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Editorial

Resilience in patients with psychotic disorder

Psychiatriki 2016, 27:13–16

The recovery movement differentiated clinical, which is related to disorder's symptoms, from personal recovery, which is outlined by a subjectively defined wellness state, characterised by hope and self-management. Schizophrenia research has long focused on risk factors and symptoms. The recovery movement triggered a focus shift from psychopathology towards better adjustment and growth despite living with schizophrenia.

The recovery movement flourished parallel with positive psychology, the scientific study of ordinary human strengths and virtues investigating human motives and potentials. Understanding of human strengths could contribute to prevention or lessening of psychiatric disorders' devastating consequences, since optimism, sense of personal control and many other positive processes promote psychological health.

Lately, the concepts of positive psychology have been implemented in schizophrenia research. Positive self-appraisals moderated suicidal ideation, even when patients experienced high levels of hopelessness.[1] Additionally, among other factors, better self-images, internal locus of control (i.e. the perception that events in one's life relate to one's actions) and emphasis on personal efforts predicted a more favourable outcome in functioning of unmedicated patients.[2]

The concept of "resilience" is closely related to positive psychology. The American Psychological Association defines resilience as ''the process of adapting well in the face of adversity, trauma, threats or significant sources of stress''. The concept of resilience includes rebound from adversity.[3]

Determinants of resilience include biological, psychological, social and cultural factors that interact in a complex manner. The major manifestations of personal resilience are social competence, problem solving, autonomy and sense of purpose.[5] Personality strengths that relate to resilience include high self-esteem, extroversion and optimism. Internal assets and personal competencies comprise the so called "phenomenological resilience" that can be measured by scales.[4,5]

Originally, research focused on resilience in relation to post-traumatic stress disorder and depression. Recently, resilience was proven a significant predictor of depressive episode recurrence in bipolar disorder.[6] Low resilience levels were also established in individuals at clinical high risk state for development of psychosis. Interestingly, individuals at high risk that developed a full-blown psychosis had shown significantly lower resilience levels compared with non-converters. Additionally, high resilience levels in individuals at high risk for psychosis related to less severe negative, anxiety and depressive symptoms, as well as higher social functioning.[7,8] Schizophrenia patients with higher resilience levels and optimism showed higher levels of happiness that associated in turn with lower perceived stress and higher personal mastery,[9] while resilience was a significant predictor of functioning in a subgroup of non-medicated schizophrenia patients.[10]

In light of evidence supporting a positive association between resilience and schizophrenia outcome and based on the fact that resilience is modifiable and could improve with treatment,[5] resilience studies are particularly meaningful, specifically within the first 3–5 years after schizophrenia onset,[11] and could lead to interventions that aim at harnessing resilience during this "critical period". Diverse positive psychology interventions aim at improving psychological well-being by developing and nourishing positive feelings, behaviours and cognitions. Lately, positive psychotherapy was adapted for schizophrenia patients and was proven a feasible intervention that might contribute to improvement in functioning.[12]

Conclusively, sustained improvement in social and occupational functioning remains the most important indicator of recovery from schizophrenia. Still, such an improvement may not be accomplished in all patients by currently available pharmacological treatment alone. Studies that implement resilience and other positive psychology concepts reinforce schizophrenia research shift from risk to protective factors, reverse the question "which factors associate with relapse and chronicity" to "which factors promote recovery" and are promising for the development of additional therapeutic approaches.

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Editorial

Η ψυχική ανθεκτικότητα σε ασθενείς με ψύχωση

Ψυχιατρική 2016, 27:13–16

Το «κίνημα της ανάρρωσης» (recovery movement) διαφοροποίησε την κλινική, που αφορά τα συμπτώματα μίας διαταραχής, από την προσωπική ανάρρωση του ασθενούς, η οποία ορίζεται υποκειμενικά από τον κάθε ασθενή και χαρακτηρίζεται από ευεξία, ελπίδα, καθώς και ικανότητα διαχείρισης του εαυτού. Η έρευνα στη σχιζοφρένεια εστίασε για μεγάλο διάστημα στους παράγοντες κινδύνου και στη συμπτωματολογία της διαταραχής. Το κίνημα της ανάρρωσης έδωσε το έναυσμα για τη στροφή της έρευνας από την ψυχοπαθολογία στην καλύτερη προσαρμογή και εξέλιξη των ασθενών παρά την ύπαρξη της διαταραχής.

Το κίνημα της ανάρρωσης άνθισε παράλληλα με τη θετική ψυχολογία, η οποία εστιάζει στην έρευνα των ανθρωπίνων δυνατοτήτων και προτερημάτων και μελετά τα κίνητρα και τις προοπτικές του ανθρώπου. Η κατανόηση των ανθρωπίνων δυνάμεων μπορεί να συνεισφέρει στην αποτροπή ή εξασθένιση των αρνητικών επιπτώσεων των ψυχικών διαταραχών, καθώς η αισιοδοξία, η αίσθηση ελέγχου του εαυτού και πολλά άλλα θετικά χαρακτηριστικά του ατόμου προάγουν την ψυχική υγεία.

Τελευταία, οι έννοιες της θετικής ψυχολογίας εισήχθησαν στην έρευνα της σχιζοφρένειας. Οι θετικές αυτοαξιολογήσεις φάνηκε να αμβλύνουν τον αυτοκτονικό ιδεασμό, ακόμα και σε ασθενείς με υψηλά επίπεδα απελπισίας.[1] Επίσης, μεταξύ άλλων παραγόντων, η θετική εικόνα εαυτού, η εσωτερική έδρα ελέγχου (locus of control), δηλαδή η θεώρηση ότι η έκβαση των γεγονότων στη ζωή σχετίζεται με τις πράξεις του ατόμου, καθώς και η έμφαση στην προσωπική προσπάθεια φάνηκε να αποτελούν προγνωστικούς δείκτες για την επίτευξη ικανοποιητικού επιπέδου λειτουργικότητας σε ασθενείς που δεν λάμβαναν φαρμακευτική αγωγή.[2]

Η έννοια της «ψυχικής ανθεκτικότητας» είναι στενά συνδεδεμένη με τη θετική ψυχολογία. Η Αμερικανική Ψυχολογική Εταιρία ορίζει την ψυχική ανθεκτικότητα ως «τη διαδικασία ικανοποιητικής προσαρμογής σε αντίξοες συνθήκες, τραύμα, απειλές ή σημαντικές πηγές στρες». Στη έννοια της ψυχικής ανθεκτικότητας συμπεριλαμβάνεται η ανάκαμψη (rebound) του ατόμου από την αντίξοη συνθήκη.[3]

Η ψυχική ανθεκτικότητα καθορίζεται από βιολογικούς, ψυχολογικούς, κοινωνικούς και πολιτισμικούς παράγοντες, οι οποίοι αλληλεπιδρούν με πολύπλοκο τρόπο. Τα κύρια χαρακτηριστικά του ατόμου με ψυχική ανθεκτικότητα είναι οι κοινωνικές δεξιότητες, η ικανότητα επίλυσης προβλημάτων, η αυτονομία και η αίσθηση ότι το άτομο έχει έναν σκοπό στη ζωή του. Στα χαρακτηριστικά προσωπικότητας που συνδέονται με την ψυχική ανθεκτικότητα περιλαμβάνονται επίσης η υψηλή αυτοεκτίμηση, η εξωστρέφεια και η αισιοδοξία. Τα προσόντα και οι ικανότητες του ατόμου διαμορφώνουν τη λεγόμενη «φαινομενολογική ψυχική ανθεκτικότητα», η οποία είναι δυνατόν να μετρηθεί με κλίμακες.[4,5]

Αρχικά, η έρευνα εστίασε στη μελέτη της ψυχικής ανθεκτικότητας σε σχέση με τη μετατραυματική διαταραχή στρες και την κατάθλιψη. Πρόσφατα, η ψυχική ανθεκτικότητα αναγνωρίστηκε ως προγνωστικός δείκτης επανεμφάνισης καταθλιπτικών επεισοδίων στη διπολική διαταραχή.[6] Επίσης, χαμηλά επίπεδα ψυχικής ανθεκτικότητας διαπιστώθηκαν σε άτομα υψηλού κινδύνου για εμφάνιση ψύχωσης. Μάλιστα, τα άτομα υψηλού κινδύνου για ψύχωση που τελικά εκδήλωσαν τη νόσο είχαν σημαντικά χαμηλότερα επίπεδα ψυχικής ανθεκτικότητας από τα άτομα που δεν νόσησαν. Επιπροσθέτως, υψηλά επίπεδα ψυχικής ανθεκτικότητας σε άτομα υψηλού κινδύνου για ψύχωση συσχετίστηκαν με ηπιότερα αρνητικά, αγχώδη και καταθλιπτικά συμπτώματα, καθώς και καλύτερη κοινωνική λειτουργικότητα.[7,8] Ασθενείς με σχιζοφρένεια με υψηλότερα επίπεδα ψυχικής ανθεκτικότητας και αισιοδοξία είχαν υψηλότερο δείκτη ευτυχίας, ο οποίος συσχετίστηκε με

χαμηλότερη αντίληψη άγχους και ισχυρότερη αίσθηση κυριαρχίας του εαυτού.[9] Τέλος, η ψυχική ανθεκτικότητα φάνηκε να αποτελεί σημαντικό προβλεπτικό δείκτη της λειτουργικότητας σε μία υποομάδα σχιζοφρενών που δεν λάμβαναν φαρμακοθεραπεία.[10]

Με βάση τις ενδείξεις που υποστηρίζουν μία θετική συσχέτιση ανάμεσα στην ψυχική ανθεκτικότητα και την έκβαση της σχιζοφρένειας, καθώς και το γεγονός ότι η ψυχική ανθεκτικότητα τροποποιείται και μπορεί να βελτιωθεί με τη θεραπεία,[5] η έρευνα γύρω από την ψυχική ανθεκτικότητα είναι σκόπιμη, ιδιαίτερα κατά την κρίσιμη περίοδο των πρώτων 3–5 ετών από την έναρξη της διαταραχής,[11] με στόχο τη δημιουργία παρεμβάσεων που να την ενισχύουν. Οι διάφορες προσεγγίσεις της θετικής ψυχολογίας στοχεύουν στη βελτίωση της ψυχικής υγείας μέσω ανάπτυξης και καλλιέργειας θετικών συναισθημάτων, συμπεριφορών και γνωστικών σχημάτων. Πρόσφατα, ένας τύπος θετικής ψυχοθεραπείας προσαρμόστηκε σε ασθενείς με σχιζοφρένεια και φάνηκε ότι μπορεί να συμβάλλει στη βελτίωση της λειτουργικότητας.[12]

Συμπερασματικά, η διατηρούμενη βελτίωση στην κοινωνική και επαγγελματική λειτουργικότητα παραμένει ο πιο σημαντικός προγνωστικός δείκτης ανάρρωσης από τη σχιζοφρένεια. Παρ΄ όλα αυτά, η θεραπευτική παρέμβαση που εστιάζει μόνο στη χορήγηση των διαθέσιμων φαρμακευτικών σκευασμάτων δεν φαίνεται να συμβάλλει στην ανάρρωση όλων των ασθενών. Οι μελέτες που εισάγουν την ψυχική ανθεκτικότητα και άλλες έννοιες της θετικής ψυχολογίας ενισχύουν τη στροφή της έρευνας στη σχιζοφρένεια από τους παράγοντες κινδύνου στους προστατευτικούς παράγοντες, αντιστρέφουν το ερώτημα «ποιοι παράγοντες σχετίζονται με την υποτροπή και τη χρονιότητα» στο «ποιοι παράγοντες προάγουν την ανάρρωση» και ανοίγουν το δρόμο για τη δημιουργία πρόσθετων θεραπευτικών προσεγγίσεων.

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Research article

Appraisal of a specific scale for quality of life (AlQoL-9) in Greek alcohol dependent individuals attending: A confirmatory factor analysis

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Alcohol abuse/dependence seriously affects quality of life (QoL). The AlQoL-9 scale, derived from the generic instrument SF-36, is the only instrument in the international literature which is specific as a measure of QoL for alcohol-dependent patients. It can provide health carers with valuable information regarding the needs of alcoholic individuals and the effects of therapeutic interventions. The aim of this study was to assess the psychometric properties of the Greek version of AlQoL-9 taking as a basis the research on the original French and English versions. A sample of 170 participants (118 males, 52 females) aged 24–74 years (mean age=48.2 years, SD=9.6) recruited from inpatient and outpatient detoxification units in different regions of Greece completed the AlQoL-9 questionnaire and the World Health Organization Quality of Life Assessment - short version (WHOQOL-BREF). The internal structure of the AlQoL-9 questionnaire was examined using confirmatory factor analysis (CFA). The associations of AlQoL-9 with sociodemographic and clinical variables were examined. The correlation coefficients between AlQoL-9 and scores on the domains of the WHOQOL-BREF questionnaire were computed as an indication of convergent validity. The average inter-item correlation between the AlQoL-9 items was 0.403. CFA supported a single factor underlying the AlQoL-9 items. Cronbach's alpha for the Greek version of the scale showed high internal consistency, 0.837, and could not be improved by omitting any item. The AlQoL-9 score showed significant associations with gender (mean 29.2, SD=6.2 for males; mean 26.1, SD=7.2 for females: $p=0.004$) and with comorbidity (mean 25.7, SD=7.8 with comorbidity, mean 29.5, SD=5.8 without: $p=0.001$). The AlQoL-9 score was significantly correlated ($p<0.001$) with all scores of the WHOQOL-BREF, most strongly with the WHOQOL domains of physical health (Pearson's $r=0.720$) and psychological health ($r=0.693$) and less so with social relationships (0.481), environment (0.411), and the single-item measures of overall health (0.554) and overall quality of life (0.522). The present study demonstrated that the Greek version of the AlQoL-9 constitutes a valid and reliable single-factor research instrument for evaluating quality of life among alcohol-dependent individuals. It is recommended to be used in combination with a generic QoL instrument e.g. the WHOQOL-BREF. It is suitable for clinical everyday practice to monitor possible patient QoL changes, as well as in large scale studies investigating QoL in the relevant population.

Key words: Alcohol-related disorder, Greece, quality of life, specific-quality of life questionnaires, validation studies.

Introduction

Measurements of quality of life (QoL) are increasingly used today not only in medical and health services studies but also as part of routine clinical care and reappraisal, across different groups of patients with physical or mental disorders and across different countries.[1–3] QoL measurements can provide health carers with valuable information regarding the needs of patients and the effects of interventions and treatment.[3–5]

Regarding alcohol abuse/dependence, this is a serious clinical condition causing major physical and psychosocial impairment and subsequently greatly affecting the perceptions of dependent individuals about their quality of life.[6] Despite evidence of the negative impact of alcohol misuse-abuse on QoL, there is a "paucity of papers" on this issue. Foster et al 1999, 2006[7,8] in their review reported 24 publications from 1982 to 1997, while Luquiens et al, 2012[9] identified only 18 studies from 1999–2012 on QoL in alcohol-dependent subjects.

Regarding QoL in Greek populations who suffer from alcohol abuse or dependence, there is evidence of notably poor QoL, even more diminished compared to psychotic patients and other patients with chronic health problems.[4,10] The majority of studies reporting QoL outcomes rely on generic and health related measurements that provide broader aspects and thematic domains included in the concept of QoL. On the other hand, they lack specificity in assessing QoL in alcohol dependence conditions.

At present, only one questionnaire is available that is specifically intended to assess the health and non-health related consequences of alcoholism for alcohol dependent individuals. This is the AlQoL-9, a nine-item questionnaire. It was developed by Malet et al, 2006[11] by condensing the French version of the SF-36, a health survey with physical and mental health summary measures,[1,2,7,12] retaining the items that were judged to be particularly pertinent to alcoholism. An English version of this measure was validated in an Australian urban sample of 138 individuals addicted to alcohol.[12]

Reliability of the instrument was found to be very satisfactory: Malet et al[11] obtained values of Cronbach's alpha 0.85 in an outpatient sample and 0.71 in inpatients, and Zubaran et al[12] obtained 0.83 in their sample of 138 individuals, consisting of both inpatients and outpatients.

The present study investigates the suitability of the Greek version of AlQoL-9 for measuring QoL in Greek alcohol dependent individuals. It carries out, for the first time, a confirmatory factor analysis of the structure of the AlQoL-9 instrument.

Material and Methods

Sample

The study sample consisted of 170 subjects (118 males, 52 females) aged 24–74 years (mean age=48.2 years, SD=9.6), who were admitted consecutively to specialised in-patient and outpatient units and detoxification programs across Greece from September 2014 to March 2015 and fulfilled ICD-10 diagnostic criteria for alcohol abuse/dependence. Data were collected from the inpatient units of "Eginition" Psychiatric Hospital in Athens, the "Dafni" Psychiatric Hospital in Athens and the "Methexis" day hospital in the Psychiatric Hospital of Thessaloniki. The outpatient units included two major therapeutic organizations for addictions, that is, OKANA in Athens ("Athena" programme), and the KETHEA departments in Athens, Thessaloniki, Alexandroupolis, Kalamata and Irakleion in Crete, as well as the Club of Alcoholics and the alcohol outpatient unit in the University Hospital of Irakleion in Crete. Sixty-two participants (36.5%) were hospitalised and 108 (63.5%) were attending out-patient programs. All subjects volunteered to participate after having been informed of their right to refuse or discontinue participation at any time and without prejudice. Detailed information on the objectives of the study and the therapeutic research protocol was provided and written informed consent was obtained from each participant. Ethical permission for the study was obtained from the First Department of Psychiatry, the National and Kapodistrian University of Athens, in accordance with the ethical standards of the relevant committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 1983.

