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CONTENT

CHILD SUICIDE: FAMILIE'S REACTIONS

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Abstract

Introduction: Suicide is a major public health problem, in which relatives play an important role in the prevention of the said problem. However, suicide and suicidal behavior affect the relatives' lives profoundly, both emotionally and socially.

Aim: This study is an initial investigation of families' emotional and behavioral responses to adolescents' suicide

Methodology: An extensive literary review of relevant articles for the period 2000-2017, was performed using Medline, PubMed and Google databases, with the following key words: "child suicide, parent's reactions, bereavement, risk factors, warnings sign, and mental health problems".

Results: Suicide is uncommon in childhood but becomes an extremely serious issue among adolescents. Several risk factors have been identified and include the presence of psychiatric illness, a previous suicide attempt, family factors, substance abuse, sexual and physical abuse, or bullying. The death of a child of any age is extremely painful for parents. Most parents experience a profound sense of guilt, shame, pain, depression when harm comes to their child, even if through no fault of their own. The same feelings are often present and are associated with help seeking in siblings bereaved by suicide. All of these factors lead to a devastating grief that is much longer lasting than most people realize.

Conclusion: Families that have experienced a suicide present severe prolonged grief with many psychological and physical symptoms such as depression, feelings of guilt, shame, pain, heart failure, hypertension, diabetes. However, the psychosocial impact on families is a very important issue who needs further investigation.

Keywords: *child suicide, parent's reactions, bereavement, risk factors, warnings sign, and mental health problems*

Introduction: Suicide is a serious public health issue and defined as the act of intentionally inflicting one's own death (Pitman A, Osborn D, et al, 2014). Suicide attempts are more frequent than suicides and a person can attempt suicide multiple times. A suicide attempt defined as nonfatal self-directed potentially injurious behavior with any intent to die as a result of

the behavior (Crosby AE, Ortega L, et al, 2011) and is an important predictor for future suicide (Nordentoft, 2007).

According to Shain, 2016 is the third leading cause of death in adolescents, following accidents and homicides and the frequency of this condition drastically increases during adolescence (Dilillo, et al., 2015). About 800 000 people die by suicide annually, resulting in an estimated 48–500 million people experiencing suicide bereavement every year worldwide (WHO, 2014).

Risk Factors

Numerous risk factors increase the risk for adolescent suicide. These factors include possessing a psychiatric illness, lack of coping skills, emotional turmoil, a distorted view of life, a previous suicide attempt, substance abuse, family factors, and more (Comer, 2014). Almost 90 % of adolescents who commit suicide are suffering from a psychiatric disorder and more than 60 % of young people are depressed at the time of death (Gould MS, et al, 2003). Literature data shows that a prior history of suicidal or parasuicidal behavior represents an important risk factor for suicide (Hamza CA, Stewart SL, Willoughby T, 2012). "Bullies", "Victims" of bulling, of sexual and physical abuse, are important risk factors for suicidal behavior or suicidal ideation, especially in subjects aged between 16 and 25 years (Shaffer D, Pfeffer CR, 2001). Safety of the home environment and the environmental precautions are aimed at restricting access to means of suicide (eg guns, ropes, medications), and family members should be aware of the risks related to the situation (Wasserman D, Rihmer Z, et al, 2012).

A person at risk for suicidal behavior most often will exhibit warning signs such as expressed or communicated ideation, threatening to hurt or kill him/herself, increased substance (alcohol or drug) use, with no reasons for living, or no sense of purpose in life, adolescents who are feeling trapped, without hope and withdrawing from friends, family and society (American Association of Suicidology, 2006.)

Family's reactions

The death of an infant, child, or adolescent, from any cause, has a devastating effect on the family. For parents, the loss of a child defies the natural order. The death of a child is a sad event that represents a source of major stress, anxiety and sorrow for the parents. When the death is a suicide, the parental reaction may be even more difficult, because of the stigma associated with self-destruction (Shear MK, Zisook S, 2014). Families experience a significant loss because they are those who are closest to the victim. Other experiences include pain, shame and distress with the potential for long-term effects including depression, suicidal ideation and other forms of distress that have been reported (Hjelmeland H, Akotia CS, et al, 2008).

For most families where a suicide has occurred, shock is the first and immediate reaction. Guilt feelings are also present in such situations especially when relatives regret things they did. Family survivors may feel that they directly caused the death, and blame themselves for not preventing the suicidal act (Bryan CJ, Rudd MD, 2006).

In 2008 Cerel, Jordan, and Duberstein reviewed a research on the impact of suicide on individuals within families and on family and social networks. After suicide, there are many changes in familial structure. Specific factors assessed include decreased family cohesion, or emotional bonding, and decreased adaptation. The cause of death of a family member may be hidden from the other members of the family, especially children, or from people outside of the immediate family due to fear of negative judgment.

Parent's relationships with the other members of the family could be affected. The crisis in the family often had the effect of bringing pre-existing problems in relationships to the fore. Parents worried about family members overreacting or getting upset, as well as about judgment and blame. An overall theme was a profound sense of isolation and a desire to keep a child's problems private. This was often linked to parents' feelings of guilt and their worries about what others might think. Many parents reported that their child's self-harm had a detrimental effect on the family's financial situation, often by making it difficult for parents to maintain a fulltime job (Ferrey AE, Hughes ND, et al, 2016).

According to Dyregrov K, Dyregrov A. 2005, younger bereaved siblings who lost brother or sister after suicide, are suffering from posttraumatic and grief reactions, insomnia, social dysfunction, depression, and anxiety. Feelings of depression, anxiety, guilt, extreme sadness, anger and nightmares are often present and are associated with help seeking in siblings bereaved by suicide (Brent D. (2010).

In a qualitative content analysis of 18 interviews with suicide-bereaved siblings, the authors found that the bereaved sibling's and the deceased sibling's unmet needs may generate negative attitudes toward health services, which reduces the likelihood of seeking professional help as well as medication acceptance in some cases (Pettersen, R., Omerov, P., et al , 2014).

In a study of Wilson & Marshall, 2010 among 164 relatives and friends of suicide victims, 56% of first-degree relatives reported great or significant need of professional help, whereas 8% of them reported no such need, but only a small percentage of suicide-bereaved relatives receive professional help.

In a modern study, the authors explored the experiences of seven biological mothers bereaved by suicide. Four themes emerged: (a) silencing grief; (b) shattered assumptions; (c) constructing a narrative; and (d) the depth of a mother's grief. Mothers experience intense prolonged grief with many psychological and physical symptoms. One of them acknowledged strong suicidal thoughts and one had attempted suicide. The findings suggest a need for care professionals to be aware of, and to target, this vulnerable subgroup (Sugrue, J. L., McGilloway, S., & Keegan, O, 2013).

According to Pitman A.L et al 2016, people bereaved by suicide report the highest levels of perceived stigma, shame, responsibility and guilt compared with people bereaved by sudden natural or unnatural mortality causes.

The stresses associated with a young person's suicide can affect relationships between family members, sometimes leading to marriage difficulties and divorce among parents (Byrne S, Morgan S, et al. 2008).

Stressful life events like suicide also impact physical health and the experience of bereavement in particular is associated with negative health outcomes. Bereavement is not only associated with an excess risk of mortality but also physical ill-health and negative psychological reactions and symptoms, including mental disorders or complications related to the grieving process (Stroebe M, Schut H, Stroebe W, 2007). There is also emerging evidence of the effect of suicide bereavement on physical health. For example, a recent case–control study found that suicide-bereaved parents have a higher risk of CVD, hypertension, diabetes and chronic obstructive pulmonary disease (COPD) (Bolton JM, Au W, et al, 2013).

Conclusions

Being the family of a child who attempts suicide meant managing a very difficult and complicated situation and the additional moral stigma. It is obviously that people bereaved by suicide report the highest levels of perceived stigma, shame, responsibility, depression and guilt. Future research should address the lack of interventions to address perceived stigma and shame in bereaved relatives and friends after a suicide.

The authors declare that they have no competing interests

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Keywords: *child suicide, parent's reactions, bereavement, risk factors, warnings sign, and mental health problems*

DIR®-INFORMED APPROACH TO ANXIETY AND TRAUMA IN SCHOOL AGE CHILDREN

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Abstract. As dwellers of our planet receive an overwhelming amount of information and live coverages of scary, traumatizing and horrifying events around the globe, anxiety takes the front seat in the clinical discourse. At the same time, children are even more susceptible to anxiety than adults, mainly because of lack of control over their lives, actual helplessness, operating largely on clues and adult whisper rather than on confirmed (and comprehended by them) facts; most of the time, they have no impact on own future. Excessive worry and uncertainty can manifest itself as aggression, "striking out", low frustration tolerance and impulsivity. Another, not less important, predictor of anxiety is the ability to self-regulate and the speed with which a child can recover from stress or perceived danger and, shutting down the initial response of hypervigilance, go back to the state of homeostasis.

Naturally, all the above greatly depends on individual history and patterns of resilience. Prior history of trauma is the most important marker of emerging symptoms of anxiety and anticipatory anxiety. Mechanisms of trauma processing, as well as family and individual history of trauma and vicarious traumatization should be closely examined in the process of assessment and addressed in psychotherapeutic treatment regardless of the nature and scope of presenting problems.

This paper examines presenting problems of latency age children, stemming from anxiety and/or psychological trauma. The author shares her experience of addressing the above issues in psychotherapeutic work using Developmental, Individual differences and Relationship based approach (DIR®). This diagnostic and treatment model defines and describes the hierarchy of developmental capacities humans are to achieve throughout their early, formative years, individual profile (unique ways of information processing) and employing affect based therapeutic interaction to promote the development of the above. Individual profile includes motor control, praxis, visual spatial capacities and integration of sensory information supplied by five organs of sense and vestibular, visceral and proprioceptive systems, language capacities, and affective relationships. DIR® can be utilized for the purpose of differential diagnosis, as well as an invaluable philosophical base. This diagnostic and treatment paradigm allows for comprehensive scrutiny of co-occurring problems, developmental capacities and a multitude of variations in sensory, medical, familial and environmental characteristics that serve as prequel to symptoms. Additionally, DIR® lends us a treatment philosophy that leaves room for the

individuality of the child. Case examples illustrate application of DIR® and utilizing elements of the DIR Floortime.

Keywords: *DIR®, DIR Floortime, anxiety, school aged children, differential diagnosis, child psychotherapy.*

Introduction

The WHO (World Health Organization) states that anxiety disorders are the most prevalent mental disorders worldwide. 1 in 13 individuals globally suffers from anxiety. According to large population-based surveys, up to 33.7% of the population are affected by an anxiety disorder during their lifetime (Data and Statistics on Children's Mental Health, CDC). Among the U.S. children, 7.1% aged 3-17 years (approximately 4.4 million) have diagnosed anxiety. The percentage of diagnosed children spikes by the age of 12. Research by the National Institute of Mental Health shows that untreated children with anxiety disorders are at higher risk to perform poorly in school, miss out on important social experiences, and engage in substance abuse (Anxiety and Depression Association of America, 2019). To complicate this picture even more, let me add that in the era of globalization children face challenges that are unprecedented. Secondary trauma, or indirect exposure to trauma, the constant stream of breaking news and gruesome details that become available in real time via mass media/social media are superimposed on the actual trauma incurred during the upsurge in social unrest and local wars. As per UNICEF, nearly 31 million children were internally displaced worldwide in 2017; 20% were reported to suffer from PTSD. For many countries, heightened terrorist activity the way it's impacted many urban communities has been opening a new level of exposure to the unanticipated danger. At the same time, traumatic occurrences become more prevalent not only in urban but also in suburban communities, and recent wave of school shootings is a prime example of such. Increased frequency of natural disasters associated with the climate change also adds a layer of anxiety and becomes a potential source of trauma. As for the vicarious exposure, for example, computer games offer simulated disasters that can be (and are) experienced by players as immediate and real. The emotional landscape of our lives is changing daily under the influence of these unending hits and misses.

