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In Memoriam
Εις Μνήμην

Costas Stefanis

(1928–2016)

Professor of Psychiatry, University of Athens

Professor Costas Stefanis, leader in Greek psychiatry, died in Athens in October 29, 2016.

He graduated in Athens University Medical School in 1953. Then, he moved first to Canada at Mondreal's MacGill university and then to the USA at the NIMH in Bethesda and Saint Elisabeth's Hospitals.

He came back to Athens and became director of psychiatric department, Athens University, at Eginition hospital (1970-1996) as well as director of the University Mental Health Research Institute of Athens (1989-2016).

He established new research units on biological level including neurochemistry, neurophysiology, chronobiology, experimental neurobiology but also he established the first open community psychiatry units in Greece.

He has been leader in a variety of international psychiatric organizations such as the World Psychiatric Association and the International Community for the Prevention and Treatment of Depression.

On the political level, Costas Stefanis has been Minister of Health and Welfare (2002–2004) as well as President of Ministers of Health of the European Union.

Professor Stefanis leaved to all of us a vacuum on scientific and personal level. We will do remember him as a very important person for the Greek people and the Greek psychiatry.

Dimitris Ploumpidis
Vassilis Kontaxakis

Εις Μνήμην
In Memoriam

Κώστας Στεφανής

(1928–2016)

Καθηγητής Ψυχιατρικής Πανεπιστημίου Αθηνών

Γεννήθηκε το 1928 στην Καλαμπάκα. Ολοκλήρωσε τις σπουδές του στην Ιατρική Σχολή του Εθνικού και Καποδιστριακού Πανεπιστημίου Αθηνών (ΕΚΠΑ) το 1953, του οποίου αναγορεύτηκε διδάκτωρ το 1960. Ειδικεύτηκε στη Νευρολογία-Ψυχιατρική στο Αιγινήτειο νοσοκομείο (1953–1956) επί καθηγεσίας Γ. Παμπούκη, ενώ στη συνέχεια μετακινήθηκε στον «Ευαγγελισμό» (1957–1960). Συνέχισε στο εξωτερικό την εκπαίδευση και την ερευνητική του δραστηριότητα, στο Πανεπιστήμιο Mc Gill του Μόντρεαλ (1960–1963) και στο νοσοκομείο St. Elisabeth στην Ουάσιγκτον (1963–1965). Στη συνέχεια επιμελητής, υφηγητής και εντεταλμένος υφηγητής της Νευρολογικής Κλινικής του ΕΚΠΑ (1966–1970). Τακτικός καθηγητής και διευθυντής της Ψυχιατρικής κλινικής του ΕΚΠΑ (1970–1996).

Στη μακρά ακαδημαϊκή του σταδιοδρομία σφράγισε καθοριστικά τόσο την οργάνωση και τη λειτουργία της Ψυχιατρικής Κλινικής στο «Αιγινήτειο» Νοσοκομείο, αργότερα του τομέα Κοινωνικής Ιατρικής, Ψυχιατρικής και Νευρολογίας του οποίου υπήρξε πρόεδρος επί σειρά ετών και γενικότερα του ΕΚΠΑ.

Υπήρξε ιδρυτής και διευθυντής του Ερευνητικού Πανεπιστημιακού Ινστιτούτου Ψυχικής Υγιεινής (1989), με πολλαπλά αντικείμενα ερευνητικής δραστηριότητας που κάλυπταν όλο το φάσμα της κλινικής και βιολογικής έρευνας και παρέμεινε διευθυντής ώς το τέλος της ζωής του.

Η παρουσία του έχει σφραγίσει την ελληνική αλλά και τη διεθνή επιστημονική κοινότητα. Δάσκαλος και εμπνευστής των περισσότερων από εμάς, έγινε ο φορέας της επιστημονικής ανανέωσης, αλλά και ισχυρός συντελεστής της ανανέωσης των ψυχιατρικών θεσμών, της λειτουργίας τους κοντά στις ανάγκες των ασθενών και της κοινωνίας.

Ως διευθυντής της ψυχιατρικής κλινικής του Αιγινήτειου Νοσοκομείου πρωτοστάτησε στον εκσυγχρονισμό της και στη δημιουργία ειδικών ερευνητικών και κλινικών μονάδων, των οποίων ο απολογισμός δεν μπορεί να γίνει σε ένα σύντομο σημείωμα. Παρά το προσωπικό του ενδιαφέρον για τη βιολογική έρευνα στην Ψυχιατρική δεν αρκέστηκε μόνο στη λειτουργία ερευνητικών εργαστηρίων, αλλά προώθησε την έρευνα και την οργάνωση μονάδων στο επίπεδο της κοινωνικής ψυχιατρικής και στήριξε την ανάπτυξη των κύριων ψυχοθεραπευτικών ρευμάτων. Ίδρυσε το πρώτο Νοσοκομείο Ημέρας (1977), το πρώτο Κέντρο Κοινοτικής Ψυχικής Υγιεινής στην Αττική αυτό του Βύρωνα-Καισαριανής (1979), τις πρώτες μονάδες ψυχοκοινωνικής αποκατάστασης (1983) στην Ελλάδα.

Από τη δεκαετία του 1950 είχε γίνει εντονότερα αισθητή στην Ελλάδα η ανάγκη μιας σύντομης ή μακρότερης εκπαίδευσης των νευρολόγων-ψυχιάτρων αλλά και των ψυχολόγων σε διεθνή κέντρα άσκησης της επιστήμης και σύνδεσης με διεθνείς οργανισμούς, ως απαραίτητο όρο ανάπτυξης, αν όχι επιβίωσης της κλινικής και της έρευνας στη χώρα.

Η συμβολή του Κ. Στεφανή στην εκπροσώπηση της Ελλάδας σε πολλούς διεθνείς οργανισμούς, επιστημονικές εταιρείες, συνέδρια και συναντήσεις ήταν λαμπρή. Την περίοδο 1977 έως 1983 υπήρξε πρόεδρος της Επιτροπής Ηθικής και Δεοντολογίας της Παγκόσμιας Ψυχιατρικής Εταιρείας (WPA) ενώ κορυφαίο γεγονός στη σταδιοδρομία του υπήρξε η προεδρεία της Παγκόσμιας Ψυχιατρικής Εταιρείας (1983–1990). Η διοργάνωση του Παγκοσμίου Συνεδρίου Ψυχιατρικής από τον καθηγητή Κ. Στεφανή στην Αθήνα το 1989, με περίπου 10.000 συνέδρους από όλο τον κόσμο θα μείνει αλησμόνητη και μοναδική εμπειρία για όσους το έζησαν εκείνη την εποχή.

Το 1994 έγινε μέλος της Ακαδημίας Αθηνών, της οποίας διετέλεσε και πρόεδρος. Ήταν ένας βαθύτατα δημοκρατικός και ενεργός πολίτης σε όλες τις φάσεις της ζωής του. Είχε για μεγάλα διαστήματα σημαντικό θεσμικό και κοινωνικό έργο στον χώρο της υγείας και σε αυτό που ονομάζουμε ψυχιατρική μεταρρύθμιση στην Ελλάδα.

Από το 1996 μέχρι το 2000 ήταν βουλευτής Επικρατείας του ΠΑΣΟΚ, ενώ από τον Ιούνιο του 2002 μέχρι τον Μάρτιο του 2004 διετέλεσε εξωκοινοβουλευτικός υπουργός Υγείας, με καθοριστική συμβολή στη λειτουργία του Αττικού Νοσοκομείου, ως Νοσοκομείου συνύπαρξης κλινικών του ΕΣΥ και Πανεπιστημιακών.

Η Ελληνική Ψυχιατρική οφείλει πολλά στον Καθηγητή Κ. Στεφανή ενώ η απουσία του αφήνει ένα δυσαναπλήρωτο κενό. Ο Καθηγητής Κ. Στεφανής αφήνει πίσω του όχι μόνο ένα πλούσιο συγγραφικό και κλινικό έργο, αλλά και μια σημαντική συμβολή στην εκπαίδευση, στη σταδιοδρομία και την κοινωνική ύπαρξη πάρα πολλών ανθρώπων. Η προσωπικότητά του, η στήριξη και η καθοδήγηση στους νεότερους συναδέλφους και το πλουραλιστικό του επιστημονικό πνεύμα θα αποτελούν πάντα φωτεινά παραδείγματα για τους νεότερους συναδέλφους.

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Editorial
Άρθρο σύνταξης

Psychiatric specialty training in Greece

Psychiatriki 2017, 28:15–18

The reform and development of psychiatric services require, in addition to financial resources, reserves in specialized human resources. The role of psychiatrists in this process, and at reducing the consequences of mental morbidity is evident.

Psychiatrists are required to play a multifaceted role as clinicians, as experts in multidisciplinary team environments and as advisors in the recognition of public needs in mental health issues, as teachers and mentors for students and other health professionals, as researchers in order to enrich our knowledge in the scientific field of psychiatry, and as public health specialists in the development of the mental health services system. This multifaceted role requires the continuous education of modern psychiatrists, but above all a broad, substantial and comprehensive training regime in the initial stage of their professional career, that is to say during specialization.[1]

Training in Psychiatry, as indeed has happened in all other medical specialties, has evolved considerably in recent decades, both in the content of education due to scientific advances in the fields of neurobiology, cognitive neuroscience, genetics, psychopharmacology, epidemiology and psychiatric nosology, and also because of advances in the educational process itself. Simple apprenticeship next to an experienced clinician, despite its importance in the clinical training of young psychiatrists, is no longer sufficient to meet the increased demands of the modern role of psychiatrists, resulting in the creation of educational programs defined by setting and pursuing minimum, though comprehensive educational objectives.[2]

This development has created the global need to develop organizations intended to supervise training programs. These organizations have various forms worldwide. In the European Union, the competent supervising body for medical specialties is the UEMS (European Union of Medical Specialities) and particularly in the case of the psychiatric specialty, the European Board of Psychiatry. In the US, the supervising bodies are the Accreditation Council on Graduate Medical Education (ACGME) and the American Board of Psychiatry and Neurology, in the United Kingdom the Royal College of Psychiatrists, in Canada the Royal College of Physicians and Surgeons, etc.[3]

In our country, the debate on the need to reform the institutional framework for Psychiatric training has been underway since the mid-90s, with initiatives especially by the Hellenic Psychiatric Association, aiming to raise awareness and concern among psychiatrists while responding to requests from competent central bodies of the state, as well as establishing Panhellenic training programs for psychiatric trainees and continuing education programs.[4]

But what is the situation of the educational map in the country today, what would be the objectives, and how might we proceed? These questions we will try to answer in an effort initiated by Hellenic Psychiatric Association (HPA) and the journal "Psychiatriki" with the publication of thematic articles starting by presenting in the next issue of "Psychiatriki"a comparative study of the training in the specialty of psychiatry at two distinct periods of time (2000 and 2014). These time-frames are of great importance, since the first is a period that in retrospect can be considered as wealthier yet missing robust priorities, while the second, at the peak of the economic crisis, constitutes a difficult environment with limited resources.

Already in the year 2000, psychiatric residency training in our country had major difficulties due to its outdated framework and its fragmentation. All areas in which training is assessed (clinical experience, theoretical training and training in psychotherapy exhibited inadequacies and limited convergence with European golden standards, in the absence of a plan and the implementation of a national education curriculum.[5,6] Certain university clinics constituted an important exception, though the bulk of the country's future psychiatrists were lagging behind in educational opportunities. Fifteen years later and under the weight of the consequences of the financial crisis, the institutional framework has not yet changed, and the overall situation seems to have worsened dramatically. Nevertheless, there are positive aspects to be evaluated, reinforced, and utilized in order to minimize the adverse effects of the economic crisis and lay sound foundations for the future.

Preparations of a national framework is imperative today more than ever and initiatives to amend the legislation on medical specialties as far as it concerns the field of Psychiatry, could benefit from the evidence, from the willingness of the trainers and trainees concerned, as well as from the elaborated proposals of the Hellenic Psychiatric Association (HPA).

Key words: Psychiatric specialty, training, Greece.

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Άρθρο σύνταξης
Editorial

Η εκπαίδευση στην ψυχιατρική ειδικότητα στην Ελλάδα

Ψυχιατρική 2017, 28:15–18

Η μεταρρύθμιση και η ανάπτυξη των ψυχιατρικών υπηρεσιών, έχουν ανάγκη εκτός από οικονομικούς πόρους και εφεδρείες σε ειδικευμένο ανθρώπινο δυναμικό. Ο ρόλος των ψυχιάτρων σε αυτή τη διαδικασία και ειδικότερα στη μείωση των επιπτώσεων της ψυχικής νοσηρότητας είναι προφανής.

Οι ψυχίατροι καλούνται να έχουν έναν πολυδιάστατο ρόλο ως κλινικοί ιατροί, ως εμπειρογνώμονες σε περιβάλλον ομάδας πολλαπλών ειδικοτήτων και ως σύμβουλοι στην αναγνώριση των δημόσιων αναγκών σε θέματα ψυχικής υγείας, ως δάσκαλοι και καθοδηγητές φοιτητών και άλλων επαγγελματιών υγείας, ως ερευνητές προκειμένου να εμπλουτιστούν οι γνώσεις μας στο επιστημονικό πεδίο της Ψυχιατρικής ή ως ειδικοί δημόσιας υγείας στην ανάπτυξη του συστήματος των υπηρεσιών ψυχικής υγείας. Αυτός ο πολυσχιδής ρόλος επιβάλλει τη συνεχιζόμενη εκπαίδευση του σημερινού ψυχιάτρου αλλά πρωτίστως την ευρεία, ουσιαστική και ολοκληρωμένη εκπαίδευσή των στο αρχικό στάδιο της εξέλιξής τους, κατά τη διάρκεια της ειδίκευσης.[1]

Η εκπαίδευση στην Ψυχιατρική όπως εξάλλου και σε όλες τις υπόλοιπες ιατρικές ειδικότητες έχει εξελιχθεί σημαντικά τις τελευταίες δεκαετίες τόσο ως προς το περιεχόμενο της εκπαίδευσης λόγω των επιστημονικών εξελίξεων στα πεδία της νευροβιολογίας, των γνωσιακών νευροεπιστημών, της γενετικής, της ψυχοφαρμακολογίας, της επιδημιολογίας και της ψυχιατρικής νοσολογίας, όσο και ως προς την ίδια την εκπαιδευτική διαδικασία. Η απλή μαθητεία δίπλα σε έναν έμπειρο κλινικό ιατρό, παρόλη τη σημασία που έχει για την κλινική εκπαίδευση των νέων ψυχιάτρων, δεν αρκεί πλέον για να καλύψει τις αυξημένες απαιτήσεις του σύγχρονου ρόλου των ψυχιάτρων, με συνέπεια τη δημιουργία εκπαιδευτικών προγραμμάτων τα οποία καθορίζονται από την τοποθέτηση και επιδίωξη των ελάχιστων μεν, αλλά συγκεκριμένων εκπαιδευτικών στόχων.[2]

Η εξέλιξη αυτή, δημιούργησε την ανάγκη διεθνώς, για την ανάπτυξη οργανισμών προορισμένων στην επόπτευση των εκπαιδευτικών προγραμμάτων. Αυτοί οι οργανισμοί έχουν διάφορα σχήματα σε όλο τον κόσμο. Στην Ευρωπαϊκή Ένωση ο αρμόδιος εποπτεύων οργανισμός για τις ιατρικές ειδικότητες είναι η UEMS (European Union of Medical Specialities) και ειδικότερα για την ψυχιατρική ειδικότητα, το Ευρωπαϊκό Συμβούλιο Ψυχιατρικής (European Board of Psychiatry). Στις ΗΠΑ αντίστοιχα το Accreditation Council on Graduate Medical Education (ACGME) και το American Board of Psychiatry and Neurology, στο Ηνωμένο Βασίλειο το Royal College of Psychiatrists, στον Καναδά το Royal College of Physicians and Surgeons κ.ά.[3]

Στη χώρα μας, η συζήτηση για την ανάγκη αναμόρφωσης του θεσμικού πλαισίου για την ψυχιατρική εκπαίδευση έχει ξεκινήσει από τα μέσα περίπου της δεκαετίας του '90, με πρωτοβουλίες ειδικότερα της Ελληνικής Ψυχιατρικής Εταιρείας τόσο σε επίπεδο ευαισθητοποίησης και προβληματισμού των ψυχιάτρων και ανταπόκρισης στα αιτήματα των αρμοδίων κεντρικών οργάνων της πολιτείας όσο και ως προς τη θέσπιση πανελληνίων προγραμμάτων εκπαίδευσης για τους ειδικευόμενους ψυχιάτρους και προγραμμάτων συνεχιζόμενης εκπαίδευσης.[4]

Ποια είναι όμως η κατάσταση του εκπαιδευτικού χάρτη στη χώρα σήμερα, ποιοι θα ήταν οι στόχοι και πώς θα μπορούσαμε να προχωρήσουμε; Σε αυτά τα ερωτήματα θα προσπαθήσουμε να απαντήσουμε σε μια προσπάθεια που εγκαινιάζει η Ψυχιατρική Εταιρεία και το περιοδικό «Ψυχιατρική» με σειρά άρθρων επί του θέματος, ξεκινώντας από την παρουσίαση

μιας μελέτης συγκριτικής παρουσίασης της εκπαίδευσης στην ειδικότητα της Ψυχιατρικής ανάμεσα σε δύο διακριτές περιόδους (2000 και 2014) που θα δημοσιευθεί στο επόμενο τεύχος της «Ψυχιατρικής». Αυτές οι περίοδοι αποκτούν ιδιαίτερη σημασία καθώς η πρώτη μπορεί να θεωρηθεί αναδρομικά περισσότερο εύρωστη αλλά με απουσία στοχευμένων προτεραιοτήτων, ενώ η δεύτερη, στο μέσον της οικονομικής κρίσης διαγράφει ένα δύσκολο περιβάλλον με περιορισμένες δυνατότητες επιλογών.

Ήδη το 2000, είχαν διαπιστωθεί σημαντικά προβλήματα στην ψυχιατρική εκπαίδευση για την ειδικότητα στη χώρα μας εξαιτίας του αναχρονιστικού πλαισίου και του κατακερματισμού που παρουσίαζε. Όλοι οι τομείς στους οποίους αποτιμάται η εκπαίδευση (κλινική εμπειρία, θεωρητική και ψυχοθεραπευτική εκπαίδευση) παρουσίαζαν μεγάλες αποκλίσεις και περιορισμένες δυνατότητες σύγκλισης με τις ευρωπαϊκές προδιαγραφές υπό το υφιστάμενο πλαίσιο.[5,6] Σημαντική εξαίρεση αποτελούσαν συγκεκριμένες πανεπιστημιακές κλινικές, με τον κύριο όγκο όμως των μελλοντικών ψυχιάτρων της χώρας να υπολείπεται σε εκπαιδευτικές παροχές. Δεκαπέντε χρόνια αργότερα και υπό το βάρος των συνεπειών της οικονομικής κρίσης, το θεσμικό πλαίσιο δεν έχει αλλάξει και η γενική κατάσταση φαίνεται να έχει επιδεινωθεί δραματικά. Παρόλ' αυτά, υπάρχουν θετικά στοιχεία που πρέπει να εκτιμηθούν, να ενισχυθούν και να αξιοποιηθούν προκειμένου να ελαχιστοποιηθούν οι δυσμενείς επιπτώσεις της οικονομικής κρίσης και να τεθούν υγιείς βάσεις για τη συνέχεια.

Σήμερα, περισσότερο από ποτέ, είναι αναγκαία η διαμόρφωση ενός εθνικού σχεδίου για την εκπαίδευση στην Ψυχιατρική και οι προσπάθειες βελτίωσης της νομοθεσίας για τις ιατρικές ειδικότητες στον βαθμό που αφορούν στην ψυχιατρική ειδικότητα, μπορούν να ωφεληθούν από τη διαθέσιμη τεκμηρίωση, την εκπεφρασμένη θέληση εκπαιδευτών και εκπαιδευομένων για τη βελτίωση του εκπαιδευτικού πλαισίου καθώς και από τις επεξεργασμένες προτάσεις της Ελληνικής Ψυχιατρικής Εταιρείας.

Λέξεις ευρετηρίου: Ψυχιατρική ειδικότητα, εκπαίδευση, Ελλάς.

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Research article
Ερευνητική εργασία

Rates of childhood trauma in a sample of university students in Greece: The Greek version of the Early Trauma Inventory-Self Report

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The self-report Early Trauma Inventory (ETI-SR-SF) was developed by Bremner et al in 2007 and has been proven a valid tool for the assessment of childhood trauma. The inventory covers four types of traumatic experiences: general trauma, physical abuse, emotional abuse and sexual abuse. The primary aim of the present study was to assess the internal consistency, test-retest reliability, convergent validity and factor structure of the Greek version of the ETI-SR-SF. The study sample consisted of 605 individuals (402 women), undergraduate and postgraduate students of Athens universities with a mean age of 24.3 years. All participants completed a questionnaire on demographic characteristics, the Greek version of the ETI-SR-SF and the Greek version of the Trauma Symptoms Checklist (TSC-40). Both ETI-SR-SF and TSC-40 were re-administered to 56 participants after three to four weeks. ETI-SR-SF was found to display high levels of internal consistency (Cronbach's α=0.91) and test-retest reliability (ICC=0.93). In addition, the internal structure of every subscale was examined by the means of factor analysis, which revealed that the items in every subscale contribute to a single factor explaining a great proportion of the variance. The correlation between total scores of ETI-SR-SF and TSC-40 was significantly strong ($r=0.42$, $p<0.001$), indicating satisfactory convergent validity. The most frequently reported type of childhood trauma was corporal punishment, at a rate of 89.9%, followed by emotional abuse (67.2%) and sexual abuse (27%). These rates are higher than those found in the international literature indicating that the various types of early traumatic experience are very common phenomena in the Greek student population. This finding should alert the experts and requires replication and further investigation by studies with larger samples. The findings of the present study suggest that the Greek version of the self-report Early Trauma Inventory (ETI-SR-SF) is a valid and reliable tool useful for future studies on childhood traumatic experiences in Greek populations. Moreover, according to our preliminary findings further investigation of the childhood trauma in Greece appears to be very much warranted.

Key words: Childhood trauma, early trauma inventory, psychometric properties, types of traumatic experience.

Introduction

Psychological trauma can be defined as the effect a traumatic event has on the psyche of the person who experienced it. As traumatic can be labeled any event which is experienced as threatening to one's safety and physical integrity and causes feelings of fear or terror and helplessness.[1] Childhood trauma occurs during the development of the individual, from infancy to completion of 18 years – age that is regarded as the landmark of adulthood.[2] The trauma during the broader developmental period before adulthood is more likely to have serious psychological impact on the individual than any traumatic experience that takes place after the completion of development over the lifespan.

The impact of a traumatic experience on the psychological development of the child depends on many factors, including the age of first occurrence, the frequency and participation of persons who have the care of the child. The chances of long-term negative effects increase the younger the child is.[3,4]

According to the literature, the main categories of traumatic experiences a growing person can have are: (a) physical abuse, defined as the intentional physical violence against the child, which may result in serious adverse health effects on the child's development and dignity, (b) sexual abuse, defined as the involvement of a child in sexual activity which does not fully understand and with which is not able to consent, (c) emotional and psychological abuse, including threats, intimidation, discriminatory behavior, rejection, ridicule and abuse, and (d) neglect of children regarding their health, education, nutrition and safe living.[5,6]

As showed by epidemiological studies, childhood trauma is a fairly common phenomenon worldwide. In a large World Health Organization (WHO) study, conducted in 21 countries with a total sample of 51,945 adults and investigating the incidence of reported traumatic experiences before the age of 18 years, 59.3% to 66.2% of the sample reported multiple traumas, on average two or more.[7] In Greece also the phenomenon of child abuse seems to be common as, according to the Institute of Child Health, 1,000–2,000 new cases of child abuse and neglect are recorded every year, more frequently in very young ages.[8]

Childhood trauma is therefore an important public health problem given the significant incidence and the serious long-term impact on the person's overall well-being.[7,9] Although several questionnaires regarding childhood trauma can be found in the literature,[10] to our knowledge none of them has been adapted to the Greek language as yet. However, it becomes very important to develop the Greek version of a clinical tool for the assessment of early trauma, which will enable the study of the phenomenon in the Greek population.

The objective of this study was to develop the Greek version of a questionnaire assessing childhood trauma and to examine its psychometric properties. After exploring the relevant literature the short form of the early trauma questionnaire by Bremner et al. (Early Trauma Inventory-Self Report-Short Form (ETI-SR-SF) was chosen.[1] The reasons for this selection were that: (a) ETI-SR-SF assesses of a wide range of traumatic experiences, and (b) it has very satisfactory reliability and validity and these properties have even confirmed by cross-cultural studies, justifying its use in different cultural contexts.[12–18]

Material and methods

Sample

The sample of the study consisted of 605 undergraduate and postgraduate students of the Athens University Medical School, Panteion University and an MSc Program organized by the First Department of Psychiatry of the University of Athens. The mean age of the sample was 24.3 with a standard deviation of 7.8 years. The male to female ratio in the sample was 1:2 (402 women).

Instruments

Demographic questionnaire

The demographic questionnaire was designed for the needs of this study and consists of twelve multiple-choice questions about personal data. More specifically, participants were asked for information on sex, age, marital status, and whether they lived alone, with parents or with partner. Finally, information was requested about the level of education and

profession of participants' father and mother, as well as the monthly family income.

The self-report version of the Early Trauma Inventory - Short form (ETI-SR-SF)[11]

The ETI-SR-SF covers four types of trauma that people may have experienced before the age of 18: (a) traumatic experience of various etiology – general trauma, (b) trauma due to physical abuse, (c) trauma due to emotional abuse, and (d) sexual abuse or harassment experiences. It consists of 27 items including: (a) 11 questions referring to various reasons of traumatic experiences, such as "Have you ever been exposed to a natural disaster threatening your life" or "Have you ever had the experience of death or serious illness of a parent or the person who took care of you when you were a child", (b) five questions associated with traumatic experiences of corporal punishment, such as" Have you ever been slapped "or" Have you ever been punched or kicked", (c) five questions associated with traumatic experiences because of emotional abuse, such as "We you frequently humiliated or ridiculed" or "Were you often ignored or made you feel worthless", and (d) six questions associated with traumatic experiences because of sexual harassment or abuse, such as "Have you ever felt someone rub his genitals on you" or "Have you been forced to touch another person in private parts of his body"? The response options are YES or NO.

An index for each type of trauma can be calculated summing up the traumatic events of each subscale in which the subject has answered affirmatively and the total trauma score is the sum of the four subscale scores. Scoring alternatives, such as severity, frequency, or the emotional impact of the traumatic event, do not add to the validity of the inventory, according to the authors.[11] However, in this exploratory study it was considered appropriate to incorporate the frequency of traumatic experiences as an alternative measure, scoring a 3-point rating scale for every item, i.e., once or twice=1, sometimes=2 frequently=3.

Trauma Symptom Checklist, TSC-40[18]

This is a 40 items self-report scale for adults, which measures certain clinical aspects of PTSD and various types of symptoms associated with trauma. The scale is designed to assess long-term impact of child abuse[19] and has been used to investigate the psychological adaptation in people who have suffered childhood trauma.[20] TSC-40, apart from the total score, also contains six subscales: anxiety, depression, disconnection, sexual abuse index, sexual problems and sleep disorders. According to the authors, the scale may only be used for research purposes. The scale has good reliability (Cronbach's a from 0.66 to 0.77 for the subscales and from 0.89 to 0.91 for the total scale).[21]

Procedure

The ETI-SR-SF was translated and adapted to the Greek language with the written permission of the author Bremner JD. The method used was the reverse translation.[22] More specifically, the questionnaire was at first independently translated into Greek by two psychologists, excellent English speakers. Both translations were compared and contrasted so as to identify the one which reflects the concepts of the questionnaire better. This version was back-translated into English (reverse translation) by one of the authors of the present study, who holds an MA in English Literature from the University of London. The back-translation was sent to the author, who made a comparison with the original and was completely satisfied. The reverse translation was translated back to Greek language and thus the Greek version was formed. In order to administer the TSC-40 to the sample of our study, we also had to develop a Greek version of this scale. The procedure was the same as for the ETI-SR-SF.

