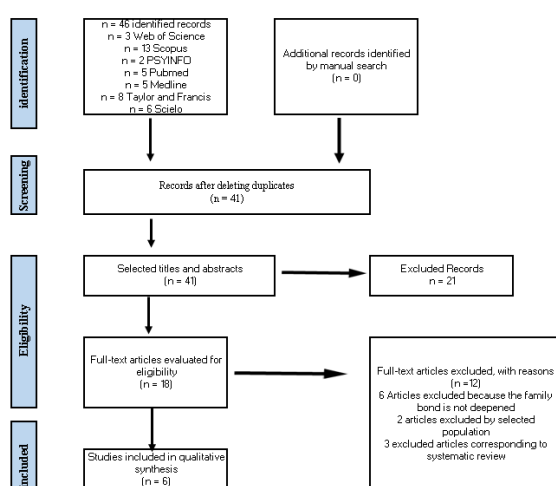
A systematic review was conducted to identify English and Spanish-written articles published between September 2021 and April 2022 in the databases Web of Science, Scopus, PubMed,

PSYINFO, Taylor and Francis, Scielo, Academic Search Ultimate, and Medline.

Search Strategy

According to the PRISMA Preferred Reporting Protocol for Systematic Reviews and Meta-Analyses, a literature search was conducted (Moher et al., 2009; Page et al., 2020). In each database, the title, abstract, and keyword search fields were examined. (["family bonding"] AND ["confinement" OR "confinements" OR "enclosure"] AND ["COVID" OR "coronavirus" OR "COVID-19"])

Figure 1. Search strategy for the selection of studies.



Selection Criteria and Study Eligibility

Each article's titles and abstracts were screened, then the full text was evaluated for eligibility. Studies were eligible for inclusion if the following conditions were met: 1) the population was adolescent or adult; and 2) the population size was adequate. 2) with the use of clinical and non-clinical instruments; 3) with both positive and negative outcomes; 4) field studies. 5) texts in English and Spanish; 6) studies that assess family-related variables; 7) If the data for the article was collected during the COVID-19 pandemic. 1) studies not related to the COVID-19 pandemic; 2) subjects living in isolation; 3) academic notes, letters to the editor, or reflections; and 4) systematic reviews were excluded. 5) individuals with specific diseases.

Data extraction

Utilizing a data extraction form, pertinent information was collected: (1) Principal author, (2) Country, (3) Research design, (4) Sample size. (6) Family bond incidence

Quality Assessment

The quality of the studies was evaluated using a modified version of the Newcastle-Ottawa Scale (NOS) for cross-sectional research. The NOS evaluates quality on the basis of its content, design, and interpretation with greater reliability and validity than other scales (Cascaes da Silva et al., 2013). The scale has three components: selection, comparability, and outcome. There are seven categories that evaluate the representativeness of the sample, the rationale for sample size, comparability between respondents and non-respondents, exposure determinations, comparability based on study design or analysis, result evaluation, and statistical analysis adequacy. Maximums of four stars for the Selection dimension, two stars for the Comparability dimension, and three stars for the Outcome dimension can be awarded if a study meets certain criteria (Epstein et al., 2018)

Results

Search results

Family Bonding during the confinement of the COVID-19 pandemic was the subject of 46 publications in total. Five were eliminated due to being duplicates. After reading the title and abstract of 21 articles, the remaining 12 were eliminated after reading the full text. Thus, six articles that satisfied the inclusion criteria were chosen for the systematic review.

Characteristics of the Study

Table 1 is a summary of the study's characteristics and this review's findings. The sample sizes of the six articles ranged from 208 to 3,960 family members, for a total of 9,343. Brazil (n = 1), Peru (n = 1), the United States (n = 1), Saudi Arabia (n = 1), Spain (n = 1), and Turkey (n = 1) each conducted one of the six studies.

Table 1. Summary of the characteristics of the study sample, study design, evaluation tools used and incidence of family bond

Authors	Country	Desing	Sample	Instrument	Measurement	Incidence of the family bond
Giannini et al., 2022	Brazil	Cross-sectional	208	Own questionnaire	Emotional state	Conflicting family relationships cause an increase in emotional states of sadness and anxiety.
Livia et al., 2021	Peru	Cross-sectional	3.960	Family APGAR	Family functioning	Better family functioning predicts higher positive emotions and lowers negative emotions. Perception of family functionality as support and emotional support. Family as protector of the psychological impact
Tuason et al., 2021	EE. UU.	Cross-sectional	938	Own questionnaire	Family Time	Family relationships help cope with the stress associated with the pandemic.
Alfawaz et al., 2021	Saudi Arabia	Cross-sectional	1.542	Own questionnaire	Family Bonding	Better family bond less likely to be anxious and depressed. Family ties are established as a survival mechanism to preserve mental well-being
López-Núñez et al., 2021	Spain	Cross-sectional	1.656	Own questionnaire and CWRP items	Family conflict	Family conflicts deteriorate mental health.
ŞENGÜN & TOPTAŞ, 2020	Turkey	Cross-sectional	344	Own questionnaire	Impact on family relationships	Family relationships have a positive effect on exposure to COVID. Reduces anxiety and generates a positive perception of stress.

Source: Own elaboration

Assessment of methodological quality

Table 2 presents the results of the evaluation of the methodological quality of the studies. The quality of the included studies ranged from satisfactory to good, earning between 4 and 7 stars. There were two seven-star studies (Livia et al., 2021; Tuason et al., 2021), two six-star studies (Alfawaz et al., 2021; López-Nez et al., 2021), and two five-star studies (Giannini et al., 2022; ENGÜN & TOPTA, 2020).

Study	Total	Selection		Comparability			Results		
		Representativeness of the sample	Size Sample	Not surveyed	Exposure checks	Design and analysis	Evaluation and Results	Statistical test	Quality
1 Giannini et al	5	*			**		*	*	Good
2 Livia et al	7	*	*		**	*	*	*	Good
3 Tuason et al.	7	*	*	*	*	*	*	*	Satisfactory
4 Alfawaz et al.	6	*	*		*	*	*	*	Satisfactory
5 López-Núñez et al.	6	*	*		**		*	*	Good
6 Şengün & Toptaş	5	*	*		*		*	*	Good

Source: Own elaboration

Incidence of the family bond during confinement by COVID-19

Among the effects that the family bond had on the changes experienced during the confinement of the COVID-19 pandemic, we discovered that

Discussion

The systematic review carried out to explore the incidence of family ties in the context of the COVID-19 pandemic. At the end of this review, it can be concluded that family bonding, when perceived as good, tends to protect and improve mental health. Particularly, confinement generates a change in individuals. It is mentioned that 93.3% of adolescents notice changes in their routine, mentioning increased anxiety and depression (Giannini et al., 2022), which oscillates with 92% perception of the effects of psychological aspects of the pandemic (ŞENGÜN & TOPTAŞ, 2020); it is noted that there is a significant difference in the appearance of negative emotions, exceeding the average in relation to positive emotions (Livia et al., 2021), considering, in turn, the loneliness and the diminished sense of agency and generated by psychological discomfort (Tuason et al. al., 2021), the indicators associated with mental health consider the presence of anxiety 58.1%, depression 50.2%, insomnia 32.2% (Alfawaz et al., 2021) and satisfaction with life 19% (López-Núñez et al., 2021). This may be due to the fact that, due to confinement, the members of a family group have experienced radical changes that are evidently perceptible in their usual routine, both at the family level and in educational, work, and social environment aspects, which has generated an emotional and psychological impact, depending on the stage of development in which they are and the support they perceive from the family environment (Cifuentes Carcelén & Navas Cajamarca, 2021), which is complemented by concern for their own health and that of people in their social circle, considering, the fear of becoming infected or infecting others; and in addition, the vulnerability to economic problems caused by confinement, job loss, and income reduction, would generate uncertainty about obtaining food and access to education, adding stressors that put the mental health of individuals

source of concern and anxiety (Valero-Cedeo et al., 2020). Furthermore, emotional stress is associated with the narrative ideas of the most tragic situations experienced during the context of the COVID-19 pandemic and the subsequent confinement, which has resulted in the loss of relatives without being able to say goodbye, along with the loss of (Discua Cruz & Hamilton, 2022).

conflicting family relationships increase emotional states of anxiety ($n = 3$); conflictive family relationships increase emotional states of sadness ($n = 2$); better family functioning preserves mental well-being ($n = 2$); family relationships regulate the perception of stress ($n = 2$); and better family functioning increases positive emotions ($n = 2$)

at risk, which could even modify eating habits and sleep (Vásquez et al., 2020).

Within the aspects influenced by the family bond, present in the studies of the change perceived during the confinement of the COVID-19 pandemic, it is mentioned that when considered, this bond as conflictive, would cause an increase in the emotional states associated with sadness and anxiety, this taking into account that the increase in coexistence with family members would have caused moments of greater stress (Giannini et al., 2022), which is mentioned in other studies, in which interpersonal conflicts resulting from family life closest and limiting privacy, would be associated with emotional suffering, characterized by fear, anxiety, irritability, sadness and stress (Brooks et al., 2020). On the other hand, the consideration of difficult times associated with the pandemic would have provided opportunities to increase sharing time, generating stronger ties and improving the perception of the family relationship (Giannini et al., 2022), which coincides with the influence that the family bond had on the psychological impact of confinement since better family functioning would generate more positive emotions and fewer negative emotions, becoming a protective factor for the psychological well-being of the members mainly, these positive emotions would be associated with indicators of satisfaction perceived with the response of the family to expressions of affection and their response to feelings of love and sadness (Livia et al., 2021); therefore, it is pointed out that the family becomes one of the most important environments, valuing that it is the main environment in which one interacts and receives support (Arias et al., 2013).

Among the studies cited, estrangement from family members, that is, a member of the family nucleus who had to endure confinement far from the other family members, is considered a precedent for elevated stress indices (Lukács, 2021). In light of the aforementioned, this is due to the fact that the possibility that our health or that of our family members will be affected is a natural

Regarding perceived stress in the context of pandemic and confinement, according to research, family bonding is presented as a coping mechanism (Tuason et al., 2021) because, during the pandemic, social loneliness and isolation are associated with an increase in the stress experienced, and that solid relationships should be regarded as keys to mental health (van Bavel

et al., 2022); In a similar vein, Lukács et al. (2002) note that distancing oneself from one's family would increase anxiety about contagion, thereby heightening stress levels.

It is believed that strengthening family ties and interactions would reduce the risk of presenting anxious and depressive symptoms, with a higher prevalence rate in women (Alfawaz et al., 2021). Close relationships within the family nucleus and the maintenance of strong ties with high resilience capacities in unfavorable times would aid in coping with the effects of changes in the risk context that is experienced (Prime et al., 2020) In contrast, it is stated that individuals would benefit from living with their families during a pandemic (ENGÜN & TOPTA, 2020).

Cross-sectional research would have evaluated family bonding and mental health only in a pandemic, closing the space to compare with a pre-confinement state, consulting it only retrospectively, or increasing the risk of recalling more biases (Lukács, 2021). In addition, the majority of the studies used online questionnaires that were not standardized and were created with specific purposes for each study, which could lead to biases; this demonstrates the need to create standardized surveys and use them on a larger scale to add and validate findings (Alfawaz et al., 2021)

All of the aforementioned should continue to motivate us to continue studying the effects of the containment of the COVID-19 pandemic on mental health and how the family manages to protect against negative effects or increase positive emotions in the different social contexts around the world and for the faithful, increase state support for families, and promote family ties, given that the family is a fundamental pillar of society

Limitations and Strengths of the Study

Strengths

This is the first systematic review that examines and summarizes the existing literature on the prevalence of family ties and the effects of the COVID-19 pandemic's containment on the adult and adolescent population.

Limitations

This systematic review has certain limitations, as all of the reviewed studies relied on self-reports, which can lead to responses that are socially desirable. Similarly, as online studies were conducted, it is possible that a portion of the population could not access the evaluation. The majority of studies were cross-sectional, meaning that they were measured at a specific time, making it difficult to extrapolate these results to

the general population and preventing causal inferences; the longitudinal study does not provide detailed information on the indicators prior to confinement. Similarly, the majority of studies had a larger proportion of women in their samples, which could impede the data analysis. Regarding this systematic review, the majority of the articles utilized non-standardized questionnaires, which could understate the data's reliability. Furthermore, the articles did not provide specific statistical data, such as prevalence, leaving a gap in knowledge

Conclusions

We can conclude that a number of studies include family bonding as one of their variables; however, it is not examined in depth, especially in terms of the factors that may interfere with it. In contrast, there is a paucity of research on this topic in Latin America and Chile. According to the reviewed studies, the effects on mental health caused by the containment of the COVID-19 pandemic would be associated with the appearance of negative emotions, feelings of stress, anxiety, depression, changes in sleep hours, and uncertainty; these would have been exacerbated by the above-mentioned health situation. Regarding the influence of the family bond on these changes, it has been observed that when it is perceived as positive and strong, this aspect becomes a protective factor for mental health, regulating the manifestation of stress, promoting the manifestation of positive emotions and reducing the manifestation of negative emotions, and serving as emotional support. It is necessary to emphasize the significance of the family unit in coping with high-risk situations like the COVID-19 pandemic. The promotion of this region must be the responsibility of social institutions.

Conflict of interest

The author declares that he has no conflicts of interest.

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Systematic review to explore the effect of yoga on anxiety in adults

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Abstract

Introduction: The National Health Service cannot chronically sustain the overwhelming demands being placed on it due to financial cuts, staff numbers and recent presence of Covid-19. As a result, anxiety levels are on the rise thus increasing the need for effective first-line treatment.

Purpose: The purpose of this systematic review was to examine the efficacy of yoga as a first-line treatment for anxiety. Previous systematic reviews have produced mixed results.

Methodology: The inclusion criteria followed the PICO research statement. The population (P) were either healthy or diagnosed with anxiety and the intervention (I) was yoga. The comparison (C) was a control group, or CBT, or used a pre-and post-intervention design. The outcome (O) was the change in the level of anxiety post-intervention.

Results and Discussion: After the review of 64 studies, 7 studies fit the inclusion criteria: four randomized controlled studies, one longitudinal study, and two pre- and post-intervention comparisons. All the studies included provided statistically significant results for the beneficial effect of yoga on anxiety.

Conclusion: This study adds to preceding literature on the current anxiety levels of adults and the potential utility of yoga as a first-line treatment for self-management of anxiety levels. This review stresses the issue of heterogeneity, mode of yoga and calls for more robust randomised controlled trials to pioneer the subject matter to help, if not prevent, to slow down the rising cases of anxiety and ill mental health worldwide.

Keywords

Anxiety, Mental Health, Yoga, Systematic Review, Adults

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Introduction

According to the “Diagnostic and Statistical Manual of Mental Disorders V” (DSM V) anxiety disorders that are divided into subtypes all of which are characterised by excessive worrying about events and situations over a period of six months and occurring on more days than not (American Psychiatric Association, 2013). Neuroimaging studies have demonstrated that those with anxiety demonstrated increased activity in the amygdala, interior insula and areas of the prefrontal cortex and decreased activity in some areas of the ventrolateral prefrontal cortex. The result is an increased sensitivity to negative events and more effortful cognitive reappraisal of an event (Buhle et al., 2013; Gorka et al., 2019; Groenewold et al., 2013). Anxiety disorders are one of the two most common mental illnesses globally and are most prevalent among those in the 20 to 39 age group and among women. Worldwide, anxiety disorders were ranked eighth among mental disorders with respect to years lived with disability and the twenty-fourth leading cause of disability-adjusted life years (Ferrari et al., 2022). Anxiety has been associated with poorer physical health, a decreased tendency to engage in healthy behaviours, and an increased tendency to engage in unhealthy behaviour (Hearon et al., 2014; Morissette et al., 2007; Sareen et al., 2005). Subtypes of anxiety frequently overlap and are frequently comorbid with other mental conditions. For example, generalised anxiety disorder is frequently comorbid with depression (Bandelow & Michaelis, 2015). In a systematic review, Horenstein and Heimberg (2020) determined that anxiety, in particular the generalised anxiety disorder, was associated with a greater utilisation of healthcare resources. In summary, anxiety is a common mental disorder, associated with a reduced number of years spent in good health, and a burden on healthcare delivery.

Yoga

Yoga has different forms and the ones most frequently offered in the western world are Yin, Kundalini, Vinyasa, and Hatha yoga (Khalsa, 2004). Yin, Kundalini, and Hatha yoga are slower paced with pauses between poses whereas Vinyasa is a more vigorous activity without pauses (Khalsa, 2004). Yoga is a practical as well as a spiritual practice that focuses on breathing techniques and postures that are believed to bring the mind and body into union (Khalsa, 2004). The suspected biomechanism in yoga is a deep relaxation achieved by a modification of the autonomic nervous system and the hypothalamic pituitary axis (Anand et al., 1961; Benson, 1975). Previously, yoga was regarded as an alternative and complementary therapy in the west. Now yoga is being examined as a cost-effective first-

line therapy for anxiety (Kirkwood et al., 2005). The fact that the physical and mental benefits of yoga are now generally accepted is evidenced by the National Health Service endorsement of yoga on their website (NHS, 2021). The effect of yoga on anxiety has become the subject of formal systematic literature reviews, e. g. Cramer et al. (2018), Khalsa (2004), Kirkwood et al. (2005), and Volbehr et al. (2018).

Research on Yoga and Anxiety

Cramer et al. (2018) conducted a systematic review and meta-analysis on eight randomised controlled trials and concluded that yoga could be an effective intervention for anxiety disorders or elevated anxiety, but the evidence was inconclusive. Further, an explanation of a biomechanical mechanism was lacking. No effects were found for participants who had been diagnosed with an anxiety disorder in accordance with the DSM-V guidelines (American Psychiatric Association, 2013). Supportive evidence was found only for those with elevated anxiety and without a formal diagnosis or diagnosed by means other than the DSM-V. Some forms of yoga were specified, e. g. Vinyasa, Agni (meditative), but most were unspecified. Volbehr et al. (2018) conducted a systematic review and meta-analysis of 18 studies. The inclusion criteria were studies on Hatha yoga and participants with a formal diagnosis of an acute or chronic mood disorder and/or anxiety disorder in accordance with the guidelines of the DSM V or earlier editions, or the International Classification of Disease 10 (American Psychiatric Association, 2013; World Health Organization, 1993). The authors found that Hatha yoga was not effective for anxiety disorders and that the results were equivalent to control groups or treatment as usual groups. Other factors to be considered in a systematic review of the effect of yoga on anxiety are comorbidities. Anxiety disorders and depression are frequently comorbid, which makes the assessment of anxiety as an independent factor difficult (Ionescu et al., 2013). Also, most recent research focuses on the effect of yoga on anxiety in a clinical population with a specific disease, such as cancer and Parkinson (Hardoerfer & Jentschke, 2018; Kwok et al., 2019). Overall, the systematic reviews and meta-analyses concluded that the results are weak for the effects of yoga on anxiety. The investigators stated that the inconclusive results could be due to the inclusion of studies that lacked: (1) adequate methods, (2) consistent means of diagnosis, (3) diagnosis at baseline, and (4) adequate description of yoga practice (Cramer et al., 2018; Kirkwood et al., 2005; Vollbehr et al., 2018). Cramer et al. (2018) commented that in-depth systematic reviews and meta-analyses are hampered by the sheer lack of volume of yoga and anxiety studies, a high risk of bias arising from methodology issues such as

variations in blinding and lack of participant randomising, and the lack of control groups.

Purpose

This systematic review attempts to fill some of the above gaps by including studies that had adequate research designs, specified the type of yoga intervention, and included only participants who were healthy or had a diagnosis of anxiety at baseline. The objective of the study is to perform a systematic review of recent literature to assess the evidence for the effect of yoga practice as a first-line therapy for anxiety. The rationale of the study is to determine if yoga practice should be recommended as part of a low-cost self-care regime for adults.

Methodology

The following databases were used to identify studies on anxiety and yoga: PubMed, Cochrane Library, British Medical Journal, and ScienceDirect. As the search tools differed by database, they are described individually. PubMed's advanced search function allowed a Boolean algorithm to filter by words in the title and abstract. The following terms were entered: anxiety AND yoga, NOT depression, NOT children, NOT meditation. NOT depression was specified in the title and abstract search because anxiety and depression are frequently comorbid and studied together. This review wanted to assess the effect of yoga on anxiety alone. Further filters included publication date of 2019 to the present and in English. The search identified 78 records. An additional search of the results filtered by clinical trial, randomised controlled trial, and the availability of a full text reduced the number of records to 11. The Cochrane Library has a database that includes only studies that are clinical trials. The advanced search keywords

used were anxiety AND yoga, NOT children, NOT depression. The search was further filtered by a publication date range of January 2019 to January 2022. The search identified 46 studies. The ScienceDirect database allowed a search by keywords, publication date range, and article type. The search terms yoga AND anxiety NOT depression, date range of 2019 to 2022, filtered by research type article yielded 23 results. For the British Medical Journal database, the keyword was generalised to yoga with an expanded publication date between 2017 and 2022 and limited to research articles. The search yielded two studies. The next step was to eliminate the duplicates from a total of 135 articles, which left 64. The method is outlined according to the 2009 PRISMA flow diagram in figure 1.

Exclusion and Inclusion Criteria

The eligibility requirements were based on the PICO formula (Population, Intervention, Comparison, Outcome). The population selected was healthy adults or adults with a primary diagnosis of anxiety and age 18 years or above. The intervention was yoga practice. The comparison was either a control group, or a pre and post-intervention assessment of anxiety. The outcome is a change in the level of anxiety as measured by a validated anxiety scale or symptom inventory. Other inclusion criteria were publication date of 2019 or later, in the English language, and a full text was available. An exception was made for publication date for articles in the BMJ database as few records were located. Studies were excluded if the methods were poor, the participants were children or were recruited from a clinical population, e. g. participants with cancer or Parkinson's. The Critical Appraisal Skills Programme was used in the assessment of the studies and in the formatting of the study synthesis (CASP, 2020).