Measures

In addition to the AlQoL-9, participants also completed the World Health Organization Quality of

Life Assessment WHOQOL-BREF questionnaire during their participation or residence in the respective therapeutic setting.[11,13]

a. AIQoL-9

The AIQoL-9 uses nine items from the SF-36, addressing quality-of-life-related issues of physical functioning, bodily pain, general health, physical limitations, mental health, emotional limitations, vitality, and social functioning (Appendix I).

The English questionnaire was translated into Greek by two independent translators, and then back translated into English by an independent bilin-

Appendix I: AIQoL-9 questionnaire

Απαντήστε σε όλες τις παρακάτω ερωτήσεις. Μερικές μπορεί να μοιάζουν όμοιες, αλλά η καθεμία είναι διαφορετική. Παρακαλούμε λάβετε χρόνο να διαβάσετε και να απαντήσετε σε κάθε ερώτηση προσεκτικά. Σημειώσατε με «Χ» την απάντηση που σας αντιπροσωπεύει.

1. Η κατάσταση της υγείας σας, σας περιορίζει τώρα στο να ανεβαίνετε αρκετές σειρές από σκαλιά; Αν ναι, πόσο;
   - Ναι με περιορίζει πολύ ☐
   - Ναι, με περιορίζει λίγο ☐
   - Όχι, δεν περιορίζει καθόλου ☐
2. Σε ποιο βαθμό είχατε σωματικούς πόνους τις τελευταίες 4 εβδομάδες;
   - Καθόλου ☐
   - Πολύ ήπια ☐
   - Ήπια ☐
   - Μέτρια ☐
   - Αρκετά ☐
   - Πολύ ☐
3. Πόσο χρόνο κατά τη διάρκεια των 4 τελευταίων εβδομάδων αισθανθήκατε πολύ νευρικοί;
   - Όλο το χρόνο ☐
   - Πολύ χρόνο ☐
   - Αρκετό χρόνο ☐
   - Λίγο χρόνο ☐
   - Πολύ λίγο χρόνο ☐
   - Καθόλου χρόνο ☐
4. Πόσο χρόνο κατά τη διάρκεια των 4 τελευταίων εβδομάδων αισθανθήκατε μελαγχολικοί;
   - Όλο το χρόνο ☐
   - Πολύ χρόνο ☐
   - Αρκετό χρόνο ☐
   - Λίγο χρόνο ☐
   - Πολύ λίγο χρόνο ☐
   - Καθόλου χρόνο ☐
5. Πόσο χρόνο κατά τη διάρκεια των 4 τελευταίων εβδομάδων αισθανθήκατε κουρασμένοι-εξαντλημένοι;
   - Όλο το χρόνο ☐
   - Πολύ χρόνο ☐
   - Αρκετό χρόνο ☐

(Συνεχίζεται)

Appendix I: AlQoL-9 questionnaire *(συνέχεια)*

Λίγο χρόνο □
Πολύ λίγο χρόνο □
Καθόλου χρόνο □

6. Γενικά, θα λέγατε ότι η υγεία σας είναι:

Εξαιρετική □
Πολύ καλή □
Καλή □
Μέτρια □
Πτωχή □

7. Κατά τη διάρκεια των τελευταίων 4 εβδομάδων, είχατε κάποιο πρόβλημα από τα παρακάτω στη δουλειά σας ή σε κάποιες καθημερινές δραστηριότητες, ως αποτέλεσμα κάποιων ψυχολογικών προβλημάτων (π.χ. αίσθημα καταπίεσης ή άγχους)

Ναι □
Όχι □

8. Κατά τη διάρκεια των τελευταίων 4 εβδομάδων, είχατε κάποιο πρόβλημα από τα παρακάτω στη δουλειά σας ή σε κάποιες καθημερινές δραστηριότητες, ως αποτέλεσμα της σωματικής σας υγείας (για παράδειγμα σας πήρε επιπλέον προσπάθεια);

Ναι □
Όχι □

9. Κατά τη διάρκεια των 4 τελευταίων εβδομάδων, πόσες φορές η σωματική σας υγεία ή τα συναισθηματικά σας προβλήματα σας δημιούργησαν εμπόδια στις κοινωνικές σας δραστηριότητες (επίσκεψη σε φίλους, συγγενείς κ.λπ.);

Συνεχώς □
Τις περισσότερες φορές □
Μερικές φορές □
Λίγες φορές □
Καθόλου □

gual psychologist, who was kept blind to the original test. The researchers of the present study made final adjustments to the Greek version in order for it to be as equivalent as possible. The AlQoL-9 includes dichotomous alternatives as well as Likert-type items varying from three to six response items based on parameters of intensity and frequency. The mean overall QoL score is expressed quantitatively without using cut-off thresholds. AlQoL-9 scores can vary from 9 (lowest, indicating poorest QoL) to 41(highest, indicating best QoL).[1,11–13]

b. The World Health Organisation Quality of Life Assessment-BREF (WHOQOL-BREF)

The WHOQOL-BREF is the abbreviated form of the WHOQOL-100 which is a health-related generic QoL instrument developed by the World Health Organization to examine the individual's assessment of his or her QoL.[3,13]

The original 26 items of WHOQOL-BREF cover four domains: (a) Physical Health and Level of Independence, (b) Psychological Health and Spirituality, (c) Social Relationships and (d) Environment. The 30-item Greek version adds four national items for purposes of cultural adaptation. These relate to: Nutrition, Social Life, Family Life and Job Satisfaction.[3] Of these items, two national ones are added in the Physical Health domain and two in the Social Relationships domain. All items are rated using a 5-point Likert scale. So, four domain scores are produced, including two general items that are scored separately (examining the individual's per-

ception of his/her overall QoL and general health status). Higher scores indicate better quality of life.[3,4,14,15]

Statistical analysis

The main analysis consists of confirmatory factor analyses carried out to examine particular structures that have been suggested by previous investigations of the psychometric properties of the questionnaire.[16] Specifically, based on the conclusions of Malet et al[11] and Zubaran et al,[12] two models were fitted and tested: (a) a single latent factor underlying all nine items; (b) two correlated latent factors, one underlying the Physical Health items 1, 2 and 6 and the other, labelled Mental Health, underlying the remaining six items. These models were fitted by maximum likelihood using IBM SPSS AMOS Version 21.0. Descriptive statistics, Pearson correlation coefficients and Cronbach's alpha statistics were calculated using IBM SPSS Statistics software Version 20.0.

Results

Sociodemographic characteristics of the sample are shown in table 1. The mean usual daily consump-

Table 1. Sociodemographic characteristics of the sample.

	Characteristic	*n*	*(%)*
Total sample		170	100
Gender	Male	118	69.4
	Female	52	30.6
Age	<40 years	37	21.8
	40–49	64	37.6
	50–59	46	27.1
	60+	23	13.5
Educational level	Primary (6 grades) or less	19	11.2
	Compulsory (9 grades)	29	17.1
	High school (12 grades)	57	33.5
	Technical education	20	11.8
	Tertiary education	45	26.5
Marital status	Single	39	22.9
	Married/cohabiting	87	51.2
	Divorced/separated/widowed	44	25.9
No of children	None	61	35.9
	One	36	21.2
	Two or more	73	42.9
Living arrangements	Alone	35	20.6
	With spouse/partner and children	52	30.6
	Spouse/partner, without children	40	23.5
	With parent(s)	36	21.2
	With child(ren)	6	3.5
	Other	1	0.6
Employment	Employed in public or private sector	58	34.1
	Self-employed	45	26.5
	Pensioner	25	14.7
	Unemployed	18	10.6
	Not working	16	9.4
	Agriculture	8	4.7
Comorbidity*	No	117	68.8
	Yes	53	31.2

* Comorbidity refers to the co-occurrence of two psychiatric conditions. The subjects with comorbidity fulfilled the diagnostic criteria for at least two psychiatric conditions. The conditions present were: affective disorders 32 (18.8%), personality disorders 13 (7.6%), anxiety disorders 6 (3.5%) and schizophrenia 2 (0.6%).

tion of alcohol of 149 participants was 278.0 gr (SD 202.7). The mean consumption of 85 participants from Athens was 253.7 gr (SD 155.0) and of the 64 participants from other regions 310.3 (SD 250.3). Table 2 shows mean responses to each of the AlQoL-9 items. In comparison to those shown by Zubaran et al,[12] all means in the Greek sample were statistically significantly higher (p<0.001) with the exception of the first item (p=0.56 in t test).

The scree plot of the eigenvalues of the correlation matrix (figure 1) strongly suggests that the items have a unidimensional structure. This was supported by a parallel analysis,[17] in which the first eigenvalue obtained from the data (4.33) was well above the 95th percentile of eigenvalues from simulated data (1.48) but the second eigenvalue (1.01) was below the mean of simulated values (1.24).

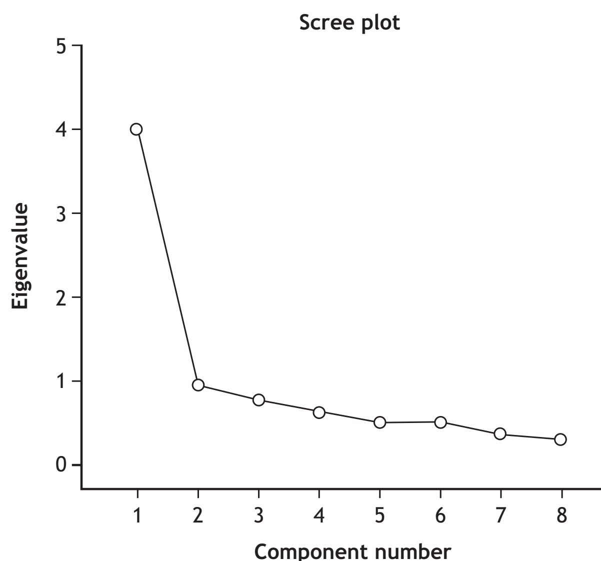

Figure 1. Scree plot of the eigenvalues of the correlation matrix of the nine items of the AlQoL-9 questionnaire.

Confirmatory factor analysis

Figure 2 shows estimates from fitting the single factor model to the data. Figure 3 shows estimates from fitting the alternative two-factor model with Items 1, 2 and 6 forming a Physical Health dimension and the remaining six items a Mental Health dimension, correlated with the first. Goodness of fit statistics for the two models are shown in table 3. Although the values of the indices are of course better for the more complex second model, those for the first one are satisfactory. Furthermore, the two factors of the second model are highly correlated as seen in figure 3. Consequently, as concluded by Malet et al,[11] the evidence for a two-factor structure is weak and the best representation of the structure appears to be provided by the single factor model.

Scale reliability and validity

The internal consistency of the AlQoL-9 scale score constructed from the sum of responses to the individual items was very good, with a value of 0.837 for Cronbach's alpha. This could not be improved by omitting any item (values of alpha after leaving out a single item ranged from 0.806 to 0.832).

The AlQoL-9 score was statistically significantly correlated with gender, with higher scores (better QoL)

Table 2. Descriptive statistics for individual AlQoL items and Pearson correlation coefficients between items.

		Correlation with item							
Item	*Mean(sd)*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*
1 (1–3)*	2.25 (0.72)								
2 (1–6)	4.47 (1.51)	0.384							
3 (1–6)	4.04 (1.23)	0.362	0.289						
4 (1–6)	3.74 (1.43)	0.329	0.285	0.640					
5 (1–6)	4.05 (1.29)	0.324	0.371	0.492	0.504				
6 (1–5)	2.94 (0.99)	0.585	0.443	0.347	0.505	0.428			
7 (1–2)	1.54 (0.50)	0.262	0.338	0.455	0.489	0.428	0.333		
8 (1–2)	1.62 (0.49)	0.377	0.446	0.343	0.364	0.433	0.389	0.577	
9 (1–6)	3.64 (1.39)	0.344	0.373	0.424	0.511	0.388	0.403	0.414	0.547

* Range of scores

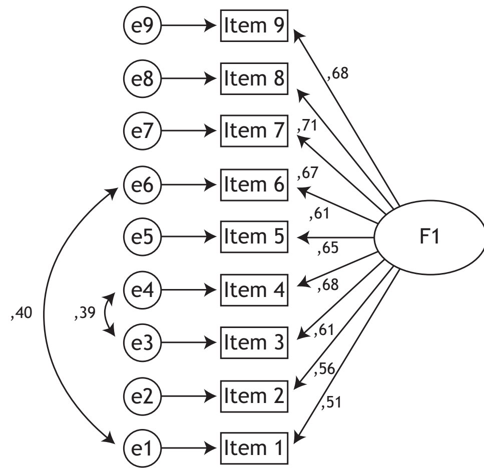

Figure 2. Estimates of the single factor model fitted to the nine items of the AlQoL-9 questionnaire. F1 denotes the single underlying latent factor. The unique effects specific to each item are labelled e1...e9.

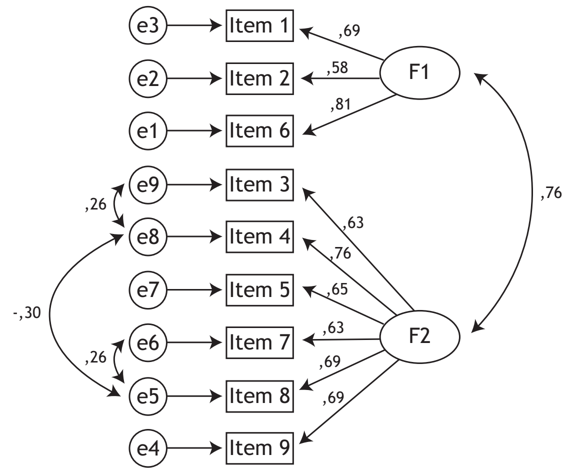

Figure 3. Estimates of the model with two correlated factors fitted to the nine items of the AlQoL-9 questionnaire. F1 denotes the underlying Physical Health factor and F2 the Mental Health factor.

for men (mean 29.2, SD 6.2) than women (mean 26.1, SD 7.2, t_{168}=2.89, p=0.004). They were also associated with comorbidity, with higher scores in the absence of other conditions (mean 29.5, SD 5.8) compared to subjects who had other conditions (mean 25.7, SD 7.8, t_{168}=3.49, p=0.001). No statistically significant association was found with age, education, occupation, family status or place of residence (all p>0.10).

Table 4 shows correlations between the AlQoL-9 scale score and scores obtained from the WHOQOL-BREF. All correlations were statistically significant at p<0.001.

Values of Cronbach's alpha for the internal consistency of the WHOQOL-BREF subscales were very good for the domains of Physical Health (alpha=0.818) and Psychological Health (0.855), and lower but still satisfactory for Social Relationships (0.603) and Environment (0.682).

Discussion

The evaluation of QoL among patients with alcohol abuse and dependence has been conducted mainly using generic QoL instruments such as the SF-36[1,2] or the WHOQOL instrument.[4] The question-

Table 3. Goodness of fit indices for two models fitted by maximum likelihood to the nine items of the AlQoL-9 questionnaire.

Model	*Factor structure*	*χ²/df*	*SRMR*	*NFI*	*CFI*	*TLI*	*RMSEA* (95% CI)
1	1 first-order uncorrelated factor	2.57	0.052	0.893	0.930	0.899	0.096 (0.068–0.126)
2	2 first-order correlated factors	1.92	0.045	0.926	0.963	0.941	0.074 (0.040–0.106)

df: degrees of freedom, SRMR=standardized root mean square residual, NFI: normed fit index, CFI: comparative fit index, TLI: Tucker-Lewis index, RMSEA: root-mean-square error of approximation, CI: confidence interval

Table 4. Pearson correlations between the AlQoL-9 scale score and the subscale scores obtained from the WHOQOL-BREF questionnaire. All correlations were statistically significant with p<0.001.

	Correlation r
Overall Quality of Life	0.522
Overall health	0.554
Physical health	0.720
Psychological health	0.693
Social relationships	0.481
Environment	0.411

naire AlQoL-9 is the only instrument developed to address the issue of QoL specifically in alcohol dependence.[10,11] Reaney et al. indicated that, as the construction of AlQoL-9 was based on the generic instrument SF-36, it has preserved similar generic qualities as well as disadvantages. However, it has the advantage of being short and thus easy to use, after the elimination of items that were shown to be not useful. By means of this process, the scale has gained in specificity.

The present study is the first endeavor to implement a valid QoL assessment tool for people with alcohol abuse/dependence, introducing the AlQoL-9 in Greece. It is also the third study on the international level that supports the use of QoL-specific measurement, after the original French AlQoL-9 study[11] and the validation of the English version in Australia,[12] testing exclusively the AlQoL-9 psychometric properties and employing for the first time confirmatory factor analysis.