All participants completed the demographic questionnaire, the ETI-SR-SF and the TSC-40. ETI-SR-SF and TSC-40 were re-administered to 56 participants within three to four weeks from the initial administration. Participation in the survey was voluntary and anonymous. Exclusion criterion was a native language other than Greek.

Statistical analysis

Internal consistency of the ETI-SR-SF was examined by calculating Cronbach's α (alpha) coefficient. Intraclass correlation coefficients (ICCs) were calculated in order to assess the test-retest reliability. In addition, Pearson's correlation coefficients (r) were calculated to assess the strength of (adjusted) associations between each item and the total score

minus the score on this item. The factorial structure ETI-SR-SF questionnaire was examined using factor analysis (principal component analysis) for each subscale. The scree-plot test was used as a criterion to determine the number of extracted factors.

The normality of the distribution in the total sample was tested with the Kolmogorov-Smirnov test. Correlations between variables were assessed using the Pearson's coefficient (r). The IBM statistical analysis software SPSS Statistics 20 was used for all analyses. The statistical significance criterion for all tests was set at p=0.05.

Results

Demographic characteristics of the sample

The demographic characteristics of the participants are summarized in table 1. Since both undergraduate and graduate students participated in the study, the age range of the sample was relatively broad and a significant percentage of the participants were already holders of Bachelor or postgraduate degrees. The vast majority of participants were unmarried (88.4%) and without children (92%). Academic performance showed normal distribution with the majority of respondents having an average level (very good). The families of origin were characterized by relatively well-educated parents, as the majority of them were higher education graduates or postgraduate degree holders.

Reliability of ETI-SR-SF

The Greek translation of the ETI-SR-SF was rated in a dichotomous way (YES/NO) and in a 3-point scale measuring the frequency of each traumatic experience, as mentioned above. The internal consistency of the questionnaire was assessed using both scoring ways. When the dichotomous rating was used, internal consistency was found to be low to non-acceptable levels. Specifically, the Cronbach's α for the relationship between subscales and total score was 0.52. Similarly, small to medium correlation coefficients were found between the subscales and total score (r=0.22–0.38). Cronbach's α values were within acceptable levels (0,81–0,88) for the three subscales –traumatic experiences of varying etiology, trauma due to emotional abuse, trauma due to sexual harassment or abuse– but not for the subscale traumatic experiences due to physical abuse (0.63). On the contrary, all the internal consistency values of the ETI-SR-SF were high when the ordinal rating was used, as shown in table 2. More specifically, the Cronbach's α for the relationship between subscales and total score was 0.91. The individual values of internal consistency between subscales and total score were also high and all the correlation coefficients between subscales and total score were strong. Test-retest reliability of

Table 1. Demographics of the sample.

	n	(%)
Gender		
Male	203	33.6
Female	402	66.4
Marital Status		
Unmarried	531	88.4
Married/Divorced	70	11.6
Children		
Yes	50	8.4
No	552	91.6
Residential status		
Alone	215	36.4
With parents/siblings	286	48.4
With boyfriend/girlfriend	89	15.1
Education level		
High School graduates	399	66.2
Technological education graduates	36	6.0
University graduates	134	22.2
Postgraduate degree	34	5.6
Average academic performance		
5–7	87	20.5
7.1–8.5	260	61.3
8.6–10	77	18.2
Father's education		
Basic	78	13.1
Secondary	145	24.4
University	334	56.1
Postgraduate	38	6.4
Mother's education		
Basic	82	13.7
Secondary	181	30.4
University	307	51.5
Postgraduate	26	4.4
	Mean (SD)	Range
Age	24.3 (7.8)	18–54
Family income (€/month)	2737 (1804)	150–15000

Table 2. Internal consistency and test-retest reliability of ETI-SR-SF.

ETI	Cronbach's α if the item is deleted	Corrected item-total correlation	ICC test-retest (95% CI)
I. Trauma of various etiology	0.85	0.89	0.89 (0.82–0.94)
II. Trauma due to physical abuse	0.84	0.82	0.85 (0.74–0.91)
III. Trauma due to emotional abuse	0.86	0.66	0.86 (0.76–0.92)
IV. Trauma due to sexual abuse or harassment	0.78	0.89	0.91 (0.85–0.95)
Total score	0.91	–	0.93 (0.89–0.96)

ETI-SR-SF was excellent, as shown by the values of ICCs, which were high for both the overall score and each subscale.

Factor analysis of the subscales of ETI-SR-SF

The structure of each subscale was examined using principal component analysis, which revealed that the items in every subscale contribute to a single factor explaining significantly large proportion of the variance (table 3). More specifically, in the subscale traumatic experiences of various etiologies one factor explains 65.1% of the variance and the factor loadings were 0.65 to 0.90; in the subscale trauma due to physical abuse one factor explains 55.3% of the variance and the factor loadings were 0.58 to 0.83; in the subscale trauma due to emotional abuse one factor explains 62.2% of the variance and the factor loadings were 0.70 to 0.87; finally, in the subscale trauma due to sexual harassment or abuse one factor explains 80.2% of the variance and the factor loadings were 0.79 to 0.94.

Convergent validity of ETI-SR-SF

Since the ETI-SR-SF assesses various types of traumatic experiences, the TSC-40 was used as convergent validity criterion because it measures post-traumatic symptoms and has shown satisfactory discrimination validity between individuals who have experienced trauma and individuals with no traumatic experience.[23,24]

The Cronbach's α of the Greek version of TSC-40 was high. The internal consistency of the TSC-40 remained at satisfactory levels after deleting each of the subscales. The correlation coefficients between the subscales and the total score were high (≥0.70) apart from the correlation of sexual abuse index

Table 3. Factor analysis of the subscales of ETI-SR-SF.

		Eigenvalues	
ETI entries	**Factor 1**	**Total**	**(%) fluctuation explained**
I. Trauma of various etiology		7.16	65.09
1	0.80		
2	0.77		
3	0.84		
4	0.75		
5	0.86		
6	0.86		
7	0.75		
8	0.64		
9	0.76		
10	0.90		
11	0.89		
II. Trauma due to physical abuse		2.77	55.31
1	0.57		
2	0.74		
3	0.83		
4	0.77		
5	0.79		
III. Trauma due to emotional abuse		3.11	62.16
1	0.70		
2	0.87		
3	0.75		
4	0.84		
5	0.77		
IV. Trauma due to sexual harassment or abuse		4.81	80.25
1	0.88		
2	0.79		
3	0.94		
4	0.92		
5	0.92		
6	0.92		

with the overall score, which was weak. Because of this finding, the internal consistency of the scale was further examined using the individual items and not the subscale scores in order to detect if some items included in the sexual abuse index cause the consistency problem. In this analysis, the Cronbach α of TSC-40 was high (0.87) and remained high after deleting each of the items (≥0.86). Therefore, all of the items and all the subscales were maintained in further analysis.

Test-retest reliability of TSC-40 was very high, both for the total score and for all subscales except for sexual abuse index. The ICC for this subscale was very low indicating that the symptoms included in the sexual abuse index do not demonstrate stability in repeated administrations of the TSC-40. (All data on the psychometrics of the Greek version of TSC-40 available by the authors upon request).

Table 4 presents the correlations between the total and subscale scores of the ETI-SR-SF and the TSC-40. All correlations were statistically significant with the exception of the correlation between trauma due to sexual harassment or abuse of ETI-SR-SF and the sexual abuse index of TSC-40. Correlations between the total score in the ETI-SR-SF and categories of symptoms associated with trauma (subscales of TSC-40) were moderate (r≥0.3) except for the correlation with sleep disorders, which however was slightly smaller than 0.30, and the correlation with sexual abuse index, which was weak. The correlation between the total scores of ETI-SR-SF and TSC-40 was of medium size. In conclusion, the correlations found indicate satisfactory convergent validity of ETI-SR-SF.

Frequency of reported trauma in the study sample

Table 5 shows the percentage of subjects in the sample who reported one or more traumatic experiences of any type, as well as the percentages of participants reporting traumatic experiences of each of the ETI-SR-SF four types separately. As shown in this table, 98% of participants reported that they had at least one traumatic experience before the age of 18. Although trauma caused by sexual harassment or abuse ranked lowest (27%), its rate in our sample indicates a socially important phenomenon.

Discussion

The main objective of the present study was to develop the Greek version of ETI-SR-SF and investigate its psychometric properties in a Greek sample. In terms of reliability, the Greek version of the ETI-SR-SF showed high internal consistency and stability over time. It is noteworthy that in this study the internal consistency of the questionnaire was found to be rather weak when the dichotomous scoring was used, but when an ordinal rating –according to the frequency of experience– was used, the internal consistency was found satisfactory to high. This finding underlines the importance of the rating method we choose, particularly in large scale studies. It is critical for the researcher to take as much information as possible from each participant when investigating a certain conceptual construct with the help of questionnaires. Conversion of the dichotomous variables to ordinal or continuous potentially increasing

Table 4. Correlations between ETI-SR-SF and TSC-40 scores.

TSC-40	ETI				
	Trauma of various etiology	**Trauma due to physical abuse**	**Trauma due to emotional abuse**	**Trauma due to sexual abuse**	**Total trauma**
Dissociative symptoms	0.18***	0.26***	*0.32***	0.18***	*0.37****
Anxiety	0.23***	0.21***	0.28***	0.15***	*0.34****
Sleep disorders	0.18***	0.18***	0.25***	0.10*	*0.29****
Sexual problems	0.28***	0.24***	*0.33****	0.24***	*0.43****
Depression	0.23***	0.23***	*0.43****	0.21***	*0.43****
Sexual abuse index	0.12**	0.10*	0.14**	0.06	0.17***
Total score	0.22***	0.27***	*0.37****	0.20***	*0.42****

Table 5. Percentage of subjects who mentioned at least one traumatic experience of any type, and percentages for every type of traumatic experiences separately.

ETI-SR-SF	n	(%)
I. Trauma of various etiology	491	82.1
II. Trauma due to physical abuse	543	89.9
III. Trauma due to emotional abuse	406	67.2
IV. Trauma due to sexual harassment or abuse	163	27.0
Percentage of subjects who reported one or more traumatic experiences	584	98.0

the variance might be useful for the reliability of the questionnaire.

The factor analysis of ETI-SR-SF subscales yielded only one factor for each subscale explaining a substantial proportion of the variance. These results indicate satisfactory discriminant ability of the four subscales of ETI-SR-SF. Moreover, the significant correlations found between the Greek version of ETI-SR-SF and TSC-40, i.e. symptoms associated with trauma, were indicative of satisfactory convergent validity. Our results are compatible with previous studies in other countries, confirming thus the cross-cultural reliability and validity of ETI-SR-SF.[12–17]

With regards to the frequency of the reported trauma, 98% of our study participants reported at least one childhood traumatic experience. This percentage is significantly higher than what was found in samples of students in other countries. More specifically, according to studies in the U.S. and Israel, the prevalence of childhood trauma in student populations ranges from 67% to 84%.[25,26] In a study conducted in Israel investigating the frequency of exposure to traumatic experiences in a sample of 983 students, 67% reported at least one traumatic experience.

The most frequently reported type of childhood trauma in the present study was corporal punishment (89.9%), followed by emotional abuse (67.2%) and sexual abuse (27%). In a very extensive retrospective study of 17,000 people with an average age of 57 years, (Adverse Childhood Experiences Study) conducted in the U.S., the incidence of various types of trauma was 28% due to corporal punishment, 11% due to emotional abuse and 22% for sexual abuse.[9]

The very high rate of childhood trauma due to physical abuse in our study is consistent with other research findings in Greece, showing that corporal punishment is a common method of discipline. More specifically, in a survey conducted by the National Center for the Study of Corporal Punishment and Alternative Punishment in a sample of undergraduate students in Athens and Thessaloniki, 73% of the students reported that as children had been receiving corporal punishment at home.[8] This study also reported higher emotional abuse rate (67.2%) compared with the findings in the U.S.

The rate of the sexual abuse in our sample (27%) is also remarkable. During the '90s, a study in the U.S. investigated the prevalence of childhood trauma due to sexual abuse in a sample of 81,241 adolescents with different national origins. 10% reported at least one sexual abuse episode, with no significant differences were found between nationalities.[27] According to U.S. studies the prevalence of sexual abuse in student populations ranges from 8.2% to 34%.[28] In conclusion, the results of this study suggest that childhood trauma in general and its different types are very common phenomena in the student population of our country. This finding should alert the experts and warrants replication and further investigation by studies with larger samples.

In summary, the findings of our study suggest that the Greek version of ETI-SR-SF is a valid and reliable tool for the assessment of childhood trauma and the four types of traumatic experiences (traumatic experiences of varying etiology, physical abuse, emotional abuse, sexual abuse or harassment) in Greek populations. The development of the Greek version of the questionnaire enables further investigation of childhood trauma in Greece and thus facilitates cross-cultural research in the field of early trauma. Moreover, according to our preliminary findings further investigation of childhood trauma in Greece appears to be very much warranted. The use of ETI-SR-SF will allow the detection of childhood trauma contributing to future research on its psychological effects and hopefully to new efforts to prevent them.

Η συχνότητα του παιδικού τραύματος σε δείγμα Ελληνικού φοιτητικού πληθυσμού: Η Ελληνική εκδοχή του Ερωτηματολογίου Πρώιμου Τραύματος

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Το ερωτηματολόγιο αυτοαναφοράς του πρώιμου τραύματος (Early Trauma Inventory-Self-Report-Short-Form, ETI-SR-SF) δημιουργήθηκε από τους Bremner, Bolus και Mayer το 2007 και αποτελεί ένα έγκυρο ψυχομετρικό εργαλείο για την εκτίμηση του παιδικού τραύματος. Το ερωτηματολόγιο καλύπτει τέσσερεις τύπους τραυματικών εμπειριών: τραυματικές εμπειρίες ποικίλης αιτιολογίας- γενικό τραύμα (general trauma), τραυματικές εμπειρίες σωματικής κακοποίησης (physical abuse), εμπειρίες συναισθηματικής κακοποίησης (emotional abuse) και εμπειρίες σεξουαλικής κακοποίησης ή παρενόχλησης (sexual abuse). Η παρούσα μελέτη είχε ως πρωταρχικό στόχο να εξετάσει την εσωτερική συνοχή, την αξιοπιστία χορήγησης-επαναχορήγησης, τη συγκλίνουσα εγκυρότητα και την παραγοντική δομή της ελληνικής εκδοχής του ερωτηματολογίου ETI-SR-SF. Το δείγμα της έρευνας περιελάμβανε 605 άτομα (402 γυναίκες), προπτυχιακούς και μεταπτυχιακούς φοιτητές πανεπιστημίων της Αθήνας, με μέσον όρο ηλικίας τα 24,3 έτη. Οι συμμετέχοντες συμπλήρωσαν ένα ερωτηματολόγιο δημογραφικών στοιχείων, την ελληνική εκδοχή του ερωτηματολογίου πρώιμου τραύματος ETI-SR-SF και την ελληνική εκδοχή της κλίμακας συμπτωμάτων σχετιζόμενων με τραύμα για ενήλικες (Trauma Symptom Checklist, TSC-40). Σε 56 συμμετέχοντες επαναχορηγήθηκαν το ETI-SR-SF και η κλίμακα TSC-40 εντός χρονικού διαστήματος τριών έως τεσσάρων εβδομάδων. Το ερωτηματολόγιο ETI-SR-SF επέδειξε υψηλό επίπεδο εσωτερικής συνοχής (Cronbach's α=0,91) και αξιοπιστίας χορήγησης-επαναχορήγησης (ICC=0,93). Επιπλέον ελέγχθηκε η δομή κάθε υποκλίμακας με παραγοντική ανάλυση, από την οποία βρέθηκε ότι τα λήμματα σε κάθε υποκλίμακα συμβάλλουν σε έναν μόνο παράγοντα, που εξηγεί σημαντικά μεγάλο ποσοστό της διακύμανσης της βαθμολογίας. Η συσχέτιση μεταξύ της συνολικής βαθμολογίας του ETI-SR-SF και της TSC-40 ήταν σημαντικής ισχύος (r=0,42, p<0,001), εμφανίζοντας ικανοποιητική συγκλίνουσα εγκυρότητα. Ο συχνότερα αναφερόμενος τύπος παιδικού τραύματος στην παρούσα μελέτη ήταν η σωματική τιμωρία, με ποσοστό 89,9%, και ακολουθούσαν η συναισθηματική κακοποίηση (67,2%) και η σεξουαλική κακοποίηση (27%). Τα ποσοστά αυτά είναι υψηλότερα σε σύγκριση με τα ποσοστά που βρίσκουμε στη διεθνή βιβλιογραφία και υποδεικνύουν ότι το παιδικό τραύμα και οι διάφοροι τύποι του είναι ένα πολύ συχνό φαινόμενο στον ελληνικό φοιτητικό πληθυσμό. Το εύρημά μας αυτό θα πρέπει να προβληματίσει τους ειδικούς και χρήζει επιβεβαίωσης και περαιτέρω διερεύνησης από μελέτες με μεγαλύτερα δείγματα. Από τα αποτελέσματα της παρούσας μελέτης προκύπτει ότι η ελληνική εκδοχή του ερωτηματολογίου πρώιμου τραύματος (ETI-SR-SF) αποτελεί ένα έγκυρο και αξιόπιστο εργαλείο, το οποίο δίνει τη δυνατότητα περαιτέρω διερεύνησης του φαινομένου του ψυχικού τραύματος στον ελληνικό πληθυσμό. Επιπλέον, τα προκαταρκτικά ευρήματα της μελέτης υποδεικνύουν την αναγκαιότητα συνέχειας στην έρευνα σχετικά με τις πρώιμες τραυματικές εμπειρίες στη χώρα μας.

Λέξεις ευρετηρίου: Παιδικό τραύμα, ερωτηματολόγιο πρώιμου τραύματος, ψυχομετρικές ιδιότητες, τύποι τραυματικών εμπειριών.

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Research article
Ερευνητική εργασία

Attention Deficit/Hyperactivity Disorder (ADHD) symptoms and cognitive skills of preschool children

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Attention deficit/hyperactivity disorder (ADHD) constitutes a neurobehavioral disorder which may potentially adversely affect children's wellbeing and academic achievement. The onset of symptoms is present prior to 12 years of age, and often the symptoms are evident in the preschool years. In fact, it has been suggested that screening for ADHD symptoms may be initiated as early as four years of age. Preschool children with ADHD have been shown to present with poor pre-academic skills and might be at increased risk for numerous school-related problems, including functional impairment during elementary school years and persistent poor academic performance thereafter. Although preschool years are characterized by rapid cognitive growth, preschoolers with ADHD may present with poorer cognitive and neuropsychological functioning. Due to the early onset of ADHD symptoms, exploring the cognitive correlates of this condition among preschool children is thought to be of notable importance. The aim of the present study was to evaluate any association between ADHD symptoms and cognitive skills among preschool children. A cross-sectional study was conducted among a nationwide random sample of 4,480 preschool children. ADHD symptoms were assessed though interviews with parents and teachers based on DSM-IV-TR criteria. Cognitive skills were assessed through a standardized school readiness test (A' TEST). Among participants, the occurrence of ADHD symptoms was 4.6% (boys/girls: 3.4/1). The presence of ADHD symptoms among children was inversely associated with non-verbal and verbal cognitive skills; specifically, with abstract thinking (aOR 1.97, 95% CI 1.30–3.00), language (2.36, 1.55–3.59), critical reasoning (2.58, 1.84–3.62), visual perception (2.42, 1.38–4.24), and visual motor skills (2.61, 1.91–3.55). Children with ADHD symptoms were five times as likely to have compromised organizational skills (4.92, 3.04–7.97). Abstract thinking was the least affected domain particularly among boys, while organizational skills were the most affected domain in both sexes, and possibly more among girls. Concluding, the present study confirms that even during preschool years, children with ADHD symptoms are more likely to present with concomitant cognitive difficulties. Thus, screening for the presence of ADHD, as well as cognitive and affective screenings among preschool aged children may facilitate the early detection and determent of the development of cognitive difficulties, and subsequently the early intervention for fostering skills that are amenable to change, such as organizational skills and planning. As a result, the study findings reveal the necessity for the evaluation of pre-academic skills among preschool children with ADHD symptoms in order to mitigate unfavorable academic functioning.

Key words: Attention Deficit/Hyperactivity Disorder (ADHD), cognitive skills, preschool children.

Introduction

Attention deficit/hyperactivity disorder (ADHD) constitutes a neurobehavioral disorder which may potentially adversely affect children's wellbeing and academic achievement. Children with ADHD present with clinically significant symptoms of hyperactivity, poor sustained attention, and diminished impulse control. The onset of symptoms must be present prior to 12 years of age, and often the symptoms are evident as early as preschool age.[1] In fact, it has been suggested that screening for ADHD symptoms may be initiated as early as 4 years of age.[2] Moreover, the American Academy of Pediatrics suggested that detectable ADHD symptoms in preschool ages may predict compromised academic skills later on.[2] This issue has not yet been fully elucidated to date among preschool children.

Prevalence rates of ADHD among preschoolers are reported to range between 3.3% and 12.8%, and are particularly elevated among boys.[3–5] The prevalence of ADHD among Greek school-aged children ranges between 6% and 18%.[6–8] Differing rates of ADHD between different countries and across studies may be affected by the assessment tool used. Also, cultural environment may affect a child's behaviour and differing attitudes of parents, teachers, clinicians, and society towards acceptable behaviour may also influence diagnosis. If assessment criteria could be consistently applied across studies, the prevalence of ADHD would probably be similar.

It has been suggested that preschool children with ADHD may present with poor pre-academic skills and might be at increased risk for numerous school-related problems, including functional impairment during elementary school years and persistent poor academic performance thereafter.[9–12] Although preschool years are characterized by rapid cognitive growth,[13] preschoolers with ADHD may present with poorer cognitive and neuropsychological functioning.[14] While ADHD prevalence rates among boys exceed those of girls, recent findings suggest that affected girls are at greater risk for presenting with impaired cognitive functioning.[15] Due to the early onset of ADHD symptoms and the increased risk for school-related problems, exploring the cognitive correlates of this condition among preschool children is thought to be of notable importance.

The aim of the present study was to confirm and expand current knowledge as well as to compare the cognitive functioning of preschool children with ADHD symptoms with their non-ADHD peers. We hypothesized that the proportion of children with ADHD symptoms exhibiting deficits in cognitive functioning, in relation to both verbal and non-verbal skills, would be significantly greater than that among their normal counterparts. Additionally, we hypothesized that both boys and girls with ADHD symptoms would be at significantly greater risk for abnormal verbal and non-verbal skills as compared to their normal counterparts, with girls being more likely to present with compromised skills. Lastly, we aimed to estimate the likelihood of impaired cognitive skills among children with ADHD symptoms, following stratification by sex and adjustment for the potential confounding effects of age, and parental educational level.

Material and method

Subjects

The cross-sectional study population consisted of a nationwide convenience sample of 4,480 preschool children. All participants attended mainstream public and private preschool settings. Children reported to have pervasive developmental disorders, intellectual disabilities, and chronic neurological disorders (e.g., epilepsy, cerebral palsy) were excluded. No children were taking medication for ADHD at the time of the study. Parental educational attainment was categorized into two levels: low/middle (≤12 years) and high educational level (>12 years). Educational status of the parent with the higher education level was used in the analyses. All data were collected during the spring and summer months of three consecutive school years (2008–2011). The study was approved by the Ethical Committee of the "P. & A. Kyriakou" Children's Hospital in Athens, Greece. Legal guardians provided written informed consent for study participation of all eligible children prior to the initiation of the study.

Measures

ADHD symptoms were assessed through ADHD Checklist[16] administered individually by two trained psychologists to both parents and teachers at preschool. The ADHD Checklist is composed of 14 items. These items are listed as the criteria for ADHD in the DSM-III-R and have been placed into a checklist format. The same checklist can be used for both parents and teachers. The 14 items evaluate a child's behavior and the likelihood of the child having ADHD. Each item is scored on a response scale of 0 to 3, where 0=not at all, 1=just a little, 2=pretty much, and 3=very much. Adding the number of all items rated as 2 or higher scores the scale Number of Symptoms Present. A score of 8 or more exceeds the DSM-III-R cutoff for a diagnosis of ADHD. The highest possible score for this scale is 14. Respondents with a total score at or above the clinical cutoff receive a "1" to indicate a diagnosis of ADHD. A "0" indicates that the respondent is not diagnosed with ADHD.

Cognitive skills were assessed individually by trained professionals through a school readiness-screening test developed and applied to children aged 5–6 years old prior to starting school in Greece (A΄ TEST). The psychometric properties of the A' TEST have been described elsewhere.[17] The test consists of three verbal and three non-verbal subtests. The verbal subtests reflect the application of verbal skills to new situations, and include: (1) Abstract thinking: The respondent is requested to identify the common underlying characteristic between two objects; (2) Critical reasoning: The child clarifies his/her comprehension of general principles and social situations; (3) Language skills: The examinee is requested to complete the missing content of an incomplete sentence. The non-verbal subtests are designed to provide an estimation of fluid reasoning, spatial perception, perceptual-organization, and visual–motor integration. The following subtests were considered to assess aspects of non-verbal reasoning: (1) Visual perception: The respondent is requested to match target symbols with search group symbols; (2) Visual motor skills: The child copies five shapes of increasing difficulty; (3) Organizational skills: The participant is requested to sequence three pictures so as to make a sensible story.

Statistical analysis

Comparisons were conducted between children with ADHD symptoms and their normal peers. Logistic regression analysis stratified by sex was used to derive age-, and parental education adjusted odds ratios (aOR) of abnormal cognitive skills scores (outcome variables) among children with ADHD symptoms as compared to their normal counterparts (exposure variable). The chi-square test was used for the comparison of categorical variables. Fisher's exact test was used instead in cases where sample sizes did not exceed five children. Statistical analyses were conducted with SAS version 9.0 (SAS Institute Inc., USA).

Results

Among the study population (n=4480), 204 (4.6%) presented with ADHD symptoms, from which 158 were boys (the boys/girls ratio was 3.4/1). Results of the descriptive analysis and the comparison of demographic characteristics and cognitive skills between ADHD and non-ADHD cases are presented in table 1.

Overall impaired cognitive skills

Overall, the proportion of children with ADHD symptoms exhibiting deficits in cognitive functioning, in relation to both verbal and non-verbal skills, was approximately two times as much as that among their normal counterparts (table 1). With regard to their verbal skills, the likelihood of presenting with abnormal abstract thinking, critical reasoning and/or language skills was increased in excess of more than two-fold among children with ADHD symptoms. Along the same line were the findings for their non-verbal skills. Visual perception and visual motor-skill deficits were increased by more than two-fold among children with ADHD symptoms as compared to their normal peers. It is notable that preschool children with ADHD symptoms were in excess of five-fold more likely to present with compromised organizational skills (table 2).

The effect of sex

Both boys and girls with ADHD symptoms were at significantly greater risk to present with abnormal verbal and non-verbal skills as compared to their

Table 1. Comparison of demographic characteristics and overall cognitive skills among preschool children with and without ADHD symptoms (n=4480).