Results

Table 1. Synthesis of Studies

Author	Study Participants (Ss)	Study Description on Aim/design/methods	Main Findings	Comments Strengths/Limitations

Brenes et al. (2020)	500 adults over the age of 60 Recruited from the general public Diagnosis: score of ≥ 26 on Penn State Worry Questionnaire Abbreviated	Aim: Compare the efficacy of CBT and Hatha yoga on worry, anxiety, and sleep and to determine if preference for CBT or yoga modified the results. Design: Randomised controlled trials. Intervention: Group Hatha yoga. 3 arms. 250 Ss were randomised to either CBT intervention or a yoga trial. The remaining Ss chose whether to enter the CBT (n = 120) or yoga intervention (n = 130). Method: anxiety assessed with Patient-Reported Outcomes Measurement Information System (PROMIS®), anxiety section. Anxiety assessed pre-intervention, at week 6, week 11, and week 37.	Logistic regressions controlled for age, psychotropic medication, race. For the randomised trial, both groups showed reduced anxiety symptoms post-intervention. However, there was no statistically significant differences between the yoga and CBT groups for change in anxiety score. CBT and yoga interventions did not differ by anxiety score in the preference group. There were no differences in anxiety reduction between the randomized groups and when Ss chose their intervention	Strengths: large sample size. Follow-up assessment Limitations: In this age bracket, Ss had comorbidities such as hypertension, diabetes, depression, anxiety, heart disease. Logistic regression analyses controlled for comorbidities, but they could have an impact on the agility needed for yoga. Over 80% of Ss were women.
Lemay et al. (2021)	United States Healthy adults. N = 20. Age 18 to 66.	Aim: Assess the effect of a 6-week Yin yoga class plus guided meditation on stress perception, anxiety, and mindfulness skills. Design: quasi-experimental. Pre- and Post-intervention assessments. Intervention: Yin yoga plus guided meditation	Compared to baseline, scores showed a statistically significant reduction in anxiety, stress, and mindfulness skills at post-intervention, at 3 months, and 6 months.	Strengths: Ss demonstrated the increasing benefit of yoga over 4 points in time. Limitations: No control group. Small sample size. 14 of the 20 Ss had prior experience with yoga and meditation. Some Ss practiced as home as well. Neither the previous

Following the duplicates being removed, the number of articles was reduced from 135 to 64. Consequently, these 64 journal articles went through screening as of the abstract and title where 46 were excluded and 20 continued to remain and be fully assessed. Thereafter, with a full assessment using the CASP tool, 7 fully eligible studies were included in the systematic review and the procedure for this is conveyed below (Figure 1). Furthermore, a complete synthesis of studies is also displayed below (Table 1)

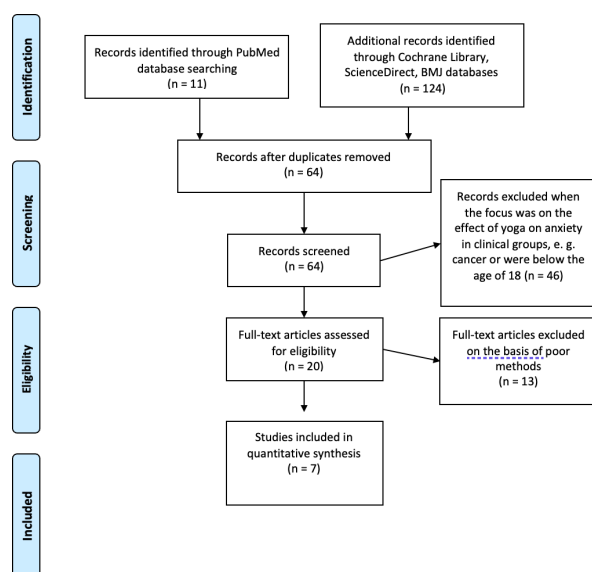


Figure 1. PRISMA flow chart of search results

Summary of the Results

The details of the studies are included in Table 1. The studies varied in their level of evidence. Four studies were randomised controlled trials, one was longitudinal, and two were quasi-experimental. All the studies included in the systematic review indicated that most yoga styles common in the west showed promise as a first-line therapy for anxiety for healthy adults and those diagnosed with anxiety. Different styles of yoga were represented in the review — Hatha, Yin, Kundalini, and Vinyasa. Four studies had healthy participants and three studies had participants with a diagnosis of anxiety in accordance with the DSM V (American Psychiatric Association, 2013). One of the eligibility criteria of the Phaniskar and Mullen (2022) study was the self-reporting of three or more symptoms on the Generalised Anxiety Scale of the DSM V. Pre-intervention mean scores of anxiety for the yoga group were provided but the standard deviation was quite high (mean 8.28, SD 4.15). Therefore, some of the participants could have had high levels of anxiety. Not all yoga styles were an effective treatment for anxiety. Marshall et al. (2020) compared two forms of yoga, Hatha and Vinyasa, and found that Hatha yoga reduced anxiety symptoms, but Vinyasa yoga did not.

Their results suggested that the style of yoga could influence the effect of the practice on anxiety. Two studies compared yoga with CBT for the first-line therapy for anxiety (Brenes et al., 2020; Simon et al., (2020)). The findings of Simon et al. (2020) suggested that Kundalini yoga was as effective as CBT but not better than CBT. Brenes et al. (2020) found that yoga was as effective as CBT among older adults. The evidence for the long-term effects of yoga on anxiety symptoms were not clear. Lemay et al. (2021) and Simon et al. (2020) examined the long-term effects of yoga on anxiety with follow-up assessments. In three- and six-month follow-up of the effect of Yin yoga on anxiety, Lemay et al. (2021) found that, compared to pre-intervention scores, anxiety levels showed a statistically significant reduction. However, the authors did not mention how or if Yin yoga was practiced in the follow-up periods. Simon et al. (2020) had two interventions, CBT and Kundalini yoga, and a control group. Compared to pre-intervention scores, at post-intervention, both CBT and Kundalini yoga produced a statistically significant at reduction in anxiety. At a six-month follow-up, the CBT group showed statistically significant reductions in anxiety levels. However, the yoga group anxiety scores were equivalent to the control group. Except for Brenes et al. (2020), none of the studies included individuals with comorbidities. Also, Brenes et al. (2020) was the only study that focused on adults aged 60 and over, an age group in which a higher level of comorbidities would be expected. In this large randomised controlled study (n = 500), the investigators compared the efficacy of CBT and yoga on worry and anxiety. Worry and anxiety were assessed as independent outcomes. Logistic regressions controlled for potential interactions between comorbidities and anxiety. A subgroup analysis revealed that CBT produced better results than yoga for participants with comorbid depression. No conclusions could be drawn on the safety of yoga as an intervention as five of the seven studies did not report adverse events. Brenes et al. (2020) and Simon et al. (2020) reported adverse events, but the events were not related to the interventions

Discussion

The findings for the effect of yoga on anxiety remain mixed. The common factor in compromising the findings of systematic studies for this study and previous research on yoga are small sample sizes and the inclusion of studies with poorer levels of evidence, e. g. Cramer et al. (2018), Kirkwood, et al. (2005) and Volbehr et al. (2018). The explanations provided by Cramer et al. (2018) and Volbehr et al. (2018) for the inconclusive results were the limited number of

studies on yoga and anxiety, lack of a clear diagnostic criteria, lack of diagnosis at baseline, lack of independent evaluators and blinding of evaluators, heterogeneity of yoga practice, and inadequate description of yoga practice. This review was able to address some of the gaps, but not all. The research of Cramer et al. (2018) and Volbehr et al. (2018) included more studies, but most of the studies included suffered the common problem of yoga studies and that is small sample size that limits the credibility of the results. Three of the studies included in this review have reasonable sample sizes: Brenes et al. (2020) (n = 500), Simon et al. (2020) (n = 230) and Telles et al. (2019) (n = 320). The statistically significant effectiveness of yoga was demonstrated across the smaller and larger sample sizes. Three of the studies included participants diagnosed with anxiety and the diagnostic criteria were clearly stated (Brenes et al., 2020; Phaniskar & Mullen, 2022; Simon et al., 2020). The findings indicated that yoga was equally effective on those diagnosed with anxiety and a healthy population.

As Cramer et al. (2018) and Volbehr et al. (2018) commented, results are inconclusive due to lack of rigorous research designs. This review suggested that yoga was effective regardless of the sample size or research design. Both Lemay et al. (2021) and Sulastri et al. (2021) used quasi-experimental designs and had small sample sizes, but the results were statistically significant. Credibility of the current review was enhanced by only including studies with validated anxiety assessment scales, i. e. Beck Anxiety Inventory, State-Trait Anxiety Inventory, Hamilton Anxiety Rating Scale. An exception was Simon et al. (2020) who used a Clinical Global Impression of Improvement scale (CGI-I) conducted by an independent evaluator. The CGI-I is commonly used in psychiatry and has been validated (Forkmann et al., 2011).

Recommendations

The evidence for the efficacy remains inconclusive. While this review found that except for Vinyasa, yoga had a beneficial effect on anxiety, Cramer et al. (2018) and Volbehr et al. (2018) did not. Therefore, yoga as a first-line therapy should be recommended with caution. With respect to future research directions, this review confirms the conclusion drawn by Cramer et al. (2018) and Volbehr et al. (2018) that more well-designed studies with larger samples are needed. Other issues in need of further examination are the impact of yoga on different types of anxiety and different levels of anxiety. Kirkwood et al. (2005) found that yoga was effective with specific types of anxiety, such as obsession compulsive disorder and snake anxiety, and suggested that research that focussed on specific types of anxiety might produce clearer results.

Limitations and Strengths of the Study

Limitations of the Study

As mentioned above, Cramer et al. (2018) stated that systematic reviews and meta-analyses on yoga and anxiety tend to have a higher risk of bias, and this systematic review is no exception. Few studies have been published between 2017 and 2022 that fit the criteria of the PICO statement and the sample sizes were small. Participant blinding is not possible in a yoga class. Three of the studies were nonrandomised and had no control groups (Lemay et al., 2021; Sulastri et al., 2021; Telles et al., 2019). As with previous systematic reviews, the current study includes research with varying levels of evidence and small sample sizes. Yoga is an ancient multi-dimensional practice and encompasses practical aspects, such as breathing techniques and poses, and more spiritually oriented aspects, such as the underlying philosophy, that are not as easily quantifiable. The content of the yoga classes was not always well- described and, in any case, would vary by instructor. The studies that included long term data did not specify how and if yoga was practiced during the follow-up periods. Except for Telles et al. (2019), women were over-represented in the studies. All the above limitations compromise the generalisability of the results.

Conclusions

There are not enough well-designed studies on the effect of yoga on anxiety to draw conclusive evidence. The results could be improved if the heterogeneity of anxiety type and yoga form were better addressed. For example, studies that included only Hatha yoga and the sample only included those diagnosed with obsessive-compulsive disorder, could produce clearer results.

Conflict of interest

The authors declare that they have no conflicts of interest.

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Ukrainian Canadian Newcomers' Stories, Hopes, and Dreams: Adapting to a New Multicultural Reality

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Abstract

Introduction: This paper focuses on the experiences of thirty-three newcomer Ukrainian Canadians as they adapt to their new multicultural reality in Canada. Challenges of leaving home and adjusting are studied along with changes to identity and strategies of resilience.

Purpose: Using a mental health and peace building lens, we hope that our findings will inform better understanding of newcomer struggles, hopes and dreams and can be helpful in transforming existing injustices in Canada's vibrant multicultural society towards positive peace

Methodology: Supported by a document search that supplies the broader context, the heart of the research is based on individual narrative interviews conducted in 2020/2021 with grassroots Ukrainian Canadians who immigrated to Canada as adults before Russia's overt invasion of Ukraine. The experiences of these modern newcomer research participants are viewed through a peacebuilding and mental health lens.

Results: While coming from the same country in a relatively short period of history, study participants were found to be a multivariate group. There were often competing needs for personal growth, security (economic and physical) and belonging. Major challenges upon arrival in their new home also varied. Along with some downshift in employment status, they experienced challenges to identity, language, finances, cultural adaptation, along with loneliness and sadness at leaving their homeland. They shared personal resilience strategies. Participants shared hopes and dreams for themselves, Ukraine, and Canada, along with advice for others considering the journey.

Conclusion: As Canada's ethnic and cultural makeup continues to evolve through embracing our current multicultural population accepting increasing numbers of immigrants, newcomers' experiences and their integration become important aspects of the multiculturalism debate which acknowledges the importance of developing harmonious relationships between Canada's new and older settler population and the Indigenous people who share this land. This study highlights the importance of newcomers engaging in cross-cultural experiences, while considering one's own identity at home and in community.

Keywords

mental health, immigration, identity, cross-culture, transformative experiences, positive peace

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Introduction

The health, strength and positive peace of a community depends upon the health and inclusion of all individuals within that community (World Health Organization 2014). In our global world, we were interested in considering the inclusion of the people closest to us, believing that the stories of their adaptation to a new country and society might offer clues for peaceful inclusion of other newcomers to not only Canada, but also other countries integrating immigrants. While numerous written resources document the stories of well-known Canadian Ukrainian scholars, politicians, and other more public figures, little is written about the experience of the "every day" Canadian Ukrainian, the grassroots people who immigrated to Canada in different waves, since the end of the 19th century. The University of Manitoba (UM) has a collection of audio-interviews with first wave pioneers from Ukraine, as collected by Michael Ewanchuk; however, at least four waves of immigration have been identified (Isajiw, Satzewich, & Duvalko, 2002) including the last wave following Independence. Some argue that a smaller group who moved following the occupation of Crimea by Russia and the outbreak of armed conflict in the East of Ukraine made up a fifth wave (Klokiw 2020). Different motives propelled the new Canadians who met a variety of challenges along their way, both in Ukraine and as they reached their new homeland, Canada. Many Canadian Ukrainians still identify very strongly with Ukraine as evidenced by the numerous and strong cultural traditions seen in song and dance troupes, Ukrainian language schools, and non-governmental organizations that continue to share Ukrainian cultural traditions and support Ukraine itself, as a country. Still, the Canadian Ukrainian community is not homogenous; that is, there is not one heterogenous group of people known as Ukrainian Canadians.

Like any group of people, there are different histories, educational backgrounds, and political interests amongst the members, and certainly not one vision for the future. While many in the earliest waves made their homes in block settlements, thus contributing to the possibility for a stronger sense of Ukrainian Canadian identity (Momryk 1993), this is no longer usually the case. As such, some worry that the notion of Canadian Ukrainian as an identity will be lost unless the community can unify around a common cause (Grekul 2005), even though agreement on politics and other issues has not been a theme in much of Ukrainian Canadian history (See, for example, Luciuk & Hryniuk, 1991).

Context

The country known as Canada was formed by settlers who essentially invaded the territory of

Indigenous nations inhabiting this northern section of what is North America – otherwise known as Turtle Island (Robinson 2018). On a web page meant to inform newcomer Canadians, the Government of Canada notes, "When Europeans explored Canada, they found all regions occupied by native peoples they called Indians, because the first explorers thought they had reached the East Indies" (Government of Canada, 2015 para 1). Vikings from Iceland colonized Greenland and the island that became Newfoundland and Labrador almost a thousand years ago; the first European settlers came largely from England and France in 1497 and later. The territory eventually named as Canada was declared to be a confederation, the Dominion of Canada, in 1867, divided at that time into four provinces: Nova Scotia, New Brunswick, Quebec, and Ontario. By 1999, the Dominion had an additional six provinces and three territories (Government of Canada, 2015).

The first Ukrainian settlers, Galicians, Bukovinians, or Ruthenians came to Canada in the 1890s and the early years of the twentieth century in tens of thousands, welcomed by an immigration policy, an effort of the Laurier government to fill the Canadian West (Mochoruk and Hinthier 2011). Further waves followed in the interwar period and then again after the Second World War when people who had been displaced from their homeland began to arrive, some directly from their homes and others via displaced persons camps (Mochoruk and Hinthier 2011) often British and American in occupied Germany (Luciuk 1986). These people, thrown together in internment camps, were from differing areas of Ukraine, and had their own varied experiences and ideologies and their integration into Canadian host communities also varied. Kunz, (as cited in Luciuk, 1986) notes, "possibly no other host factor has more influence on the satisfactory resettlement of refugees than compatibility between the refugees' background and that of the receiving population" (Luciuk, 1986, p. 467). Near the hundredth anniversary mark of the first wave of Ukrainian immigration to Canada, Frances Swyripa (1993) explains that much of the early literary representation of Ukrainian Canadians tends to highlight the role of settler or "tamer" of the wild west of Canada and a somewhat monolithic, strong community, usually based on the male experience. Swyripa (1993) and Orest Martynowych (1991) provide more nuances to this history. Despite originating from a rather small geographic area, Ukrainian Canadians', who now are both urban and rural dwellers are diverse and complex in their community organizations, religious beliefs, and political views. See for example, Orest Martynowych's, *Sympathy for the Devil: The attitude of Ukrainian war veterans in Canada to Nazi Germany and the Jews, 1933-1939* (Martynowych 2011) as well as the writing of

Jim Mochoruk (2011), and Andrij Makuch (2011). Others who document strife and conflict common across ethnicities include Stacey Zembrzycki (Zembrzycki 2011) who writes about issues of domestic violence, and Lindy Ledohowski who highlights challenges of mixed ethnicity identities often found in Canada in her work, 'A vaguely divided guilt': The Aboriginal Ukrainian (Ledohowski 2011).

Still, with breath comes change and Suzanna Lynn (2016) argues that little research has been done on how post-Independence immigrants from Ukraine to Canada interact with already-established communities in Canada, and her somewhat small study points to attitudinal and linguistic preferential differences between 'diasporic' Ukrainian Canadians and those who came post Ukrainian Independence.

More recent trends

Andrij Makuch's 2002 study of Ukrainians who came to Canada from 1991 to 2001, examines both the academic achievements and religious affiliation of the newcomers as well as their involvement in the community. Makuch concludes that, unlike many of their predecessors, newcomers have not linked themselves to the Ukrainian Canadian community in a significant way and tend to show a low level of participation in Ukrainian community organisations and events (Makuch, 2002). Oleksandr Kondrashov (2008), in his MA thesis, explores the fourth wave of Ukrainian immigration to Canada, which in his interpretation started in 1991 and was still ongoing during the period of his study (Kondrashov 2008). Kondrashov's findings related to community engagement, stress the importance of family and friends' support for the adaptation process. Similar to Makuch's observation, Kondrashov notes that ten out of sixteen respondents in his study indicated that their involvement in the Ukrainian community work was extremely low due to their primary concern being securing employment and taking care of family. Some of Kondrashov's respondents attributed lack of support to newcomers from the Ukrainian community to the economic reasons that served as a driving force toward the fourth wave's immigration, as opposed to politically driven immigration that previous waves experienced. Kondrashov's findings also indicate that people who were fluent in English preferred receiving help and information from non-Ukrainian institutions, such as immigration services or universities, as opposed to trying to engage with the Ukrainian community's support. At the same time, respondents indicated that there was often misunderstanding between the receiving Ukrainian community and the Ukrainian newcomers due to newcomers' level of expectations towards the existing community being too high without an expectation to help in return (Kondrashov, 2008).

Olesya Khromeychuk's personal essay devoted to Ukraine's thirtieth anniversary of independence depicts the differences in perceptions of "true Ukrainianness" between the unwilling immigrants who came to the UK in the post-World War II period and the economic immigrants, Ukrainians from Ukraine, who came after the collapse of the USSR (Khromeychuk 2021). Khromeychuk discusses the existing notion that "true Ukrainians" are those who were forced to leave their country as opposed to those who left willingly, although the term "willingly" may be debated. She acknowledges the cultural, linguistic, and perceptual gap between the different waves of Ukrainian immigrants and typifies identity challenges that immigrants in the 1990s faced, not only getting used to the new country, but also having to defend their love for Ukraine in the eyes of immigrants from earlier waves. Khromeychuk's experience situated in the UK mimics Kondrashov's findings in Canada.

Alla Nedashkivska (2018) analyses the processes and transformations in language preferences practiced by the so-called sixth wave, Ukrainian immigrants who arrived in Canada after the 2014 Revolution of Dignity. Nedashkivska emphasizes that the sixth wave of immigration diverges from the previous five waves in terms of linguistic practices due to the fact that a substantial number of immigrants arrived from Eastern Ukraine and Crimea, unlike the previous waves where immigrants from western Ukraine were prevalent. Through conducting social media analyses and interviews, Nedashkivska concludes that code-switching and language practices were used by the speakers to build connections with the hosting Ukrainian community. Thus, multiple participants whose first language was Russian resorted to code-switching while communicating in the Ukrainian social media pages and even insisted their children learn Ukrainian as opposed to Russian as their second/third language, and this was post-immigration (Nedashkivska 2018).

Purpose

This article describes a research project piloted to collect oral histories of Ukrainian Canadians from different, more recent waves, to learn about challenges they have met and overcome and what factors sustained them, building resilience. The specific research questions for this project were: What brought the participants to Canada? What major challenges have they had in settling? What keeps them here? What keeps them going through hard times? How, if at all, do the hopes and dreams for Ukraine vary dependent upon the time spent in Canada/time away from Ukraine/ their reasoning and timing in coming to Canada? What are their hopes and dreams for themselves and their new country?

Methodology

This study uses a feminist lens of appreciative inquiry to approach our research. Our tools are qualitative mixed methods. Appreciative inquiry, while often criticized for being an overly positive approach, has been acknowledged as a particularly respectful way to explore experiences and possibilities (Hung, et al. 2018). Bushe (2011) reminds that this approach does not ignore what may be considered negative; rather it allows for open dialogue about experiences. We wanted to acknowledge differences in people's experiences noting that one does not negate another.

Participants and Recruitment

For this pilot project, we planned to interview approximately 40 participants 18 years of age and older who immigrated to Canada as adults and had obtained at least permanent residency status. We attempted to find a gender balance, and to interview people across the age spectrum. Initially, participants were to be residents of Manitoba, as we planned to do in-person interviews.

We used both a snowball approach as described in Bogdan and Biklen (Bogdan and Biklen 2006) and advertising through posters. Snowball sampling is a kind of chain referral of one participant who then usually tells another about the study and each contacts the main directly researcher to participate. This is a type of non-probability sampling used when participants may be otherwise hard to find. In this case, we relied on people having acquaintances who have some community connection.

Advertisements told people about the study asked prospective participants to contact the researchers regarding their interest in the research. These advertisements were placed on different Facebook pages including the Centre for Ukrainian Canadian Studies (located at the University of Manitoba Facebook page, at Oseredok Ukrainian Cultural and Educational Centre (Oseredok Ukrains'koi Kul'tury i Osvity/Oserekok), Ukrainians in Canada, Ukrainians in Manitoba, Ukrainians in BC, Ukrainians in Toronto, Ukrainians in Alberta. Through these posters, prospective participants were invited to contact researchers by telephone or email indicating their interest in participation. The research was approved by the Research Ethics Board (REB) of the University of Manitoba. When COVID-19 struck, researcher had to again seek ethics approval to change the format of the interviews to audio-taped ZOOM interviews, which finally began in fall of 2020.

Ethical Considerations and Challenges

The anonymity of our participants was maintained unless they requested otherwise, though as part of the informed consent process,

we sought permission from the participants to keep their audio-recordings in a digital archive to be kept at either Oseredok or the University of Manitoba; however, this was not a requirement for participation in the research. Post-interview, participants were given a copy of their transcript for their own review, understanding that it is common for people to not have fully shared their stories, or to perhaps edit themselves a bit. Encrypted audio files of the interviews were shared, via registered mail with participants who wanted them. Most interviews lasted at least an hour, though some went much longer. Although there were challenges with virtual interviews, this format did allow participation from different corners of Canada, and even one participant spoke with us while visiting family in Ukraine. Interviews were conducted in Ukrainian and in English, the participant's choice.

Data collection and analysis

Interviews began with our thirty-three participants being asked to talk about what they knew of their family's life circumstances around the time that they were born, grounding the participant in their history. Participants from previous studies said that beginning personal interviews with reflection on history pre-birth helps and then move forward in reflection assists the individual connect with their own values and strengths (Flaherty, 2012; Flaherty, 2016). Participants were then asked about their life growing up, including school experiences, what their life was like coming to adulthood and then what made them decide to come to Canada. They were asked to talk a bit about the decision-making process, the process of moving to Canada, and their experiences upon arrival and settling in. Participants then spoke about their challenges, joys and surprises adapting to life in Canada. They spoke also about their present situations as well as their dreams for themselves and their families. Towards the end of the interview, participants were invited to share their hopes for Ukraine and for Canada. They were asked to speak about what gets them through hard times as well. Interviews ended by summarizing the content of the contact and asking participants if they had any questions about the research or the processes involved.

In analyzing the responses to these questions, as peace and conflict studies scholars, we found our best explanations in theories related to identity, (for example Cook-Huffman, 2015; Verkuten, 2018), cultural tightness and looseness (Gelfand, 2011), and of course, basic needs theories (Burton, 1979; Marker, 2003).