Considering all these factors, mental health practitioners tread through the newly discovered, vast plains. In addition to the usual palette of cases from the Anxiety Disorders cluster, there are more and more cases of anxiety with co-occurring trauma. Children are as susceptible to trauma but, because their coping mechanism is barely developed, their vulnerability is much greater than that of adults. The latency age population is the easiest to fall through the cracks because of the assumed uneventfulness of this developmental stage: these kids (supposedly) already mastered basic milestones yet had not moved into a hormonally driven turmoil of adolescence. Though, this group experiences their own unique emotional pressures, with very little emotional padding to take them through anxious, angry, terrifying thoughts, premonitions and fantasies. Coping strategies,

neither healthy nor unhealthy, those that are available to the older age group, are not developed yet. While adults have some, albeit limited, measure of control (i.e., devising an escape plan, choosing to fight back, reaching for help), and they can also employ previous experience and mobilize existing coping mechanisms, children are left at the mercy of circumstances and their own self-regulating capacity.

Diagnostic and treatment framework offered by Developmental, Individual differences and Relationship based approach (DIR® and/or DIR Floortime), a method pioneered by S. Greenspan, can be effectively used in the assessment and treatment of this diverse, as we shall see, group. DIR® is a comprehensive, dynamic, child driven and affect driven developmentally based model that takes into account not only psychodynamic and behavioral manifestations but also biologically based individual differences, namely, sensory, language, cognition, motor skills, and assesses capacities of functional emotional development (FEDC). It also incorporates familial, cultural and community systems as they influence the child. Different level capacities will be mentioned throughout this paper wherever applicable.

Neurobiology of the anxious and stressed brain

Anxiety affects several systems in the brain, from neurotransmitters in the central nervous system (CNS) to the limbic system (hippocampus and amygdala). Top-down, cortex-based anxious thoughts have the potential to activate the amygdala, which, in turn, produces the physical, bottom-up response. Cerebral cortex helps us to interpret our current experiences and to make predictions about what is likely to happen in the future. The peripheral nervous system regulates and counteracts mechanisms of arousal and dampening. Also, in the last several decades, the role of the visceral vagal response (polyvagal theory of Stephen Porges) is being better understood, too. Whether it's load conditions that activate sympathetic response undermining the existing regulation system, or "improbable fears", in D. Winnicott's formulation, of the normal developmental trajectory, either pathway can be a primary source of anxiety. Symptoms of anxiety (fears, influx of anxious mood, worry, panic attacks) can be set off by the polyvagal response to the emotionally meaningful person's "irritated, overly loud voice, a "serious" (lowered corners of the mouth, frowning forehead) face" (Itskovich, 2019). These polyvagal signals increase heart rate. In fact, all emotional and affective states require specific physiological shifts to facilitate their expression and to reach their implicit goals (e.g., fight, flight, freeze, proximity, etc.). (Porges, 2009). Individual responses to SNS overload vary from anxiously controlling, to flooded, to hyper/hypovigilant (hypervigilant – on constant alert, hypovigilant – passive and detaching under stress).

Self-regulation, Capacity 1 on the DIR® scale of functional emotional development, comes to the forefront of treatment for anxiety. The modern take on neurodevelopment holds that self-regulation, a core capacity of human development, established early on via primary relationships,

regulates functions of the amygdala (D. Siegel, 2011), while maladaptive, dysregulated responses to trauma activate sympathetic circuitry and actually contribute to amygdala shrinkage (Herrington et.al.2017). Emotion regulation and social affiliation are considered emergent properties of the regulatory functions served by the vagus. Deployment of the newer vagal system suppresses robust emotional reactions that characterize fight/flight/freeze response, a prerequisite for the emergence of complex social behavior. Through "characterizing how states of anxiety and a vulnerability to being anxious would be potentiated or dampened by different autonomic states" (Porges, 2009), we obtain greater degree of control over interventions aimed at dampening sympathetic tone or increasing sympathetic response.

Clinical presentation of the anxious and stressed brain

Because of the breadth of issues and multitude of problems that are covered by the DSM-5 anxiety cluster, as well as the purposes of this article, the author would like to concentrate on just a few. Overload of the ANS leads to disruptions not only in the fight/flight/freeze cycle, but also in the already existing attachment patterns. Attachment disruptions further contribute to clinical presentations of both post-traumatic and anxious etiology. According to the founders of the concept of mentalization, attachment trauma can further lead to a shutdown in mentalization, the mental ability to be curious and inquisitive about mental states in oneself and others (Bateman, Fonagy, 2006; Allen, Bateman, Fonagy, 2008). It becomes hard for the individual to take into account thoughts and feelings of the other and/or make accurate predictions of others' reaction or emotional response.

Another landmark feature of trauma-based anxiety is a quickly developing pattern of cognitive distortions. This leads to the "emotional reasoning" when past traumatic experience overrides the decision making, and the problem-solving capacity deteriorates as a result. An affected child tends to generalize negative experiences ("it always happens to me"), and discount positive ones, initiating self-defeating behaviors (Hecht (2013) confirms, "The right hemisphere has tendency to focus on negative information, whether that information is visual or auditory"). Black-and-white thinking (dividing the entire world into "I" and "they") comes into effect, which constitutes an arrest at the Functional Emotional Capacity 7. Affected individuals tend to "read the other person's mind" ("I know that you're going to say… etc."), always assuming the worst.

It is also important to appreciate and examine, as much as we humanly can, the factor of personal resilience. Beauchaine et. al. pose the question "why some emotionally labile individuals respond more often with appetitive (including fight) behaviors, as in the case of externalizing disorders, while others respond more often with aversive (including flight) behaviors, as in the case of internalizing disorders…" and further stipulate that "it is crucial to understand how to facilitate this innate capacity to formulate a situation-appropriate "resilient" response and restore sense of safety and security" (2001, 2002).

Oftentimes it is hard to decipher what came first, psychological trauma or anxiety, but the interplay of these two results in the most difficult clinical presentation. Regressive symptomatology, stupor, repetitive play or traumatic reenactment, hyperactivity, inactivity, withdrawal go hand in hand with anxiety symptoms. Children, regardless of their neurological makeup, may not verbally acknowledge their terror or persistent worry, but present with the range of post-traumatic symptoms instead. New behaviors may include episodes of screaming, throwing things, aggression and property destruction, hypervigilant reactions to normal changes, a lack of focus, inability to respond to people during the dissociative episode, nightmares, or expressing physical complaints. On the other hand, fear of abandonment or separation from the parent, fear of loss of life and other catastrophic thoughts can leave hard-core imprint on the young children's emotional biography. The resulting changes in functioning can facilitate disruptions in the previously established self-regulation and co-regulation patterns; the loss of the social circle; compromised school functioning; trouble with decision making; and language difficulties.

Developmental, Individual differences and Relationship based assessment and intervention

Those familiar with Stanley Greenspan's model can't help noticing how the abovementioned coincides with the functional emotional developmental capacities (FEDC). DIRFloortime lends clinicians working with latency age children the developmental lens. In addition to the FEDC's, DIR® assessment creates the unique sensory, vestibular, proprioceptive, language, neuroceptive and motor profile of the child. All the assessed areas help to plan for the individually tailored interventions supporting and amplifying the said individual characteristics. Additionally, DIR® assessment specifically examines relationship with the primary caregiver and, when feasible, assesses caregiver's FEDCs. Understanding predominant levels of functional emotional development of the adult who's significant in the child's life helps therapists to approach issues of "the best fit" between a child and a parent with greater precision.

A therapeutic relationship as both a means and ends to successful treatment is pivotal to the DIR® informed work. It is only natural for the best parents and caregivers to want to "join in", "to share", or "to be with" the child. "Interaffectivity is mainly what is meant when clinicians speak of parental "mirroring" and "emphatic responsiveness" (Stern, 1985). When such primary relationships need to be recreated in the therapy room, a DIR® -minded therapist takes on a role of witness to the child's raw emotion and listens intently to expression of special interests or concerns. The therapist makes him/herself readily available to manage fears, to help with down-regulation, and to open up uncomfortable conversations rather than avoid frightening topics or shutdown. Empathetic acceptance is the first step towards developing trust; trusting interactions can facilitate healing and restore missing steps in the developmental ladder. Yet another important dimension is the sense of mastery. If we are to work from the premise of Erik Erikson that school age children resolve issues of inferiority versus

industry, it means that they indeed can greatly benefit from therapeutic relationship promoting a sense of competency.

Profound understanding of the individual differences opens new vistas in the clinical landscape. Many highly anxious children may struggle with issues around sensory reactivity that go unnoticed and unaddressed in the traditional psychotherapy. Sensory reactivity can put such children in the perpetual (or frequent) state of sensory overload, when anxious mood is further exacerbated by the malfunctioning ability to process and integrate sensory information. Helping children to recover from the emotional and sensory overload means decrease in self-blame, in polarized and inflexible thinking, anticipatory anxiety, and a sense of helplessness and inadequacy, in addition to creating optimal conditions for sensory integration.

Another important determinant is language capacity. Because of linguistic limitations of various nature (from the, age-appropriately so, limited vocabulary to problems of delayed speech development), children are shortchanged in their choice of neuro-integration tools when it comes to verbalization of experiences, worries or fears. As a result, instead of *verbally* labeling their prevailing "emotion of an hour" as anxiety, they present many changes in *behavior*, from school refusal to psychosomatic problems to behavioral storms.

In order to mend ruptures in the step-by-step functional emotional development and to have the FEDC's develop and grow to an age appropriate maximum, a therapist can offer a number of techniques to facilitate co-regulation, from precisely measured, tailored to the child's needs physical contact, to the use of timbre, pace and rhythm of interactions. Psychodynamic case formulation is being enriched by observations form the developmental angle. Relationship building starts with a therapeutic technique of following the patient's lead. Several working objectives listed below serve an overarching goal, to narrate (or play through) the experienced, anticipated or imagined catastrophic event and reestablish sense of safety:

• **Validate** emotions and experiences (don't downplay reality; respect "improbable", fantasy versions of what happened)

• Tailor own affect not to the content but to the child's affect

• Work face to face whenever feasible

• Tolerate high affect, anger and displacement of aggression

• Tolerate rigidity and rituals

• Tolerate silences and messes

- and, later, to normalize and generalize child's perception of the event, his/her role in it and an emotional aspect of the trauma/precipitating event:

• Extend circles of interaction (see the detailed explanation in "Engaging Autism" and other writings of S. Greenspan)

• Don't concentrate on the plot and the choice of activity – go beyond superficial

• Teach self-soothing and identify new routines

• Consider FEDCs: **Move up and down the developmental ladder as needed**

Another important aspect of work is building supports for the individual profile of the child:

- Adjust pace and rhythm
- Encourage motor planning and general executive planning
- Help to learn about his/her own sensory needs and preferences

Before proceeding to two clinical vignettes, the author would also like to note that, when we speak about anxiety, its precipitants and manifestations, the little studied important distinction is gender. Difference between girls and boys of the latency age is apparent at the level of presenting problems: while boys predominantly present with active defiance and acting out ("fighting"), girls turn to self-destructive behaviors of the "flight" and "freeze" spectrum. Although two cases that the author is about to present do not confirm to the above observation, the majority of the cases in the decades-long practice fall into two categories, boys referred by the school guidance counselors or teachers and girls brought in by perturbed parents. The author feels that this tendency is worth examining in the future.