		Non-ADHD (n=4,275) n (%)	ADHD (n=205) n (%)	p*
Sex	Boys	2,415 (56.5%)	158 (6.1%)	
	Girls	1,860 (43.5%)	47 (2.5%)	<0.0001
Parental education level	Low/Middle	2,812 (65.8%)	150 (73.2%)	
	High	1,463 (34.2%)	55 (26.8%)	0.029
Overall verbal skills	Normal	3,490 (81.6%)	132 (64.4%)	
	Abnormal	785 (18.4%)	73 (35.6%)	<0.0001
Overall non-verbal skills	Normal	3,575 (83.6%)	129 (62.9%)	
	Abnormal	700 (16.4%)	76 (37.1%)	<0.0001

Table 2. Odds ratios of children with ADHD symptoms to present with compromised verbal and non-verbal skills (n=4480).

Skills		Non-ADHD (n=4275) n (%)	ADHD (n=205) n (%)	aOR* (95% CI)
Verbal				
Abstract thinking	Normal	3,987 (93.3%)	177 (86.3%)	
	Abnormal	288 (6.7%)	28 (13.7%)	1.97 (1.30–3.00)
Critical reasoning	Normal	3,839 (89.8%)	156 (76.1%)	
	Abnormal	436 (10.2%)	49 (23.9%)	2.58 (1.84–3.62)
Language	Normal	4,018 (94.0%)	177 (86.3%)	
	Abnormal	257 (6.0%)	28 (13.7%)	2.36 (1.55–3.59)
Non-Verbal				
Visual perception	Normal	4,154 (97.2%)	190 (92.7%)	
	Abnormal	121 (2.8%)	15 (7.3%)	2.42 (1.38–4.24)
Visual motor	Normal	3,665 (85.7%)	140 (68.3%)	
	Abnormal	610 (14.3%)	65 (31.7%)	2.61 (1.91–3.55)
Organizational	Normal	4,176 (97.7%)	182 (88.8%)	
	Abnormal	99 (2.3%)	23 (11.2%)	4.92 (3.04–7.97)

*aOR, adjusted odds ratio, adjusting for age

normal counterparts (table 3). Compared to boys, girls seemed to be more likely to present with compromised verbal (aOR 3.05, 95% CI 1.65–5.66 vs 2.30, 1.63–3.24) and non-verbal skills (5.32, 2.95–9.61 vs 2.30, 1.63–3.24). However, most of the confidence intervals of odds ratios presented for boys overlapped those presented for girls (table 3).

The effect of parental education

Following stratification by sex and adjustment for the potential confounding effects of age, and parental educational level, the likelihood of impaired cognitive skills remained increased among preschool children with ADHD symptoms. Specifically, children

Table 3. Occurrence and likelihood of cognitive impairments in preschool children with (versus without) ADHD according to sex.

	Boys (n=2573)			Girls (n=1907)		
	Non-ADHD (n=2,415)	ADHD (n=158)		Non-ADHD (n=1860)	ADHD (n=47)	
Skills	**n (%)**	**n (%)**	**aOR* (95% CI)**	**n (%)**	**n (%)**	**aOR* (95% CI)**
Overall verbal						
Normal	1,899 (78.6%)	101 (63.9%)	2.30	1,591 (85.5%)	31 (66.0%)	3.05
Abnormal	516 (21.4%)	57 (36.1%)	(1.63–3.24)	269 (14.5%)	16 (34.0%)	(1.65–5.66)
Abstract thinking						
Normal	2,213 (91.6%)	137 (86.7%)	1.68	1,774 (95.4%)	40 (85.1%)	3.61
Abnormal	202 (8.4%)	21 (13.3%)	(1.04–2.72)	86 (4.6%)	7 (14.9%)	(1.57–8.29)
Critical reasoning						
Normal	2,133 (88.3%)	119 (75.3%)	2.48	1,706 (91.7%)	37 (78.7%)	2.99
Abnormal	282 (11.7%)	39 (24.7%)	(1.69–3.63)	154 (8.3%)	10 (21.3%)	(1.46–6.14)
Language						
Normal	2,252 (93.3%)	139 (88.0%)	1.89	1,766 (95.0%)	38 (80.8%)	4.45
Abnormal	163 (6.8%)	19 (12.0%)	(1.14–3.13)	94 (5.0%)	9 (19.2%)	(2.09–9.47)
Overall non-verbal						
Normal	1,960 (81.2%)	103 (65.2%)	2.30	1,615 (86.8%)	26 (55.3%)	5.32
Abnormal	455 (18.8%)	55 (34.8%)	(1.63–3.24)	245 (13.2%)	21 (44.7%)	(2.95–9.61)
Visual perception						
Normal	2,329 (96.4%)	146 (92.4%)	2.22	1,825 (98.1%)	44 (93.6%)	3.56
Abnormal	86 (3.6%)	12 (7.6%)	(1.19–4.16)	35 (1.9%)	3 (6.4%)	(1.05–12.0)
Visual motor						
Normal	2,016 (83.5%)	114 (72.2%)	1.95	1,649 (88.7%)	26 (55.3%)	6.31
Abnormal	399 (16.5%)	44 (27.8%)	(1.36–2.81)	211 (11.3%)	21 (44.7%)	(3.49–11.42)
Organizational						
Normal	2,348 (97.2%)	140 (88.6%)	4.51	1,828 (98.3%)	42 (89.4%)	6.80
Abnormal	67 (2.8%)	18 (11.4%)	(2.61–7.79)	32 (1.7%)	5 (10.6%)	(2.52–18.32)

*aOR, adjusted odds ratio, adjusting for age

with ADHD symptoms were significantly more likely to have impaired abstract thinking (3.61, 1.57–8.30), critical reasoning (3.00, 1.46–6.18), and language skills (4.48, 2.09–9.58), respectively. Children among this group were also observed to have an increased likelihood for presenting with impaired non-verbal skills, including visual perception (3.55, 1.05–12.00), visual motor (6.36, 3.51–11.52), and organizational skills (6.80, 2.52–18.31).

Discussion

The study showed a prevalence rate of 4.6% for ADHD symptoms in a nationwide convenience sample of Greek preschool children, which is comparable to previous findings in other countries indicating prevalence rates within the range for similar age groups.[4] Documented variations may be attributed to both socio-cultural as well as methodological factors.[14]

While the evidence in older children is abundant, research is scarce regarding the degree to which cognitive skill deficits may be apparent in preschoolers with ADHD. Therefore, comparisons with prior studies referring to older children with ADHD should be interpreted with caution. In the present study, a school-readiness screening test (A΄ TEST) constructed to be concise and appealing to preschool children was used to assess six cognitive skills. The study findings indicate that, overall, preschool children with ADHD symptoms performed more poorly on cognitive tasks in both verbal and non-verbal subtests, relative to their non-ADHD peers.

Specifically, abstract reasoning skills were the least associated with the presence of ADHD symptoms. Albeit similar findings have not been documented among preschool children, reports among older children have indicated that the presence of ADHD is related to poorer inductive and deductive reasoning skills.[18] On the other hand, children with ADHD symptoms were more likely to exhibit compromised critical reasoning, language, visual perception and visual motor skills compared to their non-ADHD peers, in agreement with previous reports.[6,17–21]

It is noteworthy that organizational skill impairments were the most pronounced, with a five-fold increase in preschoolers with ADHD symptoms. Similar results are reported among older children, indicating that children with ADHD have greater difficulties in carrying out complex planning actions.[22] Impairments in organizational and planning skills may be behavioral expressions of deficits in executive functioning, including attention, impulse control, delay tolerance, and working memory.[19]

In accordance with previous literature,[2] our study confirmed significant sex differences for ADHD symptoms, indicating a male/female ratio of approximately 3/1. Although the incidence of ADHD is higher among preschool boys, affected preschool girls might be more likely to present with compromised cognitive skills possibly associated with school preparedness in the present sample. This finding seems to support the notion that girls with ADHD symptoms display higher rates of speech and language disorders and delays, and may thus develop elevated rates of compromised cognitive and intellectual abilities as compared to their male counterparts.[23] Indeed, studies in older children have demonstrated subtle but significant sex differences in cognition,[24] brain structure[25] and function[26] that could reflect sex-specific neural organization concerning the expression of ADHD. However, the present study did not manage to reach a definitive conclusion concerning this matter.

Parental education has been a major confounder for children's school performance as reported and accepted in the literature.[27] In the adjusted regression analysis for parental educational attainment, the association between compromised cognitive skills and ADHD symptoms persisted. Assuming that children's cognitive skills can be influenced by a number of factors (i.e., genetic endowment, parental educational level), interventions should be directed towards fostering a stimulating home environment for children and encouraging parents to invest in their children. To the extent that cognitive skills are malleable, it is important to create constructive environments, which will assist preschoolers to achieve their potential.

Although our study findings confirm that preschool aged children with ADHD symptoms performed more poorly on several cognitive tasks consisting of verbal and non-verbal measures, further investigation is needed. It seems that abstract thinking is the least affected domain particularly among boys with ADHD symptoms, while organizational skills are affected in both sexes, particularly among girls. It was not unexpected that preschool children with ADHD symptoms perform poorer on measures of cognitive functioning. Nevertheless, the extent of this difference is notable given that these children might commence school at a considerable short coming as compared to their non-ADHD peers.[9]

While current findings provide further evidence corroborating that ADHD among children is associated with notable impairment in cognitive skills, they should be interpreted in light of certain limitations. The absence of probabilistic methods for sample selection restricted to some extent the data representativeness. Moreover, ADHD symptoms in the present sample were assessed through a checklist based on DSM-III-R criteria instead of the currently used DSM-5 classification system.[28] Due to the study design, the presence and potential confounding effects of psy-

chiatric comorbidities, including oppositional defiant disorder, was not assessed. Therefore, a percentage of the identified ADHD cases may be children with underlying conditions (i.e., false-positives). Also, key confounding variables (i.e. low birth weight/intrauterine growth restriction, etc.) were not included in the present analysis. Finally, as all cross-sectional studies are designed, an etiological association between ADHD and impaired cognitive skills cannot be established. Additional longitudinal studies are needed and scheduled to be conducted by our team to elucidate the etiological association between ADHD symptoms and cognitive skills among preschool children.

The strengths of the present study include the large size of the community-based sample of preschool children evaluated, as well as the wide spectrum of verbal and non-verbal cognitive skills assessment tasks applied concurrently.

Concluding, our study confirms that even during preschool years, children with ADHD symptoms are more likely to present with concomitant cognitive difficulties. Thus, screening for the presence of ADHD, as well as cognitive and affective screenings among preschool aged children may facilitate the early detection and determent of the development of cognitive difficulties, particularly among affected girls and subsequently the early intervention for fostering skills that are amenable to change, such as organizational skills and planning. As a result, the study findings reveal the necessity for the evaluation of pre-academic skills among preschool children with ADHD symptoms in order to mitigate unfavorable academic functioning.

Note

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Η διαταραχή ελλειμματικής προσοχής/υπερκινητικότητας (ΔΕΠ-Υ) συνιστά μια νευροαναπτυξιακή διαταραχή, η οποία μπορεί να επηρεάσει αρνητικά την ευεξία και την ακαδημαϊκή επιτυχία των παιδιών. Η έναρξη των συμπτωμάτων συμβαίνει πριν από την ηλικία των 12 ετών και συχνά τα συμπτώματα είναι εμφανή από τα προσχολικά χρόνια. Μάλιστα, προτείνεται ότι η ανίχνευση των συμπτωμάτων μπορεί να αρχίσει από τα τέσσερα έτη. Έχει καταδειχθεί ότι τα παιδιά προσχολικής ηλικίας με ΔΕΠ-Υ μπορεί να παρουσιάζουν χαμηλές προ-ακαδημαϊκές δεξιότητες και να βρίσκονται σε αυξημένο κίνδυνο για πολυάριθμα προβλήματα που σχετίζονται με το σχολείο, όπως λειτουργική έκπτωση κατά τη διάρκεια της δημοτικής εκπαίδευσης και εμμένουσα χαμηλή ακαδημαϊκή επίδοση έκτοτε. Μολονότι τα προσχολικά

χρόνια χαρακτηρίζονται από ταχεία νοητική ανάπτυξη, τα παιδιά προσχολικής ηλικίας με ΔΕΠ-Υ μπορεί να παρουσιάζουν χαμηλότερη νοητική και νευροψυχολογική λειτουργικότητα. Λόγω της πρώιμης έναρξης των συμπτωμάτων της ΔΕΠ-Υ, η διερεύνηση των νοητικών χαρακτηριστικών που συσχετίζονται με αυτή την κατάσταση στα παιδιά προσχολικής ηλικίας θεωρείται σημαντική. Σκοπός της παρούσας εργασίας ήταν να αξιολογήσει τυχόν συσχετίσεις μεταξύ συμπτωμάτων ΔΕΠ-Υ και νοητικών δεξιοτήτων σε παιδιά προσχολικής ηλικίας. Διεξήχθη συγχρονική μελέτη σε εθνικό τυχαίο δείγμα 4.480 παιδιών. Τα συμπτώματα της ΔΕΠ-Υ αξιολογήθηκαν μέσω συνέντευξης με γονείς και εκπαιδευτικούς βασιζόμενης στα διαγνωστικά κριτήρια του DSM-IV-TR. Οι νοητικές δεξιότητες αξιολογήθηκαν μέσω σταθμισμένης ανιχνευτικής δοκιμασίας σχολικής ετοιμότητας (Α΄ ΤΕΣΤ). Η συχνότητα συμπτωμάτων ΔΕΠ-Υ στους συμμετέχοντες ήταν 4,6% (αγόρια/κορίτσια: 3,4/1). Η παρουσία συμπτωμάτων ΔΕΠ-Υ συσχετιζόταν αντίστροφα με τις μη-λεκτικές και λεκτικές νοητικές δεξιότητες˙ συγκεκριμένα, με την αφαιρετική σκέψη (aOR 1,97, 95% CI 1,30–3,00), τις γλωσσικές αναλογίες (2,36, 1,55–3,59), την κριτική ικανότητα (2,58, 1,84–3,62), την οπτική αντίληψη (2,42, 1,38–4,24), και τον οπτικοκινητικό συντονισμό (2,61, 1,91–3,55). Τα παιδιά με συμπτώματα ΔΕΠ-Υ ήταν πέντε φορές πιθανότερο να έχουν χαμηλές οργανωτικές δεξιότητες (4,92, 3,04–7,97). Η αφαιρετική σκέψη ήταν ο λιγότερο επηρεασμένος τομέας ιδιαίτερα στα αγόρια, ενώ οι οργανωτικές δεξιότητες ήταν ο περισσότερο επηρεασμένος τομέας και στα δύο φύλα και πιθανώς περισσότερο στα κορίτσια. Συμπερασματικά, η παρούσα μελέτη επιβεβαιώνει ότι ακόμη και κατά τη διάρκεια των προσχολικών χρόνων, τα παιδιά με συμπτώματα ΔΕΠ-Υ είναι πιο πιθανό να παρουσιάζουν συνυπάρχουσες νοητικές δυσκολίες. Οι ανιχνευτικές δοκιμασίες συμπτωμάτων ΔΕΠ-Υ, καθώς και νοητικών και συναισθηματικών δυσκολιών σε παιδιά προσχολικής ηλικίας μπορούν να διευκολύνουν την έγκαιρη αναγνώριση και πρόληψη αναπτυσσόμενων νοητικών δυσκολιών, και ακολούθως την πρώιμη παρέμβαση για την ενίσχυση δεξιοτήτων επιδεκτικών σε αλλαγές, όπως οι οργανωτικές δεξιότητες και ο προγραμματισμός. Επομένως, τα ευρήματα της μελέτης αποκαλύπτουν την αναγκαιότητα αξιολόγησης των προ-ακαδημαϊκών δεξιοτήτων σε παιδιά προσχολικής ηλικίας με συμπτώματα ΔΕΠ-Υ, με σκοπό την άμβλυνση πιθανής ακαδημαϊκής δυσλειτουργίας.

Λέξεις ευρετηρίου: Διαταραχή Ελλειμματικής Προσοχής/Υπερκινητικότητας (ΔΕΠ-Υ), νοητικές δεξιότητες, παιδιά προσχολικής ηλικίας.

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Research article
Ερευνητική εργασία

Treatment decision-making capacity in hospitalized patients with schizophrenia

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In contemporary medical ethics and clinical practice the autonomy of patients and their right to accept or refuse an offered treatment is acknowledged and respected. Prerequisite for the right of a patient to consent to any medical act is the capacity to make valid decisions regarding his/her treatment. The objective of our study was to assess –for the first time in our country– treatment decision-making capacity of hospitalized patients with schizophrenia; to explore any possible association with demographic and clinical variables; and to compare treatment decision-making capacity of patients with schizophrenia with medical patients' capacity. The sample of patients comprised of 21 patients with schizophrenia who were hospitalized in the psychiatric ward of the General Hospital of Arta, north-west Greece. Those patients' capacity was compared with treatment decision-making capacity of 78 patients hospitalized in the internal medicine ward of the same hospital. All patients' capacity was assessed within 72 hours of admission with the use of the Greek version of the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), a valid and reliable tool for capacity assessment. The performance of patients with schizophrenia on the MacCAT-T was significantly worse than medical patients' performance, suggesting that patients with schizophrenia, as a group had poorer decision-making capacity compared to medical patients. Both negative symptomatology (anergia) and positive symptoms (hostility and suspiciousness), as measured with the use of the Brief Psychiatric Rating Scale (BPRS) were associated with poor performance on the MacCAT-T. Although medical patients as a group scored better in the MacCAT-T, there were several cases that lacked decision-making capacity. In conclusion, patients with schizophrenia had higher incapacity rates than medical patients during the first days of hospitalization. Lack of treatment decision-making capacity is not necessarily the rule for patients with schizophrenia, and capacity is not present in all medical patients. The ability of patients to consent to treatment should be re-assessed during hospitalization, and when restored, informed consent should be obtained by clinicians.

Key words: Autonomy, informed consent, treatment decision-making capacity, medical patients, schizophrenia.

Introduction

In Western countries the autonomy of patients and their right to accept or refuse an offered treatment is acknowledged and respected by contemporary medical ethics and clinical practice. However, patients' decision making capacity (DMC) is a prerequisite for their right to make valid treatment decisions.[1] Treatment DMC refers to the ability of the patient to drive at logical decisions through a process that requires the ability to recruit information related to the decision, to understand this information and to be guided by such a decision. Subsequently, the patient must have the ability to express his/her decision.[2]

The assessment of the patients' treatment DMC has emerged as one of the most important legal and ethical issues in contemporary clinical practice. In the last two decades a number of reports have addressed the DMC assessment in several patients' groups,[3–5] the factors which are related to DMC,[6,7] the need for reliable assessment tools,[8] etc.

European countries, with the exception of the Netherlands and the Great Britain, do not have official guidelines for the assessment of DMC.[9] In Greece the study of DMC involves some legal texts, or international literature reviews, and a few research studies.[10–12] In Greek legislation capacity has not be separated from the general concept of competence, which involves the ability for legal transaction, according to the Civil Law, or charge, according to the Penal Law.[10] According to the Greek legislation age and health, both physical and mental, constitute the criteria for competence. People are labeled as fully competent, fully incompetent and partially competent to act, according to age and the severity of physical or mental morbidity. There is also the concept of transient incompetence, which means that at a certain time-point the person may not be capable of acting for reasons such as drug or alcohol toxicity, high fever etc.

The primary objective of the present study was to explore the capacity of patients with schizophrenia who are hospitalized in a psychiatric ward within a general hospital to make treatment decisions, according to the international definitions.[2] This is the first study on the treatment DMC of schizophrenia patients in our country. Our study focused on patients with schizophrenia because those patients –along with patients with dementia– are the most susceptible to autonomy restrictions, due to lack of insight and cognitive impairment.[6,7] A secondary study objective was to inquire for the correlation of the DMC of patients with schizophrenia with demographic and clinical variables. Another study objective was to compare DMC between inpatients with schizophrenia and patients suffering from a general medical condition who are hospitalized in the internal medicine ward of a general hospital. Those patients' treatment DMC has been recently studied by our team.[13]

Material and methods

Procedures and assessment

Our sample constituted from all patients with schizophrenia who were hospitalized in the psychiatric ward of the General Hospital of Arta, Northwest Greece, over a 2-month period (November-December 2011). This is a 13-bed facility which is usually over-crowded (120% completeness for the year 2012), in which admissions are voluntary or involuntary. A group of 78 patients hospitalized in the internal medicine ward of the same hospital was used as a comparison group. The institutional board had approved the study and oral informed consent had been obtained by all participants or their relatives.

According to the study design all patients with schizophrenia aged ≥18 years who were admitted to our unit during the 2-month interval would be recruited. Patients were excluded if their diagnosis was delusional disorder or another psychotic disorder, if they refused to participate or if they were not Greek speaking. Patients were also excluded if there was a high risk of violent behavior toward the investigators.

The assessment of the patients' treatment DMC was held within the first 72 hours after admission. The collected data included demographic and clinical information, such as gender, age, education, family status, type of current admission (voluntary or involuntary), and total number of admissions. Patients' treatment DMC was assessed with the use

of the Greek version of the MacArthur Competence Assessment Tool for Treatment (MacCAT-T),[12] one of the most widely used tools for capacity assessment. Patients' psychopathology was measured with the use of the BPRS (Brief Psychiatric Rating Scale), a 19-question scale widely used for the evaluation of symptom severity.

The MacCAT-T[14] is a semi-structured interview, usually requiring about 15 to 20 minutes to complete, plus 2–3 minutes to rate that provides relevant information disclosures to patients about their illness, the treatment options and their risks and benefits. In the present study the information about treatment involved the administration of first or second generation antipsychotic compounds. Questions to the patient require feedback, and this is used to assess the degree to which patients are understanding the information and recognizing (appreciating) the relevance of the information for their own condition. Then the clinician explores how patients are thinking through the treatment decision in order to estimate their reasoning abilities. Finally, the patient is asked to state a treatment choice, according to everything that has been considered. Then the interviewer rates the score in each of the four dimensions of the MacCAT-T; Understanding (rating 0–6), Appreciating (rating 0–4), Reasoning (rating 0–8), and Expressing a choice (rating 0–2). The Greek version of the MacCAT-T has been previously found to be reliable and valid in a sample of psychiatric patients.[12]

Statistical analysis

The correlation of categorical variables was estimated with the Pearson Chi Square and when this test could not be applied we used the Fisher's Exact Test. General linear models were used for the estimation of statistical significance in the dimensions of the MacCAT-T. For the comparison of the scores in the four dimensions of the MacCAT-T between patients with schizophrenia and patients with medical disorders we used the Bonferroni test, due to the small sample of patients with schizophrenia. Pearson's r coefficients were computed to assess correlations between MacCAT-T and BPRS scores. The Statistical Package of Social Sciences (SPSS v.18.0) and the STATISTICA 8.0 were used to perform all analyses. The statistical level of significance was set at $p<0.05$.

Results

Sample

Twenty-one patients with schizophrenia were examined. Patients were middle-aged (mean age 44.6 years) and most of them were men (62%), single (76%) and involuntarily admitted (13 patients, 62%). One-third of the patients were first-admitted patients (table 1). This sample of patients was compared with a sample of 78 patients who had been admitted to the internal medicine ward of our hospital during the same time period (table 1). Internal medicine patients were older than patients with schizophrenia, with a mean age of 61.86 years and almost half of them were men. All internal medicine patients had been admitted voluntarily and suffered from neurologic disorders (24.4%), renal disorders (21.8%), digestive disorders (16.7%) or other disorders, such as metabolic and hematologic disorders (37.2%). Seven out of the 78 internal medicine patients (9%) suffered from a mental disorder, such as schizophrenia (n=2), bipolar disorder (n=1), and depression (n=4).

MacCAT-T ratings

Patients with schizophrenia had a mean score of 3.98 on Understanding, 2.14 on Appreciation, 3.71 on Reasoning, and 1.61 on Expressing a choice, respectively (table 2, which also shows the mean scores of internal medicine patients on the four dimensions of the MacCAT-T). As shown in table 2, patients with schizophrenia scored significantly lower than internal medicine patients on all the dimensions of the MacCAT-T. This means that patients with schizophrenia were significantly less capable of making valid treatment decisions than patients who were admitted to the internal medicine ward.

The total score on the MacCAT-T was not obtained because according to its inventors there is no cut-off score for incapacity, and the MacCAT-T was not designed to provide by itself a simple binary capacity assessment. A low score on a single dimension of the MacCAT-T may be indicative of incapacity, even if the scores on the other dimensions are high. However,

Table 1. Patients' characteristics.

	Patients with schizophrenia (n=21)	Internal medicine patients (n=78)
Mean age (years)	44.6 (SD 12.05)	61.8 (SD 21.3)
Gender		
Male	13 (62.0%)	38 (48.7%)
Female	8 (38.0%)	40 (51.3%)
Family status		
Married	1 (4.76%)	45 (57.7%)
Divorced/widowed	4 (19.04%)	14 (17.9%)
Single	16 (76.19%)	19 (24.4%)
Education (in years)		
<9 years	11 (52.38%)	51 (65.4%)
>10 years	10 (37.62%)	27 (34.6%)
Involuntarily admitted	13 (62.0%)	–
Number of previous hospitalizations		
None	6 (28.57%)	
1–2	5 (23.78%)	
>3	10 (47.65%)	

high scores on the MacCAT-T are suggestive of higher capacity than lower scores.

On the basis of these limitations we compared the percentage of patients with schizophrenia and of internal medicine patients, who scored <3 on Understanding, ≤4 on Appreciating, <4 on Reasoning and <2 on Expressing a choice. A total of 76.3% of patients with schizophrenia compared to 92.3% of internal medicine patients scored ≥3 on Understanding. On Appreciation almost all internal medicine patients scored 4, compared to 19.04% of patients with schizophrenia. On Reasoning 76.17% of patients with schizophrenia scored ≥4, compared to 87.2% of internal medicine patients. On Expressing a choice almost all internal medicine patients (98.7%) scored 2, compared to 66.6% of patients with schizophrenia. Taken together these results suggest that patients with schizophrenia have lower capacity rates than internal medicine patients, but this does not mean that all patients with schizophrenia are incapable of making treatment decisions, whereas on some dimensions of the MacCAT-T, such as Reasoning, both groups scored almost equally high. Moreover, not all internal medicine patients are capable of making treatment decisions, according to the MacCAT-T ratings.

MacCAT-T and other variables

With the application of Bonferroni test we assessed the impact of education on the MacCAT-T dimensions of Understanding, Appreciating, Reasoning and Expressing a choice and we found that patients with schizophrenia scored statistically significant lower (p values <0.01, <0.00001, <0.0001, <0.051, respectively) than internal medicine patients, regardless of the years of education (less or more than 9 years). Age, way of admission in the psychiatric clinic (voluntarily or involuntarily), and the total number of admissions do not correlate with the scores on the MacCAT-T.

Table 3 presents the statistically significant correlations of psychopathology, as measured with the BPRS with the scores on the MacCAT-T dimensions. The total score on the BPRS was not correlated significantly with the MacCAT-T scores, but the scores on some items of BPRS were correlated with dimensions of the MacCAT-T. More specifically, the score on the Disorientation item of BPRS was found to be correlated with the scores on all MacCAT-T dimensions, whereas the score on Uncooperativeness was correlated to the score on Appreciating. Regarding the correlations of the 5 BPRS factors with the

Table 2. Scores on the dimensions of the MacCAT-T of patients with schizophrenia and internal medicine patients.