Situating ourselves in the research

[Author 1]: I was born, raised, and obtained most of my education in Ukraine. I moved to Canada in 2016 to pursue my Masters' Degree in Peace and Conflict Studies and upon completing

my studies continued my employment journey in Canada. As a newcomer and a researcher, I was impressed by the richness of the contributions of Ukrainian immigrants to Canada's social, political, and economic fabric, and by the divergence of historic roles, attitudes, and perceptions that Ukrainians have assumed not only during different waves of immigration but also between those waves. I have participated in this project not only as an interviewer and a co-researcher but also as one of the interviewees, and this participation has allowed me to contextualize my personal story within the project.

[Author 2]: I was born and raised in Canadian National Railway stations in small prairie villages

and towns in Canada. My earliest memories are of being the only non-Ukrainian or Polish family in Warspite, Alberta, adopted, in a way by those who surrounded our large family, supporting my parents both concretely and emotionally. In 1999 my first trip abroad was to Ukraine to participate in developing a Social Work program at L'viv Polytechnic National University. My colleagues there encouraged me to complete PhD research with them focusing on their efforts of living peacefully in their evolving society (Flaherty, 2012). This interest extends to the resilient adaptation of newcomers as they find their new homes in Canada.

Results

Study findings are shared below partially through the participants own words, to honour them. Participants are identified as they requested. When participant anonymity was requested, no name is provided. In this sharing we work to connect the findings to supporting theory.

A multivariant group

Celia Cook Huffman outlines the obligation for researchers as theorists to see people as multi-identified and multi-identifiable, emphasizing that meanings, just like identities, are complex, socially constructed, and fluid, and thus can be challenged and changed (Cook-Huffman 2015). Identities can be both transitory and rigid, bound by blended identities and migratory experiences. Verkuyten (2018) argues that identities are contextually and alternately salient assuming different meanings depending on the context. Considering migration, Verkuyten suggests additive identities where several meanings merge into one through recombination or fusion. In this sense the author theorizes that hybridity concentrates on "togetherness in difference" (interculturalism) rather than "living apart together," a thought commonly associated with multiculturalism (Verkuyten 2018).

Based on a thirty-three-nation study, Michele Gelfand concludes that cultural tightness and looseness is manifested not only in distal ecological, historical, and institutional contexts but also in everyday situations. Individuals in nations with high situational constraints tend to be more dutiful, have higher self-regulatory strength, a higher need for structure, and higher self-monitoring ability. Nations with loose cultures tend to have a lower need for order, social coordination, and norms compliance. The authors also predict that nations that have experienced chronic threats tend to develop tighter cultures (Gelfand, Raver and Nishii 2011). Despite the existence of numerous historic threats, during this research, Ukraine scored as the loosest country among the thirty-three nations that were

researched, which was attributed to a shift of cultural paradigm that occurred in the post-Soviet era after the collapse of the

USSR (Gelfand, 2021). We note that this may well have changed since Russia's invasion of Ukraine in early 2022.

Study participants varied in many ways. People were from different parts of Ukraine, and different socio-economic backgrounds. Some had never travelled outside of Ukraine prior to immigration, and some were very well-travelled, including people who previously resided in the US and other countries. Some arrived after obtaining temporary resident visas as students, spouses of students, or workers, and others arrived with their permanent residency status obtained either through the federal or provincial immigration programs by themselves or their immediate family members. Each primary applicant for permanent residency had to meet the point-based age, language, education, employment history and adaptability requirements outlined by the respective federal and provincial immigration programs (Permanent Resident Program 2022, Government of Canada 2022).

A common factor was that every participant had obtained some post-secondary qualifications in Ukraine ranging from trade school to post-doctoral degrees. The driving factors for immigration also differed from searching for better economic opportunities, dissatisfaction with the political development, environmental concerns, and avoiding mandatory army conscription, to difficulties in finding their sense of belonging in their home country and fascination with the idea of life in North America. Nine out of thirty-three participants arrived in Canada to pursue education and then decided to stay. Based on the thirty-three interviews, we would like to theorize that the overpowering looseness of Ukrainian society and lack of structure was among the largest contributing factors driving people towards immigration.

Different reasons for leaving home

The following section outlines the main themes shared by participants as they discussed their reasons for leaving their home country of Ukraine. The reasons are also summarized in Table 1 at the end of this section.

Corruption and lack of stability, which were identified by most of the respondents as concerning in their home country, can be seen as signs of a high level of looseness in a society to the extent that legal norms are not necessarily reflected in practices. Yaroslavna, a respondent who studied and practiced law in Ukraine, stated:

I felt like it's, I'm not safe, my family was not safe... like the law in our country doesn't work at all, you know... We have the law, we have the rules, but the thing is that we had to... figure out in order to work, we had to figure out how to skip that rule. Every morning started with stress...

Even the cadence of her spoken response brings home the sense of uncertainty Yaroslavna felt in her home country of Ukraine.

Two participants similarly indicated their dissatisfaction with life in Ukraine connected with trying to run a business legally; one even mentioned fear associated with intimidation tactics experienced through their business. Olha C. spoke about security concerns; not having to think about "these hard things that influence your everyday life" was one of the joys of living in Canada. Flipping the lack of stability to look at what might be considered a positive response to this challenge on the part of Ukrainian citizens, Tanya Y. spoke of Ukrainians, in this instability, being taught to be self-sufficient and strong, relying on themselves without ever asking for help. Another participant described life in Ukraine as fast and unpredictable and speaking to the notion that one must never be too nice or too tolerant in order not to be taken advantage of. One must be on guard, on the defensive. Participants overall spoke of a high need to be flexible, to be able to improvise to function with a lack of functional laws that are a reality for Ukrainians, laying the ground for the push factors of emigration.

More pointedly, another participant suggested she chose Canada because of its stability and the availability of support systems.

So, I thought it is a so much better future in Canada than in Ukraine, because at least you have a future. In Ukraine you will see today. You can't plan anything. You don't know what will happen. Even with a mortgage or something. You never know what will happen tomorrow.

As an example, she almost jokingly shared her fear of driving in Ukraine because of the other drivers' recklessness when it comes to following the rules, and the corruption she associated with getting a driving license. Yaroslavna shared a very similar sentiment about driving in Ukraine:

I felt so stressed every day. And when I was sitting in my car and started travelling and

everybody violated the rules, it was horrible. Every day! So when I... just when we went to United States, I thought "Wow, I can feel freedom!" It was a nice feeling.

What Yaroslavna referred to as freedom in the United States may be attributed partially to the prevalence of stronger social norms governing society, which include not only driving but also other aspects of everyday existence.

One participant inadvertently referred to systemic looseness and lack of strong social norms in Ukrainian society, indicating, "In Ukraine sometimes it doesn't matter what your education is or how smart you are or how hard you try; the system sometimes works against you." At the same time a number of participants referred to Canada as a kind of dream place, where if one works hard, they are usually rewarded for that work.

Thus, many of our interviewees showcased signs of discomfort with the overbearing looseness of Ukrainian civil society and expressed their satisfaction with living within a tighter context. Even though it may sound counterintuitive, they referred to the existence of stronger norms and clear rules of behavior as freedom. While it is reasonable to expect the participants' satisfaction with the infrastructure that Canada offers as a WEIRD society (Western, educated, industrialized, rich and developed) compared to Ukraine's transitional developing status, several participants alluded to being surprised that the slowness, predictability, and cultural normality of patiently waiting in long lines in Canada, whether related to getting coffee or taking care of administrative issues, eventually produced a sense of comfort in them. Although the transition to a new more rigid society was not always natural and flawless, most participants appreciated existing within this tighter context once the adaptation period is over. Based on our respondents' shared experiences, we can theorize that people who find comfort in tighter conditions when it comes to social norms, tend to express having more positive experiences in the new Canadian environment.

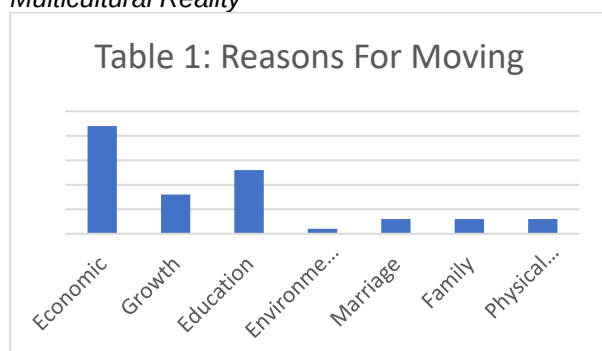
While Gelfand et al (2011) and others acknowledge that general rules of tightness and looseness do not apply consistently to entire populations and are influenced by area, level of threat, and level of mobility, a more detailed regional study of Ukraine's cultural looseness/tightness and that of Ukrainian immigrants could be warranted. However, since it is logical to presume that loose and tight cultural groups tend to showcase different levels of tolerance towards compliance and deviance of social norms, this fundamental divergence can serve as a source of conflict among populations who immigrate to Canada from different backgrounds. Thus, it is important to consider the divergence of cultural looseness and tightness of

people's original homes while providing integration support to newcomers to Canada so that multiculturalism can be embraced.

Table 1 below depicts what participants expressed as main reasons for leaving Ukraine for Canada. Some participants had multiple reasons; however, economic security was a leading factor along with improving education and seeking adventure or personal growth. And it is even more complicated than that as noted below.

Table 1

Ukrainian Canadian Newcomers Stories, Hopes and Dreams: Adapting to a New Multicultural Reality



Competing needs of personal growth, security (economic and physical), belonging

Along with identity comes other basic needs such as the opportunity for personal growth and economic stability. John Burton (1979), while not the originator of basic needs theory, positioned that a variety of needs that transcend gender, class, and culture drive human behaviour. Sandra Marker (2003) explains Burton's theory clearly noting that while these needs exist together, they are not necessarily in a hierarchy and include the following: safety/security (need for structure/stability), love/belonging, self-esteem, personal fulfillment, recognized identity, cultural security, freedom (choice), distributive justice (resources for all community members), and the ability to participate in civil society. All our participants, in various ways mentioned the fulfillment of basic needs as motivation for the big move; however, for many, the spoken emphasis was physical security for themselves and their children, if they had them, and a future that appears to have more economic security. It is still not that simple. While nine participants (almost 30%) moved to Canada temporarily, seeking to grow their education, the reason to stay was largely related to not only economic security of employment, but also the possibility to grow and develop personally. Several married women moved with husband and family, somewhat reluctantly, for economic reasons, and what would appear to be a more stable future for themselves and their children, even though that meant leaving friends, family, and work that had more personal satisfaction and status behind in Ukraine.

A sense of adventure, and another kind of self-fulfillment that helped propel many people, also had its nuances. Two young women came initially to volunteer or to work at service jobs thinking of this as an adventure or experiment for personal growth and ended up meeting their life partner on that adventure. Both women, along with two others who initially came for educational purposes, noted the heart-wrenching choice they eventually had to make: whether to marry and stay in Canada or go home to family of origin. One woman left a very good position and wonderful climate to marry, in many ways starting over in Canada, challenging her personal identity and self-sufficiency. Several others who had been to North America came overtly seeking better, more secure employment, though they were doing relatively well back home. Acknowledging the competing basic needs, Nataliya S. whose husband wanted to emigrate shared: "[b]ut for me it wasn't that easy as I worked I worked as a professor. It wasn't easy for me to start from the bottom again. Like mentally, I wasn't happy. I didn't see myself here. I didn't see myself."

Some spoke clearly about their need to belong and to fully participate in society. Two people, male and female, with very different life experiences, different levels of economic stability and geographical locations provided the clearest examples of people who moved in order to participate safely in civil society.

Five female participants spoke about their dissatisfaction with the prevalence of traditional patriarchal values and gender stereotypes that exist in Ukrainian society in general, and at their workplaces specifically which had made their employment experiences difficult serving as a glass ceiling towards employment opportunities on the one hand, on the other, in some cases, actually unsafe for females:

I love the job ethics here [in Canada]. Back in Ukraine ... I wouldn't work as an assistant to a male in Ukraine, to be honest with you. In Russia and Ukraine there is a challenge if you are a younger girl, a little bit pretty... Here I feel very safe, the [workplace] is very safe, and it is just the safest [workplace] I have ever seen.

Another participant spoke about the effect that gender stereotypes and economic instability have on young females who grow up relying on their appearances in order to gain social status through relationships with males instead of feeling empowered to achieve their own economic goals and objectives. It is good to know that the government of Ukraine has adopted a national action plan for the implementation of UN Security Council Resolution 1325 On women, peace and security and an Action Plan for the new National Human Rights Strategy which brings hope that systemic changes will occur not only at the judicial but also at the grassroots level (Ukrainian Women's Congress 2021).

In addition to challenges of gender, age was another important consideration. Two participants were surprised to observe that in Canada aging is not always seen as negative and age discrimination is not so evident at workplaces. At the same time, they expressed fascination with the ability of older people to savor their lives, travel, enjoy simple pleasures like sliding down snow hills and “act young” which stereotypically would be viewed negatively in Ukraine.

Surprises and challenges upon arrival

While our participants shared with us their major challenges and adjustments upon moving to Canada, they shared them with considerable humour. Those challenges in and of themselves provide plenty of fodder for another article on its own. Very few participants had work similar to what they were seeking lined up soon after they arrived; many worked at subsistence jobs initially and then moved up. Money that had been saved disappeared much more quickly than anticipated with things being more expensive and complicated than they anticipated in Canada, particularly housing, utilities, and public transportation. Even though most were already well educated (every participant had tertiary education) and had studied English much of their lives as a second or even third language, suffice to say that almost all wished they had obtained a better level of English before moving; however, they adjusted relatively rapidly, with many saying that they continued to learn the nuances of a language in a new culture. For some it took a while to find their sense of belonging and get used to the new culture, jokes, and social norms. Almost without exception, participants mourned not the comfort foods of home as one might think, but rather, the taste of fresh food, which, in much of Canada, does not generally have the same farm to table quality familiar in Ukraine.

Overall, participants shared that they saw the challenges they faced upon immigration as mostly positive, though in a somewhat complicated way. Essentially, it was a “what doesn’t kill you makes you stronger” attitude bundled with sheer determination that got them through, along with relational support, partially from family directly (financially, emotionally) both in Canada and in Ukraine, and indirectly through the family and cultural values they brought with them. Harkening back to Tanya Y.’s thoughts earlier this article, we found that yes, Ukrainians were taught to be strong, determined, and self-reliant, and many commented on this. However, the vast majority of participants also mentioned grasping that it was not only acceptable, but also imperative to learn to ask for help for what one needs and to seek supports, often, in this case, in the diasporic community, for there one’s language is usually understood, and some affinity found. More about this affinity later.

This next section focuses on the hopes and dreams participants shared for themselves, their families and Ukraine.

Participants’ Hopes and Dreams For Ukraine

Our participants spoke both with great sadness, sometimes frustration, and with great hope for Ukraine, their country of birth. First, all participants were clear that not only did they hope Ukraine will eventually become truly self-sufficient, strong and independent, but also all but one individual said they know this will happen. Remember, this was before Russia began its full-scale invasion.

Nadia P. spoke with some frustration about divisions in Ukraine based on political beliefs, language, pro-European vs pro-Russian views. She wanted to see more action toward unity and inclusion, to see more decisiveness and clearer articulation of goals on the part of Ukrainian leadership. Sofiya T. shared a similar sentiment wishing for Ukrainians to learn to respect each other’s divergent opinions and for leadership to take accountability over their actions and their effect on average people.

Several participants such as Valerii P. believed that Ukraine needs to build capacity and self-reliance to be able to maintain independence even when foreign support is not as prominent. Dmytro M. similarly wished for Ukraine to become a true democracy with stable economic progress.

Ironically, these hopes were fueled by the challenges that were had become increasing vivid, the catalyst being Russian aggression in the East and the annexation of Crimea by Russia in 2014. AK noted, “In Ukraine, so I’m pretty much, I’m pretty much there in my heart ...and...it’s getting better now, it’s getting... After Maidan something is... something happened. So, the nation is awake in some way, especially the new generation...” intimating that there are strong people in Ukraine and Ukraine will be self-sufficient. Like many others, she went on to voice the belief that Ukraine will continue to grow in the globalized work, and that there is already evidence of change.

Several speakers indicated the importance for Ukraine to reclaim its national, cultural, and linguistic identity, complicated as it is, and understand what is truly Ukrainian versus what was imposed on Ukraine by force. Iana P. spoke to that:

You know how those cities were Russified in the last century. We know that violence was used to enforce and there was not much choice that people had. So now we have this wonderful opportunity to come back to who we are. It doesn’t have to be traditional, no, but I think that once we remove everything that is not ours but with nonviolent ways of dealing with it, and we become

aware, I think it will change the whole dynamic [of Ukraine].

Valerii P. said he believed that Maidan served as a catalyst for political and national mobilisation of the Ukrainian people by creating a generation of new “free thinking” people. However, people with old Soviet thinking who gave in to the “ghost of socialism” as well as those who are in the middle and indifferent in their views still exist. He hoped that Ukraine would continue reforms supported by the European partners, and which would sway the people in middle to develop national consciousness. Igor S. also alluded to the importance of changing the Soviet ways of thinking, sharing that despite his first language being Russian he chose to teach his son to speak Ukrainian. Another participant spoke to the importance of reclaiming Ukrainian culture and language despite coming from an area that is known for traditionally being Russian speaking.

This hope was supported by factual changes in Ukraine, of which our newcomers were quite well informed. While Ukraine's growth and societal reforms had been hit hard by COVID 19, (The World Bank 2021), still the energy sector continued to grow, particularly alternative or renewable energy, agriculture, manufacturing (textiles and clothing), defense and aerospace and improvements to healthcare and education to name a few (Kyiv Post 2021). As participants hoped, Ukraine is continuing to develop in the globalized world. More specifically Denis V. said, “My hope has always been that Ukraine...joins the European Union and sort of the western way of life and moves away from Russia, who is clearly moving in the opposite direction.” And of course, while corruption is still evident, regarding the overall picture for stability in Ukraine, most participants noted that they could see things changing for the better, though it will take time.

For Canada

This study took place during the full-blown experience of COVID-19 across the world. While many people kind of chuckled with surprise at the question when asked about their hopes for Canada, almost all participants responded that they hoped for COVID to be over so that the Canadian government and society could get back to its work, and so that they (participants) might be able to see family members in person. They mentioned appreciation for the social programs that were implemented in this time, noting a desire “for the Canadian government to continue to support its people (like in COVID)”, including support for seniors, affordable housing, etc. They wished for Canada to continue to support democracies, including the development of Ukraine as a full democracy. They also hoped for “continued prosperity” for Canada, a land where they want their children to grow and thrive. Others drilled a little deeper into some of the issues

Canada was currently facing or not facing. Oleh C. was adamant,

I think there is a lot that needs to happen in terms of Child and Family Services development. I think that current foster care is the future of – it is gonna be the subject of multiple class action lawsuits similar to the residential school system. I don't know how this cannot be seen by people in charge because this is just unbelievable. This is one of the biggest disappointments for me personally in Canada – Child and Family Services.

Oleh went on to say that true reconciliation will require much better supports for indigenous families.

Three participants noted that they would like to see further improvement in the medical and health field and three other participants believed that Canadian society could benefit from reforming the school system to be more rigorous. While some concentrated on economic aspects wanting to see Canada become more competitive and technologically advanced, others wanted to see more education opportunities for the general public to learn about homelessness and ways of tackling the issue.

Denis V., whose work, paid and volunteer (both in Ukraine and in Canada), supports systems of good governance, summarized saying he thought Canada will continue to develop, and continue to work at this development.

[Canada must] continue dealing with maybe some of the dark parts of history that... you know... that we are finding...we maybe knew but never dealt with. But still having a dialogue, allowing... I find that sometimes in Canada now... the dialogue has been lost... It is very polarized. You only hear one side while on the other side the debate is shut down. My hope for Canada is that we always, we should always be able to debate opposing opinions. [M]aybe that is what Canada is known for: for democracy, for strong governance, for respectful debate... both sides of the debate should be able to voice their opinions and...to continue growing the country.

For themselves and their families

Participants were clear, without exception, that they hoped for and were counting on continuing economic stability in Canada for all, included in what we might call “tightness” or sense of security as noted earlier. This means continuing to grow personally and professionally, and to have similar opportunities available for the young people in their lives. Parents wanted their family to do well, for their children to feel, “secure, confident, and loved”. Many directly mentioned finding extra security and connection in the diaspora, while also believing that that community connections of all kinds were important, and what had helped them through the hardest of times. This was not a passive thought but rather a state of action for the

participants. Nataliya S. said, "We always try to be with the community. And you know, we volunteer a lot."

Almost all participants mentioned volunteering and were oriented to "to help people". For some, like Denis V., this meant community development work both in Canada and Ukraine. For Olga D. this meant changing her profession from one of successful businesswoman to health care practitioner, "to help people to reduce pain... emotional pain, physical pain, it doesn't matter." Many others found this connection through social service work.

Perhaps surprisingly, only four participants mentioned any plans to help relatives move to Canada as well. Many of these relatives were reportedly supportive of the participants' moves to Canada but had no plans or particular desire to move to Canada themselves, other than to be closer to them, and with communication made so much easier with on-line connections, this physical distance seemed a little less daunting.

"What keeps you going": Advice for those considering the journey

Without exception, participants mentioned that they would not have made the journey, nor would they have stayed in Canada, were it not for support of "dear ones" who often included family members with them in Canada and those who remained in Ukraine. Several participants noted that family members who encouraged and support them remained in Ukraine because they were living relatively comfortably there, with established communities of family and friends and work that provided at least the basic necessities of life, their basic needs as described earlier.

Many participants found strength and support in the local Ukrainian Canadian community. Olha C. shared how the feeling of shared experiences with other Ukrainian immigrants made her feel more welcome:

I was first impressed when I got to a church, when I just came to Canada and I saw all the Ukrainian people who were together who knew each other who were trying to help because they knew all... They were in your shoes before. They knew what you are going through right now, so everyone is really helpful. And now in Oseredok it is nice to see the established Ukrainian Canadian community, too. It is inspiring because you see how people manage to succeed here, to find themselves...

Yulia K. was pleasantly surprised by how the local Ukrainian diaspora managed to preserve what was lost in Ukraine. On the other hand, several participants reflected on the importance of respecting the fact that Ukrainian language, traditions, music, and culture have evolved and would like to see more acceptance for the modern

Ukrainian culture within the Ukrainian Canadian community.

No one said that the transition was easy. Iryna noted the hardships associated with immigration that often get distorted in the eyes of those who stayed behind in Ukraine due to social media. She summarized what she saw as a common, though misguided social media message:

"[The immigrants] are so lucky, they just moved to Canada or whatever and they just make money, they eat with a golden spoon and they're so happy." All those pictures on social media give us a wrong message. It's all about, "Look at me at the best moment I'm right now!" Right? It's not about, "Look at me how I'm crying at night." It's not about, "Look at me how I'm struggling with language." It's not about how I get actually... I get confused with things and I want to move [back] to my country because it is comfortable...

Building community in Canada was and is very important to setting down roots here and, somewhat surprising to us, for a number of participants that did not mean that connecting to the Ukrainian Canadian community was a priority. In contrast, Denis V. recommended newcomers be brave and venture outside of their own community, learn to interact with people who think and live differently and find something that they like about other cultures which will allow them to get to know the plurality of "the Canadian life". Another participant recommended not sticking to diaspora community forever so that the outside world does not grow so unknown that it seems hostile, something she had noticed among some of her diasporic acquaintances.

Still, community connection of some kind was necessary and desirable, as was a clear decision that Canada is indeed where one wants to live. Several participants mentioned times when they questioned their own decisions, particularly if they were the member of a couple who had not been the initiator of the quest to move. However, hope for a brighter future for themselves and their children, founded on what they saw as evidence of more stability in Canada than Ukraine was what kept them going, along with having made a clear decision to stay, being prepared to work through tough times – and ask for and accept help.