Sam: Living in the uncertain future

I met friendly and chatty Sam, an only child in a loving and caring full family, when he was 8, and proceeded to work with him until 10 years of age. He arrived to me with the diagnoses of Tourette's Syndrome, Attention Deficit Hyperactivity Disorder and Obsessive-Compulsive Disorder. His neurologist prescribed a daytime stimulant to help him attend to tasks in school. His mom related multiple evidence of poor self-regulation and complaints about his rigidity, incessant questioning and "clinginess." At intake, Sam related multiple fears and "bad dreams" centered around themes of abandonment and death. Sam's obsessive thinking, rumination and compulsive rearranging of toys and objects created mere obstacles to the normal flow of things at home, but his behavior in school seemed to be barely tolerable despite mother's constant involvement. At times, he needed emotional and even physical support throughout the school day. Issues and emergencies ranged from being bullied by other children (for instance, being called "a girl" because of avoiding sports and gross motor games, and because of his preference for bright "girly" colors in his clothes) to engaging in inappropriate touching behavior. As a result of his unmet proprioceptive needs, his unsolicited hugs could easily progress to punches.

Sam's difficulty in motor planning and executive functioning was overcompensated with exhausting rituals and verbose behavior. He had difficulty staying in bed at night, and parents had to partake in an elaborate nighttime routine of Sam's own invention to help him soothe and finally calm down enough so that he could fall asleep. Sam also had asthma and acid reflux, both conditions closely associated with the sympathetic vagal response, and both pointing to the underlying anxiety.

On the functional emotional developmental scale, Sam exhibited difficulties with self-regulation, seeing multiple perspectives, and

demonstrated somewhat rigid use of language, while exhibiting excellent logical thinking and ability to connect ideas, as well as true concern for others, especially for his family members, and empathy, albeit on his own terms.

Deficits in Capacity 7 can be reframed as problems in the development of theory of mind. Can the theory of mind, an understanding of the fact that others' minds differ, be taught? This question continues to be a matter of debate. It should be noted that not being able to feel the feeling of the other or predict their response is commonly associated with lack of empathy. Contrary to this belief, Sam spent a lot of time worrying about others and whether they want to play with him or stay in his company precisely because of the insufficient understanding of the other's mind. It was because of his high emotional sensitivity and empathetic stance that he worked himself up to a chronic state of anxiety and self-doubt.

To gain quick access to Sam's fears of the day, we leaned heavily on his creativity. Sam would start each session with the drawing or making play dough figurines that would portray his "life now" (current worry) and "a future life", in a sense, representing hierarchy of fears. Initial drawings would be overcrowded with “decorative” doodling, distracting the viewer from the subject of the picture. Sam would get lost in detail and consequently demonstrate high anxiety seeing his own inability to complete the drawing.

Taking into account his interest in art and in elaborate, extended from week to week, projects, I created a sensory minded space with the "thinking corner" (two pillows propped against two walls in a corner, under straight angle) and the "hugging machine" (a heavy throw that Sam could wrap around whenever he "needed a hug", proprioceptive input). He would leave his unfinished projects in a safe place where no one else would touch them until our next play session and was happy to find them undisturbed the next week. Creating a safe space and sense of permanence proved helpful in building trust but also putting limits on our time together. Sam gradually started to accept limits at home and subsequently shortened the nighttime routine.

Catherine Pittman et. al. notes that “with compulsions, someone might find that they repeatedly engaging in a specific behavior which gives them temporary relief, but which they feel they must perform over and over. If you find yourself preoccupied with certain thoughts or compulsions and you have trouble getting past them, this is definitely a problem that arises from the cortex pathway” (2015). In this case, Sam's fears were interpreted as metaphor and taken seriously. To help Sam get “unstuck” and to switch off the anxious content that would disrupt his functioning and forced to use various self-soothing (dysfunctional) strategies, from physically clinging, thus providing sensory stimulation, to creating elaborate nighttime rituals, therapist and a parent united in validation. When his sensory profile was taken into account as well, we became able to jointly devise a plan of intervention whereas Sam learned about his own sensory profile and need for touch and figured out creative ways to regulate his proprioceptive system with help of sensory integration accessories. Bringing a weighted vest to

school also helped the mother to begin conversation with school professionals about Sam's sensory needs and close connection between his behavioral storms and sensory dysregulation.

Sam's need for acceptance, coupled together with anxiety and repetitive behavior, made him an ideal candidate for various performance-based endeavors. He enjoyed singing and brightly colored clothing - and being on stage became a great venue for both interests. In addition to joining a school based performing arts program, mom also got him into voice lessons. Sam was finally relieved to hear that he, indeed, could be liked and even applauded to, and his self-esteem started to climb up. Greenspan (2006) aptly noted that mastery of own sensory system grows with information about specifics of one's reactivity. Sam became quite an expert in determining what intervention could truly help at the moment.

For the purpose of this paper, the author would like to discuss an episode involving Sam's mother's plans to undergo gastric bypass surgery. As she got on a strict diet and started to lose weight in preparation, she also became more active socially and rapidly developed new interests, including going back to school. In the individual session, she shared her fantasies about more fulfilling life outside of her routine of a wife and a mother and hopes of developing a stronger social persona.

Around that time, Sam produced a double drawing, of his family "now " and of the "future family". In the "future family " drawing, mom was depicted as a dotted line figure. Via therapist's running commentary, observations and reframing, Sam was assisted in further elaboration. He verbalized fear that his mother was becoming so thin that in the future she could totally disappear. When Sam's fear was brought up during the session with the mother, it became clear that she perceived his concern as the threat to her need to self-actualize rather than a legitimate fear It became urgent to help her move up to the capacity of taking in another person's perspective, the Capacity 7 on functional emotional developmental scale, so that she could emphasize with Sam's need to keep her emotionally connected through this, exciting to her but threatening to him, change. She was able to accept my reframing of Sam's anxiety as developmental crisis and commit to helping him verbalize fear of abandonment. We discussed Sam's worry in the joint session with mom who adamantly confirmed that she'd never disappear from the family life, no matter how thin and busy she 'd become. After his fears were examined in the, so to speak, broad light, I asked him to repeat the same drawing from time to time. Later versions of the "future life" drawing contained lesser amount of the "decorative" concentric circles and other distracting details, and themes became not catastrophic but rather optimistic (growing up, becoming rich, getting a pet etc.)

When we were about to terminate, Sam set a goal for himself to redecorate my office. In his zeal, he attached his "playdough installation " to a stack of my business cards.

"How do you think I feel looking at this?" I asked.

After a momentous pause, Sam replied, “You must be a little mad about your cards, but aren’t you happy to see the rainbow colors?”

To me, it meant that he could recognize my reaction while also asserting with his own idea and therefore mastered the new functional emotional capacity.

Nikky: “An unwanted child”

Nikky, a 12-year old Caucasian girl, was brought to treatment by her mother because of aggression and behavioral storms at home, academic problems that eventually turned into school refusal, and “defiant behavior” across settings. Nikky was previously diagnosed with Oppositional Defiant Disorder. She was referred for therapy by a psychiatrist who was medicating her for attention deficit with Vyvanse for some 6 years, and who finally asserted that psychotherapy would be a must.

Nikky lived with her biological mother, stepfather and twin half-sisters. Nikky's biological father resided across the country and took her for visits two to three times a year. Her mother disclosed that Nikky's relationship with the stepfather and siblings was so poor that they all were constantly tense, waiting for her to lash out verbally and physically at any moment.

When schoolteachers were contacted, they all described her as a passive, even listless student who "seems to want to fail".

During the initial session, Nikky, an underweight and short for her age blond girl, was dressed age inappropriately, wearing a unicorn themed top that appeared a size too small. While the mother recounted Nikky's multiple misdemeanors, Nikky loudly protested, refuting each item, from "unprovoked" fights with the stepfather to "being hated by siblings " (as per Nikky, her young sister and brother were "brainwashed " by both parents and instructed to ignore her). Her vocabulary was surprisingly big yet grossly inappropriate for a 12-year old; for example, she used a slang word for “delinquency” that impressed me as a police jargon.

Nikky was reportedly a healthy child, except for frequent urinary infections. Day- and nighttime incontinence across settings was disclosed, but mom felt that it was Nikky’s way of “punishing her.” Nikky responded with the rageful scream; she was clearly embarrassed to talk about enuresis. When I asked about Nikky 's strengths, mom replied with surprise that she was born a difficult child but became truly unbearable by the age of four. Incidentally, this was the time when her biological parents' divorce was finalized, and when mom remarried. Mom, sensing my disapproval, added that Nikky's life is lax and luxurious, and she has the whole floor of the house to herself and therefore should not complain.

At the time Nikky happened to be on indefinite punishment for failing school and "showing disrespect" at home, and her TV and phone privileges were taken from her. She reportedly spent her time at home staring at the wall where her TV used to hang. Because of the "no TV" punishment, she was no longer allowed in the living room, her parents ' bedroom and her siblings' room, and stayed in her basement room (that was what her mom had referred to as "Nikky 's own floor").

When I asked Nikky about her wants and needs, she requested that her mother paid attention not only to negative behaviors but, at least sometimes, to positive; moreover, she stated that she didn't want to be "punished when something good was accomplished".

Lyons-Ruth and Jacobitz (2008) write about parental unavailability as predictor of regulation problems. Early disintegration of the family laid foundation to later difficulties in self-regulation even at times when Nikky wanted to be calm and emotionally present (a basic requirement for engaging with others). It is important also to acknowledge that mother's stand in the conflict between her husband and Nikky clearly vacillated towards her husband's view of the problem. All Nikky's actions and emotional responses, including psychosomatic symptomatology (enuresis), were invariably interpreted as attention seeking.

Nikky's functional emotional developmental capacities were visibly delayed: she had difficulty co-regulating with others and overall sustaining attention on the outside world, busily recounting past hurts and injustices; her interactions with others were limited to family feuds. She had difficulty sustaining longer chains of interactions if they fell outside of her immediate concerns. She had no delays in higher level capacities and demonstrated sound logic and good verbal capacities, demonstrating a special gift for biting remarks along with age appropriate understanding of moral standards and requirements. It appeared, though, that she couldn't do her schoolwork, forge friendships or pursue interests because of the intense separation anxiety. As per FEDC scale, the gray area thinking capacity could have emerged by the age of 10, but Nikky experienced great difficulty seeing "shades of gray" in people's behavior and avoiding quick and harsh judgment.