MacCAT-T dimensions	Patients with schizophrenia (n=21)	Internal medicine patients (n=78)	Bonferroni test
Understanding			
Mean score	3.98 (SD 1.78)	5.22 (SD 1.23)	p<0.0001
6–5.1	7 (33.3%)	57 (73%)	
5–4.1	3 (14.2%)	8 (10.3%)	
4–3.1	6 (28.5%)	7 (8.9%)	
3–2.1	2 (9.5%)	4 (5.1%)	
<2	3 (14.2%)	2 (2.5%)	
Appreciating			
Mean score	2.14 (SD 1.31)	3,92 (SD 0.50)	p<0.0001
4	4 (19.04%)	76 (97.4%)	
3	4 (19.04%)	1 (1.28%)	
2	5 (23.8%)	1 (1.28%)	
1	6 (28.5%)	–	
0	2 (9.5%)	–	
Reasoning			
Mean score	3.71 (SD 2.39	6.20 (SD 1.92)	p<0.0001
8	–	27 (34.6%)	
7–6	4 (19%)	32 (41%)	
5–4	8 (38%)	9 (11.5%)	
3–2	4 (19%)	8 (10.2%)	
1–0	5 (23.8%)	2 (2.6%)	
Expressing a choice			
Mean score	1.61 (SD 0.66)	1.97 (SD 0.22)	p<0.00015
2	14 (66.6%)	77 (98.72%)	
1	4 (19.04%)	1 (1.28%)	
0	3 (14.2%)	–	

MacCAT-T scores it was found that Anergia was significantly, negatively correlated with Understanding, Reasoning, and Expressing a choice, whereas Hostility-Suspiciousness was correlated negatively to Appreciating and to Expressing a choice. It seems that both negative (Anergia) and positive symptomatology (Hostility-Suspiciousness) reduce significantly the patients' performance on the MacCAT-T.

Discussion

This is the first study in a sample of Greek patients with schizophrenia, hospitalized in a psychiatric ward of a general hospital, involving their capacity to make treatment decisions. Analysis showed that patients with schizophrenia scored significantly lower than internal medicine patients in all the dimensions of the MacCAT-T, and this suggests that patients with schizophrenia are less capable of making treatment decisions than internal medicine patients. The results are in accordance with other published studies which report incapacity rates up to 52% in patients with schizophrenia and up to 35% in internal medicine patients,[3–6,15] which often goes undetected by treating physicians.[16] Jeste et al[15] in their study which compared patients with schizophrenia and non-psychiatric patients reported that 10–52% of the schizophrenia patients and 0–18% of the non-psychiatric patients lacked DMC, as estimated with the use of the MacCAT-T. Palmer et al[17] compared 59 middle- and old-aged patients with schizophrenia or

Table 3. Correlations (Pearson's) between the scores on the MacCAT-T and the scores on the BPRS for 21 patients with schizophrenia.

BPRS	Understanding	Appreciating	Reasoning	Expressing a choice
Total BPRS score	–0.121	–0.354	–0.323	–0.380
Factor scores				
Anergia	–0.460 (0.036)		–0.590 (0.005)	–0.561 (0.008)
Hostility-Suspiciousness		–0.558 (0.009)		–0.435 (0.049)
Items				
Uncooperativeness		0.647 (0.002)		
Disorientation	–0.777 (0.000)	0.560 (0.008)	–0.755(0.000)	–0.642 (0.002)

* Only significant correlations with BPRS factor and item scores are displayed (p values in parentheses). There was no significant correlation of MacCAT-T scores with other factors or items of BPRS.

schizoaffective disorder with a sample of 38 healthy subjects, with the use of the MacCAT-T, and found that patients with a psychotic disorder scored lower on the dimension of Understanding. More recently, Owen et al[5] compared the capacity of a sample of 125 psychiatric in-patients, most of whom suffered from psychotic or severe affective disorders, with the capacity of 164 internal medicine patients, and found that 39% of psychiatric patients and 13% of the internal medicine patients were incapable of making treatment decisions. The score on Understanding was correlated to DMC in both samples. When the score on Understanding was high DMC was found to be correlated with the score on Appreciating for psychiatric patients and with the score on Reasoning, for the internal medicine patients. In a systematic review of 43 published studies on DMC in internal medicine patients Sessums et al[16] found rates of incapacity to be 18–35%, which often went unrecognized by treating physicians.

The results of our study should be interpreted with caution, since the capacity of patients to make decisions about their health and their treatment is important and has implications for clinical practice; patients rated as "capable" may decide for their treatment, whereas "incapable" patients lose their autonomy and treatment decisions may be received by another party. Clearly, our study involved DMC in patients with schizophrenia as measured within the first 72 hours of hospitalization. This means that patients' capacity does not refer to their competence as a whole, but rather is an estimation of their abilities to drive at valid treatment decisions. Moreover, DMC in this study involves patients' abilities within the first 72 hours of admission, at the time they were assessed, and not permanently.

The correlations of DMC as measured with the MacCAT-T with psychopathology as measured with the BPRS, showed that incapacity in patients with schizophrenia is correlated both with positive and negative symptomatology. Incapacity was correlated with disorientation, a BPRS item which refers to the general cognitive function of the patient. Disorientation was found to be correlated negatively and statistically significantly with the scores on all MacCAT-T dimensions (Understanding, Appreciating, Reasoning, Expressing a choice), in accordance with other studies.[17,18] On the other hand, a small proportion of internal medicine patients were rated as incapable of making treatment decisions. This may mean that several factors beyond the symptomatology of schizophrenia affect patients' DMC and should be inquired for and be taken into account by treating physicians.

Incapacity of making valid treatment decisions is not always present in patients with schizophrenia, and capacity is not always present in internal medicine patients. As a group patients with schizophrenia are less capable of making treatment decisions than internal medicine patients, yet a proportion of them maintain DMC, even if they are multi-

admitted patients. Studies on DMC in patients with schizophrenia are heterogeneous but they suggest that the diagnosis of schizophrenia does not always imply incapacity.[15] Moreover, lack of DMC does not necessarily mean that patients will refuse the offered treatment. Patients with schizophrenia may often receive a treatment regimen despite that they do not agree with the information about their disorder, or they do not fully recognize the need for treatment.[19]

Limitations

The present study has some limitations. The sample of patients with schizophrenia is small and there is no control group of patients with other psychiatric diagnoses, such as bipolar disorder. Moreover, the sample of the study has not been matched to the control sample of internal medicine patients for gender and age. During the study period the mean age of patients who had been admitted to the internal medicine ward (61.8 years) was higher than the mean age of patients with schizophrenia (44.6 years) who had been admitted to the psychiatric ward. The recruitment of a sufficient sample size of younger internal medicine patients would have take a much longer interval, because, by definition, physical morbidity is less common in younger people. Importantly, higher age was associated with incapacity in internal medicine patients,[13] and if these patients had been matched to patients with schizophrenia the observed differences would probably have been even greater. Within the group of patients with schizophrenia comparisons regarding DMC were not made between the voluntarily (n=8) and involuntarily (n=13) admitted patients, because the number would be too small to find a reliable correlation.

Implications of the study

The results of this study suggest that a significant proportion of patients with schizophrenia during early hospitalization may lack DMC. For those patients treatment decisions are made by treating psychiatrists on the basis of the patients' best interests. The capacity of patients should be reassessed in due time, and when patients would be considered as capable of making treatment decisions informed consent to treatment should be obtained. This is a way to promote the autonomy and the human rights of patients in the field of the treatment of psychotic disorders. The assessment of DMC in clinical stable, community patients with schizophrenia in contrast to the acute phase of illness is an interesting objective to be addressed by future research.

Ικανότητα λήψης θεραπευτικών αποφάσεων από νοσηλευόμενους ασθενείς με σχιζοφρένεια

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Στη σύγχρονη ιατρική ηθική και κλινική πρακτική η αυτονομία του ασθενούς και το δικαίωμά του να συναινέσει ή να αρνηθεί τη συναίνεσή του στις ιατρικές πράξεις είναι αναγνωρισμένο και σεβαστό. Η άσκηση αυτού του δικαιώματος προϋποθέτει την ύπαρξη, εκ μέρους του ασθενούς, της ικανότητας να αποφασίσει αν θα συναινέσει ή όχι στην ιατρική πράξη. Σκοπός της μελέτης ήταν να διερευνηθεί για πρώτη φορά στη χώρα μας η ικανότητα ασθενών με σχιζοφρένεια που νοσηλεύονται σε Ψυχιατρική Κλινική Γενικού Νοσοκομείου στην Ελλάδα, να αποφασίζουν για τη θεραπεία

τους και να αναζητηθούν πιθανές συσχετίσεις της ικανότητας με δημογραφικές και κλινικές μεταβλητές. Ακόμη, να συγκριθεί η ικανότητα λήψης θεραπευτικών αποφάσεων των ασθενών με σχιζοφρένεια με την αντίστοιχη άλλων ασθενών που πάσχουν από σωματικές νόσους και νοσηλεύονται σε Παθολογική Κλινική Γενικού Νοσοκομείου. Το δείγμα της μελέτης αποτέλεσαν 21 ασθενείς με διάγνωση σχιζοφρένεια που νοσηλεύονταν στην ψυχιατρική κλινική του Γενικού Νοσοκομείου Άρτας και η σύγκριση έγινε με 78 ασθενείς που νοσηλεύονταν στην παθολογική κλινική του ίδιου νοσοκομείου. Η ικανότητα των ασθενών να λαμβάνουν αποφάσεις για τη θεραπεία τους αξιολογήθηκε τις πρώτες 72 ώρες από την εισαγωγή με τη χρήση του σταθμισμένου στην ελληνική γλώσσα MacArthur Competence Assessment Tool for Treatment (MacCAT-T). Η απόδοση των ασθενών με σχιζοφρένεια ήταν σημαντικά μικρότερη σε όλα τα λήμματα του MacCAT-T, υποδηλώνοντας ότι υστερούσαν στην ικανότητα λήψης θεραπευτικών αποφάσεων σε σχέση με τους παθολογικούς ασθενείς. Τόσο η αρνητική συμπτωματολογία (ανεργία) όσο και η θετική συμπτωματολογία (επιθετικότητα-καχυποψία), όπως εκτιμήθηκαν με την κλίμακα Brief Psychiatric Rating Scale (BPRS) βρέθηκε να σχετίζονται με μειωμένη απόδοση στο MacCAT-T. Αν και οι παθολογικοί ασθενείς, ως ομάδα, απέδιδαν καλύτερα στο MacCAT-T, υπήρχαν περιπτώσεις που δεν είχαν την απαιτούμενη ικανότητα λήψης αποφάσεων για τη θεραπεία τους. Συμπερασματικά, οι ασθενείς με σχιζοφρένεια υστερούν σημαντικά σε σχέση με τους παθολογικούς ασθενείς στην ικανότητα λήψης θεραπευτικών αποφάσεων κατά τις πρώτες μέρες της νοσηλείας τους. Η υστέρηση αυτή δεν είναι δεδομένη για όλους τους ασθενείς με σχιζοφρένεια, όπως αντίστοιχα η ικανότητα λήψης αποφάσεων δεν είναι δεδομένη για όλους τους παθολογικούς ασθενείς. Η ικανότητα των ασθενών να συμμετέχουν στις θεραπευτικές αποφάσεις πρέπει να επανεκτιμάται και όταν κριθεί ότι επανήλθε, να αναζητείται η λήψη συναίνεσης των ασθενών στη χορηγούμενη αγωγή.

Λέξεις ευρετηρίου: Αυτονομία, συναίνεση, ικανότητα λήψης θεραπευτικών αποφάσεων, παθολογικοί ασθενείς, σχιζοφρένεια.

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Research article
Ερευνητική εργασία

Attitudes of psychology students to depression and its treatment: Implications for clinical practice

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Stigma and mental health literacy affect access to and quality of treatment of major depression. Though mental health professionals seem better able to recognize major depression than the general public, they often hold similarly stigmatizing attitudes towards people suffering from the disorder. These attitudes are shaped jointly by the public stigma attached to mental illnesses as well as by the content and delivery of mental health professionals' undergraduate training. In line with this, the present study aimed to explore psychology students' ability to recognize major depression, their attitudes towards the disorder, and their views surrounding helpfulness of various interventions. A random sample of 167 undergraduate students was recruited from the psychology department of one public university in Athens. During one university hour, students were administered a vignette describing a woman fulfilling the DSM-IV criteria for major depression. A self-report questionnaire exploring students' recognition abilities, attitudes to depression and views on the helpfulness of various treatment modes was also administered. In total, 80.2% of students correctly recognized major depression from the vignette. Concerning their attitudes, students were unsure about the illness and ambivalent towards the person who suffers from it. With regard to available treatments for depression, students considered discussion with a friend to be the most helpful intervention. Counseling, cognitive behavioural therapy and psychoanalysis were also viewed in a positive light. On the contrary, antidepressants were not deemed helpful by most students. Finally, recognition of as well as attitudes towards depression and its treatments seemed to improve during the second year of undergraduate study; however they remained unchanged thereafter. Consistent with these, psychology students seem to have only a rudimentary knowledge on depression, that cannot not be qualified as mental health literacy. The core misconception espoused pertains to the view that major depression is not a medical illness; a finding which can also be interpreted in light of the lingering controversy on the medicalization of normal sadness and human predicament. The clinical implications of these findings are substantial. Mental health professionals-educators should reflect on their own beliefs and attitudes towards depression, as they may convey stigmatizing messages to their students and thus perpetuate the stigmatization of the illness. Concomitantly, psychology students' attitudes to depression and its treatment might render them incapable of understanding their patients, responding to their needs and providing them with appropriate help, while they may hinder their effective collaboration with psychiatrists.

Key words: Stigma, discrimination, stereotypes, mental health professionals, beliefs, affective disorders.

Introduction

Depression is a pressing public health concern worldwide.[1] In spite of its substantial burden, the disorder remains largely under-treated with less than half of those suffering from an episode seeking professional help for it[2] and a similar proportion among those contacting health services being neither explicitly recognized as depressed nor offered appropriate treatment.[3,4] Help seeking, recognition and adequate management of depression is influenced by a broad array of factors; however stigma and discrimination emerge as preponderant barriers to these processes.[5,6]

The stigma surrounding mental illness has been largely explored in relation to schizophrenia, the most stigmatized psychiatric disorder.[7] Nonetheless, a growing body of research has demonstrated that stigma and discrimination are a primary concern for people with depression as well.[8,9] Laziness, character weakness, personal responsibility for the illness and unpredictability are the main characteristics attributed to them.[10,11] These in turn may influence lay beliefs about the effectiveness of different treatment strategies: confiding to close friends, taking vitamins or minerals or following a special diet are all regarded as helpful interventions for coping with depression.[12] Limited "mental health literacy" –i.e. knowledge and beliefs about mental disorders which aid their recognition, management and prevention[13]– has been suggested to underlie stigma.[14,15]

Studies seeking to address the role of mental health literacy argue for a continuum running from lay beliefs to professional knowledge.[13,14,16,17] Nonetheless, a recent review on the topic calls attention to mental health professionals' stereotypical views about mental disorders and their ambivalent attitudes towards people who suffer from them.[18] Concerning major depression, mental health professionals seem better able to recognize depression, as compared to the general population; however, their "mental health literacy" seems imperfect as a substantial number of them classified a major depression event as a crisis situation.[17] In the same study, mental health staff demonstrated an equal degree of desired social distance from people with major depression as the general population. In this rationale, anti-stigma interventions should prioritize targeting mental health providers' stigma, as these professionals often serve as role models and opinion leaders on mental health issues.

In Greece, depression is largely treated in the private sector and in community mental health centers, as there is no well-established Primary Care in the country.[19] In this context, mental health providers –rather than general practitioners– are responsible for treating the disorder and hence their beliefs and attitudes are of outmost importance. Furthermore, mental health staff's duty is also to foster attitudes of acceptance towards people with depression in the community. To this end, mental health practitioners need to reflect on their own attitudes, which are largely shaped by their experiences and professional training.[18]

Consistent with this, the present study endeavored to investigate the impact of undergraduate professional training on psychologists' attitudes to depression and its available treatments. The selection of psychologists was done so on the grounds of being the professional group most frequently interacting with people with depression in community mental health settings in Greece. This study is particularly important, as psychology students can attain a license to practice upon graduation, without further training.

Therefore, the study objectives were:

– To explore psychology students' ability to recognize major depression and their attitudes towards it.
– To explore students' beliefs about the helpfulness of various interventions for treating major depression
– To investigate the impact of education (year of study) on students' recognition abilities, attitudes and views.

Method

Sample

A total of 167 undergraduate psychology students, recruited from the psychology department of one university, took part in the present study. Participants were approached, after randomly selecting a mandatory class from each year of study. Students who had taken part in student-exchange programs (e.g. ERASMUS) were excluded, as their experience in other universities might have jeopardized the inter-

nal validity of the findings. The characteristics of the sample can be found in table 1.

Statistical analysis revealed no differences in the sample composition as a function of the year of study, with the exception of age ($p<0.05$); lending support to the comparability of the sub-samples.

Among the 4-year students, all of them had completed their clinical placement: 23 (53%) in community mental health centers, 10 (23.2%) in psychiatric departments of general hospitals, 7 (16.3%) in psychiatric hospitals and 3 (7%) in rehabilitation services. Roughly 93% of them reported interacting with people with depression during their placement.

Measures

Students completed the questionnaire after reading a vignette describing a woman, who fulfilled DSM-IV criteria for a major depressive episode.[20] Prior to the beginning of the study, the vignette was distributed to 5 mental health professionals (2 psychiatrists, 2 psychologists and 1 social worker), who unanimously confirmed the diagnosis.

Students' abilities to recognize major depression was assessed with the question: "Based on the text you have read, do you think Mary has a mental illness? If yes, please define the illness and its severity".

For assessing attitudes towards the person in the vignette, the Depression Stigma Scale–Personal (DSS-Personal) developed by Griffiths and colleagues[21] was incorporated in the questionnaire. The scale consists of 9 items rated on a five-point Likert Scale ranging from strong agreement ("1") to strong disagreement ("5"). The composite scale score ranged from 9 to 45, with higher values indicating higher levels of stigma. The internal consistency of the scale was considered good (Cronbach a=0.72).

Participants were also asked to rate the helpfulness of various interventions for the person in the vignette: psychoanalysis, CBT, counseling, Art Therapy, anti-depressants, vitamins, antibiotics, anti-psychotic medications, lifestyle changes (eating properly and exercising), yoga, self-help books and discussing her problems with a friend. Students had to assign a rating on a scale from 0 (not helpful at all) to 100 (absolutely helpful).

Students' gender, age, place of origin, familiarity with mental illness, year of study and information about their clinical placement were also obtained. Data were collected in the form of a self-completed questionnaire during April 2012.

Curriculum

The undergraduate program in Psychology had a 4-year duration. In particular, it required students to undertake 42 mandatory modules covering various disciplines within the realm of Psychology: Clinical, Developmental, Social, Experimental and Cognitive

Table 1. Sample characteristics.

Variable	Total n=167	1st year n=41	2nd year n=42	3rd year n=41	4th year n=43
Gender					
Male	50 (29.9%)	11 (26.8%)	13 (31%)	12 (29.3%)	14 (32.6%)
Female	117 (70.1%)	30 (73.2%)	29 (69%)	29 (70.7%)	29 (67.4%)
Family status					
Single	162 (97%)	40 (97.6%)	42 (100%)	39 (95.1%)	41 (95.3%)
Married	5 (3%)	1 (2.4%)	0 (0%)	2 (4.9%)	2 (4.7%)
Place of origin					
Athens	96 (57.5%)	22 (53.7%)	24 (57.1%)	24 (58.5%)	26 (60.5%)
Districta	71 (42.5%)	19 (46.3%)	18 (42.9%)	17 (41.5%)	17 (39.5%)
Personal experience with mental illness					
Yes	92 (55.1%)	23 (56.1%)	23 (54.8%)	21 (51.2%)	25 (58.1%)
No	75 (44.9%)	18 (43.9%)	19 (45.2%)	20 (48.8%)	18 (41.9%)
Age	21.05 (2.76)	19.44 (2.1)	20.2 (0.89)	21.49 (3.92)	23.08 (4.1)

Psychology. Furthermore, students also had to select 24 optional modules from the same disciplines. Regarding Clinical Psychology training, students have to attend 6 mandatory classes (1 during the 1st year, 4 during the 2nd year, 1 during the 3rd year and 1 during the 4th) and 6 electives. Moreover, during their final year of study, they attained some clinical experience on the field by spending 3 months in a mental health service.

In a nutshell, psychology undergraduates had completed 13 modules on Clinical Psychology and 3 months of clinical placement upon graduation.

Procedure

One mandatory class was randomly selected from each year for distributing questionnaires. Two professionals from the research team visited the class, introduced themselves and administered the questionnaires. Data collection occurred the same day for all years in order to avoid contamination of results.

The research protocol was approved by the EPIPSI Ethics Committee, in accordance to the provisions of Helsinki in 1995.

Analysis

In terms of descriptive statistics, frequencies were used for categorical variables and means with standard deviations for continuous variables.

For investigating differences among the helpfulness ratings for the various interventions for depression, a Repeated Measures ANOVA was performed.

Concerning the recognition of major depression, a categorical variable with 3 levels was created: erroneous labeling (including participants who responded that the person in the vignette does not suffer from a mental illness as well as those who stated the wrong diagnosis), almost correct labeling (entailing participants who recognized depression but underestimated its severity) and correct labeling (including participants who could identify both the disorder and its severity). For exploring the association between recognition and year of study, chi-square analysis was performed. For investigating differences in attitudes to depression and in helpfulness of various interventions as a function of the year of study, one-way ANOVA was performed. Post hoc exploration using the Bonferroni test was conducted for the significant results.

Results

The vast majority of the sample could identify that the person has a mental illness (98.2%). Nonetheless, 11 students (6.6%) misclassified the person in the vignette as suffering from anxiety or eating disorder. Moreover, 19 students (11.4%) identified the episode as a major depressive one; however, they underestimated its severity. Congruent with these, the correct diagnosis was assigned by 134 students (80.24%). Regarding their attitudes, students appeared unsure about depression and ambivalent towards the person in the vignette (table 2).

Table 2. Students' beliefs and attitudes towards major depression.

	Disagree	Unsure	Agree
People with a problem like Mary's could snap out of it, if they wanted	31.5%	13.3%	55.2%
A problem like Mary's is a sign of personal weakness	31.5%	24.5%	44.1%
Mary's problem is not a real medical illness	35.0%	19.6%	45.5%
People with a problem like Mary's are dangerous	90.2%	3.5%	6.3%
It is best to avoid people with a problem like Mary's, so that you don't develop this problem	96.5%	2.8%	0.7%
People with a problem like Mary's are unpredictable	51.7%	32.2%	16.1%
If I had a problem like Mary's I would not tell anyone	79.7%	12.6%	7.7%
I would not employ someone if I knew they had a problem like Mary's	81.8%	6.3%	11.9%
I would not vote for a politician If I knew they suffered by a problem like Mary's	76.9%	13.3%	9.8%

Concerning available interventions for depression, participants considered discussing with a friend to be the most helpful intervention for depression. As indicated in table 3, counseling, CBT and psychoanalysis were also viewed in positive light by students. A Repeated Measures ANOVA with Greenhouse-Geisser corrections demonstrated that differences reached statistically significant levels: F (6.88, 962.95)=114.31, p<0.01.

Concerning the impact of training, recognition abilities displayed a statistically significant association with year of study: x^2 (6)=18.14, p<0.01. In particular, the most knowledgeable group about depression were students going through their 2nd year of study, with 93.5% of them recognizing both the presence of major depression as well as its severity. The corresponding rates for the other groups were: 57.7% for the 1st-year of study group, 87.9% for the 3rd year of study group and 80% for the 4th year of study group. Similarly, concerning the association between year of study and attitudes to depression, one-way ANOVA revealed a statistically significant effect: F (3,163)=8.78, p<0.01. In particular, the mean value for the 1st-year of study group was 22.74 (SD=4.91), for the 2nd year of study group was 19.26 (SD=2.7), for the 3rd year of study group was 19.94 (SD=4.52) and for the 4th year of study group was 18.9 (SD=3.31). Post hoc exploration utilizing the Bonferroni test pinpointed a statistically significant difference between the 1st year of study group and the remaining three. In line with this, attitudes towards depression seem to improve after the first year of study only to reach a plateau henceforth.

Regarding helpfulness ratings for interventions, the four groups displayed statistically significant differences with respect to "vitamins", "yoga" and "self-help books" interventions, with the 1st year of study group displaying the highest ratings in all three categories: F(3,163)=4.98, p<0.01 for vitamins, F(3,163)= 4.27 for yoga and F(3,163)=4.07, for self-help books. Post hoc exploration with the Bonferroni test showed that the statistically significant difference occurred between the 1st year students and the remaining three groups.

Discussion

Study findings indicate that students were capable of identifying major depression; however, the overall pattern of results shows that their knowledge is rather crude. This finding draws a clear distinction between recognizing a clinical case and acquiring mental health literacy, while raising important questions regarding the valid assessment of the latter.

With respect to students' attitudes, the majority of them endorsed the view that people with depression are weak and can readily snap out of the illness; while depression was not acknowledged as being a real medical illness. In the case of character weakness students' attitudes resemble those of community samples.[10,11] Not conceptualizing major depression as a medical illness can possibly be accounted for by the social orientation of the university, from which

Table 3. Students' beliefs regarding the helpfulness of various interventions for depression.

To what extent from 0 to 100 do you think the following interventions are helpful for treating Mary's problems?	**Mean**	**SD**
Discussing with a friend	67.6	6.1
Counseling	64.1	4.1
Cognitive-Behavioral Therapy	59.6	7.5
Psychoanalysis	58.6	6.6
Lifestyle changes (exercising and eating properly)	53.8	7.5
Art Therapy	51.0	7.7
Yoga and/or alternative relaxation activities	48.0	6.6
Self-help books	37.2	4.8
Antidepressant medication	33.1	6.9
Vitamins	31.8	8.1
Antipsychotic medication	8.7	4.1
Antibiotics	3.3	6.4

participants were recruited. Alternatively, students' conflicting responses echoes the lingering controversy regarding the medicalization of normal sadness and human predicament.[22,23] The particular divide in opinion is also conspicuous in the narratives of people with depression, where misunderstanding about depression as an illness has emerged as a preponderant theme in a qualitative study.[8] While some people with depression were fearful that others might see them as dangerous due to their mental illness, a roughly equal proportion expressed the opposite view, preferring depression to be perceived as a mental illness. Perhaps in this way, people with depression believe that others will see them as less responsible for their condition and therefore will not blame them.

Students' ratings concerning the helpfulness of the various interventions are along similar lines. Their confidence on non-medical interventions indicates either ignorance about treatment guidelines for the disorder or their objection to the biomedical perspective. The popularity of certain non professional interventions (e.g. discussing with a friend, lifestyle changes, yoga, etc.) among them is consistent with lay responses in other surveys.[12,16] It is noteworthy that the present study could not disentangle between students' overall objection to medication or to psychiatric medication in particular.

The impact of education on influencing students' recognition abilities, their attitudes towards depression and their treatment preferences for it was found to be constricted to the first two years of undergraduate training. It seems that after these two years, any further improvement is hindered. This finding runs in parallel with the content of the curriculum, where the vast majority of clinical modules are delivered during the second year. Students seem to enter undergraduate training with lay beliefs and attitudes towards depression and its treatment, while during the first two years of study they seem to acquire some basic clinical knowledge. Nonetheless, this knowledge does not appear to become sophisticated in the ensuing years and students graduate without having acquired an in-depth understanding of the illness.

Surprisingly, the clinical placement they undertake during the 4th year does not seem to influence their mental health literacy levels. This clinical placement is relatively diverse with some students spending 3 months in inpatient units and others in community settings. The majority of 4th year students reported interacting with people with depression during their clinical placement; however, the context and characteristics of this interaction are unknown. In this reasoning, the effect of contact on stigma endorsement[24] may be different in patients with depression as compared to those with schizophrenia. For example, interacting for one hour with a person with schizophrenia might be enough time for realizing that he/she does not suffer from split personality. On the other hand, interacting one hour with a person suffering from depression might not be enough to reverse the character weakness stereotype.