Tanya Y. emphasized the importance of understanding and honoring one's roots while building a new life in a new country:

We need to be proud of who we are and where we came from and value – and this way we will value even more what we have now.

Nataliya F. spoke clearly in her advice to someone considering the move to Canada:

Well, I think my advice would be to listen to your heart and try to figure out, first, what it is you want. If you want to integrate into Canadian society, then make steps to do it. Meet other Canadians, learn language, get education, meet

other Canadians, and integrate. If you want to keep your Ukrainian culture, associate yourself with Ukrainians, keep your culture, keep your traditions, keep in touch with Ukrainian culture and with Ukrainians from at home..

Discussion

In addition to literature searches, this study was conducted with thirty-three participants, between the ages of 18 and 60, from different areas of Ukraine, living in different areas of Western Canada, twenty-four identifying as female and nine as male. Interviews which would have ideally taken place in person, because of COVID-19 were conducted in 2021 on-line using the ZOOM pro format and audio-taped separately on a hand-held device. Participants were provided with their transcripts to check accuracy of transcription and to offer opportunities to clarify or omit any parts, a process which took some time and was also important to the ethics of the study. This article briefly summarizes the main themes of these interviews, having used theories related to identity, culture, and basic needs to better understand our participants' experiences.

We learned that since Independence was declared in Ukraine, with the borders opening, so too has migration out of the country. Most of the participants in this study moved essentially to meet basic human needs, which include not only economic (and physical security in one case), but also fulfillment of their identities as people who work to their potential, (improved education and job opportunities) and actively contribute to society. People moved with vision and hope, looking to provide more of this kind of security for their children and some for other family members who may eventually join them in Canada.

Of the participants, 45 per cent migrated post-Revolution of Dignity. One woman moved around that time and felt conflicted about her choice, but efforts to move had been initiated several years prior to 2014. All migrated prior to 2021.

Most of the participants who immigrated to Canada with Permanent Residency (PR) status took at least three years of careful planning, preparation, and English classes prior to coming. Many shared that doing preliminary research and keeping their minds open allowed them to adapt to the new reality quicker. Despite challenges the participants demonstrated enormous amounts of positive resilience which allowed them to reinvent themselves in Canada.

We learned that while the fabric of post-independence immigration to Canada from Ukraine is divergent in terms of age, gender, geographic region of origin, language preferences and social-economic status, the participants were highly educated and determined to achieve growth and build better lives for themselves and their families in Canada.

After the initial struggle of finding one's place of economic, social, and cultural belonging in the new environment and fascination with the resources that Canada offers as a WEIRD (Western, educated, industrialized, rich and developed) state, the participants started to notice social phenomena and elements that could be improved such as homelessness in our population, reconciliation challenges with our Indigenous population, racial injustice, a need for medical and educational reforms, need for newcomer support, need for community connections, and a need to develop better relationships between representatives of different waves of immigration.

Participants reflections on life after becoming permanent residents of Canada were heavily focused not only on meeting their basic needs as identified by John Burton (Burton 1990) which now are seen to go beyond needs such as food, clothing and shelter, safety and security, love and belonging, to include meaningful involvement in civil society as healthy, valued members of a community (Public Health Agency of Canada 2022). These determinants of health are also some of the fundamentals of positive peace, in a culture of peace, a culture of inclusion (Boulding 2003), a society where all are supported to live their best lives (Chinn 2004).

Narrative interviews were conducted in 2020/2021, before Russia's February 2022 invasion of Ukraine, as another generation or wave of people from different parts of Ukraine moved to Canada to seek a new life. At the time of writing, more than 8 million people have left Ukraine, fleeing the devastation and destruction of the Russian invasion (UNHCR 2023). Their stories will be heard in the days to come. Still, we believe that it is important to document the experiences and thoughts of those who came before, in different circumstances. The threads of their stories, join with others who have gone before, comprising part of the fabric of a society that welcomes refugees from the war

Conclusions: Moving forward

This was a small study, conducted with a desire to better understand both the reasons for migration from Ukraine to Canada post Ukraine's independence (and before February, 2022), and the change in the make-up and engagement in the Ukrainian Canadian community.

While most of the participants eagerly embraced Canada's multicultural environment and thoroughly enjoy cross-cultural interactions by finding strength in the similarities of struggles and desires that different groups share, they see reconciliation, social justice, and positive peace for different racial and ethnic groups in Canada as the way for Canada and themselves as Canadians to grow with positivity.

Again, we note that the interviews and initial analysis took place prior to the overt invasion of Ukraine by Russia on February 24, 2022. The delay in publication is somewhat connected to the impact of this aggression on all of us, participants, and writers. Still, we believe in the importance of sharing the stories and wisdom of these participants.

Moving forward, we believe it will be important to research more fully and deeply into this topic, as this was such a small study. The next steps will include, amongst others, people who have moved to Canada following the invasion of Ukraine by Russia. Informal conversations with these people have begun as we listen, careful not to re-traumatize in our eagerness to understand and support. We do hope that even this small study shared here opens doors for all Canadians, including diaspora members, to be more curious and open to their neighbours, wherever their origin, encouraging them to share their stories, hopes, and dreams. Newcomers to Canada are never a monolithic block; all contribute in different ways depending on experiences, identities, needs, and hopes. We are richer together, supporting each other in good health.

Conflict of interest

The authors declare that they have no conflicts of interest.

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A qualitative exploration of participants' preferred elements of the 4-week, youth-led, youth-focused, group-based Shamiri intervention: A brief overview

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Abstract

Introduction: Adolescent mental health challenges have been identified as a public health concern globally, especially in low- and middle-income countries (LMICs), due to the scarcity of services, where help-seeking is often hampered by social stigma. A strategy to increase the availability of services is to implement, brief, stigma-free, and scalable interventions. The Shamiri Intervention (the Kiswahili word for “thrive”) is an example of a 4-week, group-based intervention which is implemented via 1-hour sessions within high school settings.

Purpose: The present study employed qualitative methods to explore participant feedback on their preferred elements of Shamiri Intervention. The aim is to use the feedback to help to guide and improve intervention effectiveness, acceptability, and appropriateness. The results have the potential to understand better lay-provided mental health service delivery and design among high school students in LMICs, particularly in sub-Saharan Africa.

Methodology: The project employed a qualitative phenomenological design to collect participant feedback, and reflective thematic analysis was used to analyze the data.

Results: The researchers constructed the following themes to summarize the participants' responses: learning (acquiring new knowledge related to the core components of the Shamiri Intervention, i.e., growth mindset, values affirmation, and gratitude); rewards (e.g., prizes awarded that encouraged participation); positive interaction (i.e., the peer-lead delivery); and solutions-oriented (e.g., the practicality of the Shamiri Intervention).

Conclusion: The preferred components of the Shamiri Intervention were learning, rewards for participation, positive interactions with other people, and the solution-oriented nature of the sessions. The mentioning of the features of the Shamiri Intervention could also suggest that, indeed, they are appropriate for the target population. Additionally, the support for the lay providers is critical in Shamiri intervention cost-effectiveness, accessibility, and scalability.

Keywords

Mental Health, Kenya, Youth-Friendly, Intervention

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Introduction

Mental health challenges, such as depression and anxiety, among adolescents aged 15 to 19 years have been identified as a global public health concern globally (World Health Organization [WHO], 2017). An even bigger burden is experienced in low and middle-income countries (LMICs) such as Sub-Saharan Africa (SSA) (Vigo, Thornicroft & Alun, 2016), where mental health services are scarce, require expertise and are often lengthy and expensive services (Weiz et al., 2017). The need to seek and provide mental health services is also highly hampered by social stigma (Ndeti et al., 2016), which can be fueled by the fact that traditional mental health care services focus on addressing mental illness.

Among the key proposed ways to deal with mental health challenges burden, especially in SSA, lies in formulating and embracing simple, brief, stigma-free, and scalable interventions (Yotham et al., 2018), which focus on specific psychological processes, offers a key strategy to embrace the scarcity of mental health services. Such programs include the Shamiri Intervention (the Kiswahili word for “thrive”). This character strength intervention anchored on “wise” interventions that seek to change behavior by targeting specific psychological processes for better and improved life outcomes (Walton & Wilson, 2018). The Shamiri intervention is implemented via 4-week, group-based, 1-hour sessions within high school settings. Recent high school graduates aged 18 to 22 are recruited and trained for at least 10 hours to effectively deliver Shamiri Intervention to the students.

Previous research studies indicate that the Shamiri intervention positively impact high school students, such as reducing depression and anxiety symptoms and improving their academic performance and interpersonal relationships (Osborn et al., 2021). The highlighted impact was successfully measured and evaluated by analyzing data from three gold-standard RCTs (Venturo-Conerly et al., 2021). However, the self-reported qualitative data on the program feedback provides insight into the participants’ views, thoughts, and feelings about the Shamiri program remains largely unexplored. Thus, this paper explores participants’ program feedback on what elements of the Shamiri program students preferred. This will help to guide and improve intervention effectiveness, acceptability, and appropriateness based on the thoughts and feelings of high school adolescents who are the program’s target population.

Purpose

The present study employed qualitative methods to explore participant feedback on their

preferred elements of Shamiri Intervention. These results are a first step to helping inform and improve the development and implementation of the Shamiri intervention. Further, the results also have the potential to better understand lay-provided mental health service delivery and design among high school students. They can help address the care burden and treatment gap for youth-mental health in SSA.

Methodology

Sample

We used convenience sampling/purposive to target a sample of 413 high-school students (13-18 years) with elevated levels of depression and anxiety as measured by GAD-7 and PHQ-8 to participate in the Shamiri intervention. [For more information on the sample, see Osborn et al. (2021)]. The students were selected from four high schools within Nairobi and Kiambu counties in Kenya. Parental consent was sought for the minors, and written assent was before the students participated in the study. The students were also informed of their right to withdraw from their studies.

Eligibility criteria

To participate in the study, participants were required to meet the following inclusion criteria; aged between 13-18 years old, enrolled in the 4-week Shamiri intervention programs, and able to read the questionnaire and give responses in the English language and have elevated levels of depression and anxiety.

Design

To gather qualitative information, the study adopted a phenomenological qualitative design (Moustakas, 1994). In the study, the students described what they thought or felt was their favorite about the Shamiri 4-week program (post-treatment). To understand their experiences, the data collected was analyzed in a structured way, and the authors developed themes to highlight the essence of students’ experiences.

Analysis

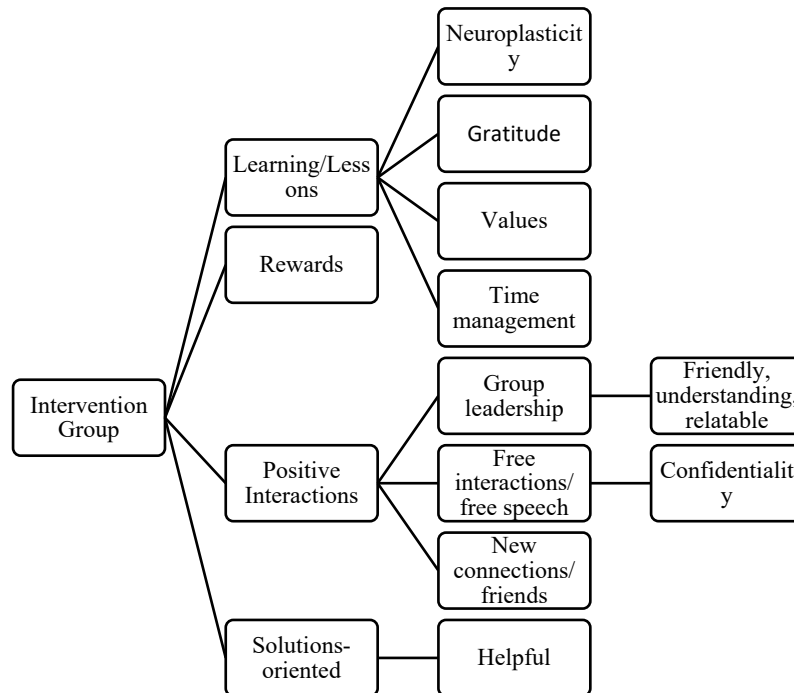
The authors employed the six stages of Reflective Thematic Analysis by Braun & Clark (2006; 2019) to analyze the qualitative data. These include familiarization, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and the write-up. The reliability analysis was also conducted to ensure reliable and consistent theme consensus. Two Kappa scores were measured between three coders on two different data sections, at 0.8 and 0.6, indicating good inter-rater reliability.

Further, Lincoln and Guba’s (1985) criteria and Creswell’s (2018) methods helped guide the reliability and validity of the findings. To achieve

credibility and confirmability, the authors used multiple coders. The large sample size and data saturation supported transferability. The dependability of the results was ensured by a rigorous and detailed thematic analysis process, which is summarized in a thematic map (See Figure 1). Quotes were also reported verbatim to ensure data-driven results. The themes were generated by a multi-cultural group of

researchers, each with different experiences and expertise; they met on several occasions to discuss the findings and support ongoing reflexivity.

Figure 1. Thematic Map



Results

The researchers constructed the following themes to summarize the participants' responses. The key themes include learning, rewards, positive interaction, and solutions-oriented.

Learning

Learning themes involved responses directly related to acquiring new knowledge. Several participants endorsed the central components of the Shamiri Intervention, which include Neuroplasticity (growth mindset), Gratitude, and Values. The components of the intervention each made up a sub-theme for this category:

Neuroplasticity

Neuroplasticity (growth mindset) refers to the fact that the human brain can grow, improve, and perform better. Neuroplasticity indicates that humans can learn new things and improve through effort and practice. When people are open to growth, they are not comfortable in one zone; they challenge themselves and see growth opportunities even during difficult situations.

"The study of growth mindset because I grew really." Participant 704

"I was able to learn how the brain works and if you want to you can change things which cannot help you at all." Participant 1592

Gratitude

Gratitude involves embracing feelings of appreciation. Gratitude is not ignoring what we already have, what we are good at, but being thankful for appreciating what we have, being thankful for what we are good at. When embraced, gratitude can improve how a person feels and treats others.

"The fact that there are many things to be grateful for and also that we should not be discouraged but work hard in anything that we do." Participant 1381

Values

Values refer to key ideas that people hold important in their lives. Values guide people in making their decisions, during interactions with other people, as well as achieving important goals in their lives.

"It made me discover that my brain is rapidly growing over time and my attitude determines its nature." Participant 292

Rewards

Rewards encompassed responses related to the prizes awarded to the participants to

encourage more participation and engagement throughout the Shamiri Intervention program. A few students commented that this was their favorite part of the intervention. However, the rewards are not a component of the Shamiri intervention, but a supporting element used to encourage session attendance.

"The part where I won a shirt." Participant 4305

Positive interactions

Positive interactions highlighted the participants' acknowledgement of the group leaders and the peer-led delivery nature of the Shamiri intervention. Several participants commented on the support they received from the group leaders that delivered the intervention. Shamiri intervention is lay-provided, and the lay providers are young people who have recently graduated from high schools, an aspect that allows them to relate well with the participants. The positive interaction's theme was further divided into the following sub-themes,

Peer Group Leadership

Peer Group Leadership involved special acknowledgement to the Shamiri Institute leaders.

"The group leaders were understanding, and they made one to understand everything." Participant 224

"The fact that the trainers are really understanding and can relate to our experiences." Participant 449

"We would get to share ideas as a group about something which helped so much." Participant 801

"The program has really helped me to realize that if I try hard, I will achieve what I am after." Participant 2067

Free Speech

Free Speech some participants specified the importance of having a confidential, safe space to share their experiences without fear that their contributions would be repeated or feel judged.

"I got a chance to speak my mind, and to learn from others." Participant 793

"I had the freedom to express myself as honestly as I could. I cannot actually tell these to the most trusted friend." Participant 339

"Understanding. Privacy and confidentiality." Participant 732

New connections

New connections captured the participants' appreciation of interacting and connecting with new people. It may indicate strength in the fact that the intervention is delivered by individuals who come from without the school setting—individuals that the students have not interacted with before— which may be an important consideration in the future scaling-up efforts of Shamiri.

"Interacting with new people and growing as a person." Participant 1071

Interestingly, neither Rewards nor Peer Group Leaders are part of the intervention but appear to be an important component of the Shamiri intervention program delivery.

Solutions-oriented

Solution-oriented addressed the responses around the practicality of the intervention. This theme helps describe the impact of the Shamiri intervention. Several participants appreciated the practicality, relatability, and applicability of the intervention.

"Interacting and sharing my problems then getting solutions." Participant 649

"Knowing how to solve a problem. Knowledge of how to achieve my goals and even how to make my worries get over me. Knowing that practice and more practice makes perfect." Participant 9142.

Conclusions

The preferred components of the Shamiri Intervention were learning, rewards for participation, positive interactions with other people, and the solution-oriented nature of the sessions. The first theme consisted of the core components of the Shamiri Intervention (growth mindset, gratitude and values affirmation), which may suggest that the three concepts are appropriate and key character strengths for this population and context. Moreover, the qualitative feedback provides additional affirmation of the ability of these evidence-based therapeutic elements to help deal with many challenges facing the provision of quality mental health care among young people. The mentioning of the Shamiri Intervention features could also suggest that, indeed, they are; a) simple, in that despite being broad, they can be easily understood by the target adolescent population. The simple aspect of the three components of Shamiri Intervention plays a significant role in making the intervention accessible—as it does not require expertise to deliver and can be lay-provided, b) stigma-free—it utilizes simple terms that do not refer to psychopathology, c) scalable—an extended impact of the intervention being lay-provided, thus can be low cost (Osborn and Wasanga, 2020).

Interestingly, the delivery of Shamiri Intervention also appeared to have been significant. For example, the participants seemed to prefer lay providers, who—as mentioned previously—make the intervention provision relatable to high school adolescents and low-cost. Additionally, the positive interactions adopted in the group-led sessions that adopt unconditional positive regard also seemed to impact participants significantly. Positive reinforcement, in the form of prizes/rewards accorded to active participants

who constantly engage and on other merits, did have a significant impact. These highlights are essential because the use of lay providers is key in Shamiri intervention cost-effectiveness, accessibility and scalability. The lay providers (young people with limited mental health training) are readily available in Africa and particularly Kenya. In totality, these aspects—low-cost, scalable, accessible—are important during scaling up mental health care services that can help address the treatment gap to the increasing mental health needs. Additional qualitative studies are required to evaluate further how we can improve the effectiveness and sustainability of the Shamiri Intervention.

Finally, our findings support task-sharing using lay providers (peer leaders) and group-based interventions as an appropriate and cost-effective method to scale-up services in this service. We believe that the preferred elements, i.e., rewards, learning, positive interactions and solutions-oriented, are essential components of the effective youth-friendly intervention in this context.

Conflict of interest

The authors declare that they have no conflicts of interest.

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Undergraduate Student's Stress, Anxiety, Depression, and their Coping styles during COVID-19

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Abstract

Introduction: COVID-19 was responsible for widespread disturbance throughout the educational system and was harmful in a variety of ways. In particular with regard to the state of a student's psychological health.

Purpose: This study examines the relationship between psychological distress (depression, anxiety, and stress) and coping strategies among the students of a private university in Bangladesh during the COVID-19 pandemic.

Methodology: A cross-sectional web-based survey was conducted from September 2020 to December 2021 on 951 respondents using the DASS-21 and Brief-COPE questionnaires.

Results: The majority of students were experiencing mild to extremely severe depression (75.8%), anxiety (88.5%), and stress (79.1%). The level of stress ($p < .001$), anxiety ($p < .001$), and depression ($p = .23$) was significantly higher among the female students compared with male students. This study also highlights the coping strategies of students. However, sex differences were not profound in adopting coping strategies. The results also showed significant correlation between some Brief-COPE measures, such as acceptance and self-blame ($r = .708$, $p < .001$); use of informational support and emotional support ($r = .599$, $p < .001$).

Conclusion: As the prevalence of mental health disorders was found to be higher among private university students, university authorities should seek necessary assistance from mental health professionals to support their students in overcoming psychological distress not only related to the pandemic but also related to their day-to-day life activities.

Keywords

Anxiety, Mental Health, Bangladeshi university students, Covid-19, Stress, Depression, Anxiety, Coping

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Introduction

Worldwide, Covid-19 has caused widespread disruption in the operations of almost every sector. And, the education sector including primary, secondary and tertiary level is no exception to it. Academia has suffered the pandemic's overall effects (Hosen et al., 2022). While most sectors were able to resume operations after the lockdown was eased, educational institutions remained closed, and their closure was extended several times (Newage Bangladesh, 2022). Despite these institutions being closed for the longest period of time, a vast majority of these students were nevertheless able to continue their education with the aid of technology (UNICEF, 2022; Priyo & Hazra, 2020).

Bangladesh has 109 private universities, 53 public universities, and 3 international universities (UGC, 2022). The process of reopening educational institutes was carried out in phases, starting with the initial opening of schools, after which the public universities followed, and then, gradually, private universities made the decision to reopen as the number of deaths caused by the virus started to decline (Mahmud, 2021). Although, private universities postponed the start of on-campus classes due to the shutdown, many of these institutes continued to provide online classes throughout the closure (Khan, Rahman & Islam, 2021).

In this respect, research suggests that pandemics have detrimental effects on mental health (Faisal et al., 2022). Furthermore, the spread of infectious diseases is linked to a decline in mental health (Mehareen et al., 2021). As per epidemiological data, people in Bangladesh are experiencing mental health issues as a result of the COVID-19 pandemic and the subsequent mass isolation, mostly owing to fear (Faisal et al., 2022; Md. A. Islam et al., 2020).

Besides, the disruption of routine daily operations brought on by the pandemic has previously shown to induce tension and anxiety, and students are no exception to these repercussions (Faisal et al., 2022). This was mainly because no one knew when the situation would be resolved (Hosen et al., 2022). Moreover, there is concern that university students, who are in a transition period between their academic and professional lives, may be particularly vulnerable to COVID-19 related mental health issues (Faisal et al., 2022; Md. A. Islam et al., 2020).

In addition, home quarantine can have a negative impact on students' mental health because of the isolation they experience from their peers, the anxiety they feel about catching the disease, the rise of domestic violence brought on by the stay-at-home lifestyle, and financial hardship caused by lost work opportunities (Mehareen et al., 2021; Rehman et al., 2021). Despite the fact that students at reputable private

universities in Bangladesh typically have a higher socioeconomic status compared to that of a public university, they were unable to compensate for the lost income through part-time jobs (Hosen et al., 2022; Shafiq, Nipa, Sultana, Rahman, et al., 2021). The students were also subjected to experiencing stress, worry, anger, boredom, loneliness, and other emotions as a result of the schedule adjustment (Huang et al., 2021).

Thus, this kind of situation creates psycho-emotional chaos, which causes anxiety, depression, and stress (Md. A. Islam et al., 2020). Stress is therefore experienced as a combination of mental and physical discomfort that occurs whenever our homeostasis is disrupted; anxiety is the body's natural response to stress; and depression is a state of disinterest in daily activities (Rehman et al., 2021). One's response to stress depends on the level of stress experienced; some people thrive under pressure, while others cope in an inappropriate manner and thus the importance of coping mechanisms in determining psychological well-being cannot be ignored (Huang et al., 2021).