We started work in joint sessions, trying to verbalize the essence of conflicts and formulate problems. The best way to be with Nikky would be joining in with her anger while also down-regulating via lower pitch and volume of speech and establishing a less stimulating sensory environment in the session- and, indeed, I began to feel as angry as she did at different moments in the course of treatment, for example, hearing that her mother never followed up with the urologist. Therefore, Nikky's feelings received validation on the nonverbal level. Additionally, I demonstrated a very different take on anger: not wailing or yelling but assertively addressing the issue. Quite soon, both Nikky and her mother came to view me as Nikky's ally and protector. Nikky's general demeanor noticeably changed, and she'd even master an occasional guarded smile.

Nikky was the most unlikely candidate for play therapy of any sort: she did not have the slightest interest in motor play, nor was she ready for symbolic play. It was unclear if Nikky was ever played with. Most of all, she was preoccupied with her current situation and with the projected altercations and "traps" set for her by the hateful stepfather. I offered Nikky to divide the session time in two halves: "We will discuss what worries you in the first half and proceed to play a game of my liking in the second." While it wasn't a classical Floortime approach to play, nor was it a traditional psychotherapeutic technique, such directive was the only way to

expose Nikky to the *idea* of playful interaction. Given a choice of activities, she attempted a board game but found it boring and hard, and rules confusing. I offered, “Almost like schoolwork.” Indeed, Nikky later recognized that her preoccupation with events at home was highly distracting during the school day, and she barely followed.

“What do you think we can play with?” She reluctantly chose family puppets but didn't know what to do with them. She held several puppets in her lap while I was setting up the doll house. I offered to put a daddy puppet on my hand, and she reluctantly agreed. She finally dropped her puppets in the middle of the "room". I suggested that it was probably a mealtime, and they all could be seated by a table. When my puppet also approached the table and called out, "Hi kids, I'm home, " she hyperventilated and got up to leave my office. Mom attempted to stop her, but I let her leave and proceeded to work with mom.

During the next couple of sessions, we worked on eliciting Nikky’s fears and establishing collaboration. However, it looked like her relationship with mom was unsalvageable.

Eventually, I requested to see both parents, without Nikky. Mom was highly hesitant, and eventually said that her husband had no interest in helping Nikky. I asked for his phone number and in a few days called to personally invite him to the session. Eventually, they both came in.

Nikky's stepfather, a tall, imposing, young looking police officer, opened the floor with the list of complaints. Unlike the mother who was unhappy with Nikky's schoolwork, he was mostly complaining about her attitude. It sounded like he was irked by the looks that she'd cast, reading into her gestures and silences. I also offered to problem solve as it came to sleeping arrangements, because Nikky reportedly was freezing at night, which didn't help her enuresis. The stepfather explained that Nikky was moved to the basement fairly recently because she was screaming at night, and he wouldn't be able to have a normal night sleep. Screaming? Yes, screaming over Skype, chatting with her father.

As I reframed some of his comments about his stepdaughter, the mother suddenly started to object some of his hostile remarks. I summarized, "It sounds like most of the problems are centered around the stepfather-stepdaughter relationship; no one is happy in your household because of it, and there's no way to reconcile. Would it benefit everyone if Nikky was to move to her dad's home?"

They both looked surprised and somewhat shocked. I asked them to share their feelings. Then, the stepfather said that seeing Nikky go would bring him enormous relief and make his family life blissful. The mother said, however, that she was confused, yet would explore this possibility with her ex.

When Nikky came for her next session, I tried to explore her relationship with her dad. Nikky clearly idealized her, rarely seen, dad. As we discussed her memories of the recent visit, I offered to bring out puppets and replay these scenarios.

The following week, Nikky came in and reached for the puppets. I restored the setting from the previous session, yet challenged Nikky to elaborate and invent new situations: what would it be like to walk to school with her dad, what food she could learn to cook etc. In a few days, Nikky's mom called and requested an individual session. She shared that she had several heated interactions with her husband, and finally told him that "she could have another husband, but her daughter is hers for life."

"You put us on edge, but now I see what I want to achieve... I didn't realize that she wasn't happy."

I suggested to find out from Nikky what she wanted. My goal was to empower Nikky and give her actual control over her life (and maybe eventually over her bladder...). For the first time, mom appeared interested in Nikky's opinion. But first I saw Nikky one on one and shared options with her. Nikky wasn't surprised: "My mom told me already that I can choose where I can live."

"Have you made the decision?"

"I decided to stay with my mom. After all, she is my mom and I think she'll be lonely without me, "

To summarize this case vignette, early disruption in attachment pattern and subsequent anxiety manifesting itself through psychosomatic symptoms (delays in physical development, enuresis) and interchange of SNS "fight" or "freeze" modes were addressed via meeting the need "… to communicate with the traumatized individuals around anything they want to communicate, with the simplest gestures – exchanging smiles, or frowns or using hand gestures" (Greenspan , 2007). Paradoxical interventions with parents along with active recruitment of mom's empathy proved effective in reengaging Nikky. The mother and daughter eventually became able to restore their primary relationship, overcome rupture in attachment, and start the slow and painstaking process of repair. Whereas the task "to reshape microcommunication and find a more flexible (gentle but expressive) tone in an "exaggerated" family, where an elevated (and often irritated) affect is used in most domestic situations" (Itskovich, 2019) continues to bear the utmost importance for Nikky's interactions with her mom, the alleviation of the chronic state of inferiority and shame paved the road to age appropriate separation and to replicating positive relationships outside of Nikky's home. Stanley Greenspan pointed out that "we have to reestablish not only safety and security in the physical sense – protection from the elements or protection from an abuser or protection from the bombs or the guns – but we have to reestablish a nurturing relationship with somebody…" (2007).

Summary

Application of the model for the purposes of play and talk therapy with anxious children entails

- Presuming competence
- Tolerance for negative affect
- Continuous flow of emotional signaling that creates a safe space ("the worst is over")

• Allowing for the story to unfold and change as the event is being processed

DIR®-informed treatment focuses on relationship building while using clinically valid information on individual's unique profile and functional emotional developmental capacities. It has the potential of becoming truly invaluable if added, for the case formulation purposes, to a psychodynamic toolbox. But most importantly, DIR® calls for respect of individual differences and focuses on the healing and on wholesome child-adult relationship that can reconnect the fabric of the child's development and emotional growth that's been previously disrupted by anxiety and trauma. Anxiety can be pervasive but so it the relationship.

The author declares that she has no competing interests

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HEART FAILURE, DEPRESSION AND EXERCISE

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Abstract.

Introduction: Patients with heart failure have high rates of physical disability, based on self-reported difficulty in performing daily living activities. Depression is also a disease entity that has a high co-morbidity in combination with heart failure. Beyond the usual medical care of heart failure, there is a plethora of research on the contribution of exercise to cardiovascular parameters and to the muscular system of patients with heart failure, its effect on their quality of life and relief of depression symptoms.

Purpose: The purpose of this study is to highlight the positive effect of exercise on patients with heart failure experiencing depression.

Methodology: The study material consisted of articles on the topic, found in Greek and international databases such as: Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link), using the appropriate keywords: heart failure, depression, exercise programs.

Results: Depression affects the clinical course and prognosis of patients with heart failure. The coexistence of depression and chronic heart failure leads to an increase in mortality. The benefits of exercise, therefore, in patients with heart failure and depression have a positive impact on the patients' quality of life by contributing to increasing their functional status, reducing their re-admissions to the hospital and relieving the symptoms of depression.

Conclusions: The high incidence of depression in patients with chronic heart failure requires measures to prevent it, such as exercise. Health professionals need to help patients understand their condition and follow therapeutic guidelines, as well as therapeutic exercise, which can improve their lifestyle and behavior, and help them prevent depression symptoms and promote their quality of life.

Introduction

Heart failure is a common and serious condition with major morbidity and mortality worldwide. As life expectancy increases, so does the need to deal with cardiovascular disease more effectively and improve patients' quality of life. (European Society of Cardiology, 2012)

Depression is also a disease entity that has a high morbidity with heart failure. The close relationship between major depression and heart failure has been shown in many studies. (Johansson et al, 2006)

Furthermore, beyond the usual medical care of heart failure, there is a plethora of research on the contribution of exercise to cardiovascular parameters and to the muscular system of patients with heart failure, its effect on their quality of life and relief of depression symptoms. (Jiang et al, 2004)

The purpose of this study is to highlight the positive effect of exercise on patients with heart failure experiencing depression.

The study material consisted of articles on the topic, found in Greek and international databases such as Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link), using the following keywords: heart failure , depression, and exercise.

Depression and heart failure

Depression affects the clinical course and prognosis of patients with heart failure. Several studies have emphasized the relationship between depression and poor prognosis. (Jiang et al, 2007)

In the study of Sherwood et al (2013), 204 patients with heart failure were assessed for severity of heart failure and depression based on a BDI (Beck Depression Inventory) scale. After a mean follow-up of three years patients with clinically severe depressive symptoms (BDI score ≥10) had a high risk of hospitalization or death. The severity of depressive symptoms has proven to play an important role in this, rather than the use of antidepressant drugs. (Sherwood, 2013)

There are still several studies indicating that the coexistence of depression and chronic heart failure leads to an increase in mortality. (Jing et al, 2004) Patients with heart failure who had moderate to severe depression had a five-fold increased risk of mortality compared to those without depression. Depression is often associated with a loss of motivation and interest in daily activities, exercise, sleep disorders and appetite changes, with a corresponding change in weight. This could explain the relationship between depression and mortality. (Faris et al, 2002;Rumsfeld et al, 2005)

It has also been found that depression affects perceptions about the severity of the disease and the patient's quality of life and not that severe heart failure causes depression. This contrasts with the traditional perception that depression occurs because of reduced functional ability due to heart failure. (Gottlieb, 2009)

Treatment of depression includes antidepressant medication, psychotherapy, a combination of them and other forms of treatment, (Christodoulou, 2004) while cardiac rehabilitation includes, among others, exercise programs.

Exercise and heart failure

Patients with heart failure have high rates of physical disability, based on self-reported difficulty in performing daily living activities. (Panagopoulou et al, 2013) As patients have reduced their ability to perform simple daily tasks, patients' quality of life has decreased, health care costs have increased as there is an increasing need for support services. The disease itself is an independent predictor of mortality. Knowing the factors

that determine physical function in patients with heart failure is thus involved in improving the patient's quality of life and disease prognosis. (Adamopoulos et al, 2001)

Therefore, all patients with heart failure are encouraged to participate in exercise programs. Regular exercise of moderate intensity is recommended. Recent studies have documented both its efficacy, with an emphasis on improving quality of life, as well as its safety. (The CONSENSUS Trial Study Group, 1987)

The exercises performed include aerobic exercise, strength training and combined exercises, which are personalized to the individual patient with heart failure. (Adams et al, 2008)

Physical activity to produce the desired results is based on some principles and programs in which patients with heart failure are not excluded. They just need to follow them to achieve the desired results: (Middleton S& Middleton PG, 2002; Raven et al, 2015;Ponikowski et al, 2016)

- Authority adaptability (trainability): the person's ability to adapt to coaching (training) stimuli.
- Authority periodicity (periodization): refers to a systematic approach to modifying exercise program variables, which allows general adjustments and reduces the risk of overtraining.
- Special situations authority: refers to the ability to change an exercise program under the new circumstances, including any injuries, illnesses, medication, lack of recovery and overtraining symptoms.
- Principle of overtraining: refers to the adverse effects of the excessive activity and exercise.
- Principle of consistency (adherence): refers to the ability of trainees to be consistent with the exercise program.
- Restoration principle: refers to the optimization of post-exercise recovery.