Clinical implications

The clinical implications of the present study are substantial. Based on findings, it seems that the mental health professionals who teach psychology students should reflect on their own beliefs and attitudes towards depression and the available treatments for it, as they might convey stereotypical views to their pupils and in this way enhance stigma. As psychology undergraduates acquire a license to practice upon graduation, their attitudes towards depression might render them incapable of understanding their patients in depth, responding to their needs and providing them with appropriate treatment. Their negative views on the helpfulness of antidepressants, as well as disagreement with the biomedical model might introduce drawbacks in their collaboration with psychiatrists in the context of community multi-disciplinary teams. As mental health professionals often serve as role models for mental health issues, their stigma endorsement might contribute to the perpetuation of public stigma with adverse repercussions on people's help seeking behaviors and the broadening of the treatment gap.

Limitations

The study was not without its shortcomings. The sample was drawn from one psychology department in the country and therefore present findings should not be extrapolated to all psychology undergraduates in the country. Furthermore, due to the cross-sectional design of the study, one cannot rule out the presence of unmeasured confounders In other words, students belonging to different years of study might display dissimilarities in their characteristics, which were not measured and controlled for in the present analysis. Following-up students from year 1 to year 4 would have allowed to draw clearer conclusions.

Στάσεις των φοιτητών ψυχολογίας απέναντι στην κατάθλιψη και τη θεραπεία της: Επιπτώσεις στην κλινική πρακτική

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Το στίγμα και οι γνώσεις σε ζητήματα ψυχικής υγείας (“mental health literacy”) έχει βρεθεί να επηρεάζουν την αναζήτηση βοήθειας και την ποιότητα φροντίδας στη μείζονα κατάθλιψη. Αν και οι επαγγελματίες ψυχικής υγείας μπορούν εξ ορισμού να αναγνωρίσουν την ύπαρξη κατάθλιψης πιο εύκολα από τον γενικό πληθυσμό, συχνά διατηρούν εξίσου στιγματιστικές στάσεις. Αυτές οι στάσεις διαμορφώνονται υπό την επιρροή του στίγματος, αλλά και από την αντίστοιχη εκπαίδευση που λαμβάνουν. Έτσι, ο στόχος της παρούσας μελέτης είναι να διερευνήσει την ικανότητα προπτυχιακών φοιτητών Ψυχολογίας στην ανίχνευση της μείζονος κατάθλιψης, τις στάσεις απέναντι στη νόσο και τις αντιλήψεις τους αναφορικά με τη χρησιμότητα ειδικών παρεμβάσεων. Τυχαίο δείγμα 167 προπτυχιακών φοιτητών Ψυχολογίας στρατολογήθηκαν από δημόσιο πανεπιστήμιο της Αθήνας. Κατά τη διάρκεια μιας πανεπιστημιακής ώρας διδασκαλίας, οι φοιτητές διάβασαν τη βινιέτα που τους χορηγήθηκε, η οποία περιέγραφε μια γυναίκα που πληρούσε τα διαγνωστικά κριτήρια μείζονος κατάθλιψης, ενώ συμπλήρωσαν το ερωτηματολόγιο της μελέτης. Συνολικά το 80,2% των φοιτητών αναγνώρισε την παρουσία κατάθλιψης στη βινιέτα. Αναφορικά με τις στάσεις τους απέναντι στη νόσο, οι φοιτητές βρέθηκε να είναι αναποφάσιστοι σε σχέση με την ασθένεια, ενώ χαρακτηρίζονταν από αμφιθυμία προς τους ανθρώπους που πάσχουν από αυτήν. Αναφορικά με τις διαθέσιμες παρεμβάσεις για τη νόσο, οι φοιτητές βρέθηκε να θεωρούν τη συζήτηση με κάποιον φίλο ως την πιο αποτελεσματική παρέμβαση. Η συμβουλευτική, η γνωσιακή-συμπεριφορική θεραπεία και η ψυχανάλυση θεωρήθηκαν επίσης βοηθητικές θεραπείες. Αντίθετα, η αγωγή με αντικαταθλιπτικά δεν θεωρήθηκε ιδιαιτέρως βοηθητική. Τέλος, οι ικανότητες αναγνώρισης της νόσου και οι στάσεις απέναντι στην κατάθλιψη και τη θεραπεία της φαίνεται να βελτιώνονται κατά το δεύτερο έτος φοίτησης στο Πανεπιστήμιο και να παραμένουν οι ίδιες έκτοτε. Επομένως, από τα αποτελέσματα προκύπτει πως οι φοιτητές Ψυχολογίας έχουν υποτυπώδεις γνώσεις για την κατάθλιψη, μακριά από την έννοια του “mental health literacy”. Η βασική εσφαλμένη αντίληψη για την κατάθλιψη αφορά στην πεποίθηση ότι η νόσος δεν αποτελεί ιατρική ασθένεια, εύρημα το οποίο μπορεί να εξηγηθεί και από την αντιπαράθεση σχετικά με την ιατρικοποίηση της φυσιολογικής θλίψης. Οι προβληματισμοί που εγείρονται από τα εν λόγω ευρήματα σε σχέση με την κλινική πρακτική είναι σημαντικοί. Οι επαγγελματίες ψυχικής υγείας που έχουν εκπαιδευτικό ρόλο οφείλουν να αναλογισθούν τις δικές τους στάσεις απέναντι στην κατάθλιψη, καθώς μπορεί να μεταδίδουν στερεοτυπικά μηνύματα στους φοιτητές. Παράλληλα, οι προκατειλημμένες στάσεις των φοιτητών παίζουν αποτρεπτικό ρόλο στην ενδελεχή κατανόηση των ασθενών με κατάθλιψη, στην παροχή κατάλληλης φροντίδας και στην ουσιαστική συνεργασία με τον ψυχίατρο σε κλινικά πλαίσια.

Λέξεις ευρετηρίου: Στίγμα, διακρίσεις, στερεότυπα, επαγγελματίες ψυχικής υγείας, πεποιθήσεις, συναισθηματικές διαταραχές.

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Special article
Ειδικό άρθρο

Psychological parameters of psoriasis

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Psoriasis is a chronic, inflammatory scaling dermatosis. The marked visible appearance of the lesions have a negative impact on body image that leads to decreased self-esteem, hence seriously compromising the patient's quality of life. The clinical picture critically affects the social well-being of the patient since the disease is commonly misunderstood and feared by the social environment as being contagious. The patient feels stigmatized and this further intensifies their lack of self-confidence and self-esteem. Feelings of shame and guilt increase the tendency toward suicidal ideation. The poor quality of life of psoriatic patients has been associated with excessive alcohol consumption, increased smoking and greater use of tranquilizers, sedatives and antidepressants. As far as mental impairment is concerned, a correlation has been found between psychological stress and the clinical severity of symptoms: the more mentally affected the patient, the more severe the dermatologic lesions. Similarly, stressful life events constitute a major risk for the occurrence and recurrence, exacerbating the severity and duration of the symptoms. Depression and anxiety can worsen the disease or cause resistance to treatment or patient's indifference, which in turn can lead to expensive and prolonged treatment. Not least, the disease itself contributes to anxiety, depression and psychological stress, thus creating a "vicious circle" that is difficult to manage. Given that women seem to invest more in their personal appearance than men, it is hardly surprising that female psoriatic patients report higher levels of depression. Similarly, the risk of mental disorders is also higher in younger patients for whom body image plays an equally significant role. The severity of the disease, side effects of therapy and mental disorders are among the causes that have been attributed to sexual dysfunction reported by some psoriatic patients. At the social level, stigma, social rejection, feelings of shame, embarrassment and lack of confidence provoked by the disease often lead to the discontinuation of daily activities and social withdrawal. This review attempts to describe the prevalence of psychological stress and its negative social impact on patients with psoriasis. The recognition and treatment of these psychosocial problems may contribute to improving the quality of life for patients and reduce treatment costs. The collaboration between the psychiatrist and the dermatologist is a fundamental prerequisite toward addressing these issues.

Key words: Psoriasis, psychological stress, quality of life, anxiety, depression.

Introduction

There is a common misperception that skin diseases are somehow less serious than other systemic diseases. This can be attributed to the fact that although skin disorders are often chronic, they are not life-threatening. As a result the perceived impact on the patient is more likely to be underestimated. Specifically in the case of psoriasis which constitutes the subject of this study, health professionals often underestimate the degree of psychological and social morbidity associated with this disease.

It is therefore obvious that the burden of psoriasis extends beyond the physical symptoms experienced by the patient. The therapies recommended to control psoriasis, not only can be related to adverse events which can have a negative effect on patient's physical activity, but they can also influence many different aspects of their life, including career, finances, leisure activities and relationships.

The consequences on the patient's social and mental health can be dramatic. The decrease in the overall quality of life can be explained by the fact that patients with psoriasis often believe that although they are unable to understand how it is to live without the disease, they can however imagine it, especially during symptom free periods.[1]

Symptoms of psoriasis

At this point it is important to mention the main symptoms of psoriasis, which greatly affect patient's mood and quality of life. The most common clinical manifestation of psoriasis is skin lesions. Intense pruritus is the second most frequently reported symptom. This view was confirmed by Gupta et al, in a study which reported that pruritus was one of the most distressing symptoms for patients with psoriasis. Depression and severity of comorbid mental disorders were found to correlate with pruritus intensity.[2]

Rapp et al stated that joint pain, burning sensation and how the bones or joints look have adverse psychological effects in patients with psoriasis. Pruritus and skin soreness were the symptoms that were closely associated with an impaired quality of life. Moreover, the physical and psychosocial aspects of psoriasis interact to create an overall negative impact on patients' well-being.[3]

It appears that psoriasis' severity has a strong correlation with both the physical symptoms and the psychosocial impact of the disease. The more severe the psoriasis, as perceived by the patient, the more uncomfortable or apprehensive the patient becomes about his or her physical appearance, and the more unsightly and excluded the patient feels.[2] This psychological distress can lead to significant depression and social isolation.

Quality of life psoriasis

Quality of Life (QOL) measurement is the ideal method to properly assess the full effect of psoriasis on patients' daily life. The development of validated psychometric tools to assess the impact of the disease is a relatively recent achievement and has become increasingly important in the evaluation of disease severity, interventions, and allocation of resources. Information with regards the quality of life include patients' subjective evaluation of the influences of their current health status on their ability to achieve and maintain a level of overall functioning that allow them to pursue valued life goals and that are reflected in their general well-being.[4]

The negative impact of psoriasis on a patient's quality of life is well documented in the literature, reinforcing the perception that the psychosocial impact of psoriasis is as important as its physical consequences, contributing to the overall morbidity of the disease.[5] Psoriasis severity is evaluated by the clinical features and the total body surface area (BSA) affected. However, clinical severity, on the basis of the criteria above mentioned, is not always easy to be determined and assessed. Thus the patients' view of the cause, the consequences of chronicity and the treatment of psoriasis are mandatory related to the clinical presentation of the disease.[5]

Therefore the assessment of the clinical severity of psoriasis is not always directly associated with patient's physical symptoms. Patients may have a relatively small BSA involved but the location of the lesions often prevents patients from participating in everyday activities and the visibility of the disease weighs heavily on emotions and self-image. For ex-

ample, a patient whose lesions are easily observed (e.g., on the hands and elbow), are evaluated as having a mild psoriasis considering the International Classification of BSA. Nevertheless the functional impairment would be great and patient is likely to be more affected socially and psychologically than a patient whose equal-sized lesions are in a less conspicuous location (e.g., on the abdomen).[6]

Krueger et al reported that the severity of psoriasis is mainly a quality of life issue.[7] The physical and psychosocial effects of the disease are difficult to be evaluated only on the basis of patients' symptoms during flares and remission. These effects should be assessed based on the long-term history of the disease as the psychological consequences of psoriasis affect and enhance patients' physical symptoms. Furthermore, disease progression can lead to further psychosocial problems and patients' mood may enhance the natural progression of the signs and symptoms of psoriasis.

To further investigate the impact of psoriasis on quality of life of elderly patients, the role of psychiatric disorders such as anxiety and depression that were present before the onset of disease is often studied. In a study of patients with skin diseases, patients were classified according to the greatest impact that mental illness had in their quality of life. Psoriasis had a significantly greater impact on the quality of life of the elderly, when compared with younger patients. Particularly among women who suffered from anxiety or depression. Older women suffering from anxiety or depression had the greatest impairment in quality of life.[8] This could probably be explained by the fact that psoriasis affects the appearance of patients' skin and women are usually much more concerned about their appearance than men. As a result psoriatic lesions have a negative impact on their body image and lead to lower self-esteem.[9]

Psychosocial impact

Clinical symptoms of psoriasis are associated with a significant reduction in patients' quality of life. In addition, their chronic daily stress of having to cope with the disease further contributes to poor QOL. Psoriasis patients often feel self-conscious, helpless, embarrassed, angry and frustrated about their illness. Furthermore they suffer from higher rates of depression and increased risk of disease reccurence.[10]

Gupta et al (1998) found a 9.7% prevalence of a death wish and a 5.5% prevalence of acute suicidal ideation in psoriasis patients.[10] A significant percentage of patients report having moderate to extreme levels of anxiety, depression, and anger, not only during flares, but also while in remission. Even the time of diagnosis can be significantly associated with psychological symptoms of the patients.

Another study of Wahl et al showed that more than half of patients with psoriasis suffered from depression and anxiety. Additionally impairment of QOL was associated with alcohol consumption, cigarette smoking and the use of tranquilizers, sleeping pills and antidepressants.[11] A recent study in Greek population confirmed those of previous studies, as patients with psoriasis experienced significant impairment in quality of life, anxiety, low self-esteem and social isolation. Especially female patients presented with lower self-esteem than male patients.[12]

As mentioned above, the psoriatic patients reported higher degrees of depression and anxiety than the healthy population, while women with psoriasis reported higher levels of depression compared with men. A study by Akay et al, showed that psoriasis can significantly worsen depression. Stressful life events play an important role in the development of the psychosocial status in patients with psoriasis. The role of stressful life events in the development of guttate psoriasis is estimated 1.7% (0.8–3.6) whereas the comorbidity with anxiety and different kinds of psoriasis is 4.6%.[13]

Stigmatization and social rejection are common problems in the experience of psoriasis. Patients have feelings of shame, embarrassment and lack of confidence because of their disease. These emotions result in significant levels of life disruption as well as social withdrawal.[14] In a study of 137 patients with moderate to severe psoriasis, 26.3% of them reported that they had experienced at least a period of social isolation in the past. Such periods were triggered by the presence of psoriasis on a visible part of the body, even if it did not affect the ability of active participation of people in social activities. Social rejection, manifest in the perceived deprivation of human touch, is correlated with many negative symptoms

in daily life of people with psoriasis as well as higher rates of psychological morbidity, including depression.[4]

Fortune et al found that stress of patients with psoriasis was the best predictor of disability scores, as this reflected the social pressures from the people around them. Except patients' physical appearance, their age distribution seems to play an important role in the emergence of mental disorder. Patients in the 18 to 45 year age group tend to experience the most difficulties related to socialization, appearance, daily activities, occupation and finances.[15]

This might be because the stigma of having psoriasis exerts its greatest influence during early adulthood when patients are trying to accept their body image and beginning to develop their social networks and careers.[16] Sampogna et al in 2006 have studied the effects of age, gender, quality of life, and psychological distress in hospitalized patients with psoriasis. Patients were divided into two age groups: younger than 65 years and older than 65 years. They showed that the older patients had lower quality of life and they were exposed to more stressful events during their life. Furthermore, the prevalence of stress and depression in psoriasis patients was higher than that of the healthy population. A significant correlation was found between the psychological stress and the clinical severity of the symptoms of psoriasis, as patients with major psychological distress had more severe psoriatic skin lesions.[9]

The correlation between employment and education level with the incidence of depression and anxiety in patients with psoriasis has been investigated. Though there was no correlation between the education level and incidence of depression and anxiety, lower depression levels were observed in employed patients.[8]

Studies failed to show a significant relationship between gender and acute onset of symptoms and comorbid mental disorders. Men and women are affected equally by the impact the disease has on their appearance, career and socialization. Psoriasis is associated with a decrease in sexual functioning for a significant proportion of patients. In a study of 120 patients, 40.8% of them were sexually affected, reporting a decline in sexual activity. Over 60% of those affected attributed this decrease to the effects psoriasis had on their appearance. Additionally physical symptoms like joint pain, scaling, and pruritus, as well as associated psychopathological disorders such as depression, seem likely to negatively affect sexual activity.[7]

In a survey of 100 patients with moderate to severe psoriasis, 19% of them had experienced instances of gross social rejection, because of the symptoms and the general state of the disease. This occurred most often at public gathering places and centers of activity, like the gym, pool, or hairdresser.[8] The feeling of rejection and stigmatization were strongly correlated with disrupted work experience, the frequent seeking of psychiatric help and excessive alcohol consumption. Patients tended to avoid interpersonal relationships and social interactions in public places where they might encounter rejection, reducing their social and occupational opportunities and further decreasing their overall QOL.[4]

Financial impact

Psoriasis is associated with a significant financial impact. According to several studies and financial calculations, it was estimated that the outpatient cost of psoriasis in 1993 was in the range of $1.6 to $3.2 billion, with an annual cost per patient of $650 to $800. The financial burden to the individual patient includes the cost of care, the time needed to care for psoriasis, interference with work and a decrease in their QOL.[17] As expected, the negative impact of psoriasis on patients' financial status and on their QOL is greater in those with more severe disease and lower family support. This is a different aspect of this complex social phenomenon. In a study including patients with severe psoriasis, the occupational disability caused by the disease was a significant factor leading to deterioration of mental symptoms and depression.[18] The study nevertheless identified and quantified the impact of the disease in the professional activity of patients. Of the employed patients, 59.3% lost time from work during the preceding year because of their illness and of those who were unemployed, 33.9% attributed their employment status to their psoriasis. Men report more occupational impairment than women. Women seem to seek medical attention more often before they reach a point of taking time off work.

Conclusions

In conclusion, the medical community seems to be focusing on the use of proper medical practices and on the impact these can have on the patient's life, especially for those with underlying psychiatric disorders. The combination of objective and subjective dimensions dominate research on quality of life.

The above mentioned studies demonstrate that psoriasis has a strong impact upon patients' daily activities and quality of life. The main cause of this impact is extensive skin involvement. This finding is consistent with a wide range of research studies indicating that the affected body surface has a significant influence on the disease progression and greatly affects quality of life.

Age has a week negative correlation with the quality of life of patients with psoriasis, suggesting that younger patients tend to achieve reduced therapeutic results. Psoriasis seems to have a greater effect on women's mental health, which leads to a greater reduction in their quality of life and a significant impact on their current treatment plan.

Ψυχολογικές παράμετροι της ψωρίασης

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Η ψωρίαση είναι μια χρόνια φλεγμονώδης δερματοπάθεια η οποία, λόγω των εμφανών δερματικών αλλοιώσεων, έχει επίπτωση στην εικόνα του σώματος, με αποτέλεσμα τη μείωση της αυτοεκτίμησης και τη δημιουργία σοβαρών προβλημάτων στην ποιότητα ζωής των ασθενών. Η κλινική εικόνα της νόσου προκαλεί επιφυλακτική και αρνητική στάση από τον κοινωνικό περίγυρο, γεγονός που επιτείνεται όταν λόγω άγνοιας η νόσος θεωρείται λανθασμένα ως μεταδοτική, με αποτέλεσμα οι ασθενείς να βιώνουν κοινωνικό στίγμα, ή και να αυτοστιγματίζονται. Το γεγονός αυτό επιτείνει ακόμα περισσότερο τη μείωση της αυτοπεποίθησης και της αυτοεκτίμησής τους, προκαλεί αισθήματα ντροπής και ενοχής και αυξάνει τα ποσοστά αυτοκτονικού ιδεασμού. Η κακή ποιότητα ζωής των ψωριασικών ασθενών έχει συσχετισθεί με μεγαλύτερη κατανάλωση αλκοόλ, αύξηση του καπνίσματος και μεγαλύτερη κατανάλωση ηρεμιστικών, υπνωτικών και αντικαταθλιπτικών φαρμάκων. Όσον αφορά στην ψυχική επιβάρυνση, έχει βρεθεί συσχέτιση μεταξύ του ψυχικού στρες και της κλινικής βαρύτητας των συμπτωμάτων της ψωρίασης, καθώς οι ασθενείς με σημαντική ψυχική δυσφορία έχουν σοβαρότερες δερματολογικές βλάβες, ενώ παράλληλα τα στρεσογόνα γεγονότα της ζωής αποτελούν σημαντικό κίνδυνο για την εμφάνιση, την υποτροπή, τη βαρύτητα και τη διάρκεια των συμπτωμάτων. Η κατάθλιψη και το άγχος μπορούν να επιδεινώσουν τη νόσο ή να προκαλέσουν αντίσταση στη θεραπεία ή παραμέληση αυτής, οδηγώντας τον ασθενή σε ακριβότερες και μακροχρόνιες θεραπείες. Αλλά και η ίδια η νόσος συμβάλλει στη δημιουργία άγχους, κατάθλιψης και ψυχικού στρες, με αποτέλεσμα να δημιουργείται ένας φαύλος κύκλος που δύσκολα αντιμετωπίζεται. Οι γυναίκες με ψωρίαση αναφέρουν υψηλότερα επίπεδα κατάθλιψης, γιατί όπως φαίνεται συνήθως επενδύουν περισσότερο στην εξωτερική τους εμφάνιση συγκριτικά με τους άνδρες. Επίσης, ο κίνδυνος εμφάνισης ψυχικών εκδηλώσεων είναι αυξημένος σε νεότερους ασθενείς, στους οποίους η εικόνα του σώματος παίζει μεγαλύτερο ρόλο. Η βαρύτητα της νόσου, οι παρενέργειες της θεραπείας και οι ψυχικές διαταραχές

είναι μερικοί από τους λόγους που μπορεί να οδηγήσουν τους ασθενείς με ψωρίαση σε σεξουαλική δυσλειτουργία. Σε κοινωνικό επίπεδο ο στιγματισμός, η κοινωνική απόρριψη, τα συναισθήματα ντροπής, αμηχανίας και έλλειψης εμπιστοσύνης που νιώθουν λόγω της ασθένειας, οδηγούν συχνά στη διακοπή των δραστηριοτήτων της καθημερινής ζωής καθώς και στην κοινωνική απόσυρση. Η παρούσα ανασκόπηση επιχειρεί να περιγράψει την επικράτηση της ψυχικής επιβάρυνσης και των αρνητικών κοινωνικών επιπτώσεων στους ασθενείς με ψωρίαση. Η αναγνώριση και η αντιμετώπιση των ψυχοκοινωνικών προβλημάτων που εμφανίζουν οι ασθενείς αυτοί μπορεί να συνεισφέρει στη βελτίωση της ποιότητας της ζωής τους και να μειώσει το κόστος θεραπείας. Η συνεργασία του δερματολόγου με τον ψυχίατρο αποτελεί βασική προϋπόθεση για την κατά το δυνατόν, καλύτερη επίλυση των ψυχοκοινωνικών προβλημάτων των ασθενών.

Λέξεις ευρετηρίου: Ψωρίαση, ψυχολογικό stress, ποιότητα ζωής, άγχος, κατάθλιψη.

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Homosexuality according to ancient Greek physicians

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Homosexuality and pedophilia in ancient Greece greatly concerned many researchers who were mainly interested in highlighting the social aspect of this phenomenon in ancient Greek society. An important source on the subject was the paintings of a man and his lover in attic black and red figured pottery, up to the end of the 5th century BC. Another main source was the information that derived from the texts of ancient Greek literature, especially poetry. Homosexuality was not only referring to relationships between males, but it was also manifested in lesbian love. It is believed that in the Homeric world homosexuality was not favored. In Greek society of the archaic period, the restriction of women at home, the satisfaction of sexual needs with courtesans, the marriage for the purpose of maintaining and managing the property, put women aside, marginalizing them in terms of social life, impeding the cultivation of emotional relationships between sexes. At the same time, in the society of those times, the aristocratic ideal, the constant communication of men during military training and the war, the male nudity in sports and the promotion of beauty and bravery in athletic contests, as well as the gatherings and the entertainment of men at the symposia, created a suitable substrate in which male homosexuality could develop. In this context, pedophile relationships were developed mainly during the archaic period, as recorded on vase paintings, where a mature man developed a special relationship with a teenager of the same social class. The mature man had the role of mentor for the juvenile, he would look after him and cover his living expenses and education cost. In this relationship, exhibiting predominantly the social dimension of an initiation process and introduction to adult life, the erotic homosexual intercourse could find a place to flourish. The above-mentioned relationship could not last forever, given that this would later transform into an emotional connection of friendship and trust. Besides, the constant homosexual relationships and male prostitution were considered to be reprehensible behaviors. Regarding the lesbian love, the main example was Sappho and her poems that praised love between women. Nevertheless, the relationship with the girls in the poems is considered to be similar to that Socrates had with his students, an intense personal relationship which would not involve sexual love and could probably be a platonic love. Ancient Greek physicians used their meth-

odological tools in order to interpret homosexuality as a mental disease, but ancient medical dogmas such as the theory of humors, stereopathology and their variations could not offer an explanation for homosexuality.

Key words: Homosexuality, Caelius Aurelianus, Soranus of Ephesus, Aristotle.

Introduction

Homosexuality[1] and pedophilia[2] in ancient Greece greatly concerned many researchers, who were mainly interested in highlighting the social aspect of this phenomenon in ancient Greek society.[3] An important source on the subject, up to the end of the 5th century BC., was the paintings of a man and his lover in attic black and red figured pottery.[4,5] Another main source was the information that derived from the texts of ancient Greek literature, and especially poetry.[6,7] Homosexuality was not only referring to relationships between males, but it was also manifested through lesbian love.[8]

Material

It is believed that in the Homeric world homosexuality was not favored. In Greek society of the archaic period, the restriction of women at home, the satisfaction of sexual needs with courtesans, the marriage for the purpose of maintaining and managing the property, put women aside, marginalizing them in terms of social life, impeding the cultivation of emotional relationships between sexes.[1] At the same time, in the society of those times, the aristocratic ideal, the constant communication of men during military training and the war, the male nudity in sports and the promotion of beauty and bravery through athletic contests, as well as the gatherings and the entertainment of men at the symposia, created a suitable substrate in which male homosexuality could develop. In this context, pedophile relationships were developed mainly during the archaic period, as recorded on vase paintings, where a mature man developed a special relationship with a teenager of the same social class. The mature man had the role of mentor for the juvenile, he would look after him and cover his living expenses and education costs. In this relationship, exhibiting predominantly the social dimension of an initiation process and introduction to adult life, the erotic homosexual intercourse could find a place to flourish. The above relationship would not last forever, given that this would later transform into an emotional connection of friendship and trust.[9] Besides, the constant homosexual relationships and male prostitution were considered to be reprehensible behaviors. Regarding the lesbian love, the main example was Sappho and her poems, which praised love between women.[10] Nevertheless, the relationship with the girls in the poems is considered to be similar to that Socrates had with his students, an intense personal relationship which would not involve sexual love and could probably be described as a platonic love.[11]

According to the above, it seems that research outlined homosexuality primarily as a result of social situations in which this was tolerated, but it was not accepted as a long-term and consistent behavior. In the above context, pedophilia was not viewed as a psychopathological condition but as an accessory to a relationship with educational elements, of an adult man with a teenage boy.[3] In the present study, it is the medical approach of ancient Greek doctors towards homosexuality that will concern us.

It should be noted that the only complete ancient medical approach of homosexuality that has been saved until nowadays is that of Soranus of Ephesus (1st–2nd c. AD) in the translation of his work by Caelius Aurelianus (5th c. AD). In this text, it is evident that along with Soranus of Ephesus, there were also earlier physicians' works incorporated in this issue. Besides the historical data

outlined above, this work reveals that in ancient Greece there were gay men or women who maintained this sexual behavior as their permanent sexual choice.[12]

Analyzing this special section of the work of Caelius Aurelianus[13] in the introduction, it is made clear that people found it hard to believe that there are effeminate men, or "soft"–as they were characterized in Greek, noting that although the acts of these people were contrary to their nature, their lust to satisfy their passion overcame their shame, so they posed themselves in a shameful use of their bodies (Aurelianus On Acute Diseases and on Chronic Diseases p. 901, 131.1–8). In this first report, one can acknowledge a contradiction, as there is evidence of the denial of people about an existing phenomenon, and then this phenomenon is further analyzed. One probable explanation of this contradiction would be that the society of the time would especially disapprove the mention of homosexuality, particularly referring to males. It should also be noted that the remark of effeminacy may refer to the fact that men had a passive role in the sexual act, and not being truly effeminate. Nonetheless, at the end of the section on homosexuality, the author indicates that some homosexuals even wore women's clothes, talked like women and exhibited female behavior in general, and this description indicates true effeminacy (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 900, 131.6–7).

Closing the introduction, the author raised his medical concerns on the issue, underlining that this situation was not a disease, as it was generally perceived to be a disease at that time, but rather a disturbance of the mind, a view also expressed by Soranus of Ephesus. Soranus of Ephesus notes that bisexual women, (Greek: τριβάδες) were more lesbian than bisexual (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 900–902, 131.7–133.2).

These two medical positions, that homosexuality was a mental disorder and that it had no features, as was the case with other diseases, were the focus of this medical debate in Greek antiquity. Distinguishing that homosexual behavior deviates from the common sexual orientation, and based on the fact that desire and erotic feeling is a mental operation, it is obvious –according to the views of ancient Greek medicine– that for this deviated erotic choice to occur, a disturbance in mental function would had a role. But although this would be a reasonable conclusion, there is the adversity that there were no evidence of paranoid behavior, common in other mental diseases, and the text emphasizes that homosexuals did have the perception of reality. Moreover, conflicting with the rules of ancient Greek medicine, there were no physical signs that would help to support the argument for the disease, nor any ancient treatment to cure it, as it is clearly stated in the text of Caelius Aurelianus (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 901, 133.5–6). According to the above, it was impossible for ancient physicians to assume a pathophysiological mechanism, as they did for other mental disorders, such as mania, melancholy and phrenitis,[14] following the dogmas of the various medical sects in antiquity.[15] As a result, ancient Greek physicians tried to identify the nature of the problem as being a mental disorder, but without being able to support this belief with medical arguments. Furthermore, we should emphasize that the concept of mental problem was absent from the ancient Greek medical thought as we perceive it today. That is to say, as a disorder that only affected the psychic world without necessarily involving body's mechanisms, as it was believed in ancient Greek medicine.

On the other hand, the author reported the view of the pre-Socratic philosopher Parmenides, who considered homosexuality as the result of circumstances at the beginning of human life, when there was a poor mix of dynamic principles that existed in the sperm of each parent, resulting in a desire for two types of love in the offspring (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 902–904, 134.3–135.8).

Additionally, it is stated by the author that many leaders of the various medical sects felt that homosexuality was a hereditary disease, which was

passed from generation to generation through the sperm, without the cause being attributed to nature, but rather to the human race. It is also stated that the incurable defects were maintained in subsequent generations, since they did not leave any kind of renewal and did not give a chance for a new beginning (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 904, 135.9–136.4). The writer expresses his opposition to this claim, arguing that hereditary diseases weaken as the person is getting older, while homosexuality becomes even stronger as the years pass by (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 904, 136.5–137.1).

Both theories about the cause of homosexuality show that it would be impossible to explain how this situation is created, following the concrete laws of ancient Greek medicine, as is the case with the rest corporal and mental diseases. This is the reason why there was a turn to embryology, aiming to show a defect at birth, explaining in that way the absence of clinical clues in homosexuality that could explain this phenomenon using solely strict medical arguments.

The embryological interpretation could be in accordance with the views of the philosopher Parmenides, relying on an ontological approach which is common in the philosophical type of thinking of ancient times, but on the other hand, such an interpretation indicates an exception for the work of the predominant physicians of that time and their theories on causes of diseases. Thus, we consider that this conception reveals the difficulty faced in explaining the phenomenon of homosexuality. We would recognize this difficulty in Parmenides' work, despite its philosophical nature, because in his time the causes of diseases' theory was initiated, but it appears that the nature of homosexuality turned him to that kind of speculation.

Concluding the analysis of the chapter on homosexuality by Caelius Aurelianus, two observations about the behavior of homosexuals should be mentioned, which we could say that are also observed sometimes in the behavior of these people today.

The first observation is that often entrained by their passion and not indifferent to the people around them, they suddenly change their behavior and for a while they attempt to demonstrate their masculinity, without realizing their limitations, in an agonizing effort for recognition, becoming victims of exaggeration, they get involved in worse actions (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 900, 132.1–6). Despite the generality of the reference, we could infer that homosexuals suffered social condemnation, resulting in their effort to prove their masculine nature. In order to do so, they indulged in excessive sexual activities with the opposite sex in a manner not common in usual sexual life, and through this exaggeration they were often converted to graphical figures without achieving their purpose, but instead confirming that they had lost their male sexual orientation.

The second observation is that the homosexual male passion aggravated in the older age (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 900, 137.1–9). The author will attribute this characteristic to the fact that while one is young with strong body that can fulfill the sexual function, sexual desire is a dual entity, in which the soul is stimulated sometimes in an active and sometimes in a passive role. However, in the elderly –who have lost their masculine forces– sexual desire is reversed in the opposite direction and therefore there is a stronger desire for a female role in sex. The author will also emphasize the argument that the young people who show homosexual behavior may lack the masculine forces and therefore the feminine elements may predominate, as it is the case with the loss of male forces in old age (Caelius Aurelianus On Acute Diseases and on Chronic Diseases p. 900, 137.9–12). These reports set out the fact that male homosexuality becomes stronger in old age. But for the ancient physician this is of particular value because it offers the opportunity to explain the phenomenon involving the body, highlighting the ambivalent status of the man, using the medical principles generally applied in ancient Greek medicine and in which psychic phenomena in one way or another was the

result of disturbances to the body. This is an interpretation which extends to the young homosexuals, relating also to the effeminate teenagers, as the absence of male forces and features would be even more visible in them.

Another plausible explanation of male homosexuality in ancient times is presented in Aristotelian Problems (Aristoteles Phil. et Co. Problemata 879a.36–880a.5). In this work, there is a discussion about the reason why other people find pleasure during the sexual act when they have the active role, and others the passive one. This difference was attributed to the physiological processes of sexual activity. The site of the genitals is the place of collection and discharge of semen, but also the spirit (air) which will be raised there by sexual desire which in turn will be satisfied with the expulsion and evacuation of them from the body. The presence or absence of the above process defines the man's active role and the woman's passive one.

Based on this principle, the author attempted to explain why effeminate men prefer the passive role in intercourse. He considered that the semen is collected in the rectum –due to some kind of abnormality– and therefore homosexual men seek for anal intercourses. At the same time, it is highlighted that there are those who want both the active and the passive role, which the author attributed to the fact that the semen is concentrated simultaneously in the anus and the genitals, indicating that the preference for the one or the other part of the body depends on where more sperm will be collected each time. Finishing, he added another reason for the passive role of men in sexual intercourse. He interpreted this as a result of a habit for those men that will turn to homosexuality from puberty and not earlier. According to him, at that time, their memory will function decisively for the fact which leads to pleasure, stressing that habit becomes second nature through repetition that establishes the habit of the collection and elimination of the sperm in the anus.

We observe that in this particular Aristotelian Problem there is no effort to analyze homosexuality well-round, as we saw it in Caelius Aurelianus' work, but rather the presentation of one probable explanation for the passive role of some men in sexual functioning.

Due to the fact that Aristotle was not a physician but rather a philosopher and a naturalist, he did not demonstrate a full medical examination of the issue of homosexuality. However, we find that in his work there is also an effort to attribute homosexuality to a disorder. In Aristotle's work, homosexuality is presented predominantly as a body disorder, focusing on the concentrating area of the sperm which is not the genitals but the anus. We observe that this interpretation not only matches the author's interest on biology and anatomy/physiology, but also through the ambiguity which distinguishes it, reflects the difficulty faced by ancient physicians to clearly define the pathogenetic mechanism of homosexuality. This is evident, since the shifting of the sperm concentration spot is not thoroughly explained.

With regards to the opinion that the selection of the passive role is the result of habit that starts in teenage life, we would mention that this claim does not connect homosexuality to a mental disorder, since there is no reference to some paranoid behavior as it would be expected according to ancient Greek medicine principles, in order to incorporate this behavior into the mental disorders' spectrum. Instead, this behavior is incorporated into the social life sphere and it emerges as a social phenomenon, an issue suitable for study by a philosopher. Here, it should be clarified that it may be appropriate to link the social interpretation approach to the social phenomenon of pedophilia in ancient times, but there is not a relevant reference in the text, and there is also evidence that in Aristotle's time this phenomenon has been declining.

In conclusion, the medical examination of the homosexual phenomenon in both sexes, by ancient Greek physicians, focuses in the agonizing and controversial effort to demonstrate the pathological status of the phenomenon, which nonetheless cease to become an accurate medical interpretation, as it would be required according to the principles of ancient Greek medicine.

Η ομοφυλοφιλία σύμφωνα με τους αρχαίους Έλληνες ιατρούς

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Η ομοφυλοφιλία και η παιδεραστία στην αρχαία Ελλάδα είναι ένα θέμα που απασχόλησε τους ερευνητές, οι οποίοι έδωσαν κυρίως έμφαση στην κοινωνική διάσταση που είχε το φαινόμενο αυτό στην αρχαία ελληνική κοινωνία και στα χαρακτηριστικά που είχε σε κάθε εποχή και σε κάθε πολιτικό σύστημα. Σημαντική πηγή για το θέμα αποτέλεσαν οι παραστάσεις εραστή και ερωμένου στην αγγειογραφία (μελανόμορφη και ερυθρόμορφη), κυρίως μέχρι το τέλος του 5ου π.Χ. αι., οπότε και περιορίζονται αυτές οι παραστάσεις, ενώ εξίσου κύρια πηγή ήταν οι πληροφορίες από τα κείμενα της αρχαίας ελληνικής λογοτεχνίας, κυρίως της ποίησης. Η ομοφυλοφιλία δεν περιορίστηκε μόνο στις ανδρικές σχέσεις, αλλά και στον λεσβιακό έρωτα. Θεωρείται γενικότερα ότι στον ομηρικό κόσμο δεν ευνοείτο η ομοφυλοφιλία. Κατά την ελληνική κοινωνία των αρχαϊκών χρόνων, ο περιορισμός της γυναίκας στο σπίτι, η ικανοποίηση της σεξουαλικής ανάγκης με εταίρες, ο γάμος με σκοπό τη διατήρηση και τη διαχείριση της περιουσίας, έθεταν τη γυναίκα στο περιθώριο της κοινωνικής ζωής και δεν ευνοούσαν την καλλιέργεια συναισθηματικών σχέσεων στα δύο φύλα. Ταυτόχρονα στην κοινωνία εκείνων των χρόνων το αριστοκρατικό ιδεώδες, η συνεχής επικοινωνία των ανδρών στην πολεμική εκπαίδευση αλλά και στον πόλεμο, η ανδρική γυμνότητα στον αθλητισμό και η ανάδειξη του ωραίου και του γενναίου στους αθλητικούς αγώνες, όπως και οι συγκεντρώσεις ανδρών στα συμπόσια, στις διασκεδάσεις και στις κοινωνικές συναθροίσεις, δημιουργούσαν ένα κατάλληλο υπόστρωμα στο οποίο μπορούσε να αναπτυχθεί η ανδρική ομοφυλοφιλία. Σε αυτό το πλαίσιο αναπτύχθηκαν κυρίως στους αρχαϊκούς χρόνους και οι σχέσεις παιδεραστίας, εραστή και ερωμένου. Αυτό διαπιστώνεται στις παραστάσεις της αγγειογραφίας κατά τις οποίες ένας ώριμος άνδρας, ο εραστής, θα αναπτύξει ιδιαίτερη σχέση με έναν έφηβο, τον ερωμένο, της ίδιας κοινωνικής τάξης. Ο ώριμος άνδρας, έχοντας τον ρόλο του μέντορα, θα αποτελέσει το πρότυπο και τον καθοδηγητή του εφήβου, του οποίου και θα φροντίσει την καθημερινή του συντήρηση, αλλά και τη μόρφωση και εκπαίδευση. Στη σχέση αυτή, που θα έχει κοινωνική διάσταση και κυρίως χαρακτήρα εισαγωγής και «μύησης» στην ενήλικη ζωή, θα βρει χώρο και η ερωτική ομοφυλοφιλική συνεύρεση, η οποία ωστόσο δεν θα διαρκέσει για πάντα, καθώς η σχέση θα εξελιχθεί διαχρονικά σε σχέση φιλίας και εμπιστοσύνης. Άλλωστε οι διαρκείς ομοφυλοφιλικές σχέσεις και η ανδρική πορνεία ήταν κατακριτές. Όσον αφορά στον λεσβιακό έρωτα, κύριο παράδειγμά του αποτελεί η περίπτωση της Σαπφούς. Με τα ποιήματά της εξυμνούσε τον έρωτα μεταξύ των γυναικών, αν και εκφράζεται η άποψη ότι η σχέση με τα κορίτσια ήταν ανάλογη με εκείνη που είχε ο Σωκράτης με τους μαθητές του. Δηλαδή ήταν μεν πολύ έντονη, αλλά χωρίς σωματική ερωτική επαφή. Επιπλέον αμφισβητείται αν συνέβαινε σωματική σχέση και με τη περίπτωση της ίδιας της Σαπφούς, αφού πιθανολογείται ότι οι σχέσεις της παρέμεναν σε πλατωνικό επίπεδο. Σε αυτό το κοινωνικό πλαίσιο οι αρχαίοι Έλληνες ιατροί επιχείρησαν να ερμηνεύσουν το φαινόμενο της ομοφυλοφιλίας κλείνοντας περισσότερο στο να αναζητήσουν την ύπαρξη μιας κάποιας ψυχικής διαταραχής στα άτομα αυτά. Αυτό αφορούσε κυρίως στους θηλυπρεπείς άνδρες. Όμως, χρησιμοποιώντας τα μεθοδολογικά εργαλεία των διαφόρων σχολών ιατρικής σκέψης της αρχαιότητας προσέκρουαν στο εμπόδιο ότι ούτε η θεωρία των χυμών ούτε η θεωρία της στερεοπαθολογίας ούτε οι παραλλαγές τους μπορούσαν να προσφέρουν μια ικανοποιητική ερμηνεία ώστε να καταταχθεί η ομοφυλοφιλία στις ψυχικές διαταραχές.

Λέξεις ευρετηρίου: Ομοφυλοφιλία, Κέλιος Αυρηλιανός, Σωρανός ο Εφέσιος, Αριστοτέλης.

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Special Article
Ειδικό Άρθρο

Stigma and self-esteem: A case of HIV-positive sex-workers

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Stigma associated with sex work and HIV can be easily recognized in public reactions towards the members of discriminated groups. Nevertheless, there are only a few studies examining the impact of discrimination to the self-esteem of individuals who suffer the coexistence of multiple stigmatizing conditions. In our case, the unprecedented stigmatization of sex workers through the media as a menace of public health as well as criminals due to their seropositivity should be examined with respect and scientificity. The sample consisted of the 27 women found to be HIV positive. The small number of subject and the uniqueness of the situation made necessary the use of qualitative research method. Data were collected of through a semi-structured interview during which personal and medical history was taken and Rosenberg self-esteem scale was completed. Information for each domain of interest was systematically collected from multiple interview guide items. Interpretive Phenomenological Analysis was used to analyze data derived from qualitative interview (IPA). Four main categories emerged from the horizontal analysis of the interviews referring to the mechanism used by those women in order to cope with stigma and protect their self-esteem, a description of their felt stigma and feelings about seropositivity, as well as the existence of self-destructive behaviors. The existence of a normal self-esteem on the majority of those women is well explained by the use of certain coping strategies in order to confront the enacted stigma, such as the avoidance of self-blame for their condition (HIV-positive), the disregard of public's discriminating comments and behaviors, the acknowledge of their competence in specific issues they have to deal with in their everyday life, in common with the existence of a strongly supportive network. Despite those women's felt stigma, structured by community's discriminating approach of their families and their feelings of helplessness and incompetence to protect their beloved, their self-esteem is not harmed and the frequency of self-destructive behaviors remained stable, possibly as a result of those coping mechanisms developed early in their lives. The circle of stigmatization that emerged through the stories of those women is not an isolated social phenomenon related only to prostitution and drug use. This is the reason why educational programs, access to HIV care services and efforts towards de-stigmatization would benefit the society in multiple levels, and would ultimately strengthen the effort of combating the global AIDS epidemic.

Key words: Stigma, self-esteem, sex workers, HIV positive, media, Interpretive Phenomenological Analysis, Greece.

Introduction

Stigma is etymologically rooted in ancient Greece. It refers to scars, usually burns, deliberately caused on someone's body (e.g. a slave, traitor, criminal) in order to indicate his inferiority and be avoided by others. Goffman's[1] seminal text defines a stigma as an attribute that is deeply discrediting, which reduces the stigmatized person from a "whole and usual person to a tainted, discounted one".

Scambler and Hopkins[2,3] have differentiated stigma into enacted and felt stigma. The former refers to episodes of discrimination against people with the stigmatized condition on the grounds of their social and cultural unacceptability whereas the latter involves two components: the shame associated with membership of the stigmatized group, and the fear of encountering enacted stigma.[2]

Self-esteem is widely recognized as a central aspect of psychological functioning[4,5] and is strongly related to other variables, including general satisfaction with one's life.[6] Merton proposed that self-fulfilling prophecies occur when a perceiver acts on his or her false beliefs about a target in such a way that those beliefs come to be confirmed by the behavior of the target.[7]

The theory of "efficacy-based self-esteem", contrasted to the theoretical concepts presented above, refers to the stigmatized individuals with low self-esteem not as passive victims of others' attitudes, but as individuals with limited control to their environment, as a result of discrimination and stigmatization. According to the theory, members of stigmatized groups have limited possibilities to form an efficacy-based self-esteem, as their access to the necessary resources for producing intended effects towards their environment is limited. Those individuals view themselves as incompetent to control their environment and interact successfully with it, thus, their self-esteem gets lower.[8]

Despite the belief that the power of stigma affects the self-concept, there is surprisingly little evidence that supports the idea that stigmatized individuals have low self-esteem. Many studies within a wide range of low status or stigmatized groups show that people have levels equal to, or higher than, non-stigmatized groups (for reviews see Hogg & Abrams,[9] Crocker & Majo,[10] Wright[11]). A number of reasons have been advanced for these findings, such as the existence of strategies that protect self-esteem, including the use of selective social comparisons, the attributions of prejudice to the higher status group,[12] and the selection of different values on which to base evaluations.[10]

Sex workers and HIV-positive individuals are high risk groups for stigmatization.[13]

In this study, we attempt to identify specific ways in which stigma may affect female HIV positive street workers stigmatized by the media in Greece of 2012, and how the stigmatization was related to their self-esteem. In other words, this study sought to address the primary question: How these women "experienced" the stigmatization and in what way this experience affected their self-esteem. We hypothesized that the shame caused by the exposure of their personal information in Social Media might negatively affect their self-esteem.

Material and Methods

The case

In Greece of 2012 the national media showed the faces of 27 female street sex workers that were found to be HIV-positive. In the framework of an intervention for epidemic surveillance in a prostitution house in Athens, the Hellenic Center of Disease Control and Prevention (HCDCP) has detected HIV-positive sex workers. Thus, the HCDCP announced the results of their investigation in order to inform and to protect people. Prior to the political elections, state, physicians and police officers "collected" prostitutes and forced them to take an HIV test. Having arrested 27 HIV-positive women (28/4/2012), the attorney of the Athens First Instance Court ordered the disclosure of the prosecution as well as of their identities and photos.

They were arrested in the center of Athens for ''endangering the public health'' and accused of practicing unsafe sex and drug trafficking. The district attorney prosecuted them under the charge of attempting both serious and intended physical injury. The women were arrested and imprisoned pending trial in the ''Koridallos'' Female Prison where the standardized assessing procedure was followed by

the Forensic Psychiatry Unit in the context of the memorandum of agreement (MOA) signed between the Unit and the Ministry of Justice. Specifically, members of the Forensic Unit, assessed the women prisoners' psychological state, addressed their mental health needs and developed a rehabilitation plan.

Participants and data collection

The sample consisted of 27 imprisoned women that were found to be HIV positive. The mean age of the women was 30.7 and ranged in age from 18–48 (table 1). The interviews were conducted in Greek since all these women speak this language fluently and have been living in Greece for a long time. The qualitative and demographic data collection was completed within a month. Interviewers received training in the particular type of semi-structured interview to minimize divergence between them and to ensure the quality of the questionnaire.

Firstly, we conducted a screening interview looking for demographic and other information such as: age, education, marital status, employment status, residence, ethnicity, number of children, history of substance use, substance type, age of onset of substance, use criminal history. Then we conducted semi-structured interviews that were developed by the multidisciplinary team of the Forensic Unit aiming specifically to outline the HIV-positive sex workers' experience after their personal information exposure in national media, and to investigate how this experience along with their lifestyle and the new issues uplifted (imprisonment, HIV), affected their feelings and thoughts about themselves and their life in general.

Additionally, for the purposes of measurement in this project, Rosenberg test was used.

Data analysis

A first, descriptive statistics were calculated for demographic, medical and behavioral data of our study sample. Interpretative Phenomenological Analysis (IPA) was used to analyse data derived from qualitative semi structured interviews. IPA is an inductive form of analysis that takes into consideration the subjective accounts of individuals' experiences and understanding rather than trying to objectively determine the facts. The thematic content analy-

Table 1. Demographic and behavioral characteristics of qualitative participants

	Participants completing qualitative interview (n=27) n/N (%)
Demographic:	
Median age (range in years)	30.07 (18–48)
Marital status:	
Married	6/27 (22%)
Single	13/27 (48%)
Separated or divorced	8/27 (30%)
Motherhood:	
At least one kid	15/27 (56%)
No kids	12/27 (44%)
Ethnicity:	
Greek	18/27 (67%)
Foreign	9/27 (33%)
Residence:	
Permanent residence	24/27 (89%)
Homeless	3/27 (11%)
Education:	
0–6 years	9/27 (33%)
6–9 years	9/27 (33%)
9–12 years	9/27 (33%)
Profession:	
Unemployed	14/27 (52%)
Stable employment	7/27 (26%)
Part-time employment	6/27 (22%)
Behavioral:	
Psychiatric history:	
Yes	14/27 (52%)
No	13/27 (48%)
Other physical disease:	
Tuberculosis	1/27 (4%)
Asthma	3/27 (11%)
Hepatitis	13/27 (48%)
None	10/27 (37%)
Substance Use:	
Yes	26/27 (96%)
No	1/27 (4%)
Type of drugs:	
All kind of drugs	6/26 (23%)
Her	1/26 (4%)
Coc	1/26 (4%)
Her/Coc	12/26 (46%)
Her/Coc/Benzos	5/26 (19%)
Her/Coc/Benzos/Meth	1/26 (4%)
Median age of onset (range in years):	16.4 (11–30)
Awareness of seropositivity:	
Yes	8/27 (30%)
No	19/27 (70%)
Criminal history:	
Yes	18/27 (67%)
No	9/27 (33%)
Supportive network before imprisonment:	
Yes	18/27 (67%)
No	9/27 (33%)
Supportive network during imprisonment:	
Yes	18/27 (67%)
No	9/27 (33%)

sis methodology was employed for the interviews analysis. Initially, all interviews were independently coded by two researchers (vertical analysis) and then were systematically processed using constant comparison (horizontal analysis). Transcripts were continually re-read and re-analysed in order to identify new themes, validate the relevance of the original themes, and refine the thematic categories. To analyze and interpret the interview data we utilized theories of self-esteem and stigma, and international literature that highlighted the strong association between stigma, prostitution and seropositivity.

Additionally, for the purposes of measurement in this project, Rosenberg test was used. The Rosenberg self-esteem scale, developed by Dr. Morris Rosenberg, is a ten-item Likert scale with items answered on a four-point scale from strongly agree to strongly disagree.

Ethics

All women gave initially verbal consent. The individuals were informed through written material about the research and they all provided written informed consent regarding their participation. The study protocol was submitted to the Ministry of Justice and approval was obtained. The same protocol was also submitted and approved by the ethics committee of the Attikon University Hospital. Following the protocol all appropriate actions were made in order to comply with the principles suggested for ethically conducted research by the British Psychological Society (BPS).

Results

Demographic characteristics and behavioral information are presented in table 1. In Rosenberg self-esteem scale 22% (6/27) of the women presented low self-esteem, 74% (20/27) of them presented normal self-esteem and a 3,7% (1/27) presented high self-esteem.

Using the technique of thematic content analysis and through the final horizontal analysis, these three main categories emerged: (a) Mechanisms protecting self-esteem (coping with stigma), (b) Felt stigma, (c) Feelings about seropositivity, accompanied by specific subcategories that allowed us to explore the feelings, thoughts and reactions of those women after their imprisonment, the confirmation about being HIV-positive, and the consequences of their exposure in social media.

A. Mechanisms protecting self-esteem (coping with stigma)

A.1. Disregard & Values' selectivity

The participants were asked to express and explore emotions and reactions triggered by the exposure of their personal information in the national media. The majority of the participants (except two) expressed a flat emotion, disregarding this stigmatizing fact. Some of them not only seemed indifferent about the exposure, but they devalued this experience in comparison to their daily life and the situations they had to cope with, belonging to a specific stigmatized group and recognizing themselves as skillful individuals.

"Sweetie… I have been through worse! In the night and the bargain with drugs there is no shame."

Another woman had a different emotional response to the exposure in social media, describing a passive-aggressive reaction accompanied by resignation:

"They got me mad. They always want to do their job (she means the politicians), like the clients. However, I do not have the strength to do something."

A.2. Support network & Information management

During the interview, the women were asked if they had already a support network consisted of family and friends, and the impact that the imprisonment had on it. It is noteworthy that most of those women made it clear that they do not want to involve their families into the negative aspects of their lives, such as the nature of their job and their drug addiction. Furthermore, they stated that they consider either people coming from the same workplace or friends who share the same drug habits as part of their supportive network. Something worth mentioning is the fact that the percentage of the sample that had supportive network before imprisonment remained stable after imprisonment (67%) with some of the women reporting that the financial or emotional support was even stronger than it was before.

"I do not care about me. But I don't want my family to be involved. They are in Bulgaria. My friends are here, in Greece. They support me and they are mad with the system."

As for those women who reported absence of support system before imprisonment, they were now enjoying a mutual understanding and peer support from other sexworkers-fellow prisoners.

A.3. Responsibility for the stigmatizing condition

All of the women underline the multiple difficulties they have to deal with in a daily basis, adding up to them the imprisonment and HIV. They support that they are responsible for neither of these two stigmatizing factors (prison, HIV), as they had no intention to get the virus, they were ignorant about being positive and never intended to transmit the disease. They recognize themselves as victims and avoid to moral blemish themselves.

"I do drugs, I sell my body for the dose, I go to prison, now AIDS? They accuse me for something I did not do. I am HIV-positive, I may die."

B. Felt stigma

B.1. Anticipated stigma

Despite the fact that the majority of those women had decided not to share with their families information about their lives, their arrest inevitably led to the revelation of their involvement in prostitution, drug addiction and their seropositivity. They expressed intense anxiety about how their families would react to this revelation and the possible consequences that the disclosure would have on their lives from now on.

"My parents don't know anything. I do not know yet if they have learned about it. I hope they have not. We do not have frequent contact. My friends and the girls here (in prison), we support each other. We do everything we can."

B.2. Acceptance of negative attitudes towards the stigmatized group and self-efficacy

At this point, we should mention that there were two cases of women and their families who already had suffered the consequences of disclosure when the interviews were conducted. These are their words:

"I feel desperate and angry. My child is with my parents at the village. The teacher got my child out of the class because she was afraid that he had AIDS. He was scared."

"My mother lives in my village. She didn't know about prostitution. She knew about my drug addiction. She was working as a cleaner in the municipality and after that she was fired. She is angry. It's ok if these things happened only to me but why my mother has to suffer all these? And what can I do from in here?"

C. Feelings about seropositivity

During the interviews, the majority of the women stated that they were not aware of being HIV-positive. When they were asked to explore and express feelings related to their seropositivity they mentioned that they were dominated by fear of having the "illness" and the "unknown" attached to it, including the risk of death.

Some of them said:

"I didn't know it. One more problem to deal with. Are there a lot of people who have died from HIV?"

It should be noted that most of the women in this study were drug addicts who worked as prostitutes in order to live by and support their drug habit. The fact of their seropositivity was felt as another even heavier burden to deal with, because of the mortality attached to the disease.

"I do drugs, I sell my body for the dose, I go to prison, now AIDS? They accuse me for something I did not do. I am HIV-positive, I may die."

Discussion

The aim of the present study was to investigate the specific ways in which stigma may affect female HIV positive street workers stigmatized by the media in Greece of 2012, and the way the stigmatization was related to their self-esteem.

The participants were street sex workers who were working in order to support their drug habits, similarly to the findings of other studies. The connection between prostitution and drug use has been vigorously researched in the scientific literature.[14] The fact that unprotected sex is common after drug injection and use of drugs such as ecstasy, ketamine and

methamphetamine, increases further the likelihood of HIV transmission from drug using female prostitutes to their clients.[14,15]

In the current study, women were indeed found to be HIV-positive, and paradoxically most of them were not aware of their seropositivity. Even though they were accused for unsafe sexual intercourse and intended transmission of the virus HIV, and were exposed through social media, they adopted and applied specific coping strategies in order to protect their self-esteem and secure the life of their families. Specifically, being well-adjusted and comfortable with their profession, they disregarded any comments on their profession, given the fact that this is a stigma they probably have dealt with for a long time. It seems their self-efficacy based self-esteem is well supported by acknowledging their ability to cope with everyday difficulties attached with their lifestyle. As it is theoretically supported, members of stigmatized groups take under consideration their competence into specific situations related to their way of life.[10] Furthermore, the majority of those women had chosen not to reveal information regarding their lifestyle/life choices to their families (even after the revelation of their seropositivity) which explains why the rates of support from family remained unaffected. Interestingly the source of perceived support from friends increased after their expose to the media, with most of them reporting that they received great peer support. As Jennifer Crocker and Brenda Major note, appraisals of significant others become incorporated into one's self-view.[12] In settings where other people with a similar stigma are present, such as in prison, the salience of the stigma is reduced, and therefore people focus on other characteristics of the person. It is pointed out that the most significant interactions and relationships for a person are more likely to be with friends, family or others with a similar condition.[10,12]

Moreover, those women seem terribly worried about their seropositivity and the mortality associated with it. Their vulnerability to low self-esteem is minimized at this point by the fact that they do not blame themselves for the stigmatizing condition. They were unaware of being HIV-positive and had no intention to transmit the virus, despite the court's accusation.

These findings are consistent with theoretical approaches[10] which suggest that the self-esteem of stigmatized people is resilient to the threat posed by stigmatization because of the coping efforts stigmatized people make (e.g., by blaming poor outcomes on being stigmatized, not to personal shortcomings). Our findings add to this theorizing by suggesting that stigmatized people may cope with stigma in more or less the same way that people cope with anything else – and our results suggest that such efforts may successfully buffer the effects of stigma on self-esteem.

On the other hand, in line with previous studies[2] a part of these women actually felt stigmatized (felt stigma) as a result of community's negative approach towards their family. The secondary stigma acquired by the family members after their exposure strikes their self-esteem. Initial reactions to a new stigma may result in the stigma assuming a central importance in the person's self-concept. It can be assumed that, even though they have dealt with the stigma engaged with their profession and drug use, they are still processing the new stigmatizing conditions.[16]

It is noteworthy that the circle of stigmatization that emerged through the stories of these women is not an isolated social phenomenon related only to prostitution and drug use, but it may be nurtured by societies who suffer from profound financial and humanistic crisis. It is of paramount importance that measures need to be taken in order to protect sex workers who are drug users and/or HIV-positive against violence and the infringement of their rights. Education, access to HIV care services and efforts towards de-stigmatization would be beneficial for the society in multiple levels, and would ultimately strengthen the effort for combating the global AIDS epidemic.

Limitations of the study

Due to the nature of the research we cannot draw causal inferences for the variables, but rather associations among them, with the direction of this association being under question.

Moreover, the interviews were taken during the first month of women's imprisonment, so those women had no contact with the community and were only informed about the stigmatizing events.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

All authors contributed to the design of the study. GK, MLP and GT interviewed the participants. GK, PT and GT prepared the dataset, analysed and prepared all the results. GK, SG and PT drafted the manuscript. GK, SG, TK, MLP and FK conducted data collection and analysis, and also helped to redraft the manuscript. AD supervised the data analysis, design of the study and redrafted the manuscript, and also made important final modifications. All authors read and approved the final manuscript.

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Στίγμα και αυτοεκτίμηση: Η περίπτωση των HIV-θετικών ιερόδουλων

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Το στίγμα που συνδέεται με την πορνεία και τον ιό HIV μπορεί εύκολα να αναγνωριστεί στις δημόσιες αντιδράσεις προς τα μέλη των μειονοτικών ομάδων. Παρόλ' αυτά, υπάρχουν λίγες μόνο μελέτες που εξετάζουν την επίδραση των διακρίσεων στην αυτοεκτίμηση των ατόμων που υποφέρουν από τη συνύπαρξη πολλαπλών στιγματιστικών συνθηκών. Στην περίπτωσή μας, ο πρωτοφανής στιγματισμός των ιερόδουλων από τα μέσα μαζικής ενημέρωσης και η παρουσίασή τους ως απειλή για τη δημόσια υγεία και ως εγκληματιών λόγω της οροθετικότητάς τους, θα πρέπει να εξεταστεί με σεβασμό και επιστημονικότητα. Το δείγμα της μελέτης αποτελείτο από 27 γυναίκες που βρέθηκαν θετικές στον ιό HIV. Ο μικρός αριθμός του δείγματος και η μοναδικότητα της κατάστασης κατέστησαν αναγκαία τη χρήση ποιοτικής μεθοδολογίας για την έρευνα. Η συλλογή των στοιχείων έγινε μέσω ημι-δομημένης συνέντευξης, που περιελάμβανε τη λήψη προσωπικού ιστορικού, ενώ συμπληρώθηκε και η κλίμακα αυτοεκτίμησης του Rosenberg. Πληροφορίες για κάθε τομέα ενδιαφέροντος συλλέχθηκαν συστηματικά από πολλά στοιχεία του οδηγού συνέντευξης. Χρησιμοποιήθηκε η ερμηνευτική φαινομενολογική ανάλυση για την ανάλυση των δεδομένων που προήλθαν από την ποιοτική συνέντευξη (IPA). Τέσσερεις βασικές κατηγορίες προέκυψαν από την οριζόντια ανάλυση των συνεντεύξεων που αφορούν στους μηχανισμούς που χρησιμοποιούνταν από τις γυναίκες αυτές προκειμένου να αντιμετωπίσουν τον στιγματισμό και να προστατεύσουν την αυτοεκτίμησή τους, μια περιγραφή του εσωτερικού στίγματος/αυτοστιγματισμού (self-stigma) και των συναισθημάτων τους σχετικά με την οροθετικότητα, καθώς και την εκδήλωση αυτοκαταστροφικών συμπεριφορών. Η ύπαρξη φυσιολογικής αυτοεκτίμησης για την πλειοψηφία των γυναικών αυτών μπορεί να εξηγηθεί από τη χρήση εκ μέρους τους ορισμένων στρατηγικών αντιμετώπισης του εξωτερικού/κοινωνικού στίγματος (enacted stigma), όπως η αποφυγή της αυτομομφής για την κατάστασή τους (οροθετικότητα), η παράβλεψη των σχολίων και των συμπεριφο-

ρών διάκρισης της κοινωνίας, η αναγνώριση των αναπτυγμένων ικανοτήτων τους σε συγκεκριμένα ζητήματα που καλούνταν να αντιμετωπίσουν στην καθημερινή τους ζωή από κοινού με την ύπαρξη ενός έντονα υποστηρικτικού δικτύου. Παρά το εσωτερικό στίγμα των γυναικών αυτών, που στηρίζεται στις διακρίσεις της κοινωνίας απέναντι στις οικογένειές τους και τα συναισθήματα αδυναμίας και ανικανότητας να προστατεύσουν τους αγαπημένους τους, η αυτοεκτίμησή τους δεν έχει βλαφθεί και η συχνότητα των αυτοκαταστροφικών συμπεριφορών παρέμεινε σταθερή, ενδεχομένως ως αποτέλεσμα των εν λόγω μηχανισμών αντιμετώπισης που ανέπτυξαν νωρίς στη ζωή τους. Συμπερασματικά, ο κύκλος του στιγματισμού που προέκυψε μέσα από τις ιστορίες αυτών των γυναικών δεν είναι ένα μεμονωμένο κοινωνικό φαινόμενο που σχετίζεται μόνο με την πορνεία και τη χρήση εξαρτησιογόνων ουσιών. Αυτός είναι ο λόγος για τον οποίο τα εκπαιδευτικά προγράμματα, η πρόσβαση στις υπηρεσίες φροντίδας οροθετικών και οι προσπάθειες ενάντια στον στιγματισμό, θα μπορούσαν να ωφελήσουν την κοινωνία σε πολλά επίπεδα, και εν τέλει να ενισχύσουν την προσπάθεια για την καταπολέμηση της παγκόσμιας επιδημίας του AIDS.

Λέξεις ευρετηρίου: Στίγμα, αυτοεκτίμηση, ιερόδουλες, οροθετικότητα, μέσα μαζικής ενημέρωσης, Ερμηνευτική Φαινομενολογική Ανάλυση, Ελλάδα.

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Books review
Βιβλιοκριτικές

Yannis Papakostas
The legend of Sisyphus. Mythological and allegoric context, BETA Medical Publications, Athens, 2016

A detailed presentation of the legend of Sisyphus and its different perceptions.

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Ιωάννης Γ. Παπακώστας
Ο Μύθος του Σισύφου. Ο μυθολογικός και αλληγορικός Σίσυφος
ΒΗΤΑ Ιατρικές Εκδόσεις, Αθήνα 2016
ISBN 978-960-452-225-5

Ο μύθος του Σισύφου αποτελεί για πολλά χρόνια αντικείμενο μελέτης του Γ. Παπακώστα. Ο τόμος αυτός είναι ο καρπός διεξοδικής ανασκόπησης των πηγών και της προσωπικής συνεισφοράς του συγγραφέα, που επιτρέπει στον αναγνώστη να προσεγγίσει τόσο τη μυθολογική όσο και την αλληγορική διάσταση του μύθου, με μια αναλυτική αναφορά στις πηγές και τις διαφορετικές εκδοχές πρόσληψης του μύθου σε κάθε κεφάλαιο.

Δεν μπορούμε να αναφερθούμε διεξοδικά στο πλούσιο μυθολογικό πλαίσιο. Συνοπτικά ο Σίσυφος μυθικός άρχοντας της Εφύρας και της Κορίνθου είναι αυτός που οχύρωσε τον Ακροκόρινθο. Χάρη στην ευφυΐα και την πανουργία του κατόρθωσε σημαντικά έργα για την εποχή του, αλλά προκάλεσε την οργή των θεών εξαιτίας της ικανότητάς του να προσπερνά τις απαγορεύσεις που επιβάλλονται στους θνητούς, με την επιδίωξη της αθανασίας, την αποκάλυψη θείων μυστικών και την εξαπάτηση των θεών. Η τιμωρία μετά τον θάνατό του, που κατόρθωσε με τέχνασμα να αναβάλει μία φορά, έχει εν πολλοίς αλληγορική σημασία. Η αενάως επαναλαμβανόμενη μεταφορά του βράχου στην κορυφή του βουνού, που ξανακυλά αμέσως στους πρόποδες, συμβολίζει το μεγαλείο αλλά και τη ματαιότητα των έργων του ανθρώπου, από την προοπτική της ατομικής προσπάθειας.

Ο μύθος έχει διαφορετικές εκδοχές, που κυριάρχησαν στις διάφορες περιόδους εξέλιξης της ανθρωπότητας. Μια εκδοχή είναι του θνητού ως Σισύφου («Σισυφοποίηση του θνητού») και μια δεύτερη του Σισύφου ως θνητού (ο εξανθρωπισμός του Σισύφου). Στη δεύτερη αυτή εκδοχή εγγράφεται και η εκδοχή του Α. Καμύ που καταλήγει ότι «ο αγώνας προς την κορυφή φτάνει για να γεμίσει μια ανθρώπινη καρδιά. Θα πρέπει να φανταστούμε τον Σίσυφο ευτυχισμένο».

Αναλύοντας τον μύθο μπορούμε να διακρίνουμε εντός του έναν μύθο εργασίας, αλλά και έναν μύθο τελειότητας. Η εγκατάλειψη του αγώνα, η θεώρηση ενός έργου ως Σισύφειου, δεν είναι κάτι που χαρακτηρίζει την κατάθλιψη;

Ο Γ. Παπακώστας λέει ότι «κατανοώντας οι άνθρωποι τη ζωή τους με σισύφειους όρους μπορούν να μην απογοητεύονται από τις αλλεπάλληλες ματαιώσεις των προσπαθειών τους· αναγνωρίζοντας τους σχετικούς περιορισμούς και χαίροντες για τις εφήμερες επιτυχίες τους, μπορούν να επαναπροσδιορίσουν τις φιλοδοξίες τους χωρίς να χαλαρώνουν τις προσπάθειές τους». Τελικά καταλήγει στο ότι η ενσυναίσθηση ή και η συμπόνια απέναντι στον Σίσυφο αφορά τους ίδιους μας τους εαυτούς.

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Miltos Livaditis

Mind and reasonability. What is known and knowledgeable, Ed. Parisianou, Athens 2016

The book offers a large and documented review on the function of mind, mental objects and reasonability, mainly focusing on the cognitive neuroscience

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Μίλτος Λειβαδίτης

Νόηση και Λογικότητα. Τα Γνωστά και τα Γνώσιμα, Εκδόσεις Παρισιάνου, Αθήνα 2016

Το βιβλίο αυτό έρχεται να επισφραγίσει τη μακρά ενασχόληση, διδακτική και συγγραφική, του Μ. Λειβαδίτη με το πρόβλημα της νόησης και το ευρύτερο πλαίσιο άσκησης της Ψυχιατρικής. Τη φιλοσοφική διάσταση της νόησης, καθώς και τα πρότυπα που προέρχονται από άλλους γνωστικούς ορίζοντες όπως η πειραματική ψυχολογία, η υπολογιστική θεωρία, η τεχνητή νοημοσύνη, αλλά και η κλινική πρακτική και η ψυχοθεραπεία. Μια πολυεπίπεδη, ευρύτατη παρουσίαση για το ζήτημα της νόησης, που ο Ι. Παπακώστας στον πρόλογό του ονομάζει χαρτογράφηση στον χώρο της νόησης. Ένα σημαντικό ερώτημα που διατρέχει τα κεφάλαια είναι εάν οι νοητικές ποιότητες είναι αναγώγιμες σε φυσικά φαινόμενα.

Η κριτική αυτή παρουσίαση ακολουθεί συστηματικά τις σύγχρονες τάσεις και βασίζεται σε εντυπωσιακού εύρους ανασκόπηση της βιβλιογραφίας. Το βιβλίο χωρίζεται σε έξι κεφάλαια. Το πρώτο: Ύπαρξη και Πραγματικότητα. Αλήθεια και γνώση προσφέρει το πλαίσιο ανάλυσης των εννοιών. Το δεύτερο: Προθετικές καταστάσεις και νοητικές αναπαραστάσεις μελετά το πρόβλημα του νοηματικού περιεχομένου και των εννοιών. Το τρίτο: Φυσικαλιστικές και δυϊστικές θεωρίες για τη σχέση μεταξύ νου και ύλης αναπτύσσει με σύγχρονους όρους πανάρχαια φιλοσοφικά και επιστημολογικά ερωτήματα. Το τέταρτο: Συνειδητότητα και φαινομενολογικές ιδιότητες αναλύει το πρόβλημα της συνείδησης και της συνειδητότητας. Το πέμπτο: Γνωσιακή Επιστήμη αναπτύσσει τις βάσεις της γνωσιακής προσέγγισης, όπως αναπτύχθηκε μετά τη δεκαετία του 1950. Το έκτο κεφάλαιο: Τι είναι λοιπόν η νόηση: παρουσιάζει μια περισσότερο προσωπική ανάγνωση του συγγραφέα για τα ζητήματα: του νοήματός του να υπάρχει ή να μην υπάρχει ένα αντικείμενο· την αλήθεια ή μη αλήθεια μιας πεποίθησης ή δήλωσης· πώς συνδέονται η πεποίθηση και η αλήθεια με τη γνώση· πώς διακρίνονται τα νοητικά αντικείμενα από τα μη νοητικά φαινόμενα·πώς δημιουργούνται οι νοητικές δυνατότητες της προθετικότητας και της αναπαραστασιακής δυνατότητας· τι προσδιορίζει το νόημα των συμβόλων και των νοητικών αναπαραστάσεων· τι μπορούμε να ορίσουμε ως φυσικό αντικείμενο· τον δυϊσμό και τον μονισμό ως μεταφυσικές θεωρίες· τα γνωσιολογικά πλεονεκτήματα και μειονεκτήματα των μονιστικών θεωριών· και τέλος, τη συμβολή της Γνωσιακής Επιστήμης στη διερεύνηση της νόησης σε επιστημονικό και φιλοσοφικό επίπεδο.

Μόνη η απαρίθμηση του περιεχομένου των κεφαλαίων απεικονίζει τον πλούτο του εγχειρήματος και την αυτόνομη παρουσίαση όχι μόνο των κεφαλαίων, αλλά και των πολλών υποκεφαλαίων του βιβλίου. Θα ήθελα στο σημείο αυτό να τονίσω ότι ένα μεγάλο πλεονέκτημα για ένα βιβλίο που επιχειρεί μια ευρεία σύνθεση φιλοσοφικών και επιστημολογικών εννοιών και με του οποίου το αντικείμενο οι περισσότεροι δεν διαθέτουμε επαρκή εξοικείωση, είναι ότι χάρη στο πλούσιο γλωσσάριο και το ευρετήριο των εννοιών στο τέλος, μπορούν οι διάφορες ενότητες να διαβαστούν αυτόνομα και με την ευκαιρία των εκάστοτε ερωτημάτων και αναζητήσεων του αναγνώστη

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Six Aristotle's topics from a Psychological perspective
Narcissism – Rightful – Sleep & Dreams
Person-centered approach – Time – Aristotle & Zeno
BETA Medical Publications, Athens, 2015
ISBN: 978-960-452-201-9

This book is divided into 6 chapters. In the first five, the writer deals with Aristotle's views and describes similarities, counterparts and parallelisms with modern scientific and psychological ideas and views. In the first chapter, the philosopher's views about friendship correlate with the construct of narcissism, whereas in the second, the philosopher formulates extensively his view of the rightful, following the rule of the "mean".

In the third chapter, the views of the man from Stagira, for sleep and dreams, come into direct parallelism with the modern notion of psychobiological model. In the fourth, the person-centered approach and the need for individualized care is stressed. In the fifth one, the relation between time and mental functions is discussed. Finally in the last one, there is an overall presentation of Aristotle's conceptions which are categorized according to modern psychoanalytic notions. It is of interest that the writer refers both to the "psychoanalytic deepening and insight" of Aristotle's and to the "cognitive –behavioral approach" of Zeno of Citium, as well as of other stoic philosophers.

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Χαράλαμπος Σ. Ιεροδιακόνου
6 Θέματα στον Αριστοτέλη από ψυχολογικής σκοπιάς
Ναρκισσισμός – Δίκαιον – Ύπνος και Όνειρα –
ο προς Ημάς – Χρόνος – Αριστοτέλης & Ζήνων
ΒΗΤΑ Ιατρικές Εκδόσεις, Αθήνα 2015
ISBN: 978-960-452-201-9

Το παρόν πόνημα του Ομότιμου Καθηγητή της Ψυχιατρικής Χαράλαμπου Ιεροδιακόνου είναι προϊόν μακροχρόνιας μελέτης Αριστοτελικών κειμένων καθώς και κειμένων άλλων αρχαίων φιλοσόφων.

Το βιβλίο αποτελείται από 279 σελίδες και περιλαμβάνει 6 κεφάλαια. Στο πρώτο κεφάλαιο παρουσιάζονται οι απόψεις του Αριστοτέλη για τη φιλία, την ανάγκη του ανθρώπου για διαπροσωπικές σχέσεις και γίνεται ιδιαίτερη μνεία, εκ μέρους του συγγραφέα, στη θέση του φιλοσόφου ότι «όλα τα φιλικά συναισθήματα (αισθήματα αγάπης προς άλλους) αποτελούν επέκταση της αγάπης προς τον εαυτό μας». Ο συγγραφέας αντιστοιχεί τις απόψεις του φιλοσόφου με τη φροϋδική έννοια του ναρκισσισμού και την Αριστοτελική φράση «αι φιλίαι ορίζονται εκ των έσω» με την ψυχαναλυτική θέση της επένδυσης της λίμπιντο στα αντικείμενα.

Στο δεύτερο κεφάλαιο αναφέρονται, εν εκτάσει, οι απόψεις του Σταγειρίτη περί δικαίου και δικαιοσύνης. Το «μέσον» αποτελεί κατά τον Αριστοτέλη τον «κανόνα» και το δίκαιον βρίσκεται ανάμεσα στο κέρδος (υπερβολή) και τη ζημία (έλλειψη). Ο φιλόσοφος τονίζει τον ρόλο της προσωπικότητας ως προς την απονομή δικαιοσύνης. Δέχεται την επίδραση της φύσης στον ανθρώπινο χαρακτήρα ως μια προδιάθεση. Ωστόσο, εξαίρει τον ρόλο της ανατροφής και της παιδείας που, όπως αναφέρει, διαμορφώνουν «το μέτρον, το δυνατόν και το πρέπον» στον χαρακτήρα. Ο κ. Ιεροδιακόνου συσχετίζει τις θέσεις του φιλοσόφου για την πλέον ακραία ενέργεια «του αδικείν εαυτόν», την αυτοκτονία, («Ο δι' οργήν σφάττων εαυτόν»), με την ψυχαναλυτική έννοια τής εναντίον εαυτού στροφής και την εκτόνωση της επιθετικότητας.

Στο τρίτο κεφάλαιο, «Ο ύπνος και τα όνειρα στον Αριστοτέλη», ο συγγραφέας παραλληλίζει τη φράση του φιλοσόφου ότι, «ούτε της ψυχής ιδιαίτερο φαινόμενο είναι ο ύπνος, ούτε ένα σώμα είναι δυνατόν να αισθανθεί», με τις σύγχρονες αντιλήψεις του βιοψυχοκοινωνικού μοντέλου. Δίνει έμφαση στην επίδρα-

ση των συναισθημάτων στη δημιουργία των ονείρων και απορρίπτει οποιαδήποτε θεϊκή παρέμβαση.

Στο τέταρτο κεφάλαιο τονίζεται η προσωποκεντρική προσέγγιση του ανθρώπου. Σύμφωνα με τον αρχαίο φιλόσοφο ο κάθε άνθρωπος αποτελεί ξέχωρη οντότητα και βιοψυχοκοινωνική ολότητα, άποψη που ισχύει και σήμερα, εξού και η ανάγκη της εξατομικευμένης φροντίδας.

Στο επόμενο κεφάλαιο καταγράφονται οι παρατηρήσεις του φιλοσόφου αναφορικά με τη σχέση χρόνου και ψυχικών λειτουργιών. Ο συγγραφέας παραλληλίζει το Αριστοτελικόν «εκρούονται εν τω βάθει» με το υποσυνείδητο και άλλες φράσεις του Αριστοτελικού κειμένου, τις μεταφέρει στα πλαίσια του ελεύθερου συνειρμού της ψυχανάλυσης, και της ψυχαναλυτικής έννοιας της συναισθηματικής «κάθεξης».

Στο τελευταίο κεφάλαιο καταγράφονται ψυχολογικές έννοιες Αριστοτελικών κειμένων και ταξινομούνται από τον συγγραφέα σύμφωνα με τις ψυχαναλυτικές απόψεις. Επιπροσθέτως, παρατίθενται θεωρίες αρχαίων φιλοσόφων άλλων σχολών.

Στο βιβλίο αυτό ο Καθηγητής μελετά και σχολιάζει κείμενα του Αριστοτέλη καθώς και άλλων αρχαίων φιλοσόφων, όπου καταδεικνύεται ο θεραπευτικός ρόλος της φιλοσοφίας. Διατυπώνει ομοιότητες, αντιστοιχίες και παραλληλισμούς των θέσεων των φιλοσόφων με σύγχρονες επιστημονικές και ψυχολογικές απόψεις, επισημαίνοντας την «ψυχαναλυτική εμβάθυνση» του Σταγειρίτη και τη «γνωσιακή συμπεριφορική οπτική» του Ζήνωνα του Κιτιέα, ιδρυτή της Σχολής των Στωικών.

Πρόκειται για ένα εγχειρίδιο όπου ο συγγραφέας, με σαφή και κατανοητό τρόπο, καταγράφει φιλοσοφικές απόψεις, τις οποίες προσεγγίζει επιστημονικά και ψυχολογικά. Κατά την άποψή μου, η εργασία αυτή έχει εξαιρετικό ενδιαφέρον, καθώς μπορεί να αποτελέσει κίνητρο για τη μελέτη φιλοσοφικών κειμένων στα οποία αναδεικνύεται η σύγχρονη σκέψη των αρχαίων φιλοσόφων και ο ρόλος της φιλοσοφίας **στην «ψυχής θεραπείαν» .**

Σταυρούλα Θεοδωροπούλου
Ψυχίατρος, Αθήνα

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"PSYCHIATRIKI"

INSTRUCTIONS TO CONTRIBUTORS*

PSYCHIATRIKI is the official journal of the Hellenic Psychiatric Association. It is published quarterly and has the same scope as the Hellenic Psychiatric Association, namely the advancement of Psychiatry. The journal invite contributions in the fields of Epidemiology, Psychopathology, Social Psychiatry, Biological Psychiatry, Psychopharmacology, Psychotherapy, Preventive Psychiatry. The journal follows the standards approved by the International Council of Scientific Publishers. For a detailed description of the specifications see "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (www.CouncilScienceEditors.gr). Other sources: *Br Med J* 1991, 302:338–341/*Can Med Assoc J* 1995, 152:1459–1465.