Therefore, coping strategies are employed by individuals to mitigate their stress, anxiety and depression (SAD). These may include emotional, spiritual, behavioural, physical, external, and cognitive strategies (Verma et al., 2021). Study revealed that young people (15-35 years) use passive coping strategies which has negative role in regulating young's mental health (Huang et al., 2021). Students preferred to use coping to mitigate their stress, including seeking help from others, attempting to solve their problems on their own or coping passively (Babicka-Wirkus et al., 2021). In the case of negative coping, it is almost always referred to as emotion-focused or avoidant coping, such as ignoring the source of distress or looking for a substitute to alleviate symptoms, like eating or smoking (Huang et al., 2021).

The literature showed that university students reported higher levels of SAD during the COVID-19 pandemic (Huang et al., 2021; Tshering & Dema, 2022). Even though Indian students displayed a low level of depression, most students were concerned about their lives and careers (Verma et al., 2021). Studies also revealed differential level of SAD based on the sex. For example, female university students are more likely to experience a severe to extremely high level of anxiety (Mehareen et al., 2021; Rahman et al., 2022; Salman et al., 2022). On the contrary, a study conducted by Muhammad et al., (2021) did not reveal any significant differences among male and female private and public university students in SAD.

Students at private universities experienced higher levels of mental stress than those at public universities (Kamruzzaman et al., 2022; Shafiq, Nipa, Sultana, Rahman, et al., 2021). On the other

hand, other researchers noted that students from public universities reported higher levels of depression than students from private universities (Mehareen et al., 2021; Muhammad et al., 2021).

Moreover, anxiety and stress are seen to be affected by socio-economic status (Muhammad et al., 2021). In addition, students who were academically behind were more likely to suffer from depression and anxiety (Tshering & Dema, 2022). It was also observed that academic environments and subject-related future worries are strongly associated with mental health problems in undergraduate students (Ali et al., 2022).

Previous researches indicate that social support and coping mechanisms are protective factors for psychological health (Huang et al., 2021). During the pandemic, students used several coping strategies, including behavioral disengagement, religion, self-distraction, instrumental assistance, planning, and acceptance as their coping mechanisms with SAD (Salman et al., 2022; Verma et al., 2021). There is also a strong correlation between SAD scores and coping styles (Huang et al., 2021). For example, perceived social support has a negative association with psychological distress (Rathakrishnan et al., 2022).

Since, it has been noted that university students experience psychological issues on a regular basis; therefore, it is crucial to look at how the global pandemic has affected students' mental health. Due to the unanticipated nature of the situation, it is important to learn about the psychological and social experiences of university students in Bangladesh and their coping styles in particular. The researchers are aware of various studies that examine Bangladeshi university students' stress, anxiety, and depression, but none of these studies specifically focuses on students' stress, depression, and anxiety as well as their coping styles.

Purpose

This study was therefore designed to examine the level of stress, depression, and anxiety experienced by university students in Bangladesh, as well as the coping styles they employ to deal with it. The specific objectives are:

- to examine the level of stress, anxiety and depression among the university students due to the COVID-19 pandemic;
- to identify the coping strategies adopted by the students to mitigate their stress, anxiety and depression;
- to examine whether there were any variations in the level of stress, anxiety and depression and the coping strategies based on the sex of the students; and the relationship between psychological distress and coping strategies.

Methodology

Measurement

In this study, we conducted a cross-sectional survey with the students from summer 2020 semester to fall 2021 semester. Using convenient sampling, we recruited study participants from East West University, a private university in Bangladesh. The survey was conducted through Google Forms because physical classes were suspended due to COVID-19 restrictions. Students were sent an email with an invitation to participate in the study and a link to access the survey platform. The students' email addresses were collected from the university portal. The response period for the survey was from 24 September 2020 to 28 December 2021. The total number of students who received the survey invitations was 1080; and the response rate was close to 88.05%, which is reasonable for an online survey. All the students voluntarily participated in the study.

The questionnaire was developed in English and was distributed among the students online. The medium of instruction of the university is English and students were comfortable with the English questionnaire.

Data Collection tool

A self-administration questionnaire was developed. The questionnaire consists of three sections including (i) basic socio-demographic characteristics; (ii) Depression, Anxiety and Stress Scale (DASS21); and (iii) Coping Orientation to Problems Experienced Inventory (Brief-COPE).

Socio-demographic data collected includes sex, age, education level (freshman year sophomore year, junior year, senior year), department (science and engineering; liberal arts and social sciences; business and economics), residential status, family members, occupational status, and average monthly income of the household.

The DASS framework has 21 items (DASS-21) which consist of three self-report scales designed to measure the emotional states of depression, anxiety, and stress of a person (Lovibond & Lovibond, 1995). Each item of DASS is measured with a four-point Likert scale' 0 (didn't apply to me at all), 1 (applied to me to some degree or some of the time), 2 (applied to me to a considerable degree or a good part of time), or 3 (applied to me very much or most of the time). The sum scores on each item (depression, anxiety, stress) of DASS-21 are multiplied by 2 to calculate the final score. The threshold to categorize the level of DAS are as follows: (depression: Normal 0-9, Mild 10-13, Moderate 14-20, Severe 21-27, Extremely Severe 28+); (Anxiety: Normal 0-7, Mild 8-9, Moderate 10-14, Severe 15-19, Extremely Severe 20+); (Stress: Normal 0-14, Mild 15-18, Moderate

19-25, Severe 26-33, Extremely Severe 34+). The stress subscales were 0.86, 0.78, and 0.74, respectively. The overall Cronbach alpha of DASS-21 was 0.89.

The Brief-COPE framework has 28 items designed to measure effective and ineffective ways to cope with stressful life events (Carver, 1997). Brief COPE employed a four-point Likert scale ranging from '1' (I have not been doing this at all) to '4' (I have been doing this a lot). The higher score of coping strategies used means that the respondents had employed coping strategies more often. (Meyer, 2001) further categorized Brief-COPE measures into two types: (i) adaptive coping strategies include active coping, acceptance, humor, planning, positive reframing, seeking social support, religion, use of emotional and instrumental support; (ii) maladaptive coping strategies include behavioral disengagement, denial, substance use, venting, self-distraction, and self-blame.

Sample

A total of 951 valid responses were collected using a convenience sampling technique. The students were from the faculties of science and engineering, business and economics, and liberal arts and social sciences. The sample was composed of 51.31% female students and 48.69% male students between the ages of 18 and 23, who were enrolled in the undergraduate

Cronbach alpha for depression, anxiety, and programs in the summer 2022 to fall 2021 semester of their university study plan.

Data Analysis

Statistical analysis was performed using Microsoft Excel 2021 and SPSS software version 26. Descriptive (e.g., percentages, frequencies, means, standard deviation) and inferential statistics were calculated using SPSS software.

Ethical Consideration

The study was conducted in line with the Helsinki declaration. Participation in the survey was voluntary and no incentives were offered for participation. The online survey incorporated a request for informed consent, and students had to provide their consent before the survey was administered.

Results

Respondent's profile:

The mean age of the respondents was 21.77 years (SD=1.48), ranging from 18 to 23 years (Table 1). More than half of the respondents were female (51.3%). Over two-fifths (41.1%) of the respondents were from their sophomore year, from the business and economics faculty (49.1%), living with a nuclear family (57.8%), and unemployed (63.0%). The average family size was 4.36 (range: 2 to 6).

Table 1: Socio-demographic profile of study participants (n=951)

Variables		Frequency	Percent
Age (in years)	18-21	457	48.1
	22 and above	494	51.9
Gender	Female	488	51.3
	Male	463	48.7
Education level	Freshman year	37	3.9
	Sophomore year	391	41.1
	Junior year	291	30.6
	Senior year	232	24.4
Living with both parents	Yes	738	57.8
	No	213	42.2
Family members	≤4 members	556	58.5
	≥5 members	395	41.5
Occupational status	Unemployed	599	63.0
	Employed	300	37
Average monthly income of household	Tk. ≤50,000	455	47.8
	Tk. ≥50,001	496	52.2
Faculty	Science and engineering	285	30.0
	Liberal arts and social sciences	199	20.9
	Business and economics	467	49.1

Psychometric properties (Based on DASS-21 scale):

The range of depression, anxiety and stress varied from normal to extremely severe levels. 25.4% of the study participants had moderate depression, 22.1% had extremely severe

depression and 24.2% were normal (Table 2). On the anxiety scale, the majority (49.0%) had extremely severe anxiety and 19.9% had moderate anxiety (Table 2). And on the stress scale, 26.9% had moderate stress, 26.5% had severe stress and 20.9% were normal (Table 2).

Table 2: Range of Depression, Anxiety and Stress among study participants (n=951) (Source: Survey, 2021)

Severity level	Depression	Anxiety	Stress
Normal	230 (24.2%)	109 (11.5%)	199 (20.9%)
Mild	115 (12.1%)	52 (5.5%)	154 (16.2%)
Moderate	242 (25.4%)	189 (19.9%)	256 (26.9%)
Severe	154 (16.2%)	135 (14.2%)	252 (26.5%)
Extremely severe	210 (22.1%)	466 (49.0%)	90 (9.5%)

While comparing the levels of stress, anxiety and depression among females and males, it was found that there was a significantly higher proportion of reported normal levels of stress,

anxiety, and depression (Table 3). In contrast, a significantly higher proportion of female respondents reported extremely severe levels of stress (12.9% vs. 5.8%), anxiety (56.6% vs. 41.0%), and depression (25.2% vs. 18.8%).

Table 3: Level of stress, anxiety and depression based on sex of the respondents

Severity level	Depression	Anxiety	Stress
Male			
Normal	130 (28.1%)	70 (15.1%)	127 (27.4%)
Mild	55 (11.9%)	30 (6.5%)	80 (17.3%)
Moderate	122 (26.3%)	94 (20.3%)	127 (27.4%)
Severe	69 (14.9%)	79 (17.1%)	102 (22.0%)
Extremely severe	87 (18.8%)	190 (41.0%)	27 (5.8%)
Female			
Normal	100 (20.5%)	39 (8.0%)	72 (14.8%)
Mild	60 (12.3%)	22 (4.5%)	74 (15.2%)
Moderate	120 (24.6%)	95 (19.5%)	129 (26.4%)
Severe	85 (17.4%)	56 (11.5%)	150 (30.7%)
Extremely severe	123 (25.2%)	276 (56.6%)	63 (12.9%)
	$\chi^2=11.33$, df=4, $p=.023$	$\chi^2=29.20$, df=4, $p<.001$	$\chi^2=38.36$, df=4, $p<.001$

Note: df=degrees of freedom; χ^2 =Chi-square test

The mean values of stress, anxiety and depression for males were found to be 10.12 (± 4.13), 8.73 (± 4.69), and 8.42 (± 5.30) and for female were 11.65 (± 4.13), 10.29 (± 4.81), and 9.78 (± 5.58), respectively. The mean value of males was found to be lower than females. Both males and females reported mild stress and moderate depression. However, females were found to have extremely severe anxiety scores.

Table 4: Mean score of stress, anxiety, and depression

SAD	Sex	Mean	Std. Deviation
Stress	Female	11.65	4.13
	Male	10.12	4.11
Anxiety	Female	10.29	4.81
	Male	8.73	4.69
Depression	Female	9.72	5.58
	Male	8.42	5.30

The one-way ANOVA showed insignificant differences in the mean values of SAD across the student's current years of study. The correlation analysis between SAD with economic affluence did not reveal any significant associations. Furthermore, this study did not find any significant relationship between the level of SAD with age and residential status of the respondents.

The independent sample t-test was performed to find differences in the level of stress, anxiety, and depression among males and females. The results indicated a significant difference in the levels of stress $t(5.69)$, $p < .001$, anxiety $t(5.07)$, $p < .001$, and depression $t(3.7)$, $p < .001$ experienced by males and females.

Coping strategies:

We examined the coping strategies of the students using the Brief COPE scale. The average score of problem focused coping was 2.84 (± 0.6), emotion focused coping was 2.52 (± 0.47) and avoidant coping was 2.06 (± 0.48) (Figure 1).

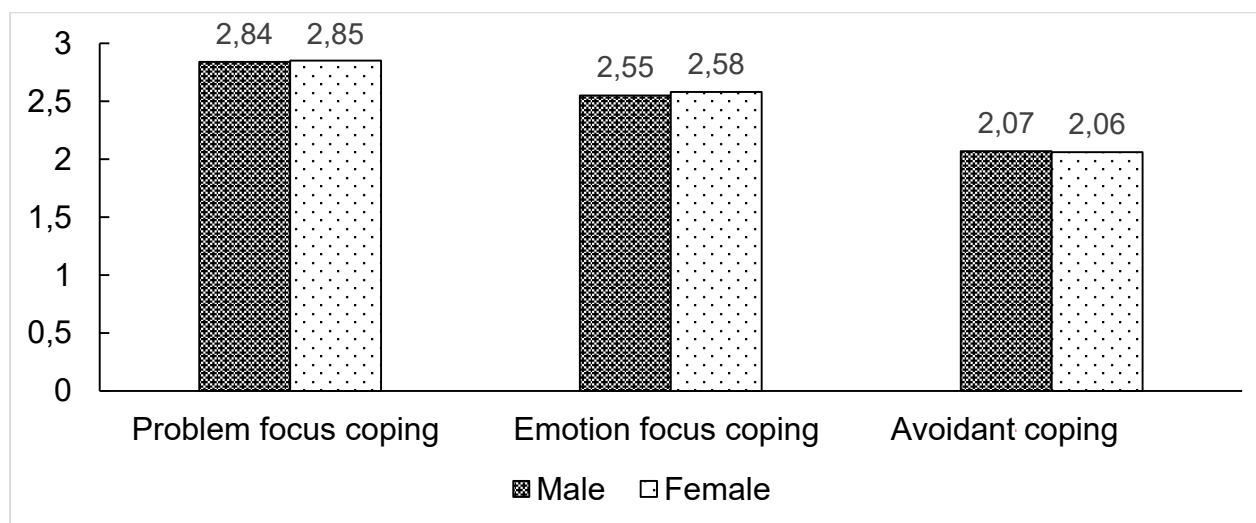


Figure1: Coping strategies and sex difference.

We used a one-sample t-test to investigate the variations in coping strategies used by male and female students. As shown in Table 5, female students mostly employed adaptive coping strategies with a mean score of 2.69 as compared with males with a mean score of 2.66. In contrast, male students mostly employed maladaptive coping strategies with a mean score of 2.18 as compared with females with a mean score of 2.17. The findings suggested that there were significant differences between the average scores of males and females in adapting 'humor' coping strategies ($t=2.211$, $p=.035$). However, no significant

differences were found for other coping strategies. By evaluating the correlation matrix, it can be noted that a higher coefficient is observed between acceptance and self-blame ($r=.708$, $p < .001$); and the use of informational support and emotional support ($r=.599$, $p < .001$). Although the correlation coefficient between religion and substance use was relatively weak, it showed a significant negative correlation ($r=-.173$, $p < .001$).

The correlation between the variables of the DASS-21 and Brief COPE scales were found to be significant, except between depression and

problem focused coping ($r=0.03$, $p=.349$). All three aspects of DASS-21 shared moderate significant positive correlation with each other. The findings showed that the correlation coefficients between anxiety and stress; depression and stress; and depression and anxiety were found to be 0.582,

0.574, and 0.513, respectively. Although the correlation coefficients between anxiety and problem focused coping ($r=.207$, $p<.001$); and stress and problem focused coping ($r=.175$, $p<.001$) were relatively weak, they showed a significant correlation.

Table 5: Descriptive statistics for total group ($n = 951$) and for sex (female = 488; male = 463)

	Total		Male		Female	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Active coping	2.97	0.76	2.98	0.75	2.97	0.77
Use of informational support	2.53	0.93	2.52	0.91	2.53	0.94
Positive reframing	2.92	0.83	2.91	0.81	2.92	0.85
Planning	2.95	0.77	2.94	0.77	2.97	0.78
Emotional support	2.37	0.87	2.35	0.85	2.40	0.89
Venting	2.35	0.80	2.34	0.78	2.37	0.82
Humor	1.86	0.91	1.79	0.89	1.92	0.92
Acceptance	2.80	0.77	2.83	0.75	2.77	0.79
Religion	2.98	0.93	2.94	0.91	3.02	0.95
Self-blame	2.46	0.97	2.48	0.98	2.45	0.96
Self-distraction	2.92	0.79	2.92	0.78	2.93	0.81
Denial	2.06	0.87	2.05	0.86	2.07	0.87
Substance use	1.22	0.55	1.22	0.55	1.21	0.56
Behavioral disengagement	2.06	0.85	2.09	0.85	2.03	0.84

Note: *=adaptive coping; #=maladaptive coping

Discussion

The findings of our study showed that the prevalence of psychological distress was higher in proportion among private university students, and more than two-third of the students were experiencing mild to severe SAD. The findings are consistent with previous studies conducted in Bangladesh (M. S. Islam et al., 2020; Kamruzzaman et al., 2022; Shafiq, et al., 2021). This may be because, despite having better socioeconomic status than their counterparts at public universities in Bangladesh, students at reputable private universities were unable to make up the difference in income through part-time employment (Hosen et al., 2022; Kamruzzaman et al., 2022).

Furthermore, the prevalence of SAD is significantly higher among the female students as compared with the male students. This finding is consistent with previous studies (Abayabandara-Herath et al., 2022; Huang et al., 2021a; M. S. Islam et al., 2020; Verma et al., 2021). This might be the case because female students' house quarantine can harm their mental health because it limits their access to social networks (pleasant interaction, friendship, social support, co-studying), the fear of contracting the illness, the increase in domestic violence brought on by the stay-at-home lifestyle, and the financial hardship

brought on by missed work opportunities (Mehareen et al., 2021; Shafiq et al., 2021).

The result also suggested that academic disciplines were not associated with the prevalence of SAD. This finding is partially consistent with (Faisal et al., 2022; Paudel et al., 2020), which reported no significant association between academic disciplines and stress or depression.

This study found no significant differences between economic affluence, stress and depression. Our study findings contradict previous studies (Abayabandara-Herath et al., 2022; Mehareen et al., 2021; Rehman et al., 2021; Shafiq, et al., 2021) that reported that students with poor economic conditions were more prone to having higher levels of depression and stress. This could be because private university students are likely to have better socioeconomic status; the study revealed no significant differences between psychological distress and income level. The variables age, residential status, and income showed an insignificant relationship with SAD. Our findings are in agreement of Faisal et al., (2022), who found that anxiety and depression symptoms as well as mental health status did not differ significantly by sex, age, residential status and education level.

The result of the correlation analysis suggests that there is a significant correlation between SAD. This finding is in line with previous studies

(Huang et al., 2021; Paudel et al., 2020; Verma et al., 2021). Moreover Brief-COPE measures (except humor) were not associated with the sex of the respondents. This finding was not in line with García et al., (2018), who reported significant differences between male and females in adopting coping strategies, including religion, venting, behavioral disengagement, denial, self-distraction, emotional support and the use of informational support. This could be due to the fact that COVID-19 affected both male and female students in an equitable manner.

Limitations and Strength of the Study

Limitations

Although our study has made a significant contribution to the field of mental health research during the pandemic, it has several limitations. Firstly, we collected the data using a Google form. Due to the strict lockdown throughout the country, it was not possible to conduct a face-to-face interview. Secondly, this study was conducted in a private university setting, and as a result, the participation of a larger group of students from a public university is missing. Thirdly, it is a cross-sectional study and thus the generalization of the findings of this study is limited to a specific context.

Conclusions

This study aimed to explore the level of stress, anxiety, and depression among the students of a private university in Bangladesh, as well as their coping styles to deal with it. The findings of our study show that a higher proportion of private university students experienced psychological distress. Sex of the students was found to be an important factor for psychological distress, as female students exhibited higher levels of stress, anxiety and depression. On the other hand, sex differences were not profound in adopting coping strategies. The results also showed a significant correlation between some Brief-COPE measures, such as acceptance and self-blame; and the use of informational support and emotional support. It is essential to develop interventions such as counselling and emphasize stress management.

Conflict of interest

The authors declare that they have no conflicts of interest.

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Note

Mental healthcare services support: the social role of medical educator involved in the destigmatization process to generate inclusion

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Abstract

Introduction: The stigmatization of mental healthcare services and users is a barrier to the achievement of mental wellness present on a global level. 800000 suicides are estimated each year, 25 suicide attempts for every suicide (ratio of 25:1), and in 2017 estimated a prevalence > 10% of people suffering from mental disorder or substance abuse (global data). The stigmatization is a multifactorial phenomenon and process that involves different factors, which overall cause health, social and economic damage. Slowing down and reducing access to mental health and well-being pathways due to their influence in the community, also affect social relationships and self-determination.

Purpose: to identify and describe the process, causes, and factors of stigmatization. Propose destigmatization activities led by the medical educator.

Methodology: The manuscript develops a proposal focused on the destigmatization process of mental health/wellbeing services and users, through the guidance of the medical educator as a figure of connection between different professions (interdisciplinary and multidisciplinary), and between different stakeholders.

Conclusion: each identifies factor described, can be involved in the destigmatization process to generate inclusion, through different social interventions led by the role of the medical educator, with the aim of supporting access to patient support processes and quality of life in communities, generating inclusion through destigmatization.

Keywords

Medical Education, Mental health, Destigmatisation, Ethics, Includability

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Introduction

The medical educator

The medical educator is mainly defined as the multidisciplinary and multifunctional professional who deals with the transformation and innovation of the healthcare sector, mainly in the academic area and in healthcare facilities, and the training of learners in the healthcare areas (Bartle, 2014). This professional figure, constantly evolving in terms of knowledge, skills, and abilities, can carry out activities related to the needs of society and the community by interfacing in the areas of healthcare, social-care, and social-works (Hean et

al., 2006). They support the strategies of teaching and learning, leadership, communication, and public-patient involvement (Samuel, 2021), carrying out activities strictly connected to the professionals who deal with mental healthcare. One of the challenges that the medical educator has to face in the universities, in health facilities, and more generally in the community, is the process of destigmatization of mental healthcare services and patients (Rush et al., 2005) to generate and improve inclusion, that is definable as the capacity of a systems (health, school, social, community) to be inclusive.

Table 1:

terminologies and definitions (adapted from Rush et al., 2005; Diener et al., 2003; WHO, 2004; Scully C., 2014; Bodeker et al., 2020)

Definitions	
Mental Healthcare	Services dedicated to mental disorders/illness and well-being.
Mental Health	State of emotional and social well-being.
Mental Illness/Disorders	Condition of change in behaviours, emotions, thinking.
Mental Wellbeing	Combination of relational functions, feelings, emotions.
Mental Wellness	Condition of good mental health.
Includability	It is a term composed of inclusion and ability; it defines the capacity of a system (community, workplace, university, services) to be inclusive.

Global Data

Globally, 800000 deaths from suicide are recorded every year, with a suicide rate of 9.8 / 100000 in 2009, down compared to 1990 with a rate of 13.6 / 100000 (Yip et al., 2021). The number of suicide attempts turns out to be related to suicides in a ratio of 20-25:1 (WHO, 2021). More than 26 million patients are estimated to be diagnosed with severe mental disorders (Wainberg et al., 2017; GBD 2019 Mental

Disorders Collaborators). The peak of self-harm, and mental and substance use disorders is observed for the age group 20-24 years (Patel et al., 2018). In 2017, it was estimated that 792 million people were affected by mental health disorders, corresponding to 10.7% of the global population (Ritchie et al., 2018; Nochaiwong et al., 2021) and in total the social economic cost of poor productivity caused by poor mental wellbeing is projected to be \$ 6 trillion by 2030 (The Lancet Global Health, 2020).