During exercise, some physiological changes occur in the function of the cardiovascular system depending on the type of exercise the individual performs.

Regardless of the etiology, heart failure begins with damage to the pump function. However, symptoms and progression of the disease include changes in peripheral organs and activation of neurohormones. (Giannuzzi et al, 2003; Georgantas et al, 2014)

Both heart failure and damage to the peripheral organs are responsible for the patient's intolerance to exercise. Exercise facilitates correction, in part, for most peripheral abnormalities and tends to reduce neuro-hormonal stimulation in patients with heart failure without harmful effects on left ventricle recovery. (Tabet et al, 2009)

The benefits of exercise, therefore, in patients with heart failure and depression have a positive impact on the patients' quality of life by contributing to increasing their functional status, reducing their re-admissions to the hospital and relieving the symptoms of depression.

Conclusions

The high incidence of depression in patients with chronic heart failure requires measures to prevent it, such as exercise.

Health professionals need to help patients understand their condition and follow therapeutic guidelines, as well as therapeutic exercise, which can improve their lifestyle and behavior, and help them prevent depression symptoms and promote their quality of life.

The authors declare that they have no competing interests

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Keywords: *mental health, depression. heart failure*

HUMAN RIGHTS OF MENTALLY ILL PATIENTS

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Abstract.

Introduction: Mental health is the development of a person's healthy view of themselves and the environment in which they live, so that they can achieve the highest degree of self-fulfillment. **Purpose:** The purpose of the present work is to investigate and highlight the rights of the mentally ill and to promote and promote the health of these patients. **Methodology:** The study material consisted of articles on the topic found in Greek and international databases such as: Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link), using keywords: mental illness, patient rights, health professionals. **Results:** The rights of mental patients and their exercise in a meaningful and effective manner is a dynamic process that encompasses the corresponding rights and obligations of mental health professionals. An important legal effort to protect the rights of the mentally ill is Resolution 46/119 of the United Nations General Assembly on the Protection of Persons with Mental Illness and Improving Mental Health Care, adopted on 17 December 1991. **Conclusions:** The exercise of the rights of the mentally ill requires their encouragement from mental health professionals, who are essentially obliged to refrain from restrictive practices.

Keywords: *mental health, human rights, mental illness, patient rights, health professionals*

Introduction

Mental health is the development of a person's healthy outlook of himself and the surroundings in which he lives, so that the individual is able to achieve the highest degree of self-fulfillment (World Health Organization, 2005). According to the World Health Organization (WHO), **mental health** is the total and harmonious function of a person's personality as whole. On the other side, **mental disorder** is the failure of the human being to adapt adequately to the demands of the society he lives in (Chamberlin, 1998)

The majority of people maintain a delicate balance between the forces exerted by those agents that allow them to lead a relatively stable life. When the balance is disturbed then, it results in stress, affecting firstly the individual himself; it causes "nervous" reactions such as anxiety or depression, often accompanied by disturbances in biological functions such as disturbed sleep or appetite disturbance. (Harding, 2000) Secondly, it has an impact on people around him, caused by so-called "antisocial behavior"

and, as a result, it causes a personality disorder. The combination of both factors makes the person inappropriate, thereby creating stress on himself and people around him, resulting in the emergence of a mental illness. (Freeman & Pathare, 2005)
People with psychological problems were always being confronted with even a great deal of fear by the community. In recent years, an effort has been made to provide psychiatric care while respecting the rights of the mentally ill. The knowledge of the rights of the mentally ill is a fundamental obligation of each and every mental health professional. (Grace, Fry & Schultz, 2003)

The **purpose** of the present study is to investigate, highlight the rights of the mentally ill, defend and promote the health of these patients.

The **study material** is consisted of articles on the topic found in Greek and international databases such as: Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link), using the keywords: mental illness, patient rights, health professionals.

Ethics and Ethical Issues while caring mentally ill patients
When providing care to the mentally ill, ethics and ethical issues arise regarding the person providing care, the patient's family and his employer.
The keystone underlying the principles and rules of ethics in the care of the mentally ill includes (Burt & Eklund, 2005):

- The principle of autonomy
- The principle of utility
- The principle of non-harm
- The principle of justice

Every process towards treatment must strive to keep the patient's nature and function confidential as well as benefit him / her and not harm him or her or offend the legal feeling. The ethical principles that govern any handling are (Beauchamp &Childress, 2001):

- The promotion the autonomy of human dignity
- Personalizing each person's needs
- Confidentiality of information
- Purity of communication

The family must be honestly informed of the progress or problems of their member in the field of rehabilitation in which the patient is involved. The family must be responsibly involved in the therapeutic work to the most possible and meaningful extent. (Burt & Eklund, 2005)
The employer's case has several peculiarities. According to the law, the employer knows that he is takes on a disabled person, for his or her salary is subsidized. Limits ought to be set regarding the pieces of information regarding the employee's health only to the point in which the person's impersonal work is guaranteed. For instance, the employer is to be informed of the fact that his employee takes some psychiatric medication, but not the specific medication being applied to him. (Freeman & Pathare, 2005)

Ethical dilemmas, such as whether patients' opinions should be respected or what the sick person thinks is right for his or her community reintegration, or what the mental health practitioner thinks is good for the patient, are involved in the design and organization of Community Reintegration (CR) via deinstitutionalization programs. These programs must focus on the principles above, while the clinical factor is also included; in other words, whether the condition of the patient allows for a clearer recognition and prioritization of his needs. (Szmukler, 1999)
The essential and effective exercise of individual and social rights by mental patients signifies corresponding rights and obligations for mental health professionals. (Burt & Eklund, 2005)

Mentally ill patients' rights

The rights of mental patients and their exercise in a meaningful and effective manner is a dynamic process that encompasses the corresponding rights and obligations of mental health professionals. An important legal effort to protect the rights of the mentally ill is Resolution 46/119 of the United Nations General Assembly on the Protection of Persons with Mental Illness and Improving Mental Health Care, adopted on 17 December 1991. (Harding, 2000)
The above UN General Assembly Resolution 46/119 (1991) consists of 25 Principles concerning civil rights and procedures and access to and quality of care, which are applied without any discrimination on disability, nationality, gender, color, language, religion, political or other opinion, national, legal or social status, age or property. (Stein, 2017)The application of these principles is subject only to restrictions on the protection of the health or safety of the individual or of third parties or the protection of public safety, order, health or morals and the fundamental rights and freedoms of others.
At national level in Greece, the provisions of Constitution 1975/1986/2001, which are directly applicable and affect the entire population, irrespective of their state of health that it must not be a prerequisite for their application. (Spyropoulos & Fortsakis, 2017)
The institutional framework of mental health in Greece today is assessed as adequate so far, as it guarantees the rights of individuals with mental disorders who are no longer within the margins of law and justice in the broader context of psychiatric reform. (Townsend, 2012)
The **rights of mental patients**, as well as the concurrent obligations of the State, Mental Health Units and mental health professionals, refer to titles and sections, in the sense that each of the following incorporates a number of individual rights / obligations as follows (https://www.psy.gr):

1. The right to decent care (voluntary and involuntary). It is the ability of every person diagnosed with a mental illness to reach out to providers of human mental health services and receive services that, based on scientific and medical data and assumptions, are most appropriate to the nature of their illness. (Pescosolido, Gardner & Lubell, 1998)
2. The right to equality. The principle of equality requires equal treatment of persons who are in substantially similar conditions, as well as the

equal treatment of persons who are in situations of multiple exclusion from social structures. (Fredman, 2001)

3. The right to information. Informing the patient and his family is necessary to secure their consent to treatment. (Anderson, 1996)
4. The right to the protection of personal data. Protecting the privacy of a mentally ill person is an explicit legal requirement, protected by statutory bodies, and a fundamental obligation of mental health professionals.
5. The right to rehabilitation. Supporting the exercise of the right to participate in rehabilitation procedures should aim at self-reliance.
6. The right to community life. This right is part of and is a specialized form of the general social right to implement reintegration into society deinstitutionalization and policies towards reducing stigma and prejudices about the risk of placing mentally ill in the community. Something that requires the creation of strong alliance societies among communities. (Sartorius & Schulze, 2005)
7. The right to claim. The individual rights of the mentally ill in Greece are protected by the provisions of Constitution 1975/1986/2001 and derive from the provision of Article 5 of the Constitution which stipulates that everyone has the right to the protection of their health and genetic identity.

Mentally ill patients and their families should be encouraged to pursue policy measures that help consolidate and strengthen their rights. (Abuse, 2013)

In conclusion, the exercise of the rights of the mentally ill presupposes their encouragement by mental health professionals, who are essentially obliged to refrain from restrictive practices. On the contrary, they have to act in a way that reinforces and supports the exercise of their rights according to reasonableness of "together" and not the reasonableness of substitution. (Tsaloglidou, 2009 & Tsaousoglou & Koukourikos, 2007)

The authors declare that they have no competing interests

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Keywords: *mental health, human rights, mental illness, patient rights, health professionals*

IMMIGRATION AND MENTAL DISORDERS

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Abstract. Introduction: Immigration is the movement of people into a country where they will remain as its permanent residents or future citizens without having citizenship.
Purpose: The purpose of this review study is to highlight the impact of immigration on the mental health of immigrants and to identify the mental disorders from which immigrants are at risk of getting ill.
Methodology: The study material consisted of articles on the topic, found in Greek and international databases such as: Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link), using the appropriate keywords: mental illness, immigrants, treatment.
Results: It is estimated that two-thirds of refugees - migrants experience anxiety and depression. Studies show that these are populations with severe social problems, unmet needs, and a range of mental health problems such as depression, panic attacks, social phobia, generalized anxiety disorder, suicidal ideation, and post-traumatic stress disorder (PTSD).
Conclusions: Addressing the mental health problems of immigrants and refugees can only be holistic. It requires much more psychosocial interventions and practical solutions, always combined with culturally appropriate psychological support methods.

Introduction

Immigration is the movement of people into a country where they will remain as its permanent residents or future citizens without having citizenship. (https://el.wikipedia.org) It is a dynamic process, the forms of which vary and change depending on the wider political, social and economic changes. It is a form of social relationship that is defined by market, nation, state, gender, constituting social categories, groups as well as the way they communicate and interact with each other. (Bagavos, Papadopoulos &Symeonaki, 2008 & Petrakou, 2009)

An immigrant is a person who changes his / her habitual place of residence, regardless of immigration reason or legal status. (https://unric.org) The immigrant suffers a series of losses: loss of support from a familiar geographic and social environment, loss of long-term relationships, communication values and roles. Even if the individual is prepared for it and completes the whole process relatively easily, he has to deal with transitional factors influencing his perceptions, views and ability to interact in his new environment. (Bhugra, 2000)

In particular, refugee-migrant is, according to the Geneva Convention on Refugees (https://el.wikipedia.org&Bagavos, Papadopoulos &Symeonaki, 2008) any person who lives outside the state whose is a citizen, due to the justified fear

of being persecuted because of race, religion or nationality, or even because he is a member of a particular social group or his political views (political refugee). Moreover, it is impossible to ensure protection in his country, or, because of this fear, does not wish to be placed under this protection. ((https://el.wikipedia.org)

The arrival and installation of the immigrant in the host country is an equally critical and difficult period, as he is confronted with a series of serious problems in an attempt to organize his life. Individual factors that influence the development to a more or less adaptive direction are the immigrant's cultural identity and self-determination, and the existence of social support network. (Bhugra et al, 1999) Such situations can lead to the collapse of self-protection mechanisms and the onset of mental disorders. (Levaditis, 2003)

The **purpose** of this review study is to highlight the impact of immigration on the mental health of immigrants and to identify the mental disorders from which immigrants are at risk of getting ill.