Apart from the printed edition, the journal is freely available in electronic version at the websites: www.psych.gr or www.betamedarts.gr

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TYPES OF ARTICLES

1. **Editorials:** Short articles in both English and Greek language covering topics of particular importance, written by members of the Editorial Board by members of International Advisory Board and by invited authors (up to 700 words and 7–8 references).
2. **Review articles:** Should be written by one or two authors. They should not exceed 3,000 words.
3. **Research papers:** These articles must be based on a research protocol. Statistical evaluation of the findings is essential. They should not exceed 3,000 words (up to 8 authors).
4. **Brief communications:** This section includes research reports which can be accommodated in a small space. They should not exceed 1,500 words.
5. **Special articles:** Invited articles concerning topics of special interest (up to 3,000 words).
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11. All articles should be accompanied by abstracts, both in Greek and English, about 400 words each. The articles that are referred as Brief communication and as Case reports should be accompanied by abstracts, both in Greek and English about 200 words each.

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Journal PSYCHIATRIKI
Hellenic Psychiatric Association,
11, Papadiamantopoulou str., GR-115 28 Athens, Greece
e-mail: editor@psych.gr

The original manuscript, three copies as well as a copy on a diskette or an electronic copy by e-mail should be submitted. The text must be written with a word processor compatible with any Windows program, or with any program for a Macintosh computer.

The submitted manuscripts should be accompanied by the "Submission form" accurately filled in.

A code number to be used in further correspondence will be assigned to all papers submitted. Manuscripts should be typewritten, double-spaced on one side of the paper with a margin of at least 3.5 cm. On the right upper corner of the first page a characterization on the article should appear (e.g., Brief Communication, Research Article).

ARRANGEMENT

All pages must be numbered, starting with the title page.

Title page: It indicates the title (which should not exceed 12 words), the names and surnames of the authors, the Institute, Hospital, University, etc. where the work was conducted and the address, telephone number and e-mail of the author who will be responsible for the correspondence. In the same page appreciation for those who have contributed to the presented work can also be included.

Abstract: The second page must include an informative abstract (400–500 words) as well as 4–6 key words.

Main part: Must be divided in sections (e.g., for the Research Papers: Introduction, Material and method, Results, Discussion). Results appearing in the tables should not be reported again in detail in the text.

References: They must be identified in the text by arabic numbers (in brackets) and must be numbered in the order in which they are first mentioned in the text (Vancouver system), e.g. *Birley*[1] *found that... but Alford*[2] *disagreed*. Cite the names of the first six authors. The list of references should include only those publications which are cited in the text.

References should not exceed 100 in the Review articles and the Special articles, 50 in the General articles, 15 in the Brief Communications and in Case reports, and 8 in the Editorials and the Letters to the Editor.

The following paradigms illustrate the various reference categories:

1. Birley JLT, Adear P, Singer D, Rosenberg M. Electrogastrographic studies in elderly patients. *Gastroenterology* 1980, 79:311–314 (Journal Article).
2. Alford J, Nemiah J. Peptic ulcer in childhood. In: Sodeman WA (ed) *Pathologic Physiology*. Saunders, Philadelphia, 1970:457–472 (Chapter in Book).
3. Kinden A. *Stress and emotion*. Springer, Berlin, 1990 (Book).
4. Larsen E, Elliot B. Fatigue in major depression. *Psychiatriki* 2007, (Suppl 1):S143–S144 (Journal Supplement)
5. Silverstone A, Leman H, Stark J. *Attempted suicide by drug-overdose*. Paper presented at 2nd Congress on Suicide behaviour, 4–6 May 2002, Rome, Abstracts Book, pp 212–213 (Conference Presentation - Abstract Book)
6. Henry A, Andrews B. *Critical issues for parents with mental illness*. N.Y. Centre for Mental Health Services 2001 (Cited 2 June 2005) Available from www. mentalorg/publications (Website)

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Symbols and abbreviations: Spell out all abbreviations (other than those for units of measure) the first time they are used. Follow Iatriki 1980, 37:139 (in Greek) or «Units, Symbols and Abbreviations: a Guide for Biological and Medical Editors and Authors» (3rd ed, 1977) available from the Royal Society of Medicine of the United Kingdom.

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"ΨΥΧΙΑΤΡΙΚΗ"

ΟΔΗΓΙΕΣ ΓΙΑ ΤΟΥΣ ΣΥΓΓΡΑΦΕΙΣ*

Η *ΨΥΧΙΑΤΡΙΚΗ* είναι το επίσημο όργανο της Ελληνικής Ψυχιατρικής Εταιρείας, εκδίδεται τέσσερεις φορές τον χρόνο και έχει τον ίδιο σκοπό με την Εταιρεία, δηλαδή την προαγωγή της Ψυχιατρικής Επιστήμης. Το περιοδικό δημοσιεύει εργασίες που αναφέρονται στους τομείς της Επιδημιολογίας, Ψυχοπαθολογίας, Κοινωνικής Ψυχιατρικής, Βιολογικής Ψυχιατρικής, Ψυχοφαρμακολογίας, Ψυχοθεραπείας, Προληπτικής Ψυχιατρικής. Οι προδιαγραφές του περιοδικού ταυτίζονται με τις οδηγίες του Διεθνούς Επιστημονικού Συμβουλίου Εκδοτών. Για την αναλυτική περιγραφή των προδιαγραφών βλ. "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" (www.CouncilScienceEditors.gr). Άλλες πηγές: *Br Med J* 1991, 302:338–341/*Can Med Assoc J* 1995, 152:1459–1465.

Εκτός από την έντυπη έκδοσή του, το περιοδικό διατίθεται ελεύθερα στην ηλεκτρονική του έκδοση από τις ιστοσελίδες: www.psych.gr ή www.betamedarts.gr

Το περιοδικό "ΨΥΧΙΑΤΡΙΚΗ" δέχεται προς δημοσίευση εργασίες που αφορούν σε πρωτότυπο υλικό που δεν έχει δημοσιευθεί προηγουμένως (εκτός σε μορφή περίληψης) ή δεν έχει υποβληθεί για δημοσίευση κάπου αλλού.

Κατά την υποβολή της εργασίας όλοι οι συγγραφείς πρέπει να υπογράψουν στο τυποποιημένο έντυπο υποβολής ότι συμφωνούν με το περιεχόμενο και αποδέχονται την υποβαλλόμενη προς δημοσίευση εργασία και μεταβιβάζουν τα συγγραφικά δικαιώματα στο περιοδικό "ΨΥΧΙΑΤΡΙΚΗ". Οι συγγραφείς ακόμη, δηλώνουν ότι: (α) δεν υπήρξε οικονομική υποστήριξη από διάφορες πηγές (εάν υπήρξε πρέπει να δηλωθεί), (β) δεν υπήρξαν αντικρουόμενα συμφέροντα σχετικά με το υλικό της έρευνας που υπεβλήθη προς δημοσίευση, (γ) το πρωτόκολλο της έρευνας εγκρίθηκε από την Επιτροπή Βιοηθικής του Νοσοκομείου ή του Ιδρύματος όπου πραγματοποιήθηκε η έρευνα σύμφωνα με τις προδιαγραφές της Διακήρυξης του Ελσίνκι (1995) όπως αναθεωρήθηκαν στο Εδιμβούργο (2000) και (δ) ότι όλοι οι ασθενείς έδωσαν τη συγκατάθεσή τους πριν συμπεριληφθούν στην έρευνα αφού προηγουμένως ενημερώθηκαν για την ερευνητική διαδικασία.

Τα κριτήρια αποδοχής των εργασιών περιλαμβάνουν την ποιότητα και την πρωτοτυπία της έρευνας, όπως επίσης τη σημαντικότητα και χρησιμότητα των δεδομένων στους αναγνώστες του περιοδικού.

Όλες οι εργασίες υπόκεινται σε μια αρχική εκτίμηση από τον Εκδότη ή μέλη της Συντακτικής Επιτροπής του περιοδικού προκειμένου να εκτιμηθεί η καταλληλότητα και η ποιότητά τους. Εάν η εργασία κριθεί καταρχήν κατάλληλη για δημοσίευση στο περιοδικό, εκτιμάται από δύο ανεξάρτητους κριτές, ειδικούς στο αντικείμενο της έρευνας. Οι κριτές δεν γνωρίζουν τους συγγραφείς της εργασίας και παραμένουν ανώνυμοι για τους συγγραφείς.

Τα σχόλια των κριτών μαζί με τις υποδείξεις και διορθώσεις τους αποστέλλονται στους συγγραφείς. Οι συγγραφείς ενημερώνονται εγγράφως για την τελική απόφαση της Συντακτικής Επιτροπής του περιοδικού όταν η διαδικασία αξιολόγησης ολοκληρωθεί. Τα ονόματα των κριτών του προηγούμενου έτους εμφανίζονται στο πρώτο τεύχος του επομένου έτους. Η Συντακτική Επιτροπή διατηρεί το δικαίωμα να κάνει φραστικές διορθώσεις στα κείμενα προκειμένου να μειώσει ασάφειες και επαναλήψεις και να βελτιώσει τη δυνατότητα επικοινωνίας ανάμεσα στους συγγραφείς και τους αναγνώστες του περιοδικού.

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ΕΙΔΗ ΑΡΘΡΩΝ

1. **Άρθρα Σύνταξης**: Σύντομα άρθρα γραμμένα ταυτόχρονα στην ελληνική και αγγλική γλώσσα που αναφέρονται σε επίκαιρα θέματα ιδιαίτερης σημασίας. Γράφονται από τη Συντακτική Επιτροπή ή από μέλη της Διεθνούς Συμβουλευτικής Επιτροπής ή μετά από πρόσκληση της Συντακτικής Επιτροπής (μέχρι 700 λέξεις και 7–8 βιβλιογραφικές αναφορές).
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4. **Σύντομα άρθρα:** Στην κατηγορία αυτή υπάγονται ερευνητικές εργασίες που μπορούν να καταχωρηθούν σε περιορισμένο χώρο. Η έκταση των άρθρων αυτών δεν πρέπει να υπερβαίνει τις 1.500 λέξεις.
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11. Όλες οι εργασίες θα πρέπει να συνοδεύονται από ελληνική και αγγλική περίληψη, περίπου 400 λέξεων η κάθε μία. Οι εργασίες που αναφέρονται ως σύντομα άρθρα και ως ενδιαφέρουσες περιπτώσεις θα πρέπει να συνοδεύονται από ελληνική και αγγλική περίληψη, περίπου 200 λέξεων η κάθε μία.

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Το δακτυλογραφημένο κείμενο πρέπει να συνοδεύεται από CD με το κείμενο της εργασίας ή να αποστέλλεται ηλεκτρονικό αντίγραφο με e-mail. Το κείμενο πρέπει να έχει γραφεί με επεξεργαστή συμβατό με πρόγραμμα Windows ή με οποιοδήποτε πρόγραμμα για υπολογιστή Macintosh.

Μαζί με τα υποβαλλόμενα άρθρα πρέπει να υποβάλλεται συμπληρωμένο το «Συνοδευτικό έντυπο υποβολής εργασίας». Οι υποβαλλόμενες εργασίες χαρακτηρίζονται με κωδικό αριθμό, που γνωστοποιείται στους συγγραφείς και ο οποίος χρησιμοποιείται σε κάθε επικοινωνία με το περιοδικό. Τα άρθρα γράφονται στη δημοτική γλώσσα. Η δακτυλογράφηση γίνεται στη μία όψη του φύλλου, με διπλό διάστημα και περιθώριο τουλάχιστον 3,5 cm.

Στην άνω δεξιά πλευρά της πρώτης σελίδας πρέπει να υπάρχει ο χαρακτηρισμός κάθε άρθρου (π.χ. Ανασκόπηση, Ερευνητική εργασία κ.λπ.).

ΔΙΑΤΑΞΗ ΤΗΣ ΥΛΗΣ

Όλες οι σελίδες αριθμούνται, αρχίζοντας από τη σελίδα τίτλου.

Σελίδα τίτλου: Περιλαμβάνει τον τίτλο του άρθρου (μέχρι 12 λέξεις), τα ονόματα των συγγραφέων στην ονομαστική, το κέντρο προέλευσης, τη διεύθυνση και το τηλέφωνο του συγγραφέα που θα επικοινωνεί με το περιοδικό. Στην ίδια σελίδα αναφέρονται επίσης άτομα, οργανισμοί, ιδρύματα κ.λπ., που ενδεχομένως συνέβαλαν στην πραγματοποίηση της εργασίας.

Περίληψη: Στη δεύτερη σελίδα γράφεται η ελληνική περίληψη, (περίπου 400 λέξεις). Στην περίληψη ανακεφαλαιώνονται τα κύρια μέρη της εργασίας. Φράσεις όπως «τα ευρήματα συζητούνται» πρέπει να αποφεύγονται. Στο τέλος της περίληψης αναγράφονται 4–6 λέξεις ευρετηρίου.

Αγγλική περίληψη: Στην τρίτη σελίδα γράφεται η αγγλική περίληψη, που πρέπει να έχει έκταση περίπου 400 λέξεων, ο τίτλος του άρθρου τα ονόματα των συγγραφέων και η προέλευση του άρθρου (ίδρυμα). Στο τέλος της περίληψης αναγράφονται 4–6 λέξεις ευρετηρίου. Η περίληψη πρέπει να δίνει ουσιαστικές πληροφορίες.

Κείμενο: Χωρίζεται σε κεφάλαια. Για τις ερευνητικές εργασίες είναι: Εισαγωγή, Υλικό και μέθοδος, Αποτελέσματα, Συζήτηση. Όσα αποτελέσματα παρατίθενται στους πίνακες δεν επαναλαμβάνονται λεπτομερώς στο κείμενο.

Βιβλιογραφικές παραπομπές: Αριθμούνται με αύξοντα αριθμό, ανάλογα με τη σειρά εμφάνισής τους στο κείμενο (σύστημα Vancouver). Π.χ. *Ο Birley[1] βρήκε ότι..., αλλά ο Afford[2] διαφώνησε...* Αναφέρονται τα ονόματα των έξι πρώτων συγγραφέων. Στον βιβλιογραφικό πίνακα περιλαμβάνονται μόνον οι βιβλιογραφικές παραπομπές που υπάρχουν στο κείμενο. Στα άρθρα ανασκόπησης και τα ειδικά άρθρα οι βιβλιογραφικές παραπομπές δεν πρέπει να υπερβαίνουν τις 100, στις ερευνητικές εργασίες και τα γενικά άρθρα τις 50, στα σύντομα άρθρα και τις ενδιαφέρουσες περιπτώσεις τις 15 και στα άρθρα σύνταξης και τις επιστολές προς τη σύνταξη τις 8. Ο βιβλιογραφικός κατάλογος συντάσσεται με αύξοντα αριθμό, που αντιστοιχεί στη σειρά εμφάνισης των βιβλιογραφικών παραπομπών στο κείμενο, όπως στα ακόλουθα παραδείγματα:

1. Birley JLT, Adear P, Singer D, Rosenberg M. Electrogastrographic studies in elderly patients. *Gastroenterology* 1980, 79:311–314 (Περιοδικό)
2. Alford J, Nemiah J. Peptic ulcer in childhood. In: Sodeman WA (ed) *Pathologic Physiology*. Saunders, Philadelphia, 1970:457–472 (Κεφάλαιο βιβλίου)
3. Kinden A. *Stress and emotion*. Springer, Berlin, 1990 (Βιβλίο)
4. Larsen E, Elliot B. Fatigue in major depression. *Psychiatriki* 2007, (Suppl 1):S143–S144 (Παράρτημα περιοδικού)
5. Silverstone A, Leman H, Stark J. *Attempted suicide by drug-overdose*. Paper presented at 2nd Congress on Suicide behaviour, 4–6 May 2002. Rome, Abstracts Book, pp 212–213 (Παρουσίαση σε Συνέδριο - Τόμος Πρακτικών)
6. Henry A, Andrews B. *Critical issues for parents with mental illness*. N.Y. Centre for Mental Health Services 2001 (Cited 2 June 2005) Available from www. mentalorg/publications (Ιστοσελίδα)

Οι συντμήσεις των περιοδικών πρέπει να γίνονται με βάση το *Index Medicus*.

Στο τέλος κάθε βιβλιογραφικής αναφοράς θα πρέπει να παρατίθεται το Ψηφιακό Αναγνωριστικό Αντικειμένου – DOI (Digital Object Identifier) ως εξής DOI:

Πίνακες: Γράφονται με διπλό διάστημα σε ξεχωριστή σελίδα. Αριθμούνται ανάλογα με τη σειρά εμφάνισής τους στο κείμενο, με αραβικούς αριθμούς (πίνακας 1), ακολουθεί σύντομη κατατοπιστική λεζάντα (π.χ. Ασθενείς που νοσηλεύθηκαν για ψευδοκύηση στο Νοσοκομείο «Αλεξάνδρα» κατά το 1988) και σε κάθε στήλη υπάρχει κατατοπιστική επικεφαλίδα. Αποφεύγονται οι κάθετες γραμμές.

Εικόνες: Πρέπει να στέλνονται είτε τα πρωτότυπα των σχεδίων (με σινική μελάνη) είτε φωτογραφίες. Στο πίσω μέρος πρέπει να αναγράφεται με μολύβι ο αριθμός της εικόνας, οι συγγραφείς και ο τίτλος της εικόνας. Όλες οι εικόνες πρέπει να αναφέρονται στο κείμενο και να αριθμούνται με αραβικούς αριθμούς.

Ονοματολογία και μονάδες μέτρησης: Για λεπτομέρειες, βλ. Ιατρική 1980, 37:139.

Διόρθωση τυπογραφικών δοκιμίων: Οι συγγραφείς είναι υποχρεωμένοι να κάνουν μία διόρθωση των τυπογραφικών δοκιμίων. Εκτεταμένες μεταβολές δεν επιτρέπονται.

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ΣΥΝΟΔΕΥΤΙΚΟ ΕΝΤΥΠΟ ΥΠΟΒΟΛΗΣ ΕΡΓΑΣΙΑΣ ΣΤΟ ΠΕΡΙΟΔΙΚΟ *"ΨΥΧΙΑΤΡΙΚΗ"*

(Υποβάλλεται μαζί με την εργασία, τρία φωτοαντίγραφα της εργασίας και την αντίστοιχη δισκέτα ή με την αποστολή ηλεκτρονικού αντιγράφου με e-mail, και τη συμπληρωματική της επόμενης σελίδας συγγραφικής ευθύνης, οικονομικής γνωστοποίησης και ευχαριστιών)

- Παρακαλώ συμπληρώστε/τσεκάρετε όλα τα σημεία του εντύπου
- Είδος εργασίας (σημειώστε με Χ):

❑ ΑΝΑΣΚΟΠΗΣΗ ❑ ΕΡΕΥΝΗΤΙΚΗ ΕΡΓΑΣΙΑ ❑ ΣΥΝΤΟΜΟ ΑΡΘΡΟ

❑ ΕΙΔΙΚΟ ΑΡΘΡΟ ❑ ΓΕΝΙΚΟ ΑΡΘΡΟ ❑ ΠΑΡΟΥΣΙΑΣΗ ΠΕΡΙΠΤΩΣΕΩΣ

- Τίτλος εργασίας .....

.....

- Ονοματεπώνυμα συγγραφέων .....

.....

.....

.....

- Φορέας ή Κέντρο (α), από το οποίο προέρχεται η εργασία .....

.....

.....

- Υπεύθυνος συγγραφέας για την αλληλογραφία .....

Ονοματεπώνυμο .....

Διεύθυνση .....

Τηλέφωνο ..... Fax: ..... E-mail: .....

- Επιβεβαιώστε (σημειώστε με Χ) όλα τα παρακάτω σημεία της εργασίας σας:
  - ❑ Περίληψη της εργασίας στα Ελληνικά και Αγγλικά, σύμφωνα με τις προδιαγραφές του περιοδικού
  - ❑ 4–5 λέξεις ευρετηρίου στα Ελληνικά και στα Αγγλικά
  - ❑ Αντιστοιχία των βιβλιογραφικών αναφορών του κειμένου με τον κατάλογο της βιβλιογραφίας, που παρατίθεται στο τέλος του άρθρου
  - ❑ Καταγραφή των βιβλιογραφικών αναφορών σύμφωνα με τις προδιαγραφές της «*Ψυχιατρικής*»

Οι συγγραφείς της εργασίας συμφωνούν με το περιεχόμενό της, τη δημοσίευσή της στο περιοδικό "Ψυχιατρική" και τη μεταβίβαση των συγγραφικών δικαιωμάτων στο περιοδικό. Το ίδιο κείμενο δεν έχει δημοσιευθεί ούτε έχει υποβληθεί για δημοσίευση σε άλλο περιοδικό. Οι συγγραφείς δεν έχουν αντικρουόμενα συμφέροντα σε σχέση με το περιεχόμενο της εργασίας και δηλώνουν ότι το πρωτόκολλο της έρευνας εγκρίθηκε από την Επιτροπή Βιοηθικής του Ιδρύματος όπου πραγματοποιήθηκε η έρευνα. Όλα τα άτομα που συμμετείχαν έδωσαν τη συγκατάθεσή τους πριν συμπεριληφθούν στην έρευνα. Οι συγγραφείς ακόμη δηλώνουν ότι δεν υπήρξε πηγή οικονομικής υποστήριξης (εάν υπήρξε πρέπει να δηλωθεί).

Υπογραφές συγγραφέων Ημερομηνία

ΨΥΧΙΑΤΡΙΚΗ: ΣΥΓΓΡΑΦΙΚΗ ΕΥΘΥΝΗ, ΟΙΚΟΝΟΜΙΚΗ ΓΝΩΣΤΟΠΟΙΗΣΗ ΚΑΙ ΕΥΧΑΡΙΣΤΙΕΣ

Με τη συμπλήρωση και υπογραφή του παρόντος εντύπου, ο συγγραφέας αλληλογραφίας αναγνωρίζει και αποδέχεται πλήρως την ευθύνη εκ μέρους όλων των συγγραφέων που συνεισέφεραν, των δηλώσεων σχετικά με τη Συγγραφική Ευθύνη, την Οικονομική Γνωστοποίηση, και την Υποστήριξη Χρηματοδότησης.

ΣΥΓΓΡΑΦΙΚΗ ΕΥΘΥΝΗ

Με την υπογραφή του παρόντος εντύπου και υπογράφοντας στα αντίστοιχα πεδία, ο συγγραφέας αλληλογραφίας πιστοποιεί ότι κάθε συγγραφέας πληροί όλα τα παρακάτω κριτήρια (Α και Β) και στη συνέχεια προσδιορίζει τη συνεισφορά τού κάθε συγγραφέως, σημειώνοντας το όνομά του/της, δίπλα στο αντίστοιχο πεδίο.

❑ Α. Ο συγγραφέας αλληλογραφίας πιστοποιεί ότι:

- Η υποβληθείσα εργασία αποτελεί πρωτότυπη και έγκυρη εργασία και το κείμενό της ή άλλο με παρεμφερές περιεχόμενο στα πλαίσια της συγγραφής μου δεν έχει δημοσιευθεί ή υποβληθεί για δημοσίευση κάπου αλλού, εκτός της περίπτωσης όπου μαζί με την εργασία περιγράφεται και επισυνάπτεται το σχετικό κείμενο. Εφόσον ζητηθεί, ο συγγραφέας αλληλογραφίας, θα παρέχει τα δεδομένα ή θα συνεργαστεί πλήρως στη συγκέντρωση και παροχή των δεδομένων στα οποία βασίζεται η εργασία. Κάθε συγγραφέας έχει εξουσιοδοτήσει τον συγγραφέα αλληλογραφίας να λειτουργεί ως ο κύριος εκπρόσωπος της συγγραφικής ομάδας, και να προβαίνει σε βελτιώσεις της εργασίας με βάση τις υποδείξεις των κριτών του περιοδικού.

❑ Β. Κάθε συγγραφέας έχει δώσει την τελική έγκριση για να γίνει η υποβολή τής εργασίας, έχει συμμετάσχει επαρκώς στην εργασία και αναλαμβάνει δημόσια την ευθύνη για όλο το περιεχόμενο και πληροί τις προϋποθέσεις για συγγραφή, εφόσον υπάρχει το όνομά του/της στην αντίστοιχη γραμμή των πεδίων των συνεισφορών που αναφέρονται παρακάτω.

Οι συγγραφείς που αναφέρονται παρακάτω έχουν συνεισφέρει σημαντικά στην εργασία στα διάφορα πεδία που αναφέρονται παρακάτω.

(ανέφερε τον αντίστοιχο συγγραφέα δίπλα στο κάθε πεδίο- κάθε συγγραφέας πρέπει να περιλαμβάνεται τουλάχιστον σε ένα πεδίο. Περισσότεροι από ένας συγγραφείς μπορεί να αναφέρονται σε κάθε πεδίο)

– Ιδέα και σχεδιασμός .....
– Συγκέντρωση δεδομένων .....
– Ανάλυση και ερμηνεία των δεδομένων .....
– Σύνταξη του κειμένου .....
– Επανεξέταση του κειμένου .....
– Στατιστική ανάλυση .....
– Χορήγηση χρηματοδότησης .....
– Διοικητική, τεχνική ή υλική υποστήριξη .....
– Εποπτεία .....

ΟΙΚΟΝΟΜΙΚΗ ΓΝΩΣΤΟΠΟΙΗΣΗ

❑ Από όλους τους συγγραφείς που έχουν συνεισφέρει στην εργασία δεν υπάρχει σύγκρουση συμφερόντων, συμπεριλαμβάνοντας ειδικά οικονομικά συμφέροντα, σχέσεις και συνεργασίες σχετικές με το αντικείμενο της υποβληθείσας εργασίας.

ή

❑ Βεβαιώνω ότι όλες οι συγκρούσεις συμφερόντων, συμπεριλαμβανομένων ειδικών οικονομικών συμφερόντων, σχέσεις και συνεργασίες σχετικές με το αντικείμενο της υποβληθείσας εργασίας είναι οι ακόλουθες:

Χορήγηση Χρηματοδότησης και ο Ρόλος του Χορηγού

❑ Δεν έλαβα χρηματοδότηση ή άλλη οικονομική ενίσχυση.

ή

❑ Βεβαιώνω ότι όλη η χρηματοδότηση, άλλη οικονομική ενίσχυση, και υλική υποστήριξη για την έρευνα και/ή την εργασία προσδιορίζονται σαφώς στη δήλωση συμφερόντων στο τέλος της εργασίας

ή

Η χρηματοδότηση ή άλλη οικονομική ενίσχυση και υλική υποστήριξη για την έρευνα και/ή την εργασία προσδιορίζονται ευκρινώς παρακάτω:

ΕΥΧΑΡΙΣΤΙΕΣ

Ο συγγραφέας αλληλογραφίας βεβαιώνει ότι:

Όλα τα άτομα που έχουν συνεισφέρει σημαντικά στην εργασία (π.χ. συλλογή δεδομένων, ανάλυση, γραφή ή συμβολή στην έκδοση) αλλά δεν πληρούν τα κριτήρια συγγραφής ονοματίζονται με τη συγκεκριμένη συνεισφορά τους στο κείμενο της εργασίας στις Ευχαριστίες. Όλα τα άτομα που ονοματίζονται στις Ευχαριστίες έχουν δώσει γραπτή συγκατάθεση προκειμένου να αναφερθεί το όνομά τους.

Αφού ολοκληρώσετε όλα τα παραπάνω απαιτούμενα πεδία, αυτή η φόρμα θα πρέπει να σταλεί μέσω φαξ ή e-mail ηλεκτρονικά μαζί με το συνοδευτικό έντυπο υποβολής και την υποβληθείσα εργασία.