Table 2:

Mental disorders prevalence. (Adapted from Søvold et al., 2021; GBD 2019 Mental Disorders Collaborators; Nochaiwong et al., 2021)



The Issue

Stigmatization: stereotype, prejudice, and discrimination

Stigmatization (Ahmedani, 2011) is described as a multifactorial process, towards a single subject or a group, towards which different actions are carried out such as the classification of physical traits, the creation of a stereotype, the action of separating us-them, the downgrade of personal status, discrimination, and the dependence of the stigmatizing action on what is considered the centre of power or society, community, and inherent socio-economic and socio-political factors (Andersen et al., 2022). It is possible to define the stigmatization of a single subject and of a group, as the set of idealizations

and actions that cause a distorted identification with respect to the reality of the single subject or of the group, within the community. In its complexity, stigmatization is different from the concept of stereotype which can be defined as the oversimplification of the image or idealization of a particular subject or group (Pickering, 2015), from the prejudice definable as the wrong judgment of devaluation based on biases (Abrams, 2009), and discrimination defined as unequal treatment and isolation based on gender, sexual orientation, religion, ideals, disabilities, pathologies, or other personal characteristics (Bhugra, 2016) which can be present both to individuals and to groups. Stigmatization can be considered social, professional, and self, and can be identified at a macro level and micro level (Holder et al., 2020).

Table 3:
comparison between social stigmatization and self-stigmatisation (adapted from Corrigan, P. et al., 2012)

Stigmatization			
	Stereotype	Prejudice	Discrimination
Social	Negative perceptions with no evidence.	Agreement with perceptions.	Behaviourally in reaction to prejudices caused by stereotypes.
Self	Negative perception of oneself.	Agreement with perceptions.	Behaviourally in reaction to prejudices caused by stereotypes.

An analysis can be carried out considering the self-inflicted stigmatization or self-stigmatization, which induces patients who use mental health services to a condition of self-isolation, self-stereotyping, creating the perception of themselves as subjects external to the social, socio-economic, and community context, and increasing the feeling of shame and blame against stigmatization (Corrigan, P. et al., 2012). Self-stigmatization has a fundamental role in the search for the correct support to reach the optimal condition of mental wellness, influencing the methods of research, relationship, motivation, as it is jointly responsible for the slowdown of the diagnostic process, and for adverse conditions for the patient. Social, cultural, socioeconomic factors

are involved in the complexity of self-stigmatization that influence the precocity in the search for adequate support, in the continuity of support, self-esteem, and complete inclusion, thus influencing the satisfaction of needs (Lannin et al., 2022; Mcleod, 2018)

Approach

The manuscript develops a theoretical proposal focused on the destigmatization process of mental health/wellbeing services and users, through the guidance of the medical educator as a figure of connection between different professions (interdisciplinary and multidisciplinary), and between different stakeholders. in the destigmatization process. The actions described have been selected to trigger and guide the destigmatization and inclusive processes for each of the levels in which stigmatization is identified (macro-level and micro-level) and for each of the different stigmatization factors (social, professional, and self-stigmatization) that are mainly involved in causing of stigmatization and exclusion, proposing a pluralistic guidance intervention in the involvement of the community, and leaded in multidisciplinary activities.

Conclusions

The proposed mental healthcare destigmatization and includability strategy places the role of the medical educator in relationship with different stakeholders such as universities, schools, social and community bodies, society, communication bodies, and with different professional figures such as healthcare workers, administrators, patients, family members, volunteers, and other figures who may be involved

Conflict of interest

The authors declare that they have no conflicts of interest.

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Mental Health Advocacy in The Gambia, West Africa

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Abstract

Introduction: To promote mental health globally, including low-and middle-income countries, research and advocacy are essential. The Republic of The Gambia is one of the smallest countries in the world and is the focus of this research.

Purpose: This study examines social and cultural aspects of access to mental health treatment in The Gambia, West Africa.

Methodology: The population of focus consisted of adults over 18 living in The Gambia. The methodological approach was a qualitative phenomenological study involving semi-structured interviews conducted via Zoom, by a researcher from The Gambia.

Results: Data were collected from 17 participants living in The Gambia at the time of the study. A team of analysts with diverse backgrounds evaluated transcripts and identified five themes highlighting social and cultural conceptualizations of mental health and mental illness, sociocultural determinants of health, interventions, barriers to care, and legal frameworks to support mental health change.

Conclusions: The findings from this study are significant for mental health providers who seek to understand different perceptions of mental health and mental illness and the associated stigma. Furthermore, this study suggests several opportunities for mental health advocacy in The Gambia.

Keywords

mental illness, mental health, The Gambia, Africa, stigma

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Introduction

The Republic of The Gambia, commonly known as The Gambia, is a former British colony that gained independence in 1965. It features a democratic system of government consisting of three branches: the legislature, the judiciary, and the executive. The president of the republic is the head of the executive branch and is assisted by a vice-president and a cabinet of ministers. The Gambia is one of the smallest countries in the world, with an estimated population of 2.2 million people (World Health Organization (WHO), 2018). According to The Gambia Bureau of Statistics (GBOS, 2013), more than half of the population is female, and over 63% are youth. Moreover, approximately 50% of the population lives in rural regions, which comprise 60% of the country (GBOS, 2013). The Gambia is also one of the poorest countries in the world, with an estimated gross domestic product per capita of \$773 in 2020 (World Bank Group, 2022). The mental health services comprise one community mental health team and an in-patient unit called Tanka Tanka Psychiatric hospital (Kretzschmar et al., 2012).

The exact prevalence of mental illness in The Gambia is unknown. A situational analysis of mental health conducted by the Mental Health Leadership and Advocacy Program (MHLAP) in 2012 revealed that, of an estimated population of 1.478 million people, approximately 120,000 had a mental disorder (MHLAP, 2012). Since then, the size of the population has nearly doubled, but no recent studies have been conducted on the prevalence of mental illness in the country. Global Burden of Disease (GBD) statistics from 2017 indicated that more than 34% of Gambians have a depressive disorder and 35.9% have an anxiety disorder. Mental health stigma has been identified as a factor significantly affecting people with mental health problems in The Gambia.

Stigma is a pervasive condition that often discredits individuals and leaves them feeling lesser than others (Abdullah & Brown, 2011; Goffman, 1963; Monteiro, 2015). The plethora of emerging research on mental health stigma in low- and middle-income countries (LMICs) highlights the role of culture and cultural differences in conceptualizations and understandings of mental health (Amuyunzu-Nyamongo, 2013; WHO, 2012, 2014). In The Gambia, explanatory beliefs about the causes and attributions of mental illness and associated labels are stereotypical, isolating, discriminating, and stigmatizing toward those with mental health issues, which may result in

mental health stigma. Empirical studies have provided a foundational understanding of the scale, nature, and lack of access to necessary mental health services (Barrow, 2016; Barrow & Faerden, 2022; Coleman et al., 2002). These studies have mentioned the need for better information on the role, association, and impact of stigma on care-seeking attitudes and as a deterrent to service utilization. An investigation of lived experiences of mental health stigma would generate significant findings and serve as a resource for the Gambian government, which plans and implements services, and nongovernmental organizations and institutions that provide mental health services. Such an investigation could address the 90% treatment gap (MHLAP, 2012).

Given the multitude of needs, it is essential to prioritize those that are most fundamental to health, including access to treatment and addressing stigma. Although MHLAP (2012) indicated that it did not specifically examine mental health stigma, this factor likely influences service underutilization. Mental health in The Gambia is rooted in culturally nuanced concepts and understandings that significantly impact the social identity of people with mental health disorders. Furthermore, they define treatment pathways and modalities for mental health care and fuel the public stigmatization of mental health issues.

The globalization and decolonization of mental health in Africa have led researchers and scholars to call for action to extend the bio-psycho-social framework of mental health assessment, diagnosis, and treatment on the continent (Monteiro, 2015). The bio-psycho-social model has long been used in contextual approaches to mental health interventions in low to middle-income countries (LMICs) in response to the need to address factors that determine or improve mental health (Engel, 1977). Research has examined systemic and structural factors in mental health, such as lack of funding, limited healthcare infrastructure, lack of mental health policy and laws, and mental health stigma and discrimination (Akinsulure-Smith & Conteh, 2018; Becker & Kleinman, 2013; Monteiro, 2015). Although such a model has increased overall mental health status in LMICs, mental health remains a stigmatized and neglected area of health and well-being in these countries. Furthermore, due to the widespread prevalence of mental illness, it has been described as an epidemic in LMICs (Hohenshil et al., 2015; Monteiro, 2015). As an LMIC, The

Gambia shares similar systemic and structural problems as many other African countries with regard to the prioritization and delivery of mental health care (Akinsulure-Smith & Conteh, 2018).

One way to conceptualize views of mental health in The Gambia is through the ecological systems theory of human development, which can be helpful for examining mental health care and access (Bronfenbrenner, 1977). Ecological systems theory considers the influences of multiple systems at different levels, which interact to influence individuals' lived experiences and the systems that surround them (Crawford, 2020). According to this theory, human development results from interactions between developing human organisms and environments at five significant levels: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem consists of a person's immediate environment and includes their personality, beliefs, and temperament. The mesosystem refers to the connection between different microsystems. For example, elements of the microsystem affect the individual's experiences (e.g., how school and home interact). Both the microsystem and the mesosystem must include the individual.

Systems that affect environments at the meso level but do not include individuals are the exosystem, which consists of microsystems interacting with each other. However, at least one of the microsystems does not include the individual at the center of the system. For example, a parent's workplace does not include the child, but the latter could be affected by characteristics of the parent's workplace (e.g., the parent is required to work long hours or stressed from work). However, because the child is not part of the parent's work environment, the workplace is not part of their microsystems or mesosystems. The macrosystem influences the characteristics of interactions between different systems; in other words, it influences the "social design" of the broader culture or subculture. For example, family culture develops within a family in the microsystem, which is influenced by the mesosystems and exosystems of each family member. All of these systems are then affected by broader society and culture. Bronfenbrenner emphasized the importance of cultures within groups and the exchange patterns within and among groups. This theory emphasizes the reciprocal effects of these different systems on personality development and social and psychological outcomes

(Crawford, 2020). Thus, ecological systems theory provides an essential perspective for investigating West Africa, access to mental health care, and associated stigma. This study begins by examining individual perspectives, then identifies themes through a phenomenological interpretive analysis. In the discussion of the findings, these themes are viewed through the lens of ecological systems theory to provide insight on how different levels of frameworks interact in the context of one's life.

The significance of this study cannot be underscored enough in the context of opportunities for mental health advocacy in The Gambia. First, as an LMIC, The Gambia should make mental health a public health priority. Mental health is a global pandemic, and the treatment gap for mental illnesses is between 76% and 85% in LMICs, compared to 35% to 50% in high-income countries (Barrow, 2016; Evans-Lacko et al., 2012). This wide treatment gap necessitates an investigation of factors that impact this disparity.

Second, Patel and Prince (2010) investigated the intersection of treatment outcomes and care-seeking behavior to bridge this treatment gap. They posited that current interventions utilized in African mental health care are ineffective without behavioral change. Furthermore, Summergrad (2016) underscored the need for early intervention to avoid secondary effects not only with regard to general health goals but also socio-economic development in particular. Therefore, qualitative and quantitative research are greatly needed to understand the nature and scale of the problem (Barrow & Faerden, 2022). With this in mind, the current counseling-, advocacy-, and social justice-focused research can provide a better understanding of how mental health is experienced and thus inform interventions.

Third, although the Gambian government has acknowledged mental health care as a priority, it has not yet implemented a framework for developing a viable system. Although The Gambia has developed a mental health policy for 2021–2030 and validated a mental health bill in 2019 to legislate mental health laws, this has not yet been implemented or enacted. Extant mental health legislation consists of the Lunatic Act (1964). Therefore, the findings from this study could inform mental health policy development and bring The Gambia in line with its obligations under the Convention on the Rights of Persons with Disabilities (2008), which it ratified.

Fourth, mental health care interventions must be decolonized in The Gambia. The current counseling and social justice research aim to reflect cultural and social understandings of the research phenomena and facilitate closer understanding, empathy, and more interactions with people with mental illness. This study is well-situated for this facilitation through its inquiry into the social and cultural factors that impact mental well-being. To approach a study with cultural humility, a term coined by Tervalon and Murray-Garcia (1998), health practitioners must exercise restraint in applying previously acquired cultural knowledge to avoid perpetuating power imbalances in the therapeutic setting (Zhu et al., 2021).

Purpose

This qualitative phenomenological study aims to explore and understand experiences of mental health and the role of mental health stigma among adults in The Gambia. To this end, two research questions were developed for the study. The first research question is, "What are the lived experiences of mental health among adults in The Gambia?" The second research question is, "What is the lived experience of mental health stigma among adults in The Gambia?" No hypotheses were developed due to the qualitative nature of the study.

Methodology

Study design

The philosophical ideals that underpin this study are grounded in phenomenology and social constructivism, which assume that absolute realities do not exist. Instead, realities are constructed through subjective experiences shaped by the environment and social interactions (Moustakas, 1994). A phenomenological approach recognizes the subjectivity of participants through their interpretation of the truth, not what is attributed to or imposed on them by the researcher (Moustakas, 1994). Therefore, several steps were followed to gather qualitative data after the institutional review board granted approval for the study. No intervention was undertaken, as this study is qualitative in nature and focuses on participants' lived experiences. For the purposes of the study, mental health was defined as a state of optimal well-being that incorporates physical and mental health (WHO, 2014). Mental health stigma is a socially constructed identification that "a social group

creates of a person or group of people based on some physical, behavioral, or social trait perceived as being divergent from group norms" (Goffman, 1963, p. 54).

Participants

The population of focus consisted of adults over the age of 18 in The Gambia. A convenience sampling strategy and snowball sampling technique were used, and participants were recruited through various means (e.g., email and social media). Additionally, the informed consent, demographic questions, and interview process required an eighth grade-level understanding of English.

Data sources and collection

To collect data, a recruitment message was shared with potential respondents, including a link to SurveyMonkey. On SurveyMonkey, interested individuals were asked to review the informed consent form and demographic questions. The latter included the following:

- *Do you live in The Gambia?*
- *Which age range do you fit into?*
- *What is your gender?*
- *What is your marital status?*
- *What is your level of education?*
- *How many people live in your household?*
- *What best describes your religious or spiritual beliefs?*
- *Which dates and times would you be available for a 30-minute Zoom interview regarding mental health in The Gambia?*

Once a suitable date and time for the Zoom interview was determined, the primary researcher contacted the participant via email to confirm these. During the interviews, the researcher followed a script with a set of open-ended questions. At the beginning of the interview, the participant was reminded that it would be audio recorded. Next, they were informed of the purpose of the study, then asked the open-ended questions. The interview questions included the following:

- *What do you know about mental health or mental illness in The Gambia?*
- *How do you think people feel about mental health/illness in The Gambia?*
- *What is your understanding of how people see mental health?*
- *What is the meaning of mental health in your language/cultural group?*

- *How might people get help for their mental health issues in The Gambia?*
- *What is your experience with seeking local and traditional healing for mental health?*
- *What is your opinion about why mental health services might be underutilized in The Gambia?*

Upon completion of the interviews, participants were thanked for their time. The audio recordings were transcribed, and any identifying information was removed. The recordings were then stored on a password-protected computer for the duration of the study.

Data analysis

The demographic data were evaluated with descriptive statistics using JASP, a statistical analysis program. Then, the qualitative data were analyzed after the transcription of the interviews. In phenomenological studies, researchers are expected to bracket their feelings, assumptions, biases, and judgments about the phenomenon to arrive at the true essence and a deeper understanding of participants' lived experience (Moustakas, 1994). Bracketing allows researchers to process the identification of the research questions, data collection, data analysis, and understanding of the essence of the lived experiences (Creswell, 1998). Furthermore, as a practice, bracketing is used to enhance trustworthiness. All three researchers identified as female and were aged 33 to 52. Moreover, two researchers identified as Black and African, while the third identified as White and of European descent. During the bracketing process, it was determined that two researchers had related lived experiences, while one had methodological experience. Potential biases and positionality included the fact that all three researchers had an interest in mental health in the population of interest, were concerned about stigma, and were aware of the impact of colonization.

Verbatim transcripts of data collected from the interviews were analyzed. First, a team of three analysts, including the principal researcher, developed an understanding of the data through reading and note-taking. The data were then coded, and a matrix was utilized to chart identified commonalities across analysts. The primary researcher also collaborated with available participants to review the data and its interpretation to achieve triangulation and saturation and

provide some checks and balances. Throughout the study, the American Counseling Association Code of Ethics was referenced (ACA, 2014), and permission was obtained from the institutional review board to conduct this research.

Results

Data were collected from a total of 17 participants living in The Gambia at the time of the study. This section presents demographic information about the study sample and reports results from the research, including direct quotations from participants.

Demographic information

A control question about residence was asked to ensure that all participants met the criteria for participation; 100% of participants indicated that they lived in The Gambia. In terms of age ranges, one person was 18–19 years old, three participants were 20–29 years old, 10 participants were 30–39 years old, one was 40–49 years old, one was 50–59 years old, and one was 60–69 years old. Regarding gender, 70% of participants were male and 30% were female. In addition, 65% of participants were married and 35% were single. Regarding level of education, five participants had a high school degree or equivalent, seven attended college but did not obtain a degree, two had an associate degree, and three had a graduate degree. When asked how many people lived in their household, three participants indicated three to four people, four participants indicated five to six people, four participants indicated seven to eight people, four participants indicated nine to 10 people, and two participants indicated 11 or more people. Finally, with regard to religious or spiritual beliefs, 88% of participants responded that they were Muslim and 12% responded that they were Protestant Christian.

Themes

Five themes were identified during the data analysis: social and cultural conceptualizations of mental health and mental illness, sociocultural determinants of mental health/mental illness, mental health care interventions and bio-psycho-social interventions, barriers to mental health care, and legal frameworks to support mental health change.

Theme 1: Social and cultural conceptualizations of mental health/mental illness

Constructions of mental health and mental illness differ across cultures and communities. One participant said, *"I want to clarify something, and I can see that the question has made a distinction between mental health and mental illness. Here in The Gambia, there is not a distinction between the two."* Regarding etiology, one participant stated, *"Others tend to say that they steal from people; that is why they are taken to the marabout and the marabout put a charm on them."* Another participant said, *"Some people feel like they are possessed by demon(s) or things like that, you know. The public will run away from them because it's believed that these people are cursed, an evil spell from the Devil or wicked spirit."* Another participant shared that mental health was also seen as something that could be inflicted: *"To some people, it's just a problem that is prompted by a jinn. It's more common here that people see it as something that is being inflicted from the spiritual world."* While many participants believe that the spiritual world inflicts mental illness, a participant stated, *"My understanding of the whole thing from people's perspective is mental illness is not God's doing. It's not God's doing."* Another participant said, *"Those ones are the ones that are mentally imbalanced. Like one of their senses is lacking."* Another participant added, *"They lack self-esteem. That's what they lack. Self-esteem and common sense."* One participant explained that *"mental health or illnesses have some interesting classifications, ranging from drug abuse related, absent-mindedness either by drug addiction or affliction by black magic."* Participants also believed that disease is a cause of mental health/mental illness. For instance, one participant said, *"Epilepsy is also believed to be part of the problem. Yeah, a gradual process that can send somebody crazy."* Another participant stated, *"Some believe, for example, that cerebral malaria causes (mental illness)."*

Many participants questioned whether there is a cure for mental illness. For example, one participant explained that, *"in The Gambia, mental health is something that is not easily curable. It's not easy for people that have mental health to recover from the mental illness in (the) Gambia."* Another participant also discussed suffering related to mental illness: *"Since I was a child to now over 40 years old, people that I know that had mental illness are still suffering from it."* Another participant said, *"Traditionally, you cannot be healed when you have mental health (issues)."*

You cannot be healed by traditional means. Something is lacking in your brain, or your system is lacking something, so a marabout cannot heal you."

The participants also expressed concerns about helping those with mental health issues. One participant explained, *"People fear them thinking that they might attack them."* Another participant noted, *"Some people even go to the extent of chasing them away because they think when people are near the mentally affected, that they themselves might also contract the mental illness."* One participant said, *"So, because they don't understand it, they have a concept, a prevalent belief system in the society, a belief that when you touch them the thing that is affecting him or her will fight you."* The participant further shared, *"I've seen that. It's like when you start helping the person, for example, even by simply escorting the person to a healer, like, for example, the hospital or even the traditional healer, you will start seeing strange things happening to you."*

Theme 2: Sociocultural determinants of mental health/mental illness

The second theme focuses on sociocultural determinants of mental health/mental illness. Regarding this topic, one participant said, *"Personally, from my own point of view, I think mental illness, if it's not caused by society, then society will exacerbate it."* Another participant stated, *"In fact, to be possessed doesn't always mean you have to be mad. However, even with the lack of access to opportunity here, many would believe the person is possessed."*

Respondents also suggested that poverty plays a role in mental illness. One participant said, *"Society now believes that you have to have money in order to be a human being. Once you don't have money, which means you have mental problem."* Another participant stated, *"The majority of members of the society feels that once you are poor, then there's something happening to you. Some may call it bewitching, like the guy in Bewitched; that is why he is poor. The person cannot have opportunity."* Another participant said,

In fact, 79 of the patients at Tanka Tanka, when I asked them, they said their condition is directly related to poverty. They traveled to look for money in Europe or America. And, when deported, it's like they have no purpose living any longer. They said that their

parents sold all compound or cattle; they had to send them through back way to Europe. If they don't reach or they are deported, they have nothing left.

A prominent subtheme was migration or failed migration. Participants discussed various issues related to this topic. One person stated, *"They see their friends are finally sending money back home, taking care of their families. And here they sit, unable to do the same. Some people actually do go insane just because of this."* One participant shared, *"We have a saying over here. We say, 'Nerves.' We say, 'This boy is nerves.' What that means is that this person wants to go abroad so bad that they're starting to go crazy."* Another participant associated deportation with mental health/mental illness: *"What aggravates the problem of these people is mostly when they are deported back to their native land. There is this stigma that goes with it when they come back."* One participant also stated, *"People see them as failures. They went to search for money and opportunity but ended up being sent back with nothing."*

Another subtheme related to the labels and names that are used to describe and refer to people with mental illness. Participants shared meanings associated with mental health/illness in some of their languages and cultural groups. For example, one participant said, *"Yes, we call them Nymatou in Mandinka. In Wolof, they call them Duff; in Jola, also, they call them Ahnmatou. These mean crazy or mad person."* Another participant said, *"If you call somebody who is not mad, you call them kangardo, they will not like that. You are abusing them."*

A third subtheme was stigma, discrimination, social isolation, and labeling. One participant explained that *"the stigma around mental health is very high. This is one of the reasons why even with the awareness creation that we are doing at the moment, many people are still reluctant to come out to local services."* This participant also said, *"There's this common statement that we say, a crazy person can never be well again (Duff due musa wayri)"* and *"if you have any mental problem, you will never recover from it."* This statement alone is very powerful in stigmatizing an individual. One participant also shared, *"Whenever there is talk of somebody being mentally disturbed, the first thing people do is try to stigmatize the person. Yeah, that's stigma, that will start even from the immediate family members, most of the*

time." Another participant also stated, *"Instead of taking you for services, they might even lock you in the house because of stigma that can follow the family."* One participant stated, *"It's like when people feel that one is mad, they will not eat with the person. They will not sit with the person in one place. So, total isolation and discrimination."*

Theme 3: Mental health care and bio-psycho-social interventions

A significant theme addressed is mental health care pathways in The Gambia. A subtheme of mental health care and bio-psycho-social interventions was local and traditional healing. For example, one participant stated, *"In most cases, many people tend to go to (a) traditional healer or a marabout rather than medical."* Another participant stated, *"Traditional healers, but mostly religious, like they normally cure with the Quran, such as Ruqya. Yeah, I've personally seen that, using methods from the Quran and some, you know, Arabic textbooks, Islamic textbooks to cure them."* One participant clarified, *"I've experienced the Muslim way of treating the problem aside from (the) medical way of treating. There is this religious formula that they use called Ruqya. Ruqya, I think is exorcism in English."* Another participant shared, *"People believe when you successfully cure a mentally ill person, that disease or that mental problem will transfer to you. If it cannot do anything to you as the healer or as the traditional doctor, it will transfer to the family."*

When discussing additional treatment options, the participants emphasized a lack of support. One person said, *"Normally, lots of family people here cannot afford to take their mental illness people to the medical sector for them to be treated, so they lack support."* Another participant shared, *"As you can see, there is only one center in The Gambia where they normally take these mad people. They shove them in one place, that is Tanka Tanka."* One participant said, *"The medical side, they only give them medication to tame them, if the person is violent, but not actually to treat the person."* One participant described this treatment pathway as follows: *"Mental health in The Gambia is more chemotropic. When I say chemotropic, I mean the use of drugs (medication). They look at every mental illness or issue as being treated only with the use of drugs."*

In terms of counseling services, one participant shared, *"Just recently, people are becoming aware of counseling and*

psychosocial support. And I think that one is more related to people who are mentally distressed." Another person said, "Many of the deportees may know about Western treatment because they are coming from detention camps. I understand that they give them counseling when they are at those camps." Another participant stated, "As for counseling and psychotherapy, they are new innovative treatment(s) but are not known. Some Europeans are starting it here. They need to sensitize the public."