The **study material** consisted of articles on the topic found in Greek and international databases such as: Google Scholar, Mednet, Pubmed, Medline and the Hellenic Academic Libraries Association (HEAL-Link), using the appropriate keywords: mental illness, immigrants, treatment.

MIGRANTS' MENTAL DISORDERS

It is estimated that two-thirds of refugees - migrants experience anxiety and depression. (Carey & Duke, 1995) Studies show that these are populations with severe social problems, unmet needs, and a range of mental health problems such as depression, panic attacks, social phobia, generalized anxiety disorder, suicidal ideation, and post-traumatic stress disorder (PTSD). (McCrone et al, 2005)

The factors that should be considered when assessing the mental health of immigrants are the following (Bhugra& Jones, 2007):

- migratory situation
- migration experiences
- adjustment
- views of host society
- cultural identity
- cultural conflicts
- national density
- achievements and expectations

According to the literature the following mental situations / disorders are closely associated with immigrants:

Schizophrenia

Immigrants undoubtedly experience chronic difficulties such as socio-economic disadvantage, discrimination, uncertainty, alienation, which in combination with biological vulnerability, poor coping strategies and limited social support are likely to lead to the genesis of psychosis. Although the psycho-social stress probably affects the majority of immigrants at risk, no applicable pathogenetic mechanism has been identified so far involving specific gene-environment interactions and linking this type of stress to the incidence of psychosis. (Brugra et al, 1997 & Selten et al, 2001)

Depression

It is well documented in the literature that the relationship between migration and depression is complex and largely dependent on the particular features of the former. The experiences of migration and the cultural process can be so difficult that it will be considered stressful for anyone, regardless of their cultural background. Social, labor and economic exclusion reduces the threshold of depression. Thus, in some cases, national minority status may override cultural characteristics as a predisposing factor for depression. (Tseng, 2007 & Beddingston& Cooper, 2007)

Suicide

Recent World Health Organization (WHO) data on suicide death rates per sex and per 100,000 population shows large differences internationally. (World Health Organization, 2004) The study of suicides indicates that not only are there different risk factors for suicide in different cultures and migrant groups but there are also - yet unspecified - protective factors (cultural or even biological), the recognition of which will greatly aid in developing prevention strategies. (Kirmayer & Young, 1999)

Personality disorders

Researchers argue that immigrant patients in traditional societies may exhibit more classic neurotic symptoms rather than behavioral ones. This is attributed to the structure of family and social networks that do not encourage emotional expression and therefore antisocial personality disorder appears. (Murphy, 1982)

Other mental disorders

The literature reports that so-called 'common mental disorders' on ethnic minorities do not appear to increase in all groups of both sexes compared to the native population. This means that either some populations have a strong psychological armor or that their expression differs and is therefore not visible by conventional diagnostic tools. (Bhugra & Jones, 2007) Intercultural studies have shown significant differences in anxiety symptoms and specific types of fear as well as the consequent physical, emotional symptoms and syndromes. (Chaturvedi & Desai, 2007)

It should be noted that Spanish researchers have described the "Chronic and Multiple Stress Syndrome" of immigrants or "Odysseus Syndrome" which is characterized by mixed depressive, anxiety, and somatoform symptoms. The syndrome gradually unfolds as the migrant is confronted with the difficulties of the migration process. It is suggested by researchers that the syndrome should be classified as an autonomous category, intermediate between adaptation disorders and post-traumatic stress disorders. (Carta et al, 2005 & Achotegui, 2002)

Migration and substance abuse

The relationship between migration and dependence such as alcohol and other substance use is complex and heterogeneous. It is generally accepted that when there is a rapid socio-cultural change, substance abuse tends to increase rapidly, especially in young people. (Tseng, 2007)

There is also evidence that substance abuse models in the country of birth, as well as the difficulties of social inclusion in the host country, significantly determine the occurrence of related disorders in first generation immigrants. (Hjern & Allebeck, 2004)

Conclusions

Addressing the mental health problems of immigrants and refugees can only be holistic. It requires much more psychosocial interventions and practical solutions, always combined with culturally appropriate psychological support methods.

The challenge of modern psychiatry at both research and healthcare levels is to recognize differences between populations, without drifting away from national or other stereotypes. Individual differences among immigrants are just as important as ethnic ones, and modern psychiatric therapy is ultimately called upon to heal the individual within his broader socio-economic context rather than the ethnic group to which he belongs.

The authors declare that they have no competing interests

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Keywords: *migration, mental health, mental disorders*

OUR BODIES OUR VOICE: A CASE STUDY ON UTILIZATION OF GOVERNANCE STREAMS TO CHANGE THE POLICY FOR PREVENTION OF SEXUAL VIOLENCE IN UNIVERSITIES AND THE ROLE OF GRASSROOTS ORGANIZATIONS

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Absrtact.

Sexual violence (SV) is an issue of global importance, with significant prevalence in the EU generally and the Netherlands in particular. Stigma and taboo often result in underreporting and exacerbate the already substantial mental health consequences of SV. Universities are recognized as high-risk settings, but in general awareness, response and prevention in Dutch universities have been limited. This article analyzes a case study of key events over a number of years resulting in policy change and active response in one university in the Netherlands, focusing on the impact and role of the Our Bodies Our Voice foundation, which started as a grassroots student initiative, using the Kingdon model of policy change. The aim is to make explicit how governance streams need to be aligned to place the issue of SV on the agenda of higher educational institutions, and findings highlight the importance of media coverage, advocacy, awareness raising and perseverance on the part of initiatives like OBOV, while building towards a policy window.

Keywords: *sexual violence, university, mental health*

Introduction

With the advent of the #MeToo era, it is not unreasonable to assume recognition of Sexual Violence (SV) as a global issue should be pervasive. However, in spite the high prevalence of Gender Based Violence in the EU generally, and the fact that over half of Dutch women having experienced SV, it has rarely been recognized as a problem in Dutch media or culture(Rutgers Institute, 2017; European Union Angency for Fundemental Human Rights, 2014; "Seksueel geweld tegen vrouwen 'doodnormaal,'" 2013). Less than a tenth of survivors report cases to the police, and only a fifth receive any sort of support in processing the trauma of SV, which coupled with the mental health consequences of PTSD, depression and anxiety among others, means the unacknowledged impact of this stigma and taboo is substantial (Bicanic, Engelhard, & Sijbrandij, 2014; Rutgers Institute, 2017; Ullman & Peter-Hagene, 2014). Furthermore, while universities are now generally recognized as high risk settings for SV, many Dutch universities continue to see their responsibility in prevention and the shaping of student culture as limited, with no need for further intervention than establishing complaints procedures (Brekelmans, 2015; Pinedo, 2016; van Schijndel, 2019). However, in one university in Amsterdam, at the time of writing numerous changes have occurred including: a pilot intervention of workshops

running in multiple departments; the hiring of a specialized individual leading a social safety taskforce; joining of the UN Orange the World campaign; and the placing of social safety on the agenda for the academic year 2019-2020 in conjunction with a statement by the Association of Dutch Universities on the need for active efforts to improve social safety (Amsterdam, 2019; "Sociale veiligheid binnen de universiteiten," 2019).

The Our Bodies Our Voice foundation is an organization that started as a grassroots student initiative and has been campaigning and networking throughout the years in which the processes resulting in these changes occurred (Cherbit-Langer, 2019; "Our Bodies Our Voice," n.d.). With the insider perspective of the foundation's founders and board members, as well as documentation on key events, it is possible to analyze the trajectory through which these changes came about, and the role they may have played in it. With the continued global significance of the issue, and the similar issues with taboo and stigma other grassroots initiatives may be facing, understanding the interaction of governance streams that formed this trajectory could provide notes for practice in the future. For this reason, after a brief discussion of the context, an analysis of events and the insider perspective of OBOV will be conducted using Kingdon's model on policy change.

Background

Sexual Violence (SV) and Gender Based Violence, while only recently being recognized as global issues, have seen promising growth in interventions, developing from local response to immediate needs in the aftermath of an occurrence, to national and international level interventions including policy and civil society initiatives focused on prevention (Michau, Horn, Bank, Dutt, & Zimmerman, 2015). This increase in awareness and willingness to act has been exacerbated by mass media movements such as #MeToo and coverage of other high-profile cases, as will be demonstrated in the analysis below. Considering the gendered nature of the problem, generalized statistics on the occurrence of sexual violence globally are often lacking, such that the extent of a problem in nations and institutions is usually measured by percentages of women affected. In line with the WHO's estimates for global prevalence, a Europe wide study has found that 33% of women have experienced physical or sexual violence since the age of 15 (European Union Angency for Fundemental Human Rights, 2014). Focusing on experiencing sexual harassment more generally, 55% of women were affected (ibid). Dutch national statistics, while not directly comparable as a result of differing definitions and a more direct focus on sexual violence, show equal or by some comparisons higher than average occurrences, where 22% of women and 6% of men have experienced manual, oral, vaginal or anal rape and/or were forced to conduct sexual acts against their will, and 53% of women and 19% of men have been sexually assaulted, using a broad definition ranging from kissing and sexual touching to rape (Rutgers Institute, 2017)

Experiencing SV has numerous mental health consequences including generally decreased phycological, physical and sexual health, where survivors may experience depression, eating disorders and suicidal ideation or attempts (de Haas, 2012). Survivors of SV are disproportionately more likely to develop PTSD than those who experience other forms of trauma, where 49% of survivors

of rape develop PTSD, in contrast to only 7.3% of people who witnessed death. (Bicanic et al., 2014) Beyond clinically measurable conditions, in a representative sample of the Dutch population, it was found that half of men and more than half of women are profoundly psychologically or behaviorally affected by experiences of sexual violence. ("Seksuele gezondheid in Nederland 2017," 2017).These consequences can be mitigated by timely and effective professional and/or social support, but studies have found that these are often lacking or subject to barriers making them inaccessible (Ullman & Peter-Hagene, 2014). For instance in the Netherlands only 1 in 5 male and 2 in 5 female survivors indicate that they received any support, and only 4% of male and 11% of female survivors reported their case to the police (Rutgers Institute, 2017).