Regarding the internal structure of the Greek version of AlQoL-9, it is observed that according to the results of the confirmatory factor analysis, the evidence for a two-factor structure seems to be weak and the best representation of the structure appears to be provided by the single factor model. Also, the scree plot suggests that the items have a unidimensional structure. In reference to convergent validity, all correlations with WHOQOL-BREF domains were positive and statistically significant (p≤0.001).

In line with previous studies examining the performance of the AlQoL-9, the Greek version of the AlQoL-9 appeared to have satisfactory psychometric properties suggesting that the AlQoL-9 is a trustworthy instrument well suited to assessing quality of life in individuals who suffer from alcohol abuse and dependence. The correlations between its nine items (table 2) were all positive and statistically significant (p≤0.001), with an average inter-item correlation of 0.403. The results of Zubaran et al,[12] showed some low correlations between Item 7 (emotional problems) and other items, which was not the case in the Greek sample. The internal consistency of the instrument in the Greek sample of 170 inpatients and outpatients as measured by Cronbach's alpha was very good (0.837). One limitation of the present study was that test-retest correlation was not assessed.

The AlQoL-9 was considered as highly acceptable by the participants because it is brief, comprehensible and easy to complete. In the first validation study of the AlQoL-9 in two independent populations, Malet et al[11] found that the instrument had good internal consistency (Cronbach's alpha coefficient of 0.71 and 0.85 for inpatients and outpatients respectively), high test-retest reliability (ICC from 0.57–0.85) and excellent acceptability. Zubaran et al[12] in their study of 138 inpatients and outpatients suffering alcohol abuse and dependence also reported good internal consistency and reliability of the AlQoL-9 (Cronbach's alpha of 0.825, mean of the inter-item correlations 0.491), and high acceptability. Since the assessment of the quality of life of people with alcohol-related problems may be susceptible to bias when general QoL scales are used, the good performance of the AlQoL-9 across countries and in various settings provides evidence for it to be considered as a validated and reliable measurement. The higher scores on eight of the nine individual items in comparison to Zubaran et al may show higher QoL in the Greek sample. Alternatively, it could be due to different response styles in the two cultures. In this light, it is noteworthy that the item that does not differ between the two samples ("Does your health limit you in climbing several flights of stairs?"), is the most objective of the nine.

The World Health Organisation Quality of Life Assessment-BREF (WHOQOL-BREF) questionnaire,[3,14] was used in the present study to provide evidence of the convergent validity of the AlQoL-9. As a measure of convergent validity the results from the AlQoL-9 scale score were compared to the scores from the WHOQOL-BREF. In case of convergence, the sub-

scales measuring similar constructs are expected to be strongly correlated, which means that the correlation should be over 0.40. On the other hand, a correlation under 0.40 shows low convergence suggesting that the subscales assess different constructs. Our findings revealed that internal consistency of the WHOQOL-BREF subscales were very good for the domains of Physical Health and Psychological Health, and fair but satisfactory for Social Relationships and Environment. The Physical Health and Psychological Health subscales of the WHOQOL-BREF were highly correlated with the AlQoL-9 score suggesting that both instruments tap homogenous constructs.

Conclusion

To conclude, the Greek version of the AlQoL-9 displayed satisfactory reliability and validity indices. Its use in research is expected to contribute to the effective reform of the national mental health system, by considering alcohol dependents' functioning and quality of life. In routine clinical practice, the systematic assessment of self-reported quality of life will help care givers to evaluate and improve the quality of life of their patients. The combined use of specific and generic QoL instruments provides a comprehensive and rich assessment of QoL.

Αποτίμηση της ειδικής κλίμακας ποιότητας ζωής (AlQoL-9) σε Ελληνικό δείγμα ατόμων με αλκοολική εξάρτηση και σε διαφορετικά θεραπευτικά προγράμματα: Μια επιβεβαιωτική παραγοντική ανάλυση

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Ψυχιατρική 2016, 27:17–26

Η διεθνής βιβλιογραφία υποδεικνύει ότι η κατάχρηση οινοπνευματωδών και η επαγόμενη ανάπτυξη εξάρτησης από το αλκοόλ επηρεάζουν σημαντικά την ποιότητα ζωής του ατόμου. Εντούτοις, τα ψυχομετρικά εργαλεία για την εκτίμηση της ποιότητας ζωής στην αλκοολική εξάρτηση είναι σπάνια. Η κλίμακα AlQoL-9 κατασκευάστηκε με βάση το γνωστό ερωτηματολόγιο γενικής λειτουργικότητας που αποτυπώνει την ποιότητα ζωής, την κλίμακα SF-36, και αποτελεί το μοναδικό εργαλείο στη διεθνή βιβλιογραφία το οποίο είναι ειδικό για τη μέτρηση της ποιότητας ζωής σε εξαρτημένα από αλκοόλ άτομα. Ο σκοπός αυτής της μελέτης ήταν η αξιολόγηση των ψυχομετρικών ιδιοτήτων της ελληνικής εκδοχής του AlQoL-9, συλλέγοντας στοιχεία από ένα πανελλαδικό δείγμα και λαμβάνοντας ως βάση την αρχική και μοναδική έρευνα που διεξήχθη στον διεθνή χώρο, με τη χρήση της αγγλικής εκδοχής του ερωτηματολογίου. Ένα δείγμα από 170 άτομα από κλειστές και ανοικτές μονάδες αποτοξίνωσης και από διαφορετικά θεραπευτικά προγράμματα από όλη την Ελλάδα συμπλήρωσαν το ερωτηματολόγιο AlQoL-9, καθώς και τη συνοπτική μορφή του γενικού ερωτηματολογίου ποιότητας ζωής του Παγκόσμιου Οργανισμού Υγείας (WHOQOL-BREF). Η δομή του ερωτηματολογίου AlQoL-9 διερευνήθηκε με επιβεβαιωτική παραγοντική ανάλυση (CFA). Εξετάστηκαν οι συσχετίσεις ανάμεσα στις βαθμολογίες της κλίμακας AlQoL-9 με τα κοινωνικοδημογραφικά στοιχεία των συμμετεχόντων, καθώς και με

τις βαθμολογίες που προέκυψαν από τους τομείς του ερωτηματολογίου WHOQOL-BREF, το οποίο έχει μελετηθεί εκτενώς σε δείγματα του ελληνικού πληθυσμού. Η επιβεβαιωτική παραγοντική ανάλυση υποστήριξε τη δομή του ερωτηματολογίου AlQoL-9 με τη χρήση ενός παράγοντα. Το Cronbach's alpha της ελληνικής εκδοχής του ερωτηματολογίου ήταν 0,837, τιμή η οποία είναι πολύ ικανοποιητική για την εσωτερική συνάφεια του εργαλείου. Ως προς την εγκυρότητα του AlQoL-9, διαπιστώθηκαν σημαντικές συσχετίσεις ανάμεσα στις βαθμολογίες της εν λόγω κλίμακας με τις 4 θεματικές υποενότητες (τομείς) και τις 2 γενικές ερωτήσεις από το ερωτηματολόγιο WHOQOL-BREF. Η μεγαλύτερη στατιστικά σημαντική συσχέτιση (p<0,001) παρουσιάστηκε στην υποενότητα που εξετάζει τη σωματική υγεία (Pearson's r=0,720) και η επόμενη μεγαλύτερη ήταν στην υποενότητα της ψυχολογικής υγείας (r=0,693), ενώ οι συσχετίσεις με τις υποενότητες των κοινωνικών σχέσεων (0,481) και του περιβάλλοντος (0,411), καθώς και με τις γενικές υποενότητες της γενικής υγείας (0,554) και της συνολικής ποιότητας ζωής (0,522) ήταν σχετικά μικρότερες. Με βάση τα αποτελέσματα, το ερωτηματολόγιο AlQoL-9 αποδεικνύεται ένα εύχρηστο ψυχομετρικό εργαλείο, το οποίο κρίνεται ως αξιόπιστο να χρησιμοποιηθεί στην εκτίμηση της ποιότητας ζωής σε άτομα που παρουσιάζουν αλκοολική εξάρτηση. Προτείνεται η συνδυαστική χρήση του ειδικού ερωτηματολογίου με μια κλίμακα γενικής ποιότητας ζωής, όπως το WHOQOL-BREF. Το AlQoL-9 προτείνεται ως ένα κατάλληλο ψυχομετρικό εργαλείο χρήσιμο στην καθημερινή κλινική πρακτική και την παρακολούθηση των πιθανών αλλαγών στην ποιότητα ζωής του ασθενούς, καθώς και σε μελέτες μεγάλης κλίμακας για τη διερεύνηση της ποιότητας ζωής στον σχετικό ψυχιατρικό πληθυσμό.

: Σχετιζόμενη με αλκοόλ διαταραχή, Ελλάδα, ποιότητα ζωής, ειδικά ερωτηματολόγια ποιότητας ζωής, μελέτες εγκυρότητας.

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Research article

Comorbid psychopathology and clinical symptomatology in children and adolescents with obsessive-compulsive disorder

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Comorbid psychopathology in children and adolescents with obsessive-compulsive disorder (OCD) has been investigated in a number of studies over the last twenty years. The aim of the present study was to investigate the phenomenology of illness and broader psychopathology in a group of Greek children and adolescents with OCD. The investigation of parental psychopathology in children and adolescents with OCD was a secondary aim of the present study. We studied 31 children and adolescents with OCD (n=31, age range 8–15 years) and their parents (n=62, age range 43–48 years) and compared to children and adolescents with specific reading and written expression learning disorders (n=30, age range 7–16 years) and their parents (n=58, age range 40–46 years). Appropriate testing showed specific reading and learning disorders, which were of mild to moderate severity for the 85% of this latter group. The diagnosis of learning disorder of reading and written expression was made through the use of standardized reading material, appropriate for ages 10–15 years. Reading comprehension and narration were tested. The written expression (spelling, syntax, content) was examined by a written text, in which the subject developed a certain theme from the reading material. Based on their level of education and occupation, the index families were classified as high (29%), average (45%) and low (26%) socioeconomic status, whereas 6.7% of control families belonged to high, 63.3% to average, and 30% to low status. In order to investigate psychopathology, the Schedule for Affective Disorders and Schizophrenia for School Aged Children, Present and Life-time version was administered to children and their parents, as well as the Child Behavior Checklist 4/18 (CBCL) to both parents and adolescents (Youth Self-Report). Also the Yale–Brown Obsessive Compulsive Scale (Y–BOCS) was rated for both children and parents. Moreover, the children were given the Children's Depression Inventory (CDI) and the Revised Children's Manifest

Anxiety Scale (RCMAS). In the OCD group, 48% had contamination obsessions, 42% aggressive obsessions and 52% had washing and cleaning compulsions. Moreover, 32% had one additional disorder and 16.1% had two additional disorders. In comparison, only 17.2% of the control group children had one comorbid disorder. The OCD proband group had higher Total Problems score, as well as higher Anxiety/Depression, Thought Problems and Externalizing scores on the CBCL. When proband parents and control parents (29 mothers and 21 fathers) were compared, the percentage of fathers in the clinical range was significantly higher in the study group (Fisher's exact test: p=0.011, two tailed), whereas for mothers the difference did not attain significance (Fisher's exact test: p=0.106, two tailed). The fathers and mothers of children with OCD were more clinically affected than those of controls. Mothers of probands differed from controls in compulsions, compared to fathers, who differed in both obsessions and compulsions. Comorbidity rate was higher to children and adolescents with OCD. A considerable number of children and adolescents with OCD had higher symptomatology of anxiety and depression than controls, as well as higher rates of thought problems. Children and adolescents with OCD also exhibited higher rates of externalizing problems. This latter finding is considered as important and needs to be highlighted in terms of case management and treatment. Moreover, the parents of children and adolescents with OCD had more OCD symptomatology than the parents of children and adolescents with learning disorders. The symptomatology of the parents may create difficulties in interactions within the family and become burdensome for a vulnerable child. In turn, the child's symptomatology may create or increase some of the symptoms in the parents i.e. anxiety and depression. These findings suggest that at least for a percentage of children and adolescents with OCD, parental and especially paternal influence may contribute to the development and severity of their symptoms, not only through hereditary factors but also through the control exerted and the anxiety created in the family context.

Key words: Aggressive behaviour, externalizing problems, children and adolescents, comorbidity, obsessive compulsive disorder.

Introduction

Comorbid psychopathology in children and adolescents with OCD has been investigated in a number of studies over the last twenty years. The Child Behavior Checklist 4/18 (CBCL)[1] has been used in some of these studies. Riddle et al[2] found that Total behavioral problems (expressed by the T score) were almost two standard deviations above the norm. Hanna[3] found that Internalizing scale scores were two standard deviations above the norm and higher than Externalizing scale scores. Mean T scores for "anxiety-depression" and "thought problems" subscales were also two standard deviations above the norm, while "withdrawal", "attention", "social problems", and "somatic complaints" subscales T-scores were found to be one standard deviation above the norm. Children with OCD and a comorbid Disruptive Behavior Disorder (DBD) had higher Internalizing and Externalizing T-scores than those without DBD. Moreover, Black et al[4] studied children whose parents had OCD and found that most of them had OCD or broad spectrum OCD as well. These children had significantly different scores than controls on the "somatic complaints" and "anxious-depressed" subscales of the CBCL. Their Total scores and Internalizing scores were also significantly higher than those of controls.

Other disorders, such as affective or anxiety disorders and DBD, are often comorbid with OCD as well as Attention-Deficit/Hyperactivity Disorder (ADHD), and tics or Tourette's syndrome (TS).[5–9] Moreover, obsessions of contamination and of aggressive content, as well as washing, cleaning, ordering and arranging compulsions appear to be the most prominent and frequent in children with OCD.[2,3,5,8,9]

According to our knowledge there is a lack of studies concerning Greece. Given information from previous studies, such as those presented above, the aim of the present study was to investigate the phenomenology of illness and broader psychopathology in a group of Greek children and adolescents with OCD. The investigation of parental psychopathology in children and adolescents with OCD was a secondary aim of the present study.

Material and method

Subjects

Thirty-one children and adolescents of Caucasian origin with OCD, aged 8–15 years (mean age 12.4±1.6), 9 girls and 22 boys, who came as outpatients at the department of Child and Adolescent Psychiatry at a general children's hospital and a community Child and Adolescent Psychiatry clinic, were examined on a consecutive basis. The children were not pre-selected. The children and adolescents were given the diagnosis of OCD when they came to our hospital and clinic. Their symptoms had appeared several months before their first examination by us. Their socioeconomic background was relatively similar, but more children treated at the hospital had greater intensity of OCD symptoms than those in the community. Their parents (n=62) were also examined. The mean age of mothers was 42.9±5.7 years and of fathers 47.8±5.9 years. We administered medication for the disorder in 25 of the children and adolescents with OCD. Children and adolescents with learning disorders of reading and written expression (n=30, 13 girls and 17 boys, aged 7–16 years, mean age 11,6±2.0) who came for remediation help at the previously noted community psychiatric clinic and their parents (n=58) were used as controls. The mean age of mothers was 40.6±2.8 years and of fathers, 44.6±1.4 years. Appropriate testing showed specific reading and learning disorders, which were of mild to moderate severity for the 85% of the children. Based on their level of education and occupation, the index families were classified as high (29%), average (45%) and low (26%) socioeconomic status,10 whereas 6.7% of control families belonged to high, 63.3% to average and 30% to low status. The protocol was approved by the institutional review board.

Measures

Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present and Lifetime version (Kiddie-SADS-PL/K-SADS-PL).[11] This well-known semi-structured interview was administered to both subjects and controls. Parents of patients and controls were also interviewed. Interviewers diagnosed children utilizing their best clinical judgment in reference to parental and child reports. At the beginning of the study a group of probands (n=16) were interviewed by two trained interviewers (DA, SK), who rated them independently. Inter-rater agreement rate was 0.76 (K=0.76).

Child Behaviour Checklist 4/18 (CBCL).[1] The CBCL categorizes children's behavior into two broadband factors: the Externalizing and Internalizing. The Externalizing factor comprises aggressive and rule-breaking behavior (e.g. temper tantrums or hot temper, destroys things belonging to others). The Internalizing factor comprises somatic complaints, withdrawn, and anxious/depressed behavior (e.g. nervous, high-strung or tense, unhappy, sad or depressed). Responses are scored on a 3-point scale (0, not true, to 2, very true or often true). Age and gender standardized scores of 60 or higher on the CBCL are indicative of clinically significant problem behaviours. Adolescents who were 11 years and older completed the Youth Self-Report,[1] which generates externalizing and internalizing subscale scores that correspond to those from the CBCL.

The Children's Yale-Brown Obsessive Compulsive Scale (C-Y-BOCS)[12] is the children's version of the Y-BOCS, a clinician rated instrument, merging data from clinical observation and parents' and children's reports. All diagnoses were based on the same procedures.

The Revised Children's Manifest Anxiety Scale (RCMAS)[13] is a 37-item self-report questionnaire and measures chronic manifestations of trait anxiety in children and adolescents. The RCMAS has been standardized by age and gender. The total score consists of 24 items and is regarded as an index of general anxiety.