Theme 4: Barriers to mental health care

The participants mentioned several subthemes under the theme of barriers to accessing mental health care: mental health literacy, awareness, and affordability. They discussed increasing access to mental health services and shared relevant experiences. One participant recounted, "We have succeeded in decentralizing the outpatient services in every region ... there is one in Basse, one in Bansang, Soma, Farafeni, and Esau. But for the in-service mental health facility, we have not succeeded in the same capacity yet." This participant continued,

For the community mental health team, previously, they used to go around the country quarterly, every three months, they will take around all their equipment, and then they will announce their outreach dates. But recently, also due to gross lack of finance or lack of a sponsor in (the) mental health sector, such services (have) been truncated in such a way that it is only available within (the) greater Banjul area. And even the greater Banjul area, it's only few communities that are benefiting from that community mental health services. Mobility is a problem ... they used to visit prison, every month. But that also has not been possible as we are speaking.

Another person stated, "They should build more health places to have those that are mentally ill." In addition, one participant expressed the need to "sensitize people on the use of the drugs and order stuff and taking care of our children in our own place."

On the issue of counseling awareness, one participant stated, "And, to me, the idea of going for counseling is still not widely spread. There needs to be awareness, and people need to accept it. It's new, and people don't trust it yet." Another participant emphasized, "People may not realize the kind of behavior that the person is indicating, or the kind of

signs that will warn them that this person is developing certain things." Another participant added, "We need to create more health awareness, educate people about health, make them know about mental health issues, especially people that don't know about mental health, the illiterates will be taught (about) mental health and what to do with a person with mental health."

Theme 5: Legal frameworks to support mental health change

A subtheme concerned human rights. One participant described human rights violations against people with mental illness who seek traditional healing:

When they reach that place, if the craziness has deeply entered inside the person's system, they might chain the person. They might put a chain on the legs to avoid misbehaving, and the marabout there will have a lot of men, big men, strong men that would help him when he is reciting and doing the healing. There are some healers that will chain some of the patient(s) that then are quite aggressive to make sure that they are in one place. And some will even include beating them. So, yes. In providing these services, they are also abusing the people, which is also against their human rights. Human right violations. That's (the) downside of the traditional healing.

Participants further discussed the need for comprehensive mental health policies and legal frameworks for mental health. One participant noted, "We have a mental health bill that has been validated in 2019. But unfortunately, it has not yet been enacted. We are pushing very hard, but yeah, it has not been enacted yet." They clarified, "The law that we are going by is the Lunatic Act. It's the law of the land, which does not provide any rights to a person with (a) mental disorder. And it's very vague." One participant also expressed interest in attempting to "train non-mental health specialists to be able to assess, diagnose, and make simple interventions for common mental health problems. ... to train the general health care personnel, to make sure that mental health services can be accessed at every facility, irrespective of where you are." One participant also expressed, "So, of recent, what we have started developing is to incorporate mental

health services into the primary health service, that is the existing health services."

Discussion

The current phenomenological investigation aims to understand the phenomena of mental health and mental health stigma among adults living in The Gambia. The findings from the study demonstrate the role of culture in people's understanding of mental health. These perceptions significantly impact the social identity of people with mental health issues, the limited access to treatment pathways and modalities for mental health care, and the public stigmatization of mental health/illness.

The first theme identified in the data analysis was social and cultural conceptualizations of mental health/mental illness. Given that 90% of Gambians identify as Muslim, it was surprising that cultural norms featured more prominently than religious beliefs in the participants' conceptualizations of mental health. The causes of mental health/illness were seen as spiritual and beyond the human realm and attributed to many explanatory forms, such as mysticism, possession by jinns or demons, and even revenge on healers or family members from responsible agents for healing or helping a person with mental illness. The transgression of norms by a person or their family member were also identified as a cause of mental health/illness. Mental illness was seen as retaliation, either from spiritually unseen forces or a wronged individual who took revenge by inflicting the condition through spiritual means. These beliefs are so long-standing that they have contextualized how people experience mental illness and are labeled, stereotyped, and discriminated against (Galvin, 2021). To foster improvements in mental health, the population must be educated on the etiology of mental health, treatments, and possibilities for care that have been identified elsewhere. Unless this education is provided, the treatment gap and mental health stigma will remain.

Firdos et al. (2021) conducted a community-based study on beliefs about mental illness in different populations in Al-Ahsa. The sample consisted of Muslim participants with similar beliefs about the causes of mental illness as the participants in this study. This study is crucial for understanding how similar Muslim countries conceptualize and experience the research phenomenon. Cultural beliefs are key to

addressing mental illness in The Gambia. To contend with the gap in treatment, psychoeducation for both the awareness and treatment of mental health concerns must consider the context of beliefs that impede treatment at both the individual and systemic levels. For mental health providers, developing cultural humility necessitates continual learning and openness toward their clients' diverse cultural experiences and beliefs (Zhu et al., 2021).

The second theme identified in this study was sociocultural determinants of mental health/mental illness. The Gambia is a LMIC; as in many similar countries, there is inherent economic inequality. This affects people's self-concept in terms of lifestyle choices. In addition, social issues such as poverty impact the majority of the Gambian population. The participants in this study discussed substance abuse and poverty as causes of mental illness and factors that deter people from accessing treatment. They also noted family support in the form of providing financial assistance to obtain treatment and purchase medication. The findings from this study align with those of a recent foundational study on mental health in The Gambia (Barrow & Faerden, 2022), which significantly discussed poverty as a factor that impedes positive mental health outcomes and cited the high costs of treatment, prescription injections, and medications as a frequent barrier to accessing care. Barrow and Faerden (2022) also found that the cost of consulting traditional healers was approximately \$187 and that the cost of biomedical interventions for injections and medications ranged from \$9–12. These high costs and disparities are significant barriers to accessing services (Barrow & Faerden, 2022). Barrow and Faerden (2022) also noted that reducing the factors that contribute to mental illness would significantly reduce the prevalence of mental health issues and help close the treatment gap, which is consistent with the findings from this dissertation.

In addition, participants in this study referenced failed migration as a social issue that leads to the displacement of Gambian youth. They noted that globalization has led many Gambians to seek better lives and improve their family's living conditions. Since opportunities are not available in their own country, they look to distant shores. One way of seeking opportunity is through the "back way" by illegally migrating through the Sahara Desert and the Atlantic Ocean and entering Europe. Although this approach has proven fruitful for some, participants noted that

widespread illegal migration has led to more control and repatriation agreements, which have made it somewhat easier for migrants to be held in detention centers and eventually deported. Participants also shared that, when people plan to leave The Gambia, their families often incur debt or sell land and resources to ensure that their children will succeed and be able to support them and augment the family's status. Conversely, entire families may suffer when people do not successfully migrate, are detained for many years, and eventually deported or returned, as stigma is also attached to these deportations. As described by participants, returnees are viewed as having lost an opportunity and mitigated to a life of poverty. This can result in stress, depression, and traumatic conditions, which may be compounded by stigma and limited access to professional counseling services.

The understandings, descriptions, and labels attached to mental illness reflect the highest level of public stigma. Stigma is socially constructed and permeates all aspects of Gambian society. Research on mental health stigma has posited that language shapes perceptions and can significantly influence psychological or cognitive processes (Granello & Gibbs, 2016). The terms that participants used to describe mental health did not reflect linguistic relativity (Wolf & Holmes, 2011) or align with "people-first" language (Granello & Gibbs, 2016). Instead, they used stereotyping and portrayed mental illness as a permanent, incurable condition that affects the self-esteem and social identity of affected people. A prevailing sentiment among participants was that people do not associate with those who suffer from mental illness. Globally, there is evidence that public stigma is a deterrent to seeking treatment for mental illness, which aligns with the findings from the present study. Participants shared that many people would lock up a family member with a mental illness rather than face public stigmatization. Women from families with mental illness are particularly affected, and their marriage prospects are limited due to the negative connotations attached to their family history of mental health (Amuyunzu-Nyamongo, 2013).

The third theme identified in the data analysis was mental health care and biopsychosocial interventions. The prevailing belief among participants was that local, traditional, or faith-based healing is the most popular and accessible type of intervention. In a seminal study on mental illness in The

Gambia, Coleman et al. (2002) found that approximately 80% of the population resorts to local and traditional pathways. These are more aligned with people's understandings of mental health, as they are rooted in local and cultural beliefs. Biomedical services in The Gambia are the mainstream conventional system of treating mental health in terms of legal services. There is limited access to outpatient services; currently, there is only one inpatient facility in the country. The participants shared that, as a result, people must find the finances to travel to the region or not go at all. The findings from this study also suggest that there was previously a community mental health team that traveled around the country every three months to provide greater access. However, this program has been challenging to maintain. Thus, a lack of funds significantly impacts community services that could enhance access to medical and mental health care.

From a multicultural standpoint (Ratts et al., 2016; Bharti et al., 2021; Sue, 1994), it is essential to recognize that counseling is an emerging field in The Gambia. Although some nongovernmental organizations are working to increase services, a lack of awareness of mental health issues in communities is a risk factor for their sustainability. Given the importance of the globalization and internationalization of mental health counseling in African countries, there have been significant intersectional challenges related to contextual factors such as stigma, lack of awareness, and lack of infrastructure (Amuyunzu-Nyamongo, 2013). Multicultural counseling may also involve certain ideals, such as decolonizing concepts. Due to people's beliefs about mental health, it is difficult to demonstrate the potential healing capacity of Western counseling. Acknowledging current beliefs while showing the possibilities of mental health care requires balance, which a multicultural counseling approach might be able to help with.

The traditional healing system of treatment includes local, traditional, spiritual, and faith-based pathways. Participants shared that these are the most available and accessible forms of treatment; they are grounded in local belief systems and accepted by many people as their first choice of treatment. Other regional studies have also highlighted this alignment with local cultural beliefs and the accessibility of treatment. Furthermore, the World Health Organization Alma-Ata Declaration (1978) recognized the role of traditional medicine in the primary healthcare

sector. The participants in this study empathized with this treatment modality. Findings from the subregion also showed that 80% of people who seek mental health treatment in Ghana rely on the abovementioned system of care (Krah et al., 2018). Findings show that, although The Gambian health sector is relatively small-scale, it is moving toward full integration of mental health care. This provides an opportunity to foster the integration of traditional healing into delivery and multicultural counseling into mainstream biomedical services or collaboration with local and traditional healers. The Gambian government could also help with the integration of multicultural counseling and psychoeducation.

The fourth theme identified in this study was barriers to mental health care. All participants suggested poverty was a social factor that immensely impacts mental well-being. They described poverty as a barrier to mental health treatment and a cause of mental illness. Therefore, reducing the circumstances that cause economic inequality could be a prime policy matter for the government. Since around 60% of the population consists of youth, the government could support training and skills development of projects to alleviate poverty among young people. Furthermore, a lack of funds to pay for medication or daily meals can impact mental health and well-being. The current research did not examine mental health among youth and women, which are two groups significantly affected by poverty; however, this area needs attention.

In addition, there is a need for mental health literacy in The Gambia while also respecting long-held traditions and values. Local people could be trained to know about mental health practices that promote wellness. Some efforts are already underway in this area, which could promote access to services. As participants shared, community mental health services could also improve access. Although such programs have been implemented in the past, they were cut due to a need for more funding. This sentiment was highlighted in a study by Kutcher et al. (2016), which aligns with the findings from the present study. For communities to benefit from counseling, adequate training from qualified professionals is required. These professionals could work within the guidelines of multicultural counseling practice and ethical standards. So far, no known counselor training programs or institutions exist in The Gambia. The training of paraprofessionals could be

helpful, but they would only partially replace professionals. Professional associations could also provide counseling in underdeveloped nations. Furthermore, the field of mental health counseling must be regulated to ensure that professionals who treat people have an appropriate clinical background.

The fifth theme identified in the study was legal frameworks to support mental health change. The Gambia has stated its stance on mental health: to promote it. To this end, greater attention should be paid to mental health policy, laws, facilities, and access to services. In addition, there has been a call to meet United Nations conventions. For instance, it addresses the rights of people with disabilities. The Gambia has an opportunity to identify well-trained, experienced mental health professionals and collaborate with them to improve services and policies. It is important to have a mental health policy in place to guide mental health regulations and access. Other studies have mentioned the need for protection for people with mental illness. For example, Lund et al. (2011) argued that legislation and policies are required to optimize mental health services in LMICs. The Gambia alludes to this in its mental health policy for 2021–2030.

With regard to policies, the ministry could begin by revising practices in the existing facility and increasing standards of care. For instance, only one facility offers substance abuse treatment and conventional mental health care. A lack of halfway houses was also noted in this study. Furthermore, it is essential to address the financial burden of family caregivers, if possible. Currently, a risk factor is that the government does not regulate traditional healing practices, which sometimes entail physical beatings and other human rights violations that can further exacerbate mental illness. There has also been a call to ensure access to food, housing, employment, safe living and working conditions, gender equity, and mental health (Cosgrove et al., 2021). Collaboration between traditional healers and counseling professionals could result in the identification of common ground to uphold human rights.

Limitations of the Study

While a qualitative data analysis yields descriptive data, it needs to be more generalizable and show the exact prevalence of issues and needs in The Gambia. Additionally, this study was conducted in English, which only sometimes

accommodates local dialects. It also excluded many people who needed to speak English. Furthermore, the data were collected via Zoom, which required an internet connection. Another limitation was that this study did not focus on women and children, who are the most widely affected.

Future Directions

Many opportunities exist for further research on implementing mental health services in The Gambia while considering the challenges of an LMIC. Future research could utilize a quantitative approach to identify the prevalence of mental illness and the need for mental health services more accurately. Additionally, a quantitative approach might identify the specific needs of people with statistical data. Future research could also investigate opportunities for multicultural counseling professionals to collaborate with traditional healers and biomedical services. Furthermore, researchers could collaborate with the government to identify legislation and policies that promote mental health and well-being in the country. This also sets a framework for other LMICs to promote mental health globally.

Conclusions

There are many opportunities for mental health care and advocacy in The Gambia and beyond. Yet, it is also essential to recognize traditional healing practices and beliefs about mental health, as these can impact mental health stigma. While working with populations that are only beginning to explore mental health services, it is vital to recognize community-based resilience in The Gambia. For instance, people must become accustomed to independently seeking care. Instead, family members are typically tasked with caring for them. Furthermore, recognizing people's inherent worth, and acknowledging and accentuating their personal strengths can help provide a buffer against the impact of mental illness. This also challenges the idea that people are solely defined by their deficits, illnesses, or life circumstances; they are capable and resilient when connected to caring communities and systems (Ward & Reuter, 2011). This reiterates the importance of ecological systems theory and how different systems interact and have great importance.

Utilizing Bronfenbrenner's ecological systems theory, many people with mental health issues rely on the family system for care

and access to mental health care. Participants noted that families utilize pathways that align with their worldviews and cultural nuances since they are the decision makers for individuals who need mental health care. This reflects the family's vital role in a collectivist system. The mesosystem concerns the connections between peers and family. Sometimes, families fear sharing that a family member is struggling with mental illness because of prevailing beliefs about being possessed or cursed. This can cause isolation and stress for the family system. In addition, it is essential to recognize that, with some psychoeducation, communities might be able to unite for early intervention. The exosystem involves links between social systems that do not directly involve an individual (e.g., a family member's job requires travel). The macrosystem describes the overarching culture, such as the challenges of socioeconomic status and poverty in The Gambia. Finally, the chronosystem involves beliefs embedded in the Gambian culture that can be passed down from generation to generation, such as the assumption that all people with mental illness are dangerous, cursed, and often incurable. As evidenced by the results from this study, there is also a widely held belief that little can be done to support the health of people with mental illness beyond attempts to use traditional methods of healing or institutionalization. However, some participants with a higher level of education recognized that there are opportunities to revise policies, systems, and care. In LMICs, mental health care cannot be one-dimensional, and financial needs must be addressed. In addition, cultural humility is vital to advocate for people in The Gambia. It is essential to help clients identify issues as they see them and focus on the specific needs of populations worldwide to promote mental health and well-being.

Conflict of interest

The authors declare that they have no conflicts of interest.

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Exploring the Feasibility of Integrating Mental Health into a Family Planning Program in low-resource settings

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Abstract

Introduction: Mental health challenges remain a pressing issue, underscored by the glaring gap between the elevated demand and the scarce resources. Research has highlighted the effectiveness of integrating mental health services with primary care services, particularly in low-resource settings.

Purpose: The objective of this research was to evaluate the perceived implications and feasibility of integrating basic mental health services into an existing community-based family planning initiative in Pakistan. By adopting a community-driven and co-produced methodology, our study not only ensured a deeper resonance with local needs but also paved the way for a sustainable and transformative uptake of mental health services in low-resource settings. This co-produced strategy, anchored in mutual collaboration and shared expertise with the community, promises a more holistic, enduring, and adaptive integration of essential health services within community frameworks.

Methodology: This study utilized a qualitative research approach to obtain a comprehensive understanding of the program's feasibility and potential for expansion. Interview tools and guides, tailored to the regional language, were developed by the Research Associate to gather insights from the lady health workers involved in delivering the intervention, as well as from the clients. Overall, our team conducted 24 interviews, of which 9 were with the lady health workers and 15 with clients. The interviews were facilitated by the Research Associate and a Psychologist.

Results: Utilizing the socio-ecological model, we thematically analysed factors at individual, interpersonal, and community levels that support or hinder the integration of mental health services with existing community-based programmes. We also examined the intervention's impact on its users and the healthcare providers.

Our analysis underscores the significant potential of integrating mental health services into existing community-based health programmes, such as family planning, in low-resource settings. Predominant themes highlighted women's willingness to use these services, influenced by strong relationships and trust in the lady health workers, ease of access to services, and community support. Identified barriers to integration included prevailing poverty, a preference for direct financial incentives in addition to counselling, confidentiality concerns in tight-knit communities, and the lingering stigma surrounding mental health.

Conclusion: Our findings highlight the value of community collaboration in healthcare, particularly in low-resource settings. The co-production approach blends professional guidance with local insights, fostering community ownership and enhancing program sustainability. As the first to merge mental health with family planning in Pakistan, our

research suggests that future health initiatives can greatly benefit from community-driven methods, leading to more sustainable and transformative health outcomes..

Keywords

Mental health integration, family planning, women, health workers, socio-ecological model, co-production, community-based methodology

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Introduction

Mental health disorders, including anxiety, depression, and bipolar disorder, contribute significantly to the global burden of disease, with heightened risks such as suicide (WHO, 2017). Lower-middle-income countries (LMICs) face particular challenges due to high rates of untreated mental illnesses, resulting in a substantial treatment gap of nearly 90% (Patel et al., 2018). The World Health Organization (WHO) has prioritized mental health as part of global efforts to achieve Sustainable Development Goal #3, aiming to ensure healthy lives and well-being for individuals of all ages by 2030 (United Nations, 2015). However, LMICs encounter numerous obstacles, including violence, poverty, and economic recession, exacerbating the burden of mental health issues and impeding progress toward these goals (Kieling et al., 2011).

Co-production, a burgeoning approach in global health research, refers to the collaborative and participatory process wherein service users and stakeholders work alongside professionals to design, implement, and evaluate services, ensuring a tailored and contextually relevant fit (Bovaird & Loeffler, 2012). This method champions the principle that those who are affected by health services, particularly in resource-limited settings, have a vital role to play in shaping those services (Osborne et al., 2016). Research consistently underscores the transformative potential of co-production in enhancing the sustainability, efficiency, and quality of health service delivery. For instance, a study in Uganda demonstrated that through co-production, community health initiatives

achieved higher user satisfaction, increased community trust, and a stronger sense of ownership, leading to the longevity of health interventions (Nabatchi et al., 2017). Another exploration in Kenya revealed that co-produced health initiatives addressed community-specific needs more adeptly, fostering resilience and adaptability in the face of local challenges (Heaton et al., 2016). Such evidence strongly indicates that harnessing the power of co-production can be instrumental in magnifying the impact and reach of health services in settings with constrained resources.

Community-based interventions have been widely recognized as effective strategies for delivering mental health services to underserved populations, offering enhanced accessibility, flexibility, and sustainability compared to formal healthcare settings (Hobfoll et al., 2017). Additionally, these programs promote social and economic inclusion, which is crucial for LMICs (Patel et al., 2018).

As an LMIC, Pakistan is faced with extreme income inequality. This creates an environment conducive to social disparities experienced by the population, mainly within the housing, education, and health sectors. Despite the high prevalence of mental health disorders in Pakistan, it is one of the most neglected fields in the health sector. Approximately 10-16% of the total population suffers from mild to moderate psychological illnesses (Hussain et al., 2018). Most psychological services offered in the private sector are not affordable for the masses, especially in the lower and middle-income groups.

Additionally, these conditions are made worse for women due to the patriarchal structures existing within Pakistani society; factors such as domestic abuse, child marriages, lack of decision-making power, economic dependence, lack of reproductive rights etc. can adversely affect women's mental health (Ali, 2012). A study conducted with pregnant women in Karachi revealed that 70% of the total participants experienced symptoms of depression and anxiety due to factors such as fear of stillbirth, abortion, miscarriage, role in decision-making, and domestic violence. (Ali et al., 2018)

Efforts have been made in Pakistan to integrate mental health services with community-based programs. For example, a study in Karachi trained nurses to deliver mental health interventions to households and nursing homes, positively impacting participants' mental health and quality of life (Ali et al., 2015). Similarly, in rural Punjab, integrating a cognitive-behavioral therapy (CBT)-based intervention into a community primary health worker model demonstrated improvements in maternal depression, infant health, and perceived social support (Rahman et al., 2008)

In 2014, IRD Pakistan implemented a lay counseling model for mental health, training community members as counselors to provide first-line counseling therapy for mild to moderate anxiety and depression (IRD Pakistan, 2014). This program aimed to bridge the prevalent treatment resource gap in LMICs and has provided free counseling services to thousands of individuals (ibid).