Research in the UK and the US has found that there is a disproportionately higher incidence of SV in university settings than in the general population, and while no research has confirmed that this is the case in the Netherlands, similarities in structure and culture of such institutions make it likely to be similar. (Rutgers Institute, 2017; "Seksueel geweld tegen vrouwen 'doodnormaal,'" 2013; Fenton, Mott, McCartan, & Rumney, 2016; Newl & s, 2016; Pinedo, 2016). This is demonstrated most clearly by the concentration of a variety of high risk factors including age, attending higher education, regular alcohol consumption, and a growing campus culture and hookup culture (Rutgers Institute, 2017; "Seksueel geweld tegen vrouwen 'doodnormaal,'" 2013; Fenton et al., 2016; Newl & s, 2016; Pinedo, 2016). Thus far Dutch institutions have relied on existing complaints procedures and confidential advisors to deal with occurrences on a case by case basis, but over the last two years in particular, evidence has shown these measures to be ineffective (Logtenberg & van de Wiel, 2019). The national level pervasive stigmatization of the issue is shown most clearly in the preference of local media to cover occurrences of false reporting, rather than the recently published statistics demonstrating the troubling incidence of SV ("Seksueel geweld tegen vrouwen 'doodnormaal,'" 2013). SV is seen by the general population as a problem that occurs only in other, distant locations and survivors seeking to break the silence are seen as attention seekers (Brekelmans, 2015; "Seksueel geweld tegen vrouwen 'doodnormaal,'" 2013; van Schijndel, 2019).

Thus, a concerning threat to student health has gone unaddressed as a result of stigma taking the form of a culture of tolerance. In response to this, several student activists together with key actors at the university and experts from abroad collaborated to create the Our Bodies Our Voice (OBOV) foundation ("Our Bodies Our Voice," n.d.). The foundation aims to raise awareness about sexual violence and transform the culture within universities to create a safer environment for students and staff alike (ibid). Through workshops, they aim to provide participants with the necessary information and skills to support survivors and help dismantle the stigma around SV, and to create a safe, confidential space for discussions about participants' attitudes towards sex, boundaries and consent (ibid). OBOV also recognizes the substantial body of research indicating that sustainable change in SV prevention is only possible through multi-level, long-term intervention, for which institutional backing is a significant prerequisite (Mat, Altinyelken, Bos, & Volman, 2019; Michau et al., 2015). As a manifestation of such institutional support, policy changes that demonstrate the support of main decision-making bodies is of central importance to prevention.

Therefore, in the following analysis, the conditions required to create a policy window in which SV can be placed on the agenda will be established through the case study of OBOV's successful intervention in the Netherlands.

Method

In order to understand agenda setting and policy change on an issue like SV in a sufficiently comprehensive manner, knowledge from the field of Governance for Global Health provides the most useful background, as it captures the roles of different actors and processes in policy making. A framework from this field that focuses on the prerequisites for policy change is the Kingdon model, an adapted version which was therefore used for a structured analysis of key events and insider accounts of OBOV board members and founders .Though the model is intended for the analysis of the actions of policy entrepreneurs at a national level, the model is being applied here to understand the impacts of student activism and collaboration to evoke institutional change, at a single university level. Kingdon's model consists of three different 'streams' representing processes and circumstances that are needed for policy change to occur (Buse, Mays, & Walt, 2012). The first is the problem stream, which relates to perceptions of problems and the responsibility of the body under consideration. Second is the policy stream which consists of actors analyzing the problem and solutions being considered. Lastly the politics stream refers to swings in general national (in this case institutional) mood, changes of key actors or campaigns by interest groups. For an issue to be taken seriously and put on the agenda, all three streams need to overlap creating a policy window. Each of the three streams will be analyzed relating to the specific context of a University in the Netherlands, using experiential knowledge of the founders as well as documentation and media coverage around the issue. Conclusions will then be drawn about the conditions that created the policy window and the role that OBOV played in its creation.

Results

In analyzing through streams rather than a linear account, key events can at times be difficult to present coherently. For that reason, a brief summary of the founding of OBOV is presented here to help maintain a central narrative. Towards the end of 2017, a number of concerned students from different departments of a university in Amsterdam established for themselves that the issue of SV was not being dealt with appropriately. They began collaborating, combining existing efforts that had failed to gain traction with input from external organizations, and the media impetus provided by the #MeToo movement to organize an event for the discussion of policy on SV prevention in the university. The event, titled Our Bodies Our Voice occurring in May 2018 attracted numerous students, staff members and key actors in influential positions within the university (Koeyvoets, 2018). The ensuing discussion and support encouraged the students to begin an organization by the same name in the summer of 2018, using experience from their respective backgrounds to set up a series of workshops. These began running around the end of 2018 and start of 2019, during which time the organization achieved the status of a foundation. Working through each of the streams, you will see the points at which this process of development overlaps with and underscores parallel processes.

Problem stream

Starting with the problem stream, the described culture of stigma, silence and lack of media coverage hampered if not actively prevented public recognition of the problem. The culture within the universities in Amsterdam specifically, and the Netherlands in general, were similar with action on the part of the university deemed unnecessary and the normalization of sexual violence such as groping in social situations ("Seksueel geweld wordt vaak niet eens herkend," 2017). Considering the general aversion to reporting among the student body, where less than 25% of students suffering from mental health issues seek support, the preference to be seen as normal likely extends and increases in stigmatized situations like surviving SV (Van der Heijde, Vonk, & Meijman, 2015; Verouden, Vonk, & Meijman, 2011). It took the massive media coverage of high profile cases in the USA for the first conversations on the topic to start (Brekelmans, 2015). Specifically the Stanford Letter, written by a survivor to the perpetrator of SV before the trial, and the #MeToo movement which started to open a conversation about SV in the film industry, and spread to a general movement raising awareness of SV (Newl & s, 2016; Seales, 2018).

In many ways this first media attention was a prerequisite for the very formation of the OBOV foundation, where running workshops and events on a problem that no one believes exists, proved somewhat challenging. After the pilot program was negotiated during the academic year 2018-2019, further media attention emphasized the issue's importance as in 2019 for the first time two local cases gained moderate media attention. The first concerned a professor and department head who sexually harassed women in his department for more than a decade without consequence, and the second concerned a student reporting sexual violence against another student in Rotterdam, and having the reporting procedures almost intentionally misdirected to discourage her taking action (Logtenberg & van de Wiel, 2019; van Schijndel, 2019). These cases provided a basis to support actors already campaigning the issue's significance, following the OBOV event of the previous year, making it impossible to continue to ignore the existence of the problem on a national level in universities.

Policy Stream

Resulting from but also parallel to the gradual recognition of SV as a problem in Dutch universities, it was possible for the first discussions on the extent of the issue and potential solutions to begin. The first OBOV event, aimed to open such a discussion with the student body on policy for SV prevention and response, highlighting the fact that the age group 18-24 is four times more likely to experience SV, and that 61% of students attending higher education have experienced SV as compared to 53% of the general population (Rutgers Institute, 2017; Koeyvoets, 2018). Building from the event, the academic year 2018-2019 saw roughly monthly meetings of key figures concerned with student welfare in the university to further discuss potential courses of action. One of the central topics of the early discussions concerned the extent and limitations of responsibility of a University, as their role has primarily been seen by the Dutch public as a purely academic one, where reporting is only necessary in extreme cases or cases concerning a staff member. However, recognizing at least in part the role a university plays in shaping student culture, as well as the academic impacts the mental health consequences of sexual violence have, suggestions of awareness campaigns, workshops and online help-seeking information began to

take hold. These were informed by the local Sexual Assault Center (CSG Amsterdam), experiential knowledge from board members of OBOV, as well as the policy research conducted by the Student Life Officer at Amsterdam University College, Lydia Roberts, aiming to create policy and responsiveness similar to that found in universities like King's College London.

Simultaneously, the Chief Diversity Officer who had attended the original OBOV event and these exploratory meetings accepted a proposal for a pilot program of workshops to be run at three different departments. The structure of the program worked on the basis of evidence from numerous international sources, emphasizing the need to tackle culture and underlying drivers as well as sustained long-term investment in prevention (Michau et al., 2015). While the overarching program aims to raise awareness, create a culture of consent and strengthen institutional commitment, the individual workshops focus on bystander intervention and active listening training; the former being a method used in the united states and the UK in recent years, which has been shown in reviews to address primary prevention and engage men as well as women in positively ending violence; the latter focusing on appropriate response to first disclosures, as negative responses can have substantial impacts on overall recovery and the development of PTSD (Fenton et al., 2016; Ullman & Peter-Hagene, 2014). Workshops were tailored to specific departments and select groups, working with students in mixed groups, men only and staff members separately. Furthermore, in the process of tailoring workshops and understanding the individual context, OBOV conducted the first exploratory research on SV in a Dutch university, though the sample was not representative, and findings were not verified for statistical significance. They found that 55% of students in this group knew someone who had been pressured to engage in sexual activity against their will, but simultaneously 51% thought that sexual abuse was not a problem in the University, showing if nothing else the complex duality still at play and highlighting the need for active response.

Politics stream

In terms of the politics stream, two main drastic changes in overall mood or attitudes within the institution occurred during the academic year 2018-2019: the assumption that the university does address the areas it is considered responsible for; and that its responsibility is limited to the academic campus and actions of staff members. The former changed primarily as a result of the aforementioned case of the professor who was able to avoid any consequences for continuous inappropriate behavior, showing that the existing programs were already flawed. Likely as a result, a statement was made by the association of Dutch universities on the subject of social safety, in which undesirable sexual approaches are mentioned specifically, emphasizing that universities are responsible for creating a safe environment ("Sociale veiligheid binnen de universiteiten," 2019). In particular, they mention the need to strengthen the existing system with the addition of a note on the need for frequent research into social safety within the institution (ibid). Already this statement shows a substantial shift on the second front as well, that being the extending of university responsibility, but it is still limited and open to interpretation. Within the university of OBOV's intervention, the continued work between the CDO and OBOV, the placing of social safety on the agenda for the year by the board of

directors and the creation of a social safety task force, capture the presence of both paradigm shifts. Though most statements concern the idea of social safety generally speaking, the process of joining UN women's Orange the World campaign on sexual violence prevention, as well as statements from the chair of the taskforce, demonstrate the underlying concern with this specific issue (Amsterdam, 2019). This results in part as a crisis response to the public case, but also from the work of visible actors like the Chief Diversity Officer, and hidden actors, like the exploratory panel of concerned parties and experts, who met over the course of the year and took a letter of advice to the higher levels of administration of the university requesting the creation of a position focused on social safety.

Discussion

A policy window occurs when all three streams intersect, and this is the point in time when agenda setting and policy change become possible. From recurring themes and events in the analysis, it is apparent that there is a significant amount of inter play and exchange between the various theoretical streams, with the metaphor of water appearing very appropriate. The events in the problem stream by which it became clear that SV is a public issue, created the conditions in which the development of OBOV, from event to foundation, was possible. Additionally, it was through this event and the ongoing collaboration of other individuals impacted by the defining events of the problem stream that created motion in the policy stream. In turn the exploratory panel, and the workshops proposed by the CDO and OBOV, in focusing on effective solutions help to raise awareness further, folding back into the problem stream. Finally, the exploratory panel from the policy stream, undeniably coupled with key events in the problem stream, increasing awareness of the problem at higher levels in the institution, resulted in shifts in the politics stream with the perceived responsibility of the university expanding. With just two of any of the three elements, change would not have been possible. For example, the creation of the taskforce resulted from key events making the board aware of the problem, key actors causing a shift in perceived responsibility and the exploratory panel suggesting a fixed position to allow for sufficient investment.

However, this analysis in its layered complexity does not lend itself well to the identification of best practices. Though discussion of each of the separate streams allows for an internally consistent narrative, the exact nature of the overlap is very fluid, making conclusions for future intervention complicated. In essence the use of the model in analysis emphasizes the weight of coincidence and timing in policy change, very little of which is easy to directly influence, quantify or identify direct causes of. The primary conclusion that can be drawn as a result of this analysis is that the three streams did align in the academic year of 2018-2019, with awareness of the problem, discussions of solutions, and interaction of key actors with the general mood, intersected and reinforced each-other, the occurrence of each rippling in to the other.

In order to identify specific elements of best practices for grass-roots initiatives like OBOV, a more linear model may have presented more concrete analysis. However, the overview given by the Kingdon approach does present the opportunity for observations on circumstances and situations outside the direct

influence of such organizations that are significant. For instance, media coverage of issues related to SV has a substantial impact on all streams and provides opportunities to work towards a window. Another key element in creating such a window is networking with key actors and other concerned parties, as OBOV did with the CDO and the panel. Much like media events, the building of a social movement on an institutional level has ripple effects throughout the streams. In particular the original OBOV event, bringing together concerned parties and increasing awareness of the issue and the need to respond, played a substantial role in creating motion. It also provided the basis for the pilot program of workshops together with the CDO, and in bringing together diverse concerned individuals, and helped concentrate knowledge and expertise such that the evidence-based solutions incorporated in the workshops could be identified. Finally, building off of the role of context and coincidence highlighted by the model, the perseverance of concerned individuals awaiting a policy window is paramount. If there is no one to take advantage of the starting elements of a policy window, it is unlikely to take hold, whereas the ripple effect of persistent action may contribute to the aligning of the streams.

Broader implications

It is impossible to identify exactly what circumstances allowed the #MeToo movement to take hold when it did, where countless other attempts to gain attention were silenced. Regardless there is now a marked difference in the before and after, where claims that there is no problem are now less likely to be accepted at face value. Harvard originally claimed to be exempt from the national issue of SV, but it was soon discovered that cases were simply silenced (Brekelmans, 2015). Recognition of the problem of SV in the Netherlands generally and at universities in particular took a similar path, where it was easy to assume there was no problem so long as no one looked. The desire to put distance between ourselves, our institutions, and a stigmatized issue like SV is understandable, but in the face of the disastrous consequences, also unacceptable. What this analysis can contribute to the larger discussion around SV as a global issue is that this pattern of denial continues to occur and will likely persist at different levels in different countries. However, in the post #MeToo era, it has become easier to connect with other concerned parties and activists, if nothing else, and with each making ripple effects and reaching for policy windows, the promising changes we have seen will continue.

Implications for research

At the time of writing there has been limited research on policy change and agenda setting at the university level for comparison. Research conducted in the UK and USA where the majority of available articles are from primarily take a national perspective, investigating policy implementation comparatively. In instances where individual universities are considered the focus is on exploration of risk factors, culture and the efficacy of specific interventions (Cierniak, Heiman, & Plucker, 2012; Fenton et al., 2016; Newl & s, 2016). The assumption across these studies is an existing recognition of the problem of SV in university contexts, which requires no further discussion. There is little to no other literature on SV related policy making at any level in other EU countries, though this is likely related to the limitations of language in researching to English. Most research focusing on the early stages of SV prevention are focused on low and

middle-income countries, establishing community-based interventions focusing on gender equality (Michau et al., 2015). The only comparable research was conducted by students in Brazil following the publication of troubling statistics on SV, prompting investigation for guideline development purposes, though the process of agenda setting is not investigated (Maito, Panúncio-Pinto, Severi, & Vieira, 2019). A more relevant case study of policy making at Yale traced similar elements such as the denial of problematic dynamics until contrary evidence becomes public, and the role of a student activist group in agenda setting, where their organizing of work groups played a central role in developing a network of experts, as also found in the current study(Bagley, Natarajan, Vayzman, Wexler, & McCarthy, 2012).

More generally speaking the role of civil society in placing violence against women on the agenda is well established, with a substantial body of literature investigating the role of feminist actors and organizations in policy making (Htun & Weldon, 2012). One set of case studies in the UK highlights the role of feminist activists in placing domestic abuse on local and national agendas, though contrary to radical theory the development of connections and networks with other allies was a significant factor in success (Abrar, 1996). The conclusion that local actions were inherently tied to events and trends on the national level to some degree mirror the role ascribed in this article to international events like the #MeToo movement. They also similarly highlight the role of key actors or organizations in seizing opportunities provided by the local and national changes. Finally, a case study of the Edinburgh Zero Tolerance policy, tracing local context and politics, the role of government research and concerned actors in key positions, similarly finds that effective networking at different institutional levels, and the perceived salience of the issue were determining factors (Mackay, 1996). It may be interesting to investigate the significance of emphasis on feminist movements in establishing the issue in the UK and USA and how that may differ or converge with the ongoing developments elsewhere at present.

One other case study on policy making and SV in Nepal made use of the Kingdon model, using it to analyze how changes in the framing of the issue from a health to a human rights perspective helped played a role in aligning streams to create a policy window (Colombini et al., 2016). In general, the Kingdon model is still frequently used to discuss health policy in Europe and abroad, as its flexibility allows it to be applied to many different contexts, much as we found here (Rawat & Morris, 2016). However, contrary to our experience some other researchers found it useful in establishing causation, though it has no predictive power (Rawat & Morris 2016). Others find that on a national level the generalist nature of the model does not allow for sufficiently detailed analysis, though the current study may indicate the potential of the model for smaller scale investigations at the institutional level.

Conclusion

Despite the alarmingly high prevalence of sexual violence (SV) internationally, in the Netherlands specifically, and in the university context in particular, previous years have seen limited response, on the part of the relevant institutions (Rutgers Institute, 2017; European Union Angency for Fundemental Human Rights, 2014; “Seksueel geweld wordt vaak niet eens herkend,” 2017). The pervasive stigma and denial which has resulted in a culture of tolerance has

led to significant underreporting and lack of support, in spite of the severe mental health consequences posed by SV related trauma (Bicanic et al., 2014; "Seksueel geweld tegen vrouwen 'doodnormaal,'" 2013; Ullman & Peter-Hagene, 2014). However, the current case study shows how a combination of factors and the effort of a number of key actors have resulted in policy change and agenda setting, with SV at the center of numerous efforts and changes in the academic year of 2019-2020 at one university in Amsterdam. The events leading up to these changes were analyzed using a governance framework called the Kingdon model.

The model itself proved as fluid as the metaphor of policy streams implies, and while this makes direct conclusions difficult, it does emphasize the weight of coincidence and timing in policy change, which cannot always be directly influenced. Other researchers have also found its flexibility useful, and in spite of the model's age it is still in frequent use, though the lack of detail or depth in its current form may lend itself better to other forms of analysis than its original national level configuration. It also helps to identify factors external and adjacent to the direct role of an organization like OBOV that are noteworthy, such as the role of media coverage in creating policy windows and the importance of networking with other key actors when coverage occurs. Events like the one organized by OBOV in the early stages play a vital role in creating social movement at an institutional level that ripple out into other streams, and also allow for a concentration of knowledge. Finally, because policy windows are time sensitive it is important for organizations or concerned actors working towards recognition of a certain issue to persevere, in order to take advantage when the opportunity arises. Thankfully for individuals working in SV prevention, in the post #MeToo era, it is easier to question denial and silence, bringing policy windows closer and continuing the global trend towards awareness and response.

Our research Presents a somewhat novel contribution to research as we were unable to identify other articles focusing on agenda setting pertaining to SV in universities, as most research focuses on national level analysis and comparison in locations where agenda setting has already occurred (Cierniak et al., 2012; Fenton et al., 2016; Newl & s, 2016). Research on early phases is primarily focused on low- and middle-income countries and focus on community interventions and gender equality (Michau et al., 2015). While some other articles do trace similar trends in universities where key events with media coverage allow student activist organizations to rally networks of experts and put the issue on the institutional agenda (Bagley et al., 2012; Maito et al., 2019). Finally, older studies in the UK and USA trace the role of civil society and feminist organizations in agenda setting in local and national settings, which similarly identify networking and salience as key (Abrar, 1996; Mackay, 1996). As such our research contributes to an existing if somewhat fragmented body of knowledge, which could do with further investigation to build information as more institutions and nations start to tackle SV and move towards prevention.

The authors declare that they have no competing interests

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QUALITY OF LIFE AMONG ELDERLY POPULATION

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Abstract.

Introduction: Quality of Life (QoL) among elderly is an important issue that reflects the status of well-being of this vulnerable population.

Aim: This study aims to assess quality of life among elderly population and to examine possible correlations with associated demographic, social and health factors.

Material and Method: A cross sectional study was conducted, in which 257 elderlies from Greece were participated. For the data collection the WHOQOL-BREF (30-items Greek version) questionnaire was used as well as a questionnaire with questions about demographic data, social & health factors. Descriptive statistics such as frequencies, means, percentages and standard deviations have been utilized. Inferential statistics such as t-test and pearson r correlation have been used to determined correlations between relevant variables. Level of significance accepted is $p < 0.05$.

Results: From the total 257 elderlies 55.6% (n=143) were women and 44.4% (n=114) were men with a mean age 75.12±8.39. The mean score of overall QoL is 14.14±2.87 and the mean of each factor of WHOQOL-BREF is 13.56±2.79 for physical health, 13.61±2.74 for mental health, 13.72±2.60 for social relationships and 13.70±1.96 for environment. Age, marital status, number of children, level of education, residence area, lifestyle, chronic diseases and serious illnesses are the factors that affects levels of QoL among Greek elderly population

Conclusions: Results indicates that levels of QoL between elderly are moderate and many demographic, social and health factors are correlated with QoL status.

The authors declare that they have no competing interests

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Keywords: *Elderly, WHOQOL-BREF, Quality of Life*

The role of psychotherapy in the treatment of Post-partum depression in Nigeria

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Abstract.

Statement of the problem: After childbirth, the levels of hormones (oestrogen and progesterone) in a woman's body quickly drop. This leads to chemical changes in her brain that may trigger mood swings. In addition, many mothers are unable to get the rest they need to fully recover from giving birth. The new mother cannot explain why she is not happy yet tries to smile and giggle when people are with her. She perhaps feels unhappy but cannot decipher why she feels this way.

Postpartum depression does not have a single cause, but likely results from a combination of physical and emotional factors. The relationship between both mother and child is for the first three weeks awkward as she struggles with the feeling of lowliness that cannot be explained.

Methodology & Theoretical Orientation: A total of 20 women were interviewed. Ten within two weeks post-delivery were engaged in a conversation to find out how they felt about their new state of life. Another ten in about two months post-delivery also bore their minds. These women reside in Lagos, South-West Nigeria and their experiences are similar to what is seen in other parts of the country.

Of all living subjects investigated, of the ten within the first two weeks of child birth explained to have sought the help of a therapist when they couldn't no longer bear it. It was liberating and they claimed to have a deeper and greater level of affection for their babies respectively.

Conclusion: Post-partum depression in Nigeria is between 15%-57% of the entire maternal cycle which means it is very common amongst nursing mothers. Psychotherapy or any form of therapy as whole is not so embraced in the Nigeria just as mental illness is still been seen as a religious battle thereby having a low number of them refusing to seek medical help. It is believed that the first step to getting treatment is by speaking out and this in itself is a technique in psychotherapy.

The author declares that he has no competing interests

Keywords *maternal cycle, mental illness, post-partum depression, psychotherapy, Nigeria*