The Children's Depression Inventory (CDI)[14] is a widely used, 27-item self-report of depressive symptoms for children and adolescents. Raw scores range from 0 to 54, a score of 13 was used as a threshold for depression in this study, as is indicated by the author. However, the specificity of the CDI for the diagnosis of depression has been questioned and some investigators have suggested that it measures emotional distress in a general sense.[15]

The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) was given to the parents. Y-BOCS is a 10-item, clinician-rated, semi-structured instrument, designed to assess the symptom severity of

OCD over the past week.[16] Each item is rated from 0 (no symptoms) to 4 (extreme symptoms). Y-BOCS consists of the obsession and compulsion subscale, and produces a total score (total range of 0–40). A total score under 16 is considered mild and a score under 7 is considered subclinical.[17] We used the cut off point of 16 and above, to signify symptoms of considerable severity. The interviewers were aware of the parents' group status. A considerable body of data attests to the reliability, validity and sensitivity of this instrument.[17] Each parent was interviewed separately.

The diagnosis of learning disorder of reading and written expression was made through the use of standardized reading material, appropriate for ages 10–15 years. Reading comprehension and narration were tested. The written expression (spelling, syntax, content) was examined by a written text, in which the subject developed a certain theme from the reading material.[18] We chose the group with mild and moderate reading and writing disability (RWD) as representing a group closest to the general population. Only RWD and no other psychopathology[19] have been reported for the parents of children with RD. Since 10–60% of children[20] with RD suffer from ADHD, anxiety disorders[21] and depression,[22] we might hypothesize that a percentage of their parents suffers or suffered from similar disorders, although we did not find pertinent literature support.

Statistical analysis

Differences between the proband and control group were tested utilizing the chi-square test or Fisher's exact test when categorical variables were compared. Normality of distributions for the quantitative measures was examined by the Kolmogorov-Smirnov test. A t-test or the equivalent non parametric test (Mann-Whitney) was used for comparisons between groups. In case of unequal variances, t values and degrees of freedom were adjusted to account for lack of homogeneity. For comparing subscales of the same inventory, multivariate analysis of variance was employed, followed by univariate tests, in case of significant results. The significance level was set at 0.05 while in case of post-hoc multiple comparisons it was appropriately adjusted after Bonferroni correction.

Results

Phenomenology of illness and child psychopathology

Of the probands, 48% had obsessions of contamination, 42% of aggression, 22.5% obsessions of sexual context, 52% washing and cleaning compulsions and 32% rituals (table 1). The rate of male to female was 2.4:1. Furthermore, 32% of the children with OCD had one additional disorder and 16.1% had two, according to Kiddie-SADS-PL/K-SADS-PL. Comorbid disorders present were: depressive disorder (26%), anxiety disorders (29%) i.e. generalised anxiety, separation anxiety, social phobia, agoraphobia and disorders like tics (16%), ADHD (19%), oppositional disorder (30%), enuresis (3%) and encopresis (3%). Only 17.2% of the controls had one comorbid disorder i.e. separation anxiety, enuresis or ADHD and none had more than one. The difference regarding comorbidity was statistically significant ($\chi^2(1) = 6.54$, p=0.01).

The probands' group had significantly higher Total Problems scores on the CBCL than the control group (probands: mean 51.7, SD 22.9, controls: mean 32.8, SD 21.5, p=0.004, two tailed test). Multivariate comparisons of the Internalizing and Externalizing Problems subscale indicated a significant difference (Wilk's λ=0.722, F(2, 47)=6.940, p=0.002) and univariate tests revealed that probands had higher scores on both scales in comparison to controls, although only the Externalizing Problems scale differed significantly after Bonferroni adjustment. Also, multivariate analysis of the 8 problem subscales revealed statistically significant differences between

Table 1. C-Y-BOCS scales and Symptom categories of children and adolescents with OCD (n=31).

C-Y-BOCS scales and Symptom categories	*Mean±SD*	*(%)*
Obsessions	11.61±5.16	
Contamination		48%
Aggression		42%
Sexual		22.5%
Compulsions	12.77±2.67	
Washing and cleaning		52%
Rituals		32%
Total	24.39±5.68	

probands and the control group (Wilk's λ=0.591, F(8, 41)=3.552, p=0.003). The differences were due to the following syndromes: "anxiety-depression" and "thought problems", after Bonferroni adjustment (table 2). Large effect sizes were found for Total problems (d=0.87), for the Externalizing problems scale (d=1.09), the subscales of anxiety-depression (d=1.29) and thought problems (d=1.53), whereas for the Internalizing problems scale and the aggression subscale the effect size was medium (d=0.62 and d=0.77 respectively).

No differences were found between the two groups studied (18 probands and 21 controls), on Total Problems (t(37)=1.41, p=0.167) or on the Externalizing and Internalizing Problems scales of the Youth Self-Report (Wilks λ=0.951, F(2, 36)=0.919, p=0.408). However, multivariate analysis of the 8 problem subscales for the study group and the control group gave statistically significant results (Wilks λ=0.612, F(7, 31)=2.805, p=0.022). The difference was due to the "problems of thought" subscale, where probands scored higher than controls (mean±SD=9.56±3.84 vs 5.49±2.71, t(37)=3.86, p<0.001).

No statistically significant differences were found between probands and controls on depression (CDI) (means±SD: 10.63±8.25 vs 13.08±7.99, t(50)=–1.086, p=0.283). Children with OCD did not differ from controls on anxiety (RCMAS). Multivariate comparison of the two subscales gave a marginally non significant result (Wilk's λ=0.902, F(2, 52)=2.814, p=0.069), even though the average scores were higher in probands for both manifest anxiety and lie scales.

For the C-Y-BOCS for the probands group (n=31), means and SDs for Total score Obsessions and Compulsions subtotals were respectively: 24.39±5.68, 11.61±5.16, 12.77±2.67. In addition, obsessions and/or compulsions common to both parents had 7 children, common to one parent 8 children and 10 children had different obsessions and/or compulsions from their parents. The parents of the remaining 6 children did not report OC symptomatology.

Parents OCD symptomatology

The Y-BOCS was answered by both parents of 25 of the 31 probands (27 mothers and 25 fathers). For 36% of these 25 children (n=9), at least one parent had scores within the clinical range, that is 28% of fathers (n=7) and 11% of mothers (n=3), whereas no parent in the control group was within the clinical range. When proband parents and control parents (29 mothers and 21 fathers) were compared, the percentage of fathers in the clinical range was significantly higher in the study group (Fisher's exact test: p=0.011, two tailed), whereas for mothers the difference did not attain significance (Fisher's exact test: p=0.106, two tailed). The fathers and mothers of children with OCD were more clinically affected than those of controls. Mothers of probands differed from controls in compulsions, compared to fathers, who differed in both obsessions and compulsions (table 3).

Table 2. CBCL scores for children with OCD and controls.

	Probands (n=22)		*Controls (n=28)*		*Significance of difference*		
	Mean	*SD*	*Mean*	*SD*	*t*	*df*	*p*
Anxiety/Depression	10.48	5.01	4.56	4.44	4.424	48	<.001
Withdrawal/Depression	4.06	2.94	2.36	2.56	2.189	48	0.033
Somatic problems	3.47	3.30	1.84	2.27	1.982	35.769	0.055
Social problems	5.05	4.11	3.50	3.48	1.439	48	0.157
Thought problems	8.02	4.33	3.69	2.40	4.215	30.948	<.001
Attention problems	4.86	3.42	4.71	2.38	.188	48	0.852
Rule breaking behavior	2.64	1.68	2.44	2.35	.335	48	0.739
Aggressive behavior	8.74	5.25	5.21	4.20	2.649	48	0.011
Externalizing problems	18.01	9.34	8.76	8.08	3.754	48	<0.001
Internalizing problems	11.38	6.37	7.65	6.02	2.124	48	0.039
Total problems	51.70	22.90	32.80	21.51	2.996	48	0.004

Table 3. Obsessive-Compulsive symptomatology (Y-BOCS): parents.

	Study group			Control group			
	n	*Mean*	*SD*	*n*	*Mean*	*SD*	*Asymp. Sig. (2-tailed)**
Mothers (total)	27	6.26	6.18	29	2.07	2.46	0.006
Obsessions	26	2.77	3.02	29	1.17	1.23	0.078
Compulsions	26	3.73	3.89	29	0.90	1.50	0.001
Fathers (total)	25	9.28	8.37	21	1.29	1.59	0.001
Obsessions	21	4.38	4.28	21	0.62	0.86	0.002
Compulsions	21	3.71	3.77	21	0.67	0.86	0.011

*Mann-Whitney test

Discussion

The children with OCD in our study had a high level of emotional and behavioral problems, particularly in the dimensions of thought, depression, and anxiety, which was similar to what other investigators have found.[2,23] They also presented with considerable rates of comorbid depressive disorder (26%) comparable (29–33%) to those of other studies.[2,3,5,6] In those same studies, a rate of anxiety disorders ranging from 17% to 48% was found. In our study, the rate was 29%. Tics were present in 16% of the index children, a rate smaller than in other studies (20–27%).[2,5] Regarding obsessions of contamination, aggression and compulsions of washing and cleaning, our findings resemble those of other studies.[23] As in the studies of children from Denmark,[8] Spain,[9] Poland,[24] and the U.S.,[2] compulsions of cleaning (52% in our sample) were the most prominent ones. Obsessions of contamination were the most frequent, followed by obsessions of aggression, as in previous studies.[2,3,8] However, a recent English study[25] found obsessions of aggression to be the most frequent followed by those of contamination. The ratio of male to female (2.4:1) was similar to that of other studies.[5,6] No differences were found between our probands and controls on the CDI and the RCMAS, which were used to measure depression and anxiety respectively. Children and adolescents with specific disorders of learning of which the control group was comprised also experience anxiety and depression, which may explain the absence of difference between the two groups.[26] It is important to note, though, that the average scores of probands on manifest anxiety and lie scales were higher, even though the comparison was marginally not significant.

The probands in our study were significantly different than controls on Externalizing scale of the CBCL, the Total Problems scale and on the subscales of "anxiety-depression", and "thought problems". It is of interest that the mean scores for the sub-scale of "aggression" were the highest, following those of "anxiety-depression" and "thought" and that the score of Externalizing problems was higher than the Internalizing scale. We found oppositional disorder, a disorder of the DBD spectrum,[27] at the rate of 30% in our children. Similarly, Geller et al[5] found DBD in his probands to be approximately 43%, March[7] mentions DBD among the main comorbid disorders of OCD, while Flament[23] mentions that in those subjects with OCD and comorbid DBD, usually boys,[28] both Internalizing and Externalizing scores were higher. In addition, other authors note that children with OCD "may become irascible, defiant, demanding or assaultive in their need to perform their compulsions".[11] Therefore, the high scores on the aggression subscale and on the Externalizing problems scale in our study demonstrate this aggressive and oppositional aspect of a subgroup of children with OCD. A large effect size was found in our study for the Externalizing but not for the Internalizing problems, in contrast to the higher mean T scores of the Internalizing compared to the Externalizing scale found by others.[2,13] This result might be explained by considering the high aggression mean score on the CBCL, and the fact that most of the children with OCD in this study came into the hospital during an acute crisis period. In other words, this crisis

may be expressed by increased aggression and the higher Externalizing scores. Toro et al[9] note that withdrawal from peers (65%) is very frequent and, in accordance to this finding, there is a high score on the withdrawal subscale of the CBCL in our study. Also, in agreement to the study by Black et al,[4] the "Anxiety-Depression" subscale's mean scores in the CBCL were high.

The parents of children with OCD had more OCD symptomatology than the parents of children with learning disorders. The symptomatology of the parents may create difficulties in interactions within the family and become burdensome for a vulnerable child. In turn, the child's symptomatology may create or increase some of the symptoms in the parents i.e. anxiety and depression. Compared to controls, more fathers of probands had severity of obsessions and compulsions in the clinical range. Severe compulsions had only a smaller percentage of probands' mothers. The findings show that at least for a percentage of children with OCD, parental and especially paternal influence may contribute to the development and severity of their symptoms, not only through hereditary factors but also through the control, exerted and the anxiety created in the family context.

Calvo et al[29] found an increase in psychopathology, specifically of adjustment disorders, depression, anxiety and personality disorders, including OCD, in parents of children with OCD compared to parents of controls with pediatric ailments. Black et al[4] examined data from the viewpoint of parents with OCD whose children developed "broadly defined OCD" during the follow-up period and found that these parents suffered more than controls from lifetime major depression, panic disorder and special phobia. Of the parents of children with OCD in our study, 36% had OC symptomatology, a rate comparable to that found by Lenane et al[30] but higher than the one given for first degree relatives by Pauls et al[31] (18% for OCD and OCS), although these investigators note that the rate was twice as high among the relatives of the probands with earlier onset.

In agreement with Lenane et al,[30] we found increased OC symptomatology in probands' fathers compared to mothers and controls. Thomsen and Mikkelsen[32] found that fathers of probands were more likely to have clinical OCD but mothers to have sub-clinical symptomatology. In contrast, Calvo et al[29] found a higher rate of diagnosis of OCD in mothers than fathers of probands. Also, Black et al[4] found that female gender of the parent with OCD, along with family dysfunction and high symptom levels were predictive of "broadly defined OCD" in the child after two years of follow-up. In contrast, Black et al[33] in another study did not find an increase of OCD spectrum disturbance among the first-degree relatives of adult probands, but found an increased prevalence of anxiety disorders. The morbid risk for broadly defined OCD (OCD plus sub-syndromal OCD) was higher among the parents of probands, in particular among mothers, but not at a statistically significant level. A study with larger numbers is required to determine if indeed fathers do show more OC symptomatology. Despite the fact that more control families than probands' belonged to the average and low socioeconomic status, we did not find more psychopathology in this group, as would be expected, regarding the children's parents. As noted, the families of controls were well organized, working families. Studies give varying results in terms of the social class background of children with OCD, starting from a high social status[34] to lower socioeconomic status.[35] Others note that there is cultural homogeneity in OCD across cultures[36] and that caucasians have the greater symptom severity and comorbidity.[37] In our study, most of the OCD children came from a high and average social status.

This study presents some limitations. The sample size is small, mainly due to the difficulty of collecting data because of the relatively uncommon prevalence of the disorder. The same problem characterizes other studies.[2,4,29,31,32] Larger studies are needed in order to have smaller probability of type-II error and clarify the differences regarding the psychopathology of fathers and mothers, particularly differences in prevalence of OCD. Further, the parents were not examined through formal diagnostic interviews. Although the Y-BOCS is not a diagnostic tool, more fathers had OC symptoms in the clinical range (a score of 16 or greater) than mothers. Furthermore, a significant difference of fathers compared to mothers and controls with regard to OC symptomatology emerges from the subscale for obsessions and com-

pulsions of the SCL-90-R. Another limitation is the control group we have chosen. We thought a group other than one with anxiety disorders or depressive disorder might be pertinent, since it is known that, in clinical settings, there is around 8–10% comorbidity with panic disorders and that in adolescents and adults with OCD comorbidity includes depressive disorders. Since the one-year prevalence of OCD is 1.5–2.1% and in our study, out of 52 parents, 7 fathers and 3 mothers presented with OC symptomatology, whereas from the 50 control parents, none, we may think that the control group is closer to the general population. Also, comparison of SCL-90-R and STAI scores between the control group and Greek general population supports the use of this group as controls.[38,39] Nevertheless, a replication of the study after inclusion of a control group with depressive disorders and/or non-clinical participants would be methodologically desirable.

In conclusion, our study showed that a considerable number of children and adolescents with OCD are presented with externalizing problems, similar to that described in other countries. This aspect of children and adolescents with OCD is important to be recognized when considering case management and treatment. Finally, there is a confirmation through our study, that the CBCL is a valuable tool, which can point towards the detection of important aspects of the psychopathology of these children and adolescents.

Συννοσηρή ψυχοπαθολογία και κλινική συμπτωματολογία σε παιδιά και εφήβους με ιδεοψυχαναγκαστική διαταραχή

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Η συννοσηρή ψυχοπαθολογία των παιδιών και εφήβων με ιδεοψυχαναγκαστική διαταραχή (ΙΔΨ) έχει διερευνηθεί σε πλήθος μελετών την τελευταία εικοσαετία. Ο σκοπός της παρούσας μελέτης ήταν να διερευνήσει τη φαινομενολογία της ασθένειας και την ευρύτερη ψυχοπαθολογία σε μία ομάδα παιδιών και εφήβων με ΙΔΨ στην Ελλάδα. Η διερεύνηση της γονικής ψυχοπαθολογίας στα παιδιά και εφήβους με ΙΔΨ ήταν ένας δευτερεύων σκοπός της παρούσας μελέτης. Μελετήσαμε 31 παιδιά και εφήβους με ΙΔΨ (n=31, ηλικιακό εύρος 8–15 έτη) και τους γονείς τους (n=62, ηλικιακό εύρος 43–48 έτη) και διενεργήσαμε συγκρίσεις με παιδιά και εφήβους με ειδικές μαθησιακές διαταραχές της ανάγνωσης και της γραπτής έκφρασης (n=30, ηλικιακό εύρος 7–16 έτη) και τους γονείς τους (n=58, ηλικιακό εύρος 40–46 έτη). Κατάλληλες δοκιμασίες έδειξαν ειδικές μαθησιακές διαταραχές της ανάγνωσης και της γραπτής έκφρασης, οι οποίες ήταν ήπιας έως μέτριας βαρύτητας για το 85% αυτής της δεύτερης ομάδας. Η διάγνωση μαθησιακής διαταραχής της ανάγνωσης και της γραπτής έκφρασης διενεργήθηκε μέσω της χρήσης σταθμισμένου αναγνωστικού υλικού, κατάλληλου για ηλικίες 10–15 ετών. Ελέγχθηκαν η αναγνωστική κατανόηση και αφήγηση. Η γραπτή έκφραση (ορθογραφία, συντακτικό, περιεχόμενο) εξετάστηκε μέσω ενός γραπτού κειμένου, στο οποίο το υποκείμενο ανέπτυσσε ένα συ-

γκεκριμένο θέμα από το αναγνωστικό υλικό. Με βάση το επίπεδο εκπαίδευσης και επαγγέλματος, οι οικογένειες των παιδιών και εφήβων με ΙΔΨ κατηγοριοποιήθηκαν ως υψηλής (29%), μέσης (45%) και χαμηλής (26%) κοινωνικοοικονομικής κατάστασης, ενώ το 6,7% των οικογενειών στην ομάδα μαρτύρων ανήκε στην υψηλή, το 63,3% στη μέση και το 30% στη χαμηλή κοινωνικοοικονομική κατάσταση. Προκειμένου να διερευνηθεί η ψυχοπαθολογία, χορηγήθηκε στα παιδιά και τους γονείς τους η συνέντευξη Schedule for Affective Disorders and Schizophrenia for School Aged Children, Present and Life-time version, καθώς το ερωτηματολόγιο Child Behavior Checklist 4/18 (CBCL) στους δύο γονείς και τους εφήβους (Youth Self-Report). Επίσης, βαθμολογήθηκε η κλίμακα Yale-Brown Obsessive Compulsive Scale (Y-BOCS) για τα παιδιά και τους γονείς τους. Επιπλέον, στα παιδιά χορηγήθηκαν τα ερωτηματολόγια Children's Depression Inventory (CDI) και Revised Children's Manifest Anxiety Scale (RCMAS). Στην ομάδα των παιδιών και εφήβων με ΙΔΨ, 48% είχε ιδεοληψίες μόλυνσης, 42% επιθετικές ιδεοληψίες, και 52% είχε ψυχαναγκασμούς πλυσίματος και καθαρισμού. Επιπλέον, το 32% είχε μία επιπρόσθετη διαταραχή και το 16,1% είχε δύο επιπρόσθετες διαταραχές. Συγκριτικά, μόνο το 17,2% της ομάδας μαρτύρων είχε μία συννοσηρή διαταραχή. Η ομάδα των παιδιών και εφήβων με ΙΔΨ είχαν υψηλότερη βαθμολογία Συνολικών Προβλημάτων, καθώς και υψηλότερη βαθμολογία Άγχους/Κατάθλιψης, Προβλημάτων Σκέψης και Εξωτερικευόμενων Προβλημάτων στο CBCL. Όταν συγκρίθηκαν οι γονείς των παιδιών και εφήβων με ΙΔΨ και οι γονείς των μαρτύρων (29 μητέρες και 21 πατέρες), το ποσοστό των πατέρων στο κλινικό εύρος ήταν σημαντικά μεγαλύτερο στην ομάδα με ΙΔΨ (Fisher's exact test: p=0,011, two tailed), ενώ για τις μητέρες η διαφορά δεν ήταν στατιστικά σημαντική (Fisher's exact test: p=0,106, two tailed). Οι πατέρες και οι μητέρες των παιδιών και εφήβων με ΙΔΨ ήταν περισσότερο κλινικά επιβαρυμένοι συγκριτικά με τους γονείς των μαρτύρων. Οι μητέρες των παιδιών και εφήβων με ΙΔΨ διέφεραν από την ομάδα των μαρτύρων ως προς τους ψυχαναγκασμούς, συγκριτικά με τους πατέρες, οι οποίοι διέφεραν και στις ιδεοληψίες και στους ψυχαναγκασμούς. Το ποσοστό συννόσησης ήταν υψηλότερο στα παιδιά και εφήβους με ΙΔΨ. Ένας σημαντικός αριθμός παιδιών με ΙΔΨ είχε υψηλότερη συμπτωματολογία άγχους και κατάθλιψης από τους μάρτυρες, καθώς και υψηλότερα ποσοστά προβλημάτων σκέψης. Τα παιδιά και οι έφηβοι με ΙΔΨ εκδήλωναν, επίσης, υψηλότερα ποσοστά εξωτερικευόμενων προβλημάτων. Αυτό το εύρημα θεωρείται σημαντικό και χρειάζεται να τονιστεί αναφορικά με τη διαχείριση και τη θεραπευτική αντιμετώπιση αυτών των περιπτώσεων. Επιπλέον, οι γονείς των παιδιών και εφήβων με ΙΔΨ είχαν υψηλότερη συμπτωματολογία ΙΔΨ από τους γονείς των παιδιών και εφήβων με μαθησιακές διαταραχές. Η συμπτωματολογία των γονέων ενδεχομένως δημιουργεί δυσκολίες στις αλληλεπιδράσεις εντός της οικογένειας και μπορεί να επιβαρύνει ένα ευάλωτο παιδί. Από την άλλη πλευρά, η συμπτωματολογία του παιδιού ενδεχομένως δημιουργεί ή αυξάνει ορισμένα από τα συμπτώματα των γονέων, όπως άγχος και κατάθλιψη. Αυτά τα ευρήματα υποστηρίζουν την άποψη ότι τουλάχιστον για ένα ποσοστό παιδιών και εφήβων με ΙΔΨ, η γονική και ιδιαίτερη η πατρική επιρροή μπορεί να συμβάλει στην εμφάνιση και τη βαρύτητα των συμπτωμάτων τους, όχι μόνο μέσω κληρονομούμενων παραγόντων αλλά και μέσω του ελέγχου που ασκείται και του άγχους που δημιουργείται στο οικογενειακό πλαίσιο.

: Επιθετική συμπεριφορά, εξωτερικευόμενα προβλήματα, παιδιά και έφηβοι, συννόσηση, ιδεοψυχαναγκαστική διαταραχή.

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Research article

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Comparing immigrant children with native Greek in self-reported-Quality of Life

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Research on an international and national context regarding immigrant children and adolescents' quality of life (QoL) is rather scarce. Few international studies have been conducted investigating the presence of psychopathology and providing evidence of behavioural and psychological problems in immigrant adolescents. Regarding immigrant quality of life, thus far investigation was directed mainly to adult immigrant individuals and not to their children. The aim of the present study was to investigate the quality of life (QoL) of immigrant children and young adolescents who live in the greater Athens area, and to compare them with their native Greek peers living in the same communities and attending the same schools. Method: Sixty three immigrant children, from Albanian and Eastern European origin (mean age 11.9 years) and 489 native children (mean age 11.33 years) were administered a QoL instrument specifically developed for children and adolescents: the Kid-KINDL^R Questionnaire for 8–12 years old and the Kiddo-KINDL^R Questionnaire for 13–16 years old. The dimensions examined in the KINDL^R questionnaire refer to: physical well-being, emotional well-being, self- esteem, friends, family life and everyday life (school life). The Greek version is reported to show satisfactory values of validity and reliability. Administration of questionnaires was conducted at school after parent consent. Analysis included student's t-test, chi-square test, and multivariate linear regression analysis, as to investigate the relationship between KINDL^R QoL dimensions' scores and nationality status, after controlling for gender and age. The results indicated that self-reported QoL scores of immigrant children were significantly poorer in comparison to native children in the domains of self-esteem and family life, as well as in the total QoL scores. In the rest of the QoL domains, similar scores were reported in both immigrant and their native classmates, that is in the dimensions of physical well-being, emotional well-being, friends and school. Investigating the effect of gender in KINDL^R QoL parameters, after controlling for nationality and age, no evidence was found for differences between male and female children. Regarding the effect of age, older compared to younger in age children scored significantly lower in emotional well-being, self-esteem, and friends, school and total QoL. The results provide evi-

dence of QoL deficits in self-esteem and family life in immigrant children. QoL deficits seem to increase in more areas as immigrant children grow older. Dimensions regarding self-perception and family may be interrelated, mutually influencing one another. It may be suggested that immigrant children seem to experience reduced self-esteem and distressful feelings within family interpersonal relations. As they grow older, distress seems to become more evident in emotional and social areas of QoL. Mental health interventions should take into account the multilevel impact of family interpersonal experiences on child's psychosocial development, as to design and deliver appropriate interventions supporting parenting for immigrant groups of individuals. Also, specialized mental health promotion programs need to be provided for adolescent immigrant individuals.

Key words: Quality of life, immigrant children, immigrant adolescents, self-esteem.

Introduction

During the 90s, a large number of economic immigrants moved from the former Eastern countries to Western Europe, while many of them settled with their families in host countries such as Greece. Research on immigrant children is mostly investigating the presence of psychopathology,[1–4] while several studies provide evidence of behavioural and psychological problems in immigrant adolescents.[5–7] Regarding quality of life (QoL), thus far the investigation involves mainly adult immigrants,[8–10] while evidence on immigrant child and adolescent QoL is rather scarce[11–14] and one relevant study indicated that children of immigrant parents had a significantly lower HRQOL total score.[15] Furthermore, some of these studies reported contradictory findings. Specifically, Ravens-Sieberer et al[14] indicated that QoL in immigrant children (according to their parents' reports) was not lower than that of native children. In contrast, as reported in the Pantzer et al study,[13] immigrant adolescents experienced problems with their peers reporting bullying, discrimination and poor social support. It is noteworthy that boys reported better quality of life than girls, as well as younger adolescents (12–14 years) than older ones. It is argued by the authors of the above study that QoL is mediated by the economic situation of the adolescent.

Regarding adult populations, the findings of Bayram et al[9] showed that adult Turkish immigrants may report higher quality of life in the host country than Turks living in their own country. Moreover, adult immigrants from Eastern Europe, even if less satisfied with life in general, reported "higher satisfaction with the societal conditions than the natives"[9] (Bayram et al 2007, p. 67). It is worth mentioning that adult immigrants have taken the initiative to immigrate, while one cannot argue the same for their children, who may be violently moved in a foreign country, away from the familiar environment and lacking the verbal skills to speak the language of the host country.

The aim of the present study was to investigate the quality of life of immigrant children and make a comparison with a similar age group of children living in the same community and attending the same mainstream schools. The present study was carried out during 2007–2008 in schools located in two municipalities of Athens (Byron and Kessariani), presenting a number of immigrant students in each classroom (i.e. 3 or 4 accounting for 10% to 15% of the class population).

Material and method

Participants

Group A (immigrant children) 63 children (34 boys, 29 girls), mean age was 11.86±1.85; age range was 8–14 years. Regarding their parents, 85% were of Albanian origin while the rest were Eastern Europeans.

Group (Native Greek children) 489 native Greek children (245 boys, 244 girls), mean age was 11.34±2.00, age range was similar.

Both groups of children attended the same schools and lived in the same community.

Instruments

There are 3 versions of the KINDL[R] instrument, one for children between 4–7, one for children between 8–12 years and one for adolescents of 13–16 years (Kid-KINDL[R] Questionnaire/8–12 years, Ravens-Sieberer and Bullinger, 2000; Kiddo-KINDL[R]

Questionnaire/13–16 years, Ravens-Sieberer and Bullinger 2000).[16]

The dimensions of the KINDL^R questionnaire refer to: physical well-being, emotional well-being, self-esteem, friends, family life and everyday life (school life). For each dimension there are 4 items and children's responses are recorded on a five Likert-scale. Higher scores indicate better quality of life.

The 3 forms of the KINDL^R questionnaire have been translated for the Greek population.[17] The questionnaires were used recently in populations of Greek children and the statistical analysis has shown that the Cronbach's α coefficient exceeded the acceptable minimum of 0.7 ranging from 0.71 to 0.90 for children aged 13 years or more and 0.70–0.80 for children aged below 13 years.[18,19] The Greek version of the questionnaires can be found in: http://www.kindl.org.

Procedure

After approval was granted by the Pedagogical Institute operating under the Ministry of Education, and the Committee of Ethics of the University of Athens, a letter asking for written consent was sent to the parents via the schools, along with explaining the aim of this study. The children were then able to complete the questionnaires at school provided they had the written consent from their parents. One of the researchers was present in the classroom at the time of administration providing information about the purpose of the study.

Statistical methodology

Dimensions of the KINDL^R questionnaire and demographic characteristics were compared between immigrant and native children using the criteria Student's t-test and chi-square test as appropriate. Kolmogorov-Smirnov test evaluated the assumption of normality. Subsequently, multivariate linear regression analysis was used to investigate the relationship between KINDL^R dimensions' scores and nationality status, after controlling for gender and age. Seven statistical models were performed with dependent variable each domain of the KINDL^R questionnaire: "Physical Well-being" (model 1), "Emotional Well-being" (model 2), "Self-esteem" (model 3), "Family" (model 4), "Friends" (model 5), "School" (model 6) and "Total" (model 7). In all models, nationality status, gender and age were used as independent variables. Significance level was set at p=0.05. The data were analyzed with SAS statistical package (Version 9.1, SAS Institute Inc, Cary, NC).

Results

The study sample consisted of 552 participants aged 8–17 years. Among them, 279 were males and 273 females. The mean age was calculated at 11.39±1.99 years. Regarding to nationality, 489 children were natives and the remaining 63 immigrants.

Table 1 presents the distribution of demographic characteristics and the KINDL^R dimensions according to nationality status. There was no evidence for a significant difference in the distribution of gender (p=0.564) and the mean age (p=0.050) between native and immigrant children. In respect with the dimensions of the KINDL^R questionnaire, mean scores of "Physical Well-being" (p=0.868), "Emotional Well-being" (p=0.335), "Friends" (p=0.549) and "School" (p=0.205) were not found to differ significantly between the two groups of participants. On the other hand, significantly lower mean scores in two domains of quality of life, namely "Self-esteem" (p<0.0001) and "Family" (p<0.0001), were noted in immigrants compared to native participants. When summarizing the six parameters of the KINDL^R questionnaire, the mean "Total" score was estimated at 73.17±6.92 and 78.15±9.66 for immigrants and natives respectively, a difference that was highly significant (p<0.0001).

Further on, multivariate linear regression analysis was performed (table 2). In accordance with the univariate findings, the KINDL^R parameters associated with nationality status were "Self-esteem" (p<0.0001) and "Family" (p<0.0001) along with "Total" score (p=0.0003). Specifically, the mean "Self-esteem" scores of immigrants were almost 15 points less than the respective scores of natives (b=–15.16; 95% CI: –19.38, –10.94; p<0.0001). Immigrants scored almost 9 points less than the natives in the domain of family life ["Family" (b=–9.11; 95% CI: –12.51, –5.72; p<0.0001)]. As a whole, in the "Total" score immigrant children were found to achieve significantly poorer results (b=–4.54; 95% CI: –6.99, –2.10; p=0.0003). Investigating the effect of gender in KINDL^R parameters, after controlling for nationality and age, we found no evidence for a different score pattern between males and females in none statistical model. Regarding the effect of age, according to the multivariate findings, mean scores of "Physical Well-being"

Table 1. Distribution of demographic characteristics and KINDL^R questionnaire dimensions in the group of 552 study participants according to nationality status.

Variables	*Immigrants (n=63)*	*Natives (n=489)*	*p-value*
Gender			0.564*
Males	34 (53.97)	245 (50.10)	
Females	29 (46.03)	244 (49.90)	
Age (years)	11.86±1.85	11.34±2.00	0.050**
Dimensions of KINDL^R (score)			
Physical Well-being	80.48±11.60	80.17±13.80	0.868**
Emotional Well-being	81.67±11.67	83.23±12.17	0.335**
Self-esteem	52.62±10.51	68.24±16.63	<0.0001**
Family	72.30±9.75	81.62±13.24	<0.0001**
Friends	83.02±15.09	84.10±13.29	0.549**
School	68.89±13.00	71.54±15.95	0.205**
Total	73.17±6.92	78.15±9.66	<0.0001**

*p-value derived from chi-square test
**p-value derived from Student's t-test

Table 2. Results of multivariate linear regression analysis models for the changes in the score of each dimension of the KINDL^R questionnaire by nationality status, gender and age in the group of 552 study participants.

Variables	*Category or increment*	*Coefficient b (95% CI)*	*p-value*
Physical Well–being (model 1)			
Nationality status	Immigrants *vs* Natives	0.35 (–3.24, 3.93)	0.849
Gender	Females *vs* Males	–0.68 (–2.95, 1.59)	0.558
Age	1 year more	–0.14 (–0.71, 0.43)	0.634
Emotional Well–being (model 2)			
Nationality status	Immigrants *vs* Natives	–1.07 (–4.23, 2.09)	0.506
Gender	Females *vs* Males	–0.14 (–2.14, 1.87)	0.895
Age	1 year more	–0.96 (–1.46, –0.45)	0.0002
Self-esteem (model 3)			
Nationality status	Immigrants *vs* Natives	–15.16 (–19.38, –10.94)	<0.0001
Gender	Females *vs* Males	–0.38 (–3.05, 2.30)	0.782
Age	1 year more	–0.91 (–1.58, –0.24)	0.008
Family (model 4)			
Nationality status	Immigrants *vs* Natives	–9.11 (–12.51, –5.72)	<0.0001
Gender	Females *vs* Males	1.93 (–0.23, 4.08)	0.080
Age	1 year more	–0.25 (–0.79, 0.30)	0.372
Friends (model 5)			
Nationality status	Immigrants *vs* Natives	–0.73 (–4.28, 2.83)	0.689
Gender	Females *vs* Males	0.26 (–2.00, 2,51)	0.824
Age	1 year more	–0.67 (–1.24, –0.10)	0.021
School (model 6)			
Nationality status	Immigrants *vs* Natives	–1.55 (–5.53, 2.43)	0.445
Gender	Females *vs* Males	–0.56 (–3.08, 1.96)	0.661
Age	1 year more	–2.16 (–2.80, –1.53)	<0.0001
Total score (model 7)			
Nationality status	Immigrants *vs* Natives	–4.54 (–6.99, –2.10)	0.0003
Gender	Females *vs* Males	0.07 (–1.48, 1.62)	0.929
Age	1 year more	–0.85 (–1.24, –0.46)	<0.0001

and "Family" were not found to differ significantly according to age (p=0.634 and p=0.372 respectively). Nevertheless, older, as compared to younger in age, children scored significantly less in "Emotional Well-being" (p=0.0002), "Self-esteem" (p=0.008), "Friends" (p=0.021), "School" (p<0.0001) and "Total" (p<0.0001).

Discussion

To the best of our knowledge this is the first study to investigate the QoL in immigrant young children between 8 and 14 years. Previous results come from studies investigating QoL solely in adolescents.[6,12,13]

Regarding the present study, the completed questionnaires by immigrant children and young adolescents accounted for 12% of all completed questionnaires. This is in concordance with the percentage of immigrant students attending schools (10–14.5%) in the current year. Eighty five per cent of this immigrant population came from Albania while the rest from other countries. All participating immigrant students attended mainstream schools and none of them had serious learning difficulties according to the reports of their schoolteachers.

The findings of the present study show lower quality of life in the self-esteem dimension, which is in line with the findings of other studies.[6,7] Furthermore, lower quality of life was reported in the domain of family life. Dissatisfaction of immigrant children with their family life may relate to excessive working hours of both parents, suggesting that they do not have the time to deal with their children effectively. In terms of gender, there are no differences, in that boys and girls reported a similar level of self-esteem, a somewhat surprising finding not in line with previous studies in which boys have been reported with higher self-esteem than girls.[13] Girls were reported to be twice as likely as boys to perceive worse health and health related quality of life in the physical and emotional dimensions.[20] In the present study, it was hypothesized that immigrant children would report worse quality of life in the domain of "friends" and "school life", in agreement with findings reported by other surveys[13] providing evidence that the occurrence of discrimination and bullying is higher among immigrant than in native adolescents. However, this hypothesis was not confirmed. A possible explanation would be that because the questionnaires were completed at school, immigrant students might have been unwilling to report in the presence of classmates their experiences or feelings of rejection and discrimination imposed by other children. This is possible to happen because complaints from both immigrant parents and their children regarding discrimination and exclusion have been frequently reported in the local Mental Health Centre in which one of the researchers is appointed to offer mental health services.

Regarding the dimension of emotional well-being, our findings are in line with Derluyn et al study,[21] where no differences were found between immigrant and non immigrant adolescents in terms of facing emotional problems. The authors however assume that migrant adolescents may not report experiencing any emotional problems, because they are not willing to reveal them outside the family environment. This hypothesis is based on the study conducted by Sam[7] showing that "a good deal of low self image, depressive tendencies and psychological and somatic symptoms" were present among immigrant adolescents.

Finally, in terms of gender or age, the results of the present study do not provide evidence of differences between immigrant boys and girls. Nevertheless, older, as compared to younger in age children scored significantly less in the dimensions of KINDL[R] measuring "Emotional Well-being" "Self-esteem", "Friends", "School" and "Total" QoL. Such differences found in groups of older immigrant adolescents, may possibly reveal increasing deficits in dimensions of QoL that were not experienced by younger children. If immigrant children's deficits tend to increase during adolescence, then this is also an indication that should be noticed by families, schools and mental health professionals.

Also, relational deficits within immigrant families need to be further investigated, based on immigrant children's self-reported feelings of dissatisfaction with family. It is noteworthy that results from Greek adolescents do not confirm the presence of negative perceptions regarding family relations.[22] Further investigation may focus on identifying possible gaps in interpersonal communication or in parental care as to provide proper interpretations and relevant interventions for immigrant children's self-reported feelings of dissatisfaction with family.

Conclusion

It seems that the participating immigrant children were willing to report experiencing lower self-esteem and higher disappointment about their family life. Regarding bullying, incidents against immigrant children have been reported in the local health services. However, because the participating children did not report lower QoL on the dimensions of friends and school life –as it was expected in the case of children suffering violent behavior from other children– it would be fruitful to investigate these issues in a future study with the use of qualitative methodology.

Clinical Implications

Interventions can be proposed to promote immigrant child QoL: (a) interventions aiming to empower children and adolescents, (b) interventions focusing on the enhancement of their self-esteem, (c) family interventions aiming to make parents more aware of issues concerning their family's quality of life and the needs of their children.

Συγκριτική μελέτη Ποιότητας Ζωής παιδιών και εφήβων μεταναστών και Ελλήνων γονέων

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Οι ερευνητικές προσπάθειες σχετικά με την διερεύνηση της Ποιότητας Ζωής (ΠΖ) των παιδιών σχολικής ηλικίας και εφήβων με γονείς μετανάστες είναι σχετικά λίγες τόσο στη διεθνή όσο και στην ελληνική βιβλιογραφία. Λίγες μελέτες έχουν πραγματοποιηθεί σχετικά με την ψυχοπαθολογία και τα προβλήματα συμπεριφοράς ή τα συναισθηματικά προβλήματα σε εφήβους μετανάστες. Αναφορικά με την Ποιότητα Ζωής των μεταναστών αυτή διερευνήθηκε κυρίως σε ενηλίκους. Σκοπός της παρούσας έρευνας είναι η διερεύνηση της Ποιότητας Ζωής των παιδιών και νεαρών εφήβων με γονείς μετανάστες, που ζουν στην ευρύτερη περιοχή της Αθήνας, και η σύγκριση της με την Ποιότητα Ζωής των ελλήνων συμμαθητών τους που κατοικούν στην ίδια περιοχή και φοιτούν στα ίδια σχολεία. Εξήντα τρία παιδιά με γονείς μετανάστες (μέσος όρος ηλικίας 11,9 έτη) που προέρχονται από την Αλβανία και τις Ανατολικές Ευρωπαϊκές χώρες και 489 παιδιά με Έλληνες γονείς (μέσος όρος ηλικίας 11,33 έτη) συμπλήρωσαν ένα ερωτηματολόγιο ειδικά κατασκευασμένο για παιδιά και εφήβους: το ερωτηματολόγιο Kid-KINDL^{R} Questionnaire /8–12 years και το ερωτηματολόγιο Kiddo-KINDL^{R} Questionnaire/13–16 years στον χώρο του σχολείου. Οι διαστάσεις που διερευνώνται με το KINDL^{R} αφορούν τη σωματική υγεία, τη συναισθηματική ευεξία, την αυτοεκτίμηση, τη σχέση με τους φίλους, την οικογενειακή ζωή και την καθημερινή ζωή (σχολική ζωή). Η συμπλήρωση των ερωτηματολογίων έγινε στον χώρο του σχολείου με τη γραπτή συγκατάθεση των γονέων. Η στατιστική ανάλυση περιελάμβανε το student's t-test, το x^2 και πολυπαραγοντική γραμμική ανάλυση παλινδρόμησης για τη διερεύνηση της σχέσης μεταξύ διαστάσεων του KINDL^{R} και της εθνικότητας ελέγχοντας τους παράγοντες του φύλου και της ηλικίας. Τα αποτελέσματα έδειξαν ότι η Ποιότητα Ζωής των παιδιών των μεταναστών είναι χειρότερη σε επίπεδο στατιστικά σημαντικό στους τομείς της αυτοεκτίμησης και της ζωής στα πλαίσια της οικογένειας σε σύγκριση με τους Έλληνες συμμαθητές τους, καθώς και στη συνολική Ποιότητα Ζωής. Στους άλλους τομείς, όπως στη σωματική υγεία, τη συναισθηματική ευεξία, την κοινωνική και τη σχολική ζωή αναφέρουν την ίδια ΠΖ. Η διερεύνηση του παράγοντα του φύλου και της ηλικίας μετά τον έλεγχο της εθνικότητας και της ηλικίας, έδειξε ότι δεν υπήρχε διαφορά μεταξύ αγοριών και κοριτσιών. Αναφορικά δε με την επίδραση της

ηλικίας, τα μεγαλύτερα παιδιά αναφέρουν υποδεέστερη ΠΖ στον τομέα της συναισθηματικής ευεξίας, την αυτοεκτίμηση, τους φίλους και τη συνολική ΠΖ σε σχέση με τα μικρότερα. Τα αποτελέσματα δείχνουν ότι τα παιδιά των μεταναστών αναφέρουν χειρότερη ΠΖ στον τομέα της αυτοεκτίμησης και της οικογενειακής ζωής. Αυτά τα ελλείμματα φαίνονται να διογκώνονται καθώς τα παιδιά μεγαλώνουν. Η αντίληψη εαυτού και η αντίληψη για την ποιότητα της οικογενειακής ζωής είναι αλληλοεξαρτώμενες στα παιδιά των μεταναστών και η μία επιδρά στην άλλη. Μπορούμε να υποθέσουμε ότι τα παιδιά των μεταναστών βιώνουν χαμηλή αυτοεκτίμηση και αγχογόνα συναισθήματα στο πλαίσιο των οικογενειακών σχέσεων. Καθώς μεγαλώνουν η δυσφορία γίνεται πιο έκδηλη στον συναισθηματικό και κοινωνικό τομέα. Οι ψυχολογικές παρεμβάσεις οφείλουν να λάβουν υπόψη την πολύπλοκη επίδραση των οικογενειακών εμπειριών στην ψυχοκοινωνική ανάπτυξη του παιδιού, ώστε να σχεδιάσουν και να εφαρμόσουν τις κατάλληλες παρεμβάσεις υποστηρίζοντας τον γονικό ρόλο στους μετανάστες. Επιπλέον εξειδικευμένα προγράμματα προαγωγής της ψυχικής υγείας πρέπει να οργανωθούν για τους εφήβους μετανάστες.

: Ποιότητα ζωής, παιδιά μετανάστες, έφηβοι μετανάστες, αυτοεκτίμηση.

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Research article

Occupational identity crisis of professionals dealing with difficult adolescents

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This study tests the hypothesis of vulnerability in health and social care professionals dealing with difficult adolescents. This vulnerability appears to be underpinned by an occupational identity crisis that seems to diminish the ability of these professionals to recognize the suffering of these adolescents. A questionnaire was developed and then distributed during a network day bringing together members of various institutions and bodies working with difficult adolescents. Ninety-three professionals responded. Occupational identity weaknesses were identified: inadequate basic training, experiences of solitude, feelings of powerlessness and exposure, inadequate personal and institutional resources. Actors involved express their need for inter-institutional and inter-sectoral network but find it uneasy to implement. Some changes can be recommended to reduce this occupational identity crisis: increased efforts towards continuing training, development of possibilities of reflection within institutions, and more structured partnerships and actions.

Key words: Difficult adolescents, occupational Identity crisis, professionals' vulnerability, children welfare services, inter-sectorial network.

Introduction

Judging by the predominant discourse of their teams, the services working with problematic adolescents feel in crisis all over the world and particularly in France. We take the example of Western Brittany where we have been working on such topic, long enough to go beyond the manifest discourses. What these discourses put forward here as in many other places in France, is the idea that this crisis is related to two main factors: (a) the organizational constraints recently imposed on the services providers, and (b) the changes in the pathologies and behaviors of the adolescents they have to attend. Against such a background, these institutions have to face the daily problem of working with at-risk adolescents, whose behaviors put at risk the service providers as well. To remain as close as possible to the situation we have chosen in this paper to name them: difficult adolescents because of the rejection they generate (Saint-André & Botbol, 2013a). Additionally, such a designation takes into account not only these adolescents' functioning (violent behaviors, life course marred by shifts, narcissistic weaknesses, etc.) but also the counter-attitudes of the service providers. Mutajeunes network was created in 2007 to respond to the needs of these teenagers and of their service providers (Saint-André & Botbol, 2013b), bringing together all the relevant institutions in Brest (University Department of Child and Adolescent Psychiatry, County and Region Children

Welfare System, Governmental and Non Governmental Foster Home systems and units, Juvenile Justice System local units, Students and adolescents consultation service). Network meetings aim to give professionals the opportunity to share their experiences with these difficult adolescents; and to work through their feelings of powerlessness and insecurity and the difficulties they face in dealing with these adolescents' violent behavior.

This paper will study the hypothesis that occupational identity is a corner stone of this crisis because it is caught in a feedback loop contributing simultaneously to increase the professionals' vulnerability and to feed their feeling of helplessness preventing them from identifying the psychological issues behind the difficult behavior shown by these teenagers. In this perspective it will consider how our network organization could address this issue.

Material and method

Questionnaire

To explore our hypothesis, a questionnaire was developed and distributed during a colloquium on difficult adolescents, organized by Muta'jeunes. At the beginning, before distributing the anonymous questionnaires, we presented our approach and research subject to the participants. We have collected the questionnaires at the end of the day. During the colloquium speakers addressed different notions enabling a common definition of difficult adolescents.

The questionnaire contains 19 questions grouped into seven items:

- Respondents' characteristics
- Training
- Respondents' feelings when interacting with these adolescents
- Perceptions of networking usefulness
- Perceptions of partnership activities
- Perceptions of hierarchy
- Perceptions of the outcomes

Data entry was carried out using Epi Data software (Lauritsen & Bruus).

Respondent characteristics (Q 1–2)

From a total of 130 colloquium attendees, 93 filled in the questionnaires.

- 12 health and social care professionals
- 21 professionals from social and educational nongovernmental organizations
- 60 professionals of the local administration ("Le Conseil Général")
- Foster Families were overrepresented (n=41): they work either with NGOs or Local Government's services

To try to control the selection bias due to the number of non respondents, the answers to the first two questions of the survey were anonymously confronted to the colloquium attendance sheets (participant's function and affiliation). No socio-demographic characteristics were found distinguishing respondents from non-respondents.

Results

Adequacy of training for the care of difficult adolescents (Q 3–5)

The initial training is thought to poorly prepare for the problems related to difficult adolescents (63.44%–59). Respondents consider professional experience (64.52%–60, X^2=21.04; $p<0.00001$) and continuing training (78.49%–73, X^2=40.49, $p<0.00001$) to be the most useful resources for addressing the issues of difficult adolescents.

Respondents Often feel powerless (Q 6). They also Often feel alone (Q 7). More than 60% (56) of respondents believe that they are Always and Often held accountable (Q 8) for what happens to this adolescents. But we observe a large number of No Opinion responses.

Perceptions of hierarchy (Q 9–10)

Respondent professionals generally feel supported by their hierarchy (Often and Always 70.97%–66) (Q 9). They also seem quite satisfied by the decisions taken by their hierarchy (Q 10).

The high rate of No Opinion responses to these two questions has also to be noted.

Perception of interventions targeting difficult adolescents (Q 11–13)

A certain level of dissatisfaction can be noted in the response to Q 11. A small majority of the respondents (52.69%–49), believe that care Always or Often has a positive impact on the future of difficult adolescents (Q 12). For 52.69% (49) of respondents the care are Often consistent enough (Q 13).

A high rate of No Opinion was noted for these three questions as well.

Perception of networking (Q 14–15)

More than 65% (61) of respondents feel their opinion is at least Often taken into account during network meetings (Q 14). For 55.91% (52) of them (Q 15), the meetings with other professionals are Always or Often relevant. Once again, there is a high rate of No Opinion (table 1).

Respondent are divided more or less equally in finding Quite Easy and Often Difficult working with profession-

Table 1. Respondents' feelings during interventions with these adolescents (Q 6–8).

	Opinion	*Always*	*Often*	*Rarely*	*Never*	*No opinion*
Q6- Do you ever feel powerless in your work?	(%) (n=93)	0% (0)	53.76% (50)	37.63% (95)	2.15% (2)	6.45% (6)
Q7- Do you ever feel alone in your work?	(%) (n=93)	0% (0)	40.86% (38)	45.16% (42)	9.68% (9)	4.3% (4)
Q8- In your daily work, do you feel that you are increasingly asked to be accountable?	(%) (n=93)	10.75% (10)	49.46% (46)	25.81% (24)	3.23% (9)	10.75% (10)
Q9- On the subject of difficult adolescents, do you feel supported by your hierarchy in the decisions and actions you take?	(%) (n=93)	17.2% (16)	53.76% (50)	13.98% (13)	4.3% (4)	10.75% (10)
Q10- In the management of difficult adolescents, do you feel that the positions adopted and decisions taken by your hierarchy are appropriate?	(%) (n=93)	4.3% (4)	56.99% (53)	22.58% (21)	1.08% (1)	15.05% (14)
Q11- Do you think that the resources earmarked by your institution to manage difficult adolescents are (quantitatively) adequate?	(%) (n=93)	2.15% (2)	34.41% (33)	43.01% (40)	3.23% (9)	17.2% (16)
Q12- Do you think that today's care for difficult adolescents has a positive impact on the life course of these young people?	(%) (n=93)	3.23% (9)	49.46% (46)	30.11% (28)	0% (0)	17.2% (16)
Q13- On the subject of difficult adolescents, do you think that there is consistency of care among the different partners?	(%) (n=93)	0% (0)	52.69% (49)	27.96% (26)	0% (0)	19.35% (18)
Q14- During network meetings with other professionals, do you feel that what you say is taken into account?	(%) (n=93)	3.23% (9)	62.37% (58)	17.2% (16)	1.08% (1)	16.13% (15)
Q15- Do you feel that your meetings with other professionals from the network lead to relevant and key decision-making in terms of care?	(%) (n=93)	3.23% (9)	52.69% (49)	23.66% (22)	1.08% (1)	19.35% (18)

als from other institutions and other field of expertise (Q 16). Notably the same results are found (non significant difference: X^2=2.182) when the professionals from other institutions are from the same field of expertise (Q17).

However, a large majority of the respondent find significantly easier to work with the professionals from their institution, whatever their field of expertise (Q 18: identical skills: X^2=6.33: $p<0.02$; not identical X^2=15.588: $p<0.0001$).

The evaluation of the respondents on this common initiative is positive.

Professionals working in hospitals and Socio Educational professionals working in other institutions show significant differences. Belonging to a hospital team appears to be a protective factor concerning the respondents' professional experience (Q 4), internal security (Q 7) and evaluation of the positive impact of their work (Q 15).

Discussion

The problem of training

For respondents, initial training does not prepare them well enough to deal with difficult adolescents. This weakness is a known vulnerability factor of professional identity: "Any identity process, in the professional sphere, is ideally based on original training that only the people in a given job can pride themselves on" (Vilbrod 2003).

Table 2. Perceptions of Inter-sectorial Partnership on difficult adolescents (Q 16–18).

	Opinion	*Very easy*	*Quite easy*	*Often difficult*	*Very difficult*	*No opinion*
Q16- On the subject of difficult adolescents, do you think that working with professionals from other institutions and other fields of expertise (health, legal, school, education, etc.) is ...?	(%) (n=93)	4.3% (4)	43.01% (40)	48.39% (45)	3.23% (9)	1.08% (1)
Q17- On the subject of difficult adolescents, do you find that working with professionals from other institutions but from the same field of expertise (health, legal, school, education, etc.) is ...?	(%) (n=93)	3.23% (9)	54.84% (51)	39.78% (97)	1.08% (1)	1.08% (1)
Q18- On the subject of difficult adolescents, do you find that working with professionals from your institution (all fields of expertise included) is ...?	(%) (n=93)	15.05% (14)	60.22% (56)	20.43% (19)	3.23% (9)	1.08% (1)

Notably this belief is observed in spite of the recent significant reforms implemented in France to better match training programs and the needs different of service users (Blaevoet 2003, Sainsaulieu 2008). Since it has been shown that construction of the Self and training (Prestini-Christophe 2003) are closely related, our results are consistent with the hypothesis that these training programs changes fail to provide tools that are sufficiently relevant to overcome the destabilization induced by there implementation.

Conversely, most respondents think that first-hand experience may partly compensate for this shortcoming in initial training. Continuing training is seen as ensuring consistency between professional practice and other questions, and enables career empowerment (Le Borgne-Uguen 2003). Therefore, continuing training could be a relevant skills management tool for an environment –social (Ion, 2005) and health care (Vega 2000) services– in which practices are undergoing significant changes (Lantrin 2003).

How professionals feel: a lack of personal and professional resources

As it was expected, over half of the respondents, 53.76% (50), feel powerless when faced with difficult adolescents.

Table 3. Value of networking days (Q 19).

Q19: Do you think that initiatives such as working days on difficult adolescents (based on the model used today) contribute to improving:	*Yes*	*No*	*No opinion*
Inter-professional (partnership) relationships? (%)–(n)	84.95% (79)	1.08% (1)	13.98% (13)
Your knowledge of other institutions? (%)–(n)	83.87% (78)	3.23% (9)	12.9% (12)
Your knowledge of other professions? (%)–(n)	78.49% (73)	9.68% (9)	11.83% (11)
Relationships between actors on the ground and hierarchy? (%)–(n)	64.52% (60)	13.98% (13)	21.5% (20)
Quality of care for difficult adolescents? (%)–(n)	80.65% (75)	5.38% (5)	13.98% (13)
Understanding of the challenges involved in the provision of care for difficult adolescents? (%)–(n)	83.87% (78)	3.23% (9)	12.9% (12)

Table 4. Respondents opinion and their institutional affiliation.

		Private+public Socio-educational	*Service providers working in hospitals*
Q 4- Professional experience	Entirely+Partially Satisfactory	49	11
	Inadequate	29	1
Q 7- Do you feel alone?	Always+Often	36	2
	Rarely+Never	41	10
Q 15- Positive impact of Pre-hospital and Emergency Care (PEC)	Always+Often	37	12
	Rarely+Never	28	0

Regarding the number of respondents who work in an institution, the strong feeling of solitude expressed by 40.86% (38) of respondents is questioning. One possible reason for this result is that the institutional reforms which have taken place over recent decades have often had the consequence of cutting short team's meetings and supervisions whereas an increasing insistence is put on improving staff productivity. The strength of this feeling of solitude could also result from new forms of organization that tend to favor prescribed work at the expense of actual work, of which the latter is often more inventive and source of well being at work (Dejours 1998, Pelluchon 2011).

This hypothesis is consistent with the fact that service providers working in hospitals express a lesser feeling of solitude (X^2=3.842; $p<0.05$) and a bigger satisfaction with knowledge gained from experience (X^2=3.894; $p<0.05$). In fact, the context of their daily activity improves accessibility to supervision and development tools, relying in particular on the multidisciplinary resources available in hospitals.

On the other hand, 60.21% (56) of respondents felt that changes in practices result in increased accountability and increased feelings of insecurity in occupational lives. This feeling seems to be heightened by the growing predominance of prescribed work from the aforementioned tendency to insist on manual based procedures. Implementing specific team work moments within each institution could be one mean of reducing this vulnerability factor as it would enable work through professionals' counter-attitudes and regulate their emotional proximity to these adolescents. These moments of psychological remediation for professionals should aim at revitalizing their ability and enjoyment of thinking, which is generally severely affected by their relation with difficult adolescents and their tireless acting out. This would mean that the experience gained from the actual work carried out with these adolescents should be better formalized; no longer ineffable, this work would become sufficiently coherent to strengthen the foundations of professional identity.

Perception of working with others: the difficulty of network activities

As our results show, inter-institutional or inter-sectorial work is sometimes seen as difficult and unrewarding. Institutional identity, more than job identity, seems to be an obstacle for network activities. Institutional belonging (operating perspectives, priorities and different professional and cultural backgrounds) therefore seems to take precedence over professional identity (qualifications, training, job culture, etc.). The difficulties of the service users in the present study necessitate network activities and partnership actions (Halfon 2002, Laget 2002).

Interaction with others helps to build the foundations of professional identity, notably through mutual recognition. As such, limited knowledge of others and their institutions and subsequent false representations thereof, means that recognition is not operational and its absence has a harmful effect on inter-institutional work. Added to this, is the potential conflict between the institution's philosophy and its missions, which exposes professionals to tensions and often difficult paradoxes.

Partnership cannot be merely decided by law. It may need instead multi-professional training programs on the model proposed by the University Diploma in Difficult Adolescents (DU Adolescents difficiles) promoted by the French government's 2002 health and justice act (Botbol 2008, Circulaire 2002).

Perception of interventions with these adolescents

Just over one third of respondents, 36.56% (34), believe that resources for providing care to difficult adolescents are at least Often adequate and just under half of respondents, 46.24% (43), regard them as unsatisfactory. These results were unexpected as professionals tend to complain about the inadequate resources available for their actions. A halo effect or a recruitment bias may also explain this discrepancy. Nevertheless, it is likely that, when faced with violent behaviors, often unveiling institutional weaknesses, they must have adequate resources at their disposal. A very slight majority of respondents 52.69% (49) believe that care Always or Often has a positive impact on the future of difficult adolescents. It is the meaning of the care professional's action that is being questioned here. In fact, the desire to cure is often a strong incentive to professionals' involvement in the education and health sector (Vega, 2000; Vilbrod, 1995). In that sense, doubting the pertinence of their action and feeling useless and inefficient can also induce significant distress, which may be a strong contributory factor to occupational identity crisis.

Care providers working in hospitals give different responses, as they view more positively the impact of care (X^2=8.124; $p<0.01$). Within the context of a crisis, the short-term temporality of hospitalization could falsify the assessment that these individuals make of their actions, the positive effects of a single hospitalization masking the difficulties that only emerge in a long term follow-up. For care providers involved in these long-

term follow-ups, institutional tools mean that they can distance themselves and analyze the changes differently.

Perception of networking

Although the respondents' perception of network activities is mostly positive, inter-institutional work seems often difficult.

Nevertheless, service professionals are satisfied with the partnership organization of the network's common working days as the one to which they were attending. It seems likely that the network days are a valuable support for occupational identity insofar as it becomes possible to influence directly certain shortcomings identified in the assessment of partnership interventions: improved knowledge of partners, possibility of increased formalization of working practices with a view to recognition, a break with feelings of solitude considered stressful in working with difficult adolescents, etc.

Limitations of the study

The conditions in which the respondents were asked to fill out the questionnaire may have caused a bias in the results. Additionally, the theme of the day could have influenced the questionnaire answers and as previously discussed, questions wording may have induced a halo effect. It would be worthwhile extending this preliminary study with a qualitative analysis using semi-structured interviews with a better control of possible selection bias.

Conclusion

The objective of this study was to consider the hypothesis of an occupational identity crisis among care professionals working with difficult adolescents in specialized medical and social sectors.

The results of this study confirm the hypothesis of a crisis in professional identity of those working with these adolescents. Although initial training is often deemed inadequate for dealing with difficult teenagers, continuing training and knowledge gained from experience are the most solid referential. Despite its stated objectives to reduce the difficulties of providing care for these young people, network activities are a painful experience in some difficult cases. Nevertheless, we note high expectations in this regard. With improvements to initial and continuing training, these partnership actions seem to be one way of developing work that is even more relevant for difficult adolescents than for more classical cases, since they promote the establishment of a common basis of reference and a better understanding of the network actors. Globally, all the data collected in this study point towards the need to organise institutions and services in such a way that they promote development processes for stakeholders, and the need within each institution to establish times and spaces for reflection, not only through relevant training but also as part of daily professional practices. Everything indicates that today, this is the most accessible way to secure professional identities while at the same time strengthening partnership practices.

All the authors declare they have no actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

Η κρίση επαγγελματικής ταυτότητας των επαγγελματιών που ασχολούνται με δύσκολους εφήβους

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Ψυχιατρική 2016, 27:44–50

Η μελέτη εξετάζει την υπόθεση της ευπάθειας σε επαγγελματίες της υγειονομικής και κοινωνικής φροντίδας δύσκολων εφήβων. Αυτή η ευπάθεια φαίνεται να συνδέεται με μια επαγγελματική κρίση ταυτότητας που μειώνει τη δυνατότητα αυτών των επαγγελματιών να αναγνωρίζουν την οδύνη των

εν λόγω εφήβων. Ένα ερωτηματολόγιο αναπτύχθηκε και διανεμήθηκε κατά τη διάρκεια ημερίδας όπου συγκεντρώθηκαν τα μέλη του δικτύου των διαφόρων οργάνων και οργανισμών που εργάζονται με δύσκολους εφήβους, στην περιοχή της δυτικής Βρετάνης. Απάντησαν ενενήντα τρεις (93) επαγγελματίες. Αναγνωρίστηκαν οι αδυναμίες της επαγγελματικής τους ταυτότητας: ανεπαρκής βασική εκπαίδευση, εμπειρία μοναξιάς, συναισθήματα αδυναμίας και έκθεσης σε δυσκολίες, ανεπαρκή ατομικά και θεσμικά εφόδια. Οι εμπλεκόμενοι εκφράζουν την ανάγκη τους για δια-ιδρυματικό και δια-τομεακό δίκτυο, ωστόσο θεωρούν δύσκολη την πραγματοποίησή του. Συστήνουν μερικές αλλαγές για να μειωθεί αυτή η επαγγελματική κρίση ταυτότητας: περισσότερη συνεχιζόμενη εκπαίδευση, ανάπτυξη δυνατοτήτων σκέψης εντός των οργανισμών και πιο δομημένες συνεργασίες και ενέργειες.

: Δύσκολοι έφηβοι, επαγγελματική κρίση ταυτότητας, ευπάθεια επαγγελματιών, πρόνοια παιδιών, διατομεακό δίκτυο.

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Brief communication

Compulsory admissions: Possibly another dark side of the Greek economic crisis

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A number of previous articles have dealt with the negative impact of the Greek Economic crisis on public health, including significant increases in major depression prevalence and suicide and homicide rates. The mentally ill seem to represent a vulnerable social group, with particular difficulties in this context. The number of compulsory assessments and involuntary admissions was recorded by reviewing patient records in the Department of Psychiatry of the University Hospital of Patras, through years 2006–2013. Compulsory assessments increased from 176 in 2006 to 262 in 2009 and 354 in 2013, representing a 48.86% and 101.13% increase in the first and the fifth year of economic crisis, respectively. The assessments resulted in 160 involuntary admissions in 2006, which escalated to 262 admissions (63.75% rise) in 2013. Even though a rise in involuntary placements could be attributed to other factors as well, it may also partly represent a not so evident side of the Greek economic crisis.

Key words: Involuntary placement, economic crisis, psychosis, public health.

A number of previous articles have dealt with the negative impact of the Greek economic crisis on public health.[1–4] Among the reported parameters are increases in suicide and homicide rates, major depression prevalence, new HIV infections, tuberculosis incidence, malaria reemergence, and neonatal deaths.[6] It has been accepted that the mentally ill represent a vulnerable social group, because of functional deterioration, increased health needs and stigma, and as such, face partic-

ular difficulties in this context. A rise in compulsory assessments and admissions in our department possibly mirrors, to a certain extent, this strain on the mentally ill population.

The number of compulsory assessments and involuntary admissions was recorded by reviewing patient records in the Department of Psychiatry of the University Hospital of Patras, through years 2006–2013, which, at that time, has been the major inpatient service in an administrative area of about 1.000.000 people. It was found that compulsory assessments increased from 176 in 2006 to 262 in 2009 and 354 in 2013, representing a 48.86% and 101.13% increase in the first and the fifth year of economic crisis, respectively. The assessments resulted in 160 involuntary admissions in 2006, which escalated to 262 admissions (63–75% rise) in 2013. The examined patients were 155 in 2006, 226 in 2009 and almost doubled to 297 in 2013. The patients that were involuntary assessed more than once in the same year, corresponding to the so-called revolving door cases, rose by 137.5%, from 16 to 38, through the same time period. Also, an exceptional rise by almost six times in 2013 compared to 2006, from 16 to 92, was noted in the number of assessments that did not warrant hospitalization, and were mainly represented by alcohol/substance use (15 assessments, 16.3%), as well as stable or mildly relapsed psychotic and bipolar patients (41 assessments, 44.6%), who could not afford regular health care due to family exhaustion, lack of services, or poverty (fig. 1).

A rise in involuntary placements as a consequence of ongoing deinstitution alization processes has been previously noted, even in countries with well-organized mental health systems, such as the UK.[6] Yet, the social and economic stress and the fact that many people in Greece lost health insurance and therefore access to therapy could have contributed to this increase, by increasing morbidity across all diagnostic categories, including psychotic patients, who are mainly represented in involuntary admissions.[7] This could stand for a not so evident side of the Greek economic crisis.

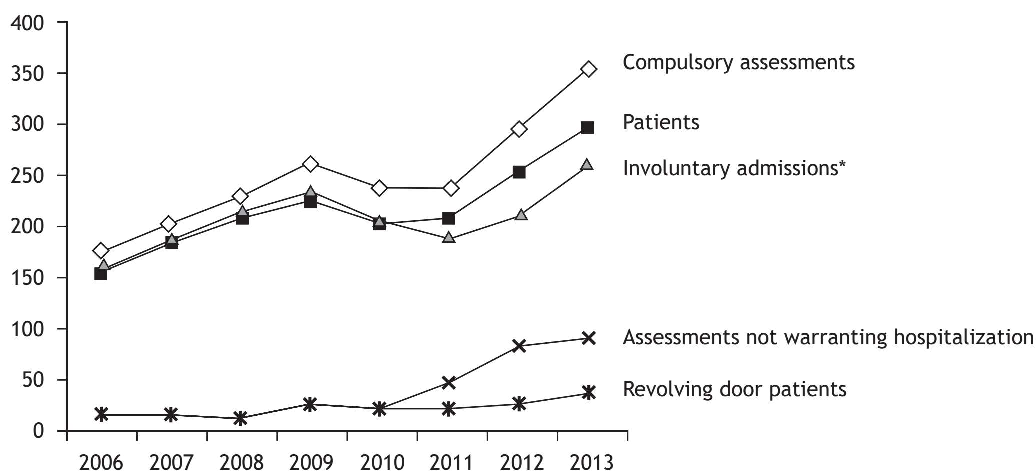

Figure 1. Number of compulsory psychiatric assessments, involuntary examined patients, involuntary admissions*, assessments not resulting in hospitalization, and repeatedly examined patients during the period 2006–2013.

* A percentage of these admissions, 16.9–51.5% each year, were hospitalized in other inpatient services of the country, due to overcrowding of the ward.

Ακούσιες νοσηλείες: Ακόμα μία σκοτεινή πλευρά της Ελληνικής οικονομικής κρίσης

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Ψυχιατρική 2016, 27:51–53

Σε προηγούμενες εργασίες έχουν επισημανθεί οι αρνητικές συνέπειες της οικονομικής κρίσης για τη δημόσια υγεία, όπως η αύξηση της συχνότητας της κατάθλιψης και του δείκτη αυτοκτονιών και ανθρωποκτονιών. Οι ψυχιατρικοί ασθενείς φαίνεται να αντιπροσωπεύουν μια ευάλωτη ομάδα του γενικού πληθυσμού, με αυξημένη επιβάρυνση στο πλαίσιο της δυσμενούς οικονομικής συγκυρίας. Έγινε καταγραφή του αριθμού των ακούσιων εξετάσεων και νοσηλειών που έλαβαν χώρα στην Ψυχιατρική Κλινική του Πανεπιστημιακού Γενικού Νοσοκομείου Πατρών, κατά τα έτη 2006–2013. Ο αριθμός των ακούσιων εξετάσεων αυξήθηκε από 176 το 2006 σε 262 το 2009, και 354 το 2013, που αντιστοιχεί σε αύξηση κατά 48,86% και 101,13% το πρώτο και το πέμπτο έτος της περιόδου της οικονομικής κρίσης, αντίστοιχα. Οι ακούσιες εξετάσεις κατέληξαν σε 160 ακούσιες νοσηλείες το 2006, και 262 νοσηλείες (αύξηση κατά 63,75%) το 2013. Αν και η αύξηση των ακούσιων νοσηλειών μπορεί να σχετίζεται και με άλλους παράγοντες, το φαινόμενο αυτό μπορεί να αντιπροσωπεύει εν μέρει μια αφανή πλευρά της οικονομικής κρίσης στην Ελλάδα.

: Ακούσια νοσηλεία, οικονομική κρίση, ψύχωση, δημόσια υγεία.

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Brief communication

Financial crisis and criminality in Greece: 2008 vs 2011

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Psychiatriki 2016, 27:54–57

The current financial crisis has an ongoing impact on public mental health and quality of life. The aim of the current study was to investigate the potential impact of the financial crisis on criminality in Greece, verifying differences in crime rates between the years 2008 and 2011. Data on crime in Greece for the years 2008 and 2011 were provided by the Crime Analysis Section of the Public Security Department of the Hellenic Police Headquarters. The overall and the specific crude crime rates were calculated per 100.000 residents and per police region of Greece. A significant increase in the overall crime rate between 2008 and 2011 was found ($t=5.01$, $p=0.001$). Moreover, between 2008 and 2011 there was a significant increase in the following specific criminality rates: homicide ($t=2.41$, $p=0.03$), fraud ($t=7.35$, $p=0.001$), extortion ($t=3.22$, $p=0.009$), illegal weapon possession ($t=5.27$, $p=0.001$), theft/burglary ($t=4.62$, $p=0.001$) and robbery ($t=3.23$, $p=0.007$). There were not statistically differences in the specific rates of sex-related crimes (rape, sexual exploitation) and drug-related crimes were not observed. According to the results of our study, criminality in Greece shows significant increase during the current financial crisis as reflected by many crime indicators.

Key words: Financial crisis, criminality, Greece.

Introduction

The financial crisis that begun in 2008 affecting many European countries has an ongoing impact on public mental health and quality of life. There is evidence that economic downturn has many attributes which can occur simultaneously, including premature deaths from intentional violence, suicides and homicides.[1,2] There has been a significant increase of suicide, attempted suicide and suicidal ideation during the financial crisis in Greece.[3–6] The aim of the current study was to investigate the potential impact of the financial crisis on criminality in Greece, verifying differences in crime rates between the years 2008 and 2011.

Material and Methods

Data on crime in Greece for the years 2008 and 2011 were provided by the Crime Analysis Section of the Public Security Department of the Hellenic Police Headquarters. In order to create a comprehensive global index of criminality, we calculated an overall crime rate including the following crimes committed: homicides, financial crimes (fraud, extortion), drug-related crimes, illegal weapon possession, sex-related crimes (rape, sexual exploitation), thefts/burglaries, and robberies. The overall and the aforementioned specific crude crime rates were calculated per 100.000 residents and per police region of Greece. T test for paired samples has been used to control the differences in the rates between 2008 and 2011. For the statistical analysis the SPSS package was used.

Results

A significant increase in the overall crime rate between 2008 and 2011 was found ($t=5.01$, $p=0.001$). Moreover, between 2008 and 2011 there was a significant increase to the specific rates of homicide ($t=2.41$, $p=0.03$), fraud ($t=7.35$, $p=0.001$), extortion ($t=3.22$, $p=0.009$), illegal weapon possession ($t=5.27$, $p=0.001$), theft/burglary (t-4.62, $p=0.001$) and robbery ($t=3.23$, $p=0.007$). Statistic differences in the specific rates of sex-related crimes (rapes, sexual exploitation) and drug-related crimes were not observed. Table 1 shows the total and the specific crime rates for the years 2008 and 2011 in different police regions of Greece.

Comments

In times of economic stress an increase in both property crimes and violent crimes is expected.[7] A study exploring the impact of economic crisis on crime indicators for the years 2008–2009, at country level, showed that in 7 out of 11 countries in which there was an observed significant impact of the economic crisis, there was an increase in at least one criminality rate. The largest increase was noted in robberies followed by homicides. Specifically homicides appeared to be related to economic changes in countries that already presented high levels of violence.[8]

According to the results of this preliminary study there is a significant increase of criminality in Greece during the crisis and between the years 2008 and 2011. In particular, an increase is revealed as much in crime against property (fraud, theft/burglary) as in most indicators of violent crimes (homicides). However, it is worth noting that the main limitation of this preliminary report is that the study covers only two years (before the crisis and during the crisis). Further data including more years during the crisis are needed in order to establish the effect of the Greek financial crisis on the criminality of the country.

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Acknowledgements to the Hellenic Statistical Authority (ELSTAT) and the Crime Analysis Section of the Public Security Department of the Hellenic Police Headquarters for the data that shared with us. The first author is supported by a grant from "Alexander S. Onassis" Public Benefit Foundation for doctoral studies.

Table 1. Total and Specific crime rates (per 100.000 residents) for the years 2008 and 2011 in different police regions of Greece

Police Regions of Greece	A	A	B	B	C	C	D	D	E	E	F	F	G	G	H	H	I	I	J	J
	2008	2011	2008	2011	2008	2011	2008	2011	2008	2011	2008	2011	2008	2011	2008	2011	2008	2011	2008	2011
West Greece	355.77	1126.37	0.27	1.21	2.44	20.97	1.35	0.81	1.22	0.81	71.99	96.52	15.97	37.64	0.95	0.81	253.87	938.84	7.71	17.74
Peloponnese	407.19	1029.23	0.93	3.23	3.17	17.33	1.72	1.36	0.26	0.85	74.94	95.13	21.28	40.09	1.19	1.36	296.84	835.92	6.87	32.10
Epirus	197.28	337.74	0.28	0.85	1.42	7.61	0.28	0.56	0.28	0.85	73.34	81.41	14.5	31.27	0.28	0.28	104.61	203.66	2.27	10.42
Central Greece	397.77	626.34	1.18	1.26	4.22	11.19	0.51	1.08	0.34	0.72	126.63	63.88	14.86	20.21	1.01	0.36	241.26	509.05	7.77	16.96
West Macedonia	138.32	254.68	0.34	0.34	3.07	10.27	1.7	0.34	0.34	1.03	71.55	72.57	11.92	19.51	1.36	0.34	46.33	141.37	1.7	3.77
East Macedonia and Thrace	185.72	339.23	0.56	1.65	2.79	5.62	0.56	1.49	–	0.50	70.36	85.38	16.16	18.99	1.81	0.33	87.78	205.12	5.71	11.73
South Aegean	345.46	581.65	1.31	0.96	2.94	9.95	7.84	5.14	–	2.89	165.38	79.61	22.88	29.21	1.96	1.93	137.6	431.42	5.56	9.95
Ionian Islands	298.37	720.42	0.87	1.28	1.75	6.83	5.69	3.84	0.44	2.14	78.75	116.58	32.37	42.70	0.44	0.85	173.69	514.16	4.37	18.79
Central Macedonia	204.73	537.95	0.8	1.39	2.62	10.65	1.48	0.89	0.91	0.51	88	102.57	22.57	27.26	1.6	2.03	84.58	373.63	2.17	7.61
Thessaly	183.81	286.21	0.41	1.09	1.22	6.80	0.82	0.41	0.27	1.22	69.83	51.99	13.31	22.73	1.36	0.41	93.47	177.74	3.12	14.56
Crete	497.96	925.63	2.31	2.44	4.62	9.60	3.63	3.09	1.15	2.93	102.26	101.09	100.94	104.84	4.12	0.98	270.17	667.28	8.74	18.23
North Aegean	146.62	208.73	0.5	1.51	0.5	9.03	3.99	–	0.5	–	67.82	88.31	15.46	20.07	2.99	3.01	53.86	81.28	1	5.02
Attica	1349.09	1671.08	1.7	2.09	25.14	35.56	2.41	1.70	2.51	3.11	114.49	85.03	24.62	25.25	4.92	4.43	1111.26	1382.74	62.02	124.87
Thessaloniki	1246.8	1317.17	1.49	0.51	14.25	28.55	1.05	1.37	1.22	2.92	108.39	132.73	27.62	40.38	5.16	6.09	1049.08	1020.93	38.55	51.79
Pared samples t-test	t(13)=5.01 p=0.001		t(13)=2.41 p=0.031		t(13)=7.35 p=0.001		t(12)=–1.93 p=0.077		t(10)=3.22 p=0.009		t(13)=–0.23 p=0.819		t(13)=5.27 p=0.001		t(13)=–1.57 p=0.141		t(13)=4.62 p=0.001		t(13)=3.23 p=0.007	

A=Total crime rate
B=homicides
C=frauds, D=rapes
E=extortions, F=narcotics
G=weapons, H=sexual exploitation
I=thefts/burglaries
J=robberies

Οικονομική κρίση και εγκληματικότητα στην Ελλάδα: 2008 vs 2011

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Ψυχιατρική 2016, 27:54–57

Η παρούσα οικονομική κρίση έχει μια συνεχιζόμενη επίδραση στην ψυχική υγεία και την ποιότητα ζωής των πολιτών. Ο σκοπός της παρούσας μελέτης ήταν να διερευνήσει την πιθανή επίδραση της οικονομικής κρίσης στην εγκληματικότητα στην Ελλάδα εντοπίζοντας διαφορές στους δείκτες εγκληματικότητας ανάμεσα στα έτη 2008 και 2011. Πληροφορίες για τις εγκληματικές ενέργειες στην Ελλάδα τα έτη 2008 και 2011 προήλθαν από το τμήμα καταγραφής και ανάλυσης εγκλημάτων του τμήματος ασφαλείας του αρχηγείου της Ελληνικής Αστυνομίας. Ο συνολικός δείκτης εγκληματικότητας και οι αδροί ειδικοί δείκτες υπολογίστηκαν ανά 100.000 κατοίκους και ανά αστυνομική περιφέρεια της Ελλάδος. Εντοπίστηκε μια σημαντική αύξηση του συνολικού δείκτη εγκληματικότητας μεταξύ των ετών 2008 και 2011 (t=5,01, p=0,001). Επιπρόσθετα, μεταξύ των ετών 2008 και 2011 εντοπίστηκε σημαντική αύξηση των παρακάτω ειδικών δεικτών εγκληματικότητας: ανθρωποκτονία (t=2,41, p=0.03), απάτη (t=7,35, p=0,01), εκβιασμός (t=3,22, p=0,009), παράνομη οπλοκατοχή (t=5,27, p=0,001), κλοπή/διάρρηξη (t=4,62, p=0,001) και ληστεία (t=3,23, p=0,007). Δεν εντοπίστηκαν στατιστικά σημαντικές διαφορές σε σχέση με εγκλήματα σχετιζόμενα με το σεξ (βιασμός, σεξουαλική εκμετάλλευση) και τα εγκλήματα που σχετίζονται με παράνομες ουσίες. Σύμφωνα με τα αποτελέσματα της μελέτης μας, η εγκληματικότητα παρουσίασε σημαντική αύξηση κατά τη διάρκεια της παρούσας οικονομικής κρίσης, όπως αυτή καταδεικνύεται με πολλούς ειδικούς δείκτες εγκληματικότητας.

: Οικονομική κρίση, εγκληματικότητα, Ελλάς.

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Books review

Charalambos S. Ierodiakonou
The Psychology of Aristotle, the Philosopher.
A Psychoanalytic Therapist's Perspective,
Karnac, London, 2011

Professor Charalambos Ierodiakonou has been dealing with the work of Stagerite philosopher Aristotle for 12 years. He confesses that he has been enchanted with this task (Ierodiakonou, 2015). With justification! The thematic width of the work of Aristotle is so extensive, the information, the hypotheses and the theories are so rich, the language is so clear and complete that whoever has the desire, the time and the motivation to discover Aristotle, feels justified. This is how Ierodiakonou felt when he decided (originally out of a sense of duty given his professorship at the Aristotelian University and subsequently out of interest and admiration) to deal with the work of Aristotle.

An additional but important reason that motivated Ierodiakonou to get to know Aristotle was the relevance of Aristotle's work with psychology and psychoanalysis. In many of the books of Aristotle there is broad and detailed reference to these subjects. Ierodiakonou has managed to assemble all references related to these subjects in a single book. This is a major contribution because in this way the reader is provided with the opportunity to find assembled, composed, commented upon and analyzed all the information for the collection of which the reader would probably have needed to devote as many years as Ierodiakonou has devoted to study the work of Aristotle in depth.

This book, therefore, represents a precious source of information on the views of the philosopher regarding the human soul in all its expressions.

Two of the most impressive aspects of the book (and of Aristotle's teaching) are the balancing point between the biological approaches and the psychological ones, and the use of paradigms from the animal kingdom, an indication of the broad scientific vista of Aristotle but also of his ability to observe. I am tempted to mention the observed phenomenon of differentiation of the role of the rooster when the hen disappears and the newborn chicken are in need of care and protection. This phenomenon impressed Aristotle, was selected for presentation by Ierodiakonou and (as you can see) has been chosen by the present reviewer to underline the choice of both these authors. The paradigm shows the importance of the environment in the shaping of behavior and eventually the personality (ethos) of living organisms; at the same time it underlines a biologically determined and environmentally catalyzed selection of priorities.

Naturally, the book of Ierodiakonou does not deal so much with the observations of Aristotle on animal behavior. There are other topics discussed in the book with greater emphasis, especially those that could be considered as precursors of modern psychoanalysis. The expertise of Ierodiakonou on these issues is a guarantee for the interpretative validity of the work of Aristotle on a topic of diachronic importance as that of the human psyche.

In conclusion, I consider this book on Aristotle very useful indeed, not only for mental health professionals but for the general public as well.

Thank you, Professor Ierodiakonou, for this important and useful book.

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Ierodiakonou H. 6 Topics by Aristotle from a psychological perspective. *Synapsis* 2, 2015:70–71 (in Greek)

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Χ .
Η Ψυχολογία του Φιλοσόφου Αριστοτέλη.
Από τη Σκοπιά του Θεραπευτή Ψυχαναλυτή,
Karnac, Λονδίνο, 2011

Εδώ και δώδεκα χρόνια ο Καθηγητής Χαράλαμπος Ιεροδιακόνου ασχολείται με το έργο του Σταγειρίτη φιλοσόφου Αριστοτέλη. Καθ’ ομολογίαν του ιδίου (Ιεροδιακόνου 2015) η ενασχόληση αυτή τον έχει γοητεύσει. Δικαίως! Το θεματικό φάσμα του έργου του Αριστοτέλη είναι τόσο ευρύ, οι πληροφορίες, οι υποθέσεις και οι θεωρίες τόσο πλούσιες, η διατύπωση τόσο καθαρή και πλήρης – που όποιος έχει τη διάθεση, τον χρόνο και το κίνητρο να ασχοληθεί με τον Αριστοτέλη αισθάνεται δικαιωμένος. Έτσι αισθάνθηκε και ο Χαράλαμπος Ιεροδιακόνου όταν αποφάσισε (αρχικά, όπως αναφέρει, από συνειδητοποιημένη υποχρέωση ως Καθηγητής του Αριστοτέλειου Πανεπιστημίου, και στη συνέχεια από ενδιαφέρον και θαυμασμό) να ασχοληθεί με το έργο του φιλοσόφου.