In this pioneering research, we employed a co-produced and community-centric approach to mental health service delivery. Instead of in conventional clinical settings, services were rendered directly within communities. Lady health workers, originally engaged in providing family planning services to women in rural Sanghar, received training in basic mental health counseling. These trained professionals then ventured into the community to offer counseling sessions to their clientele. The feasibility and impact of this innovative approach were assessed using qualitative research methods.

Purpose

This qualitative exploratory study aimed to understand the feasibility of integrating mental health into an already existing family planning program. Another important goal was to examine the reception and perceived impact of mental health integration within an

already existing service. This study is a stepping stone toward scaling up the services in primary care.

Methodology

Study design

Utilizing a qualitative research approach, semi-structured interview guides were prepared and translated to Sindhi, the local language, by the Research Associate. Insights were sought from two pivotal groups: lady health workers and service users. A purposive sampling technique was employed for this study. A total of 24 comprehensive interviews were undertaken, encompassing 9 from key informants and 15 from clients. Prior to the interviews, all participants granted their informed consent. Conducted exclusively in Sindhi to ensure comfort and accuracy, the sessions were audio-recorded, subsequently transcribed verbatim, and then meticulously translated into English. The interviews took place in May 2021, and were conducted by the Research Associate and Psychologist.

Study Participants

The study protocol was reviewed and approved by IRD_IRB_2020_02_013. Written informed consent was obtained from participants. Participants included a randomly selected sample of 15 women from a population of 297 women who had received the mental health intervention. Additionally, the 9 lady health workers that delivered the intervention were also included in the study sample for this research. A compensation of 500 PKR was also provided to both clients and lady health workers who agreed to be a part of the qualitative interview in order to cover transport.

The Intervention

The mental health intervention included initial screening for depression and anxiety using the Patient Health Questionnaire - 4 (PHQ-4) which was administered by lady health workers. These 9 health workers were trained and supervised by a psychologist. Clients who were symptomatic for depression and anxiety or self-reported the need for counselling, were enrolled for 3 to 6 sessions. Baseline and end line screening tools included the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder questionnaire-7 (GAD-7). All tools were translated to Sindhi. Each counselling session lasted 30-40 minutes. To monitor quality, weekly supervision and operational discussion with each Lady health worker were

conducted by the Psychologist and Research Associate.

Questionnaire design and outcome measures

To assess the perceived impact, facilitators, and barriers of the mental health intervention, two separate interview guides were designed for clients and lady health workers. The key informant interviews with lady health workers included open ended questions about their experience within the community as a lady health worker, community response to contraceptives and mental health services, barriers in accessing and providing mental health services. They were also asked about the impact of mental health services on their personal lives in addition to the clients' lives.

Similarly, the client interviews also included questions about their experience and perceptions of lady health workers. To assess the impact of mental health intervention, the clients were asked about benefits and changes they perceived in their individual lives, interpersonal skills, symptom alleviation etc. Moreover, they were also asked about any perceived barriers or facilitators to the mental health intervention.

Analysis

The study results were structured using the socio-ecological framework (SEM) mapped onto individual, interpersonal and community level factors. This framework is used in this study because it helps us understand how different factors at each level interact with each other to shape the experiences and perceptions of the service consumers and providers. The socioecological framework has been utilized widely for health promotion, violence prevention, feasibility and effective implementation studies. (Kilanowski, 2017, Bamuya et al., 2021). Individuals operate in a multi-layered system. The success or failure of a program consequently relates to the system it is operating in. SEM is suitable for this study as it informs about the possible facilitators and barriers of mental health integration at all levels an individual operates in. The interviews were recorded in the local language and later transcribed into English. Each interview was assessed, and themes were identified through the selective coding process. Codes from all the interviews, including clients and lady health workers, were categorized into broader themes according to the SEM model.

Results

The primary purpose of this study was to understand the response to mental health integration and its feasibility. The results have been divided according to various themes in the SEM model.

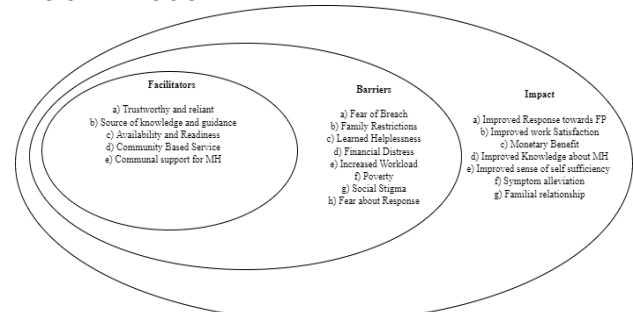


Figure 1: Identified themes mapped onto the Socio-ecological Model. This includes themes identified by the service users (clients) and service providers (Lady Health Workers).

Levels	Themes
Individual	. Positive perception of MH services a. Positive perception of MWs b. Financial distress due to lack of resources c. Fear of peoples' judgment
Interpersonal	a. Familial relationship with MWs b. Fear of breach c. Permission Issues
Community	. Communal support for mental health a. Community needs and expectations around support provided

Table 1: Breakdown of themes and subthemes using Socioecological Model

Facilitators Individual Level.

There were several individual-level factors that were identified that helped in facilitating the mental health intervention with the community.

Marvi Workers are Trustworthy and Reliant. The clients reported that they were able to trust and rely upon the lady health workers because of their experiences of coming to their homes to provide family planning options.

"We were tension free about everything. We said that we trust baji. She came to us for the first time to inject us, and since that day I have shared every problem with her." (P11)

The clients usually referred to the lady health workers as “baji” (sister) and reported that they felt comfortable in sharing their personal issues with these lady health workers because they were supportive and maintained confidentiality:

“No, no we would trust no one other than sister...whatever problem we face we consult her and she solves it for us. She guides us time and again, we are indebted to her.” (K011)

Marvi Workers are a source of guidance and knowledge. The lady health workers were a source of guidance for these women because they provided guidance about family planning and additional domestic issues,

“We are poor and are barred from going anywhere and also stuck in food scarcity. They've helped us by hearing our problems and providing solutions to them.” (P4)

Clients reported that the lady health workers were helpful and were always readily available for guidance. According to the results, the clients were satisfied with the degree of information and guidance provided by these workers:

“They come to us timely. They give us strength. They brought a change. They give us contraceptive pills. Now we are thankful for them.” (P13)

Interpersonal Level.

An interpersonal level factor was identified by the clients as a facilitator for this mental health intervention.

Availability and Readiness of Lady health workers. Clients found ease of access to lady health workers as they belonged to the same community. At the same time, the willingness of lady health workers to make extra efforts to provide support to the clients helped in not just building trust and relationships, but also comforted the clients.

“Whenever I feel worried, my children come here and tell her about me. She comes and consoles me and tells me that I should not be worried about everything. Everything will be fine.” (P2).

Community level.

Communal Support for Mental health.

Despite the challenges of permission from the family, there is a general community support for mental health intervention. This sense of community seems to facilitate mental health integration.

“Yes our entire village knows about it.....they help us in attending more sessions.” (P2)

Suggested Support Mode. The clients mentioned a preference for community-based services rather than hospital-based mental health sessions. The reason behind it seems to be the easy accessibility of services and overcoming the permission issues by family members.

“Home-based is far better.....Because, our guardians will not allow us to go to the hospital.....Yes, as soon as husband goes for work, marvi workers should come here for sessions.” (P1)

Barriers

Individual level.

In addition to facilitators, participants also recognised certain factors as barriers for the mental health intervention and provided suggestions.

Financial Distress due to Lack of Resources.

Financial distress was a frequently reported problem by the clients. Mental health was secondary to them as their basic survival needs were not met. They mentioned how the lack of basic necessities such as food, money, housing caused emotional distress but it would get them all consumed and they would not get mental health help,

“Sister, there is a worrisome situation at home. Poverty, illness, day to day affairs and sometimes there is nothing to eat. Sometimes, we eat one meal and wait for another. These are our daily worries. Poor people face such types of tensions. If there is something to eat for today, then we start worrying about tomorrow.” (A0418)

This theme was also present in lady health workers interviews as an expectation from the clients. Lady health workers reflected on their experiences with the clients and reported that clients expect compensation in the form of money, jobs, basic resources with the mental health intervention:

"They see it (counseling) as hoping to get some kind of (monetary) help..... That's because previously organizations often came to them and gave them monetary funds so they can't help but hope for the same from us." (LHW 01)

Some clients were also skeptical of the benefits from the mental health intervention because they didn't think only talk therapy could help their issues:

"Some of them said what benefit would come to them by talking, unless I was giving them something" - (LHW-05)

Increased Workload. Lady health workers reported an increase in workload due to the mental health intervention alongside family planning sessions. Data management was particularly an issue because they had to maintain forms and registers which required extra time. As a suggestion, LHW said that there should be limited sessions in one month to make the work more manageable:

"So, due to this we were not getting time for paperwork as we had to maintain registers which you gave us. In this context our workload had increased." (LHW F09)

Interpersonal level.

A few barriers were mentioned by the lady health workers and clients that hindered the uptake of mental health services.

Fear of Breach. One of the main reasons for initial resistance towards counseling was that women thought their confidentiality would be breached by the LHW. While discussing why more women do not choose to take counseling despite the community having so many fundamental life issues, a LHW said that:

"Sister, they did not want to share anything. They had a fear that people would come to know about their problems and mock them." (LHW 05).

Familial Issues /Restrictions. Familial issues was a common barrier in both lady health workers and clients interviews as both of these groups faces restrictions and lack of permission restrictions from family members especially husbands. Other familial issues included their children and other responsibilities at home.

"Men said their women shouldn't go anywhere, to anyone but should remain home." (LHW 01)

This finding corroborates with client interviews as well where the restriction from family decreased their mental health service uptake,

"Because husbands of such women don't allow their wives to attend sessions at home," (S0323)

Learned Helplessness. This theme was not commonly reported, however, it gives important information about barriers on an interpersonal level. Lady health workers suggested a lack of initiative and a sense of learned helplessness in the community members that hinders their ability to seek mental health assistance,

"They are always hoping to extract money from here and there. Never do they think of earning money by labor. Always thinking of getting it from an institution and then letting us do the work." (LHW 01)

Community level.

Social Stigma. Social stigma was a common but less frequently reported factor as a community level barrier to mental health services. People seeking mental health support were perceived differently by some community members. It prevented them to seek help initially,

"Baji at the initial stage they said to us that we are not mental to attend these sessions" (LHW 03)

Clients also shared that some community members either consider it useless or make fun of the mental health services,

"Each neighbor has its own way of thinking. Some people are laughing at it and some consider it right. And some are saying that if they are asking from you then they are making a joke out of it." (P13)

Poverty. A hindrance pointed out by lady health workers and clients was poverty. The clients seemed to have an expectation of material support with counseling to overcome their financial challenges. This poverty seems to be one hindrance for them in seeking support.

"Yes their lives did change for the better but there was one problem that even we

couldn't consult and that was poverty they always used to tell us that we are only anxious due to poverty". (LHW 06)

They shared how they feel helpless due to poverty and lack of basic resources,

"I have tension for my children and home. My father is disabled and I am nervous about his treatment as well. I am equally tense for my daughters as well. Sometimes we have one meal a day and worry for the next". (P7)

Fear and apprehension about community response. Another important but less frequently reported barrier in the view of lady health workers was their fear of how this intervention is going to be received by the community. The lady health workers were apprehensive about people trusting them with their mental health.

"Whether or not the villagers would listen to us, will treat us well or not. Whether they will say that why are we doing all this. We were bothered by these things." (LHW, 01)

Impact

Individual level.

The mental health intervention had a positive impact on both clients and lady health workers.

Improved sense of self-sufficiency.

Reportedly, after the mental health intervention, clients were able to establish lifestyles that are more self-sufficient and contributed more effectively to household expenses.

"She told us about methods of survival. She told me that if I continue sewing my life can turn the other way round. I can lead my life in a better way. I get wages and from that I buy flour and that is how we are surviving." (P10)

Clients also reported that these sessions helped them initiate small businesses that further improved their financial situation,

"Yes lady health worker gave us a session that we should start a little business so that our kid's expenses of pens and copies should be met easily...(so) I started a shop using only 500 Rs, so that all the expenses of copies and pens could be paid by the shop." (P9)

Lady health workers also emphasized the role of education in self-reliance because the clients were able to utilize their time more

effectively and develop skills that can help them achieve long term independence. One LHW suggested that basic skills like mathematics can help these women operate their businesses effectively.

Additionally, due to the intervention lady reported that they were able to provide guidance about finance management, mental health, domestic issues which further impacted the clients' ability to make better decisions:

"One lady took a loan from the bank and was worried about how she would return it so I advised her that ... it would be wise to buy a goat. Client bought the goat and she (goat) got pregnant. After the birth, the client sold the goat and kept the offspring. She thanked us a lot" (LHW 1)

Improved Knowledge about Mental Health.

Participants reported that initially there was a lack of awareness about mental health and this often led to confusion and fear about the process. Lady health workers also experienced this in the form of resistance towards counseling sessions:

"In the beginning they were very scared. The kind of questions they had in their minds were "what is this, what is being explained, what if we tell them about our secrets and they share it with others". (LHW 06)

However, once the sessions started and were being delivered by the lady health workers, there was a marked improvement in the clients' knowledge and acceptability of mental health:

"At first, we didn't care much about it. Later, they taught us about it (mental health) and now we understand and are aware of its importance." (P4)

Lay health workers also reported an improvement in their own knowledge and perception about mental health and counseling:

"First we had only heard about these things but when we were in the training we learned a lot about what mental health is. Problems can happen, depression can happen. Tension and depression is a part of every woman's life therefore we do these (counseling) sessions." (LHW 06)

Alleviation of Symptoms. The mental health intervention aided in alleviating symptoms of depression and anxiety through the counseling sessions. Clients reported that by discussing their grievances with the lady health workers, their stress levels reduced and they were able to maintain a healthier lifestyle,

"It (counseling) helped us in life. Especially with mental health. We have started helping ourselves and we do not get depressed very often." (P3)

Moreover, the lady health workers themselves reported that they observed a marked reduction in the clients' stress levels due to the mental health intervention:

"..When at first I used to visit them I didn't see any kind of happiness on their faces and they were not sharing their problems and worries... But now as I meet with them, they talk about their problems, I feel from their eyes that they are now relaxed from every worry." (LHW 09)

Lady health workers also observed an improvement in the clients' physical health due to the mental health sessions:

"Due to depression, anxiety they suffered from low blood pressure.. but now everything's fixed, they say. Earlier their faces or bodies used to be weak ,but after consultation they're taking care of themselves and are now in much better health." (LHW 06)

Improved Work Satisfaction. Lady health workers reported that their work satisfaction improved due to the mental health intervention:

"We felt good that because of us someone else's life was better and with it our lives have improved as well. We are doing much by going out, for others and for ourselves. We liked that I am capable enough to be a Marvi worker and a counselor. So, it has benefited us a lot." (LHW-05)

In addition to work satisfaction, being a part of the mental health intervention improved the lady health workers sense of self because they started receiving the community's respect and gratitude.

Monetary Benefit. The intervention became a source of extra income for the lady health

workers and opened new avenues of earning livelihood.

Interpersonal level.

Family-esque relationship with lady health workers due to mental health sessions. The mental health sessions according to clients have played a great part in forming family-like relationships with lady health workers.

"We just followed her, whatever she said. Yes they've guided us a lot. We are very thankful and pray for them. since they have started working here for our betterment. We praise them a lot." (P2)

Similar responses were found in LHW interviews,

"Now our relationship with our client is getting better. Previously the woman who used to only talk about contraception now shares her life with us and with that we also get happy that there is a connection of trust building". (LHW 06)

Improved response of clients towards FP due to mental health. Lady health workers found the impact of mental health intervention on improvement in clients' attitudes regarding family planning as well,

"First, we used to go to them at least ten times a day but now they themselves come to us along with their other family members as well." (LHW 09)

Suggestions.

Further Community-Based Program. Lady health workers and clients considered mental health integration to be helpful and wanted this program to go further. They wanted it to be community-based rather than in the hospital due to accessibility and permission issues.

"There must be continuous sessions on health and education as they give us knowledge." (P5)

"Yes ma'am this was a good thing, because the main problem was money because these women whatever happens wouldn't spend money and go to hospitals. " (LHW-05)

Monetary Support. Both lady health workers and clients pointed out the impoverished state of being in the community. They expected and suggested monetary support

along with counselling to overcome this challenge,

"Sister, we don't have a water tap. We don't have a school for a year, where our children can study. They're roaming freely and we don't have any religious academy. We lack roads, we're sick here. Recently, rain poured and our roads deteriorated.....After that, you should help us tackle poverty." (P2)

Lady health workers also mentioned the expectation of the community for monetary support that also prevented them from seeking mental health support as their basic needs were not met,

"We were visiting them for consultation...after the consultation, their husband would ask them about what they were asked and how they responded and if they are going to help us with our poverty / will they give us anything". (LHW, 06)

Discussion

Exploring the perceptions of service users and service providers helped us understand the feasibility and impact of introducing a mental health intervention in a community-based family planning program. The dissemination of the mental health intervention through lady health workers was well-received amongst the community. It reduced the amount of effort required to build trust and a working relationship between a health worker and client. One of the major reasons for this seems to be the positive impact in the women's' lives and their families. Improvement in their physical and mental health along with better solutions for their financial issues were found to have been motivating for them to continue the intervention. In addition to that, the lady health workers were readily available and went an extra mile to be helpful. It was further supported by the communal support for the mental health integration, which shows that within a collectivist culture, community support is integral for mental health interventions with individuals. Community based services are often successful because of these existing networks of support that offer an environment of trust for the clients (Ali et al., 2018). This relationship of trust is specifically important for women because they are often restricted by male family members from seeking help from external resources or male health workers. Furthermore, spreading

awareness about mental health through lady health workers was also easier because the community already considered them a source of knowledge regarding sensitive matters such as family planning. Therefore, integrating mental health information into this program increased the acceptability of mental health.

The most significant barriers came out to be on an interpersonal level where most women had difficulty seeking permission to attain mental health intervention. Gender inequality is found to be related to increased mental health burden for women. It comes from a financial distress and low education levels (Collier et al, 2020). When someone's basic survival needs are unmet, all the other needs become secondary. Poverty made it difficult for women to prioritize their mental health needs that led to a difficulty for some women to avail the intervention. The women who received this intervention also suggested that this intervention will be more helpful if coupled with financial incentives to alleviate financial distress. Thus, a psychosocial intervention seems to be an answer for an impoverished community

The mental health intervention helped the clients to be more self-sufficient, and improved their sense of self. This improvement contributed to greater initiatives to improve their finances and increase their family income. This signifies the impact of mental health intervention on a larger scale and helps reduce the major stressor of poverty in the first place. This can be beneficial while introducing a psychosocial support model whereby these women can be further empowered through financial interventions that can help them create sources of income to support themselves and their families.

The intervention was also helpful in increasing the mental health knowledge of women who received the intervention and the lady health workers as well. This improved awareness and seems to have a positive impact on attitudes towards mental health. The most reported improvement was seen in the symptoms of psychological and physical symptoms of mental health problems that the clients experienced. The symptom reduction has been found as a result of community mental health intervention in previous studies as well (Anne et al., 2012).

The mental health integration not only benefited the clients but also had a positive impact on lady health workers work satisfaction. Previous studies also point towards improved sense of efficacy in healthcare providers with mental health

training to be better able to provide help to people with mental health problems (Jenkins, 2010). They felt more connected with their work and felt a sense of satisfaction in it by helping others. This also had a positive impact on their relationship with clients who started seeing them as family members and were more inclined towards mental health interventions.

Another interesting finding was a perceived improvement in attitude related to family planning and better uptake. Poor mental health was associated with low contraceptive and family planning measures uptake (Catalao, 2020). This reflects how an improvement in mental health can have a positive impact on contraceptive outcomes as well and further studies can be conducted to investigate the impact of mental health on family planning uptake in lower middle-income communities.

To improve the feasibility and implementation of mental health intervention, suggestions were provided by the clients and lady health workers. Finances and mental health are closely interrelated. Studies have found that people in debt and financial difficulties have more mental health problems and poorer recovery. Financial difficulties and a lack of basic resources seem to have contributed to the mental health problems of the community under study immensely. The clients and lady health workers suggested some monetary or basic resource assistance along with mental health intervention for better outcomes. This is expected to result in better mental health outcomes. Moreover, the intervention was provided on a home/community-based level and was found effective due to accessibility and ease. Thus, continuation of service on the community level rather than in hospital settings was recommended by both lady health workers and clients. This mode of delivery is reliable and sustainable in other studies as well.

Integration of mental health in family planning is supported by multiple factors including the ease of access and communication with the health workers, trust and being a community service. The need of upskilling health workers being the frontline psychosocial support provider has been identified by the World Health Organization to bridge the need and resource gap. However, the current curriculum of lady health workers is missing the mental health curriculum. A commentary on Pakistani context also suggests upskilling lady health workers and

bridge the existing mental health gap (Rabbani, 2023).

Limitations of the Study

A key limitation of the study was that husbands of LHWs and clients were not interviewed. In the cultural context of Pakistan, decision-making power for women often lies with the husband. So, in the future studies it is pivotal to understand their perception of mental health services to ensure more effective integration.

Conclusions

This pioneering study marks a significant advancement in Pakistan's public health research, offering a first-of-its-kind integration of mental health services into an established family planning initiative using a co-produced, community-centred approach. The transformative and sustainable impact observed reaffirms the pivotal role of co-production in ensuring the efficacy and relevancy of health service delivery, particularly in resource-constrained settings (Bovaird & Loeffler, 2012; Osborne et al., 2016). Such a collaborative method, as our study underscores, can bridge persistent treatment gaps, offering a template for diverse health conditions beyond just mental health.

A salient finding of our research is the accentuated comfort and acceptability of community-based sessions over traditional clinical environments. These community sessions provided an ambiance of trust and relatability, fostering improved mental health outcomes and catalysing enhanced service uptake (Ali et al., 2018). The community's implicit trust in the lady health workers, already recognized as repositories of knowledge on sensitive matters, facilitated seamless integration and acceptance of mental health education.

Furthermore, our program ignited a wave of empowerment among women, emblematic of the transformative potential of community-focused interventions. Women, traditionally bound by societal constraints, found an avenue to candidly discuss their challenges, take charge of their mental health, and proactively forge sustainable solutions to elevate their circumstances. This empowerment extends beyond the individual, as evidenced by the broader community effects on family planning and the improved attitudes towards it (Catalao, 2020).

The inclusion of financial support with mental health services in the form of a psychosocial intervention is an avenue warranting future exploration, given the profound linkage between financial distress and mental well-being (Collier et al, 2020). Encouragingly, the community-driven model, underscored by our findings, showcases the potential of delivering vital services at the doorstep, furthering the goals of accessibility and effectiveness.

The World Health Organization's emphasis on upskilling frontline health workers finds validation in our study's results. The glaring omission of a mental health curriculum in current training, as highlighted by Rabbani (2023), underscores a crucial opportunity for systemic enhancements.

Our study, while groundbreaking, does come with its limitations, most notably the absence of insights from male family members, a critical stakeholder in the cultural fabric of Pakistan's decision-making processes. Yet, this very gap also provides direction for subsequent research endeavors, emphasizing the importance of holistic perspectives in understanding health intervention impacts.

In conclusion, this research represents a pivotal moment in public health initiatives within Pakistan, elucidating the transformative potential of co-produced, community-centric health programs.

List of Abbreviations

Lady Health Workers- LHWs
Patient- P
Socioecological Model - SEM
Low Middle Income Countries -LMICs

Conflict of interest

The authors declare that they have no conflicts of interest.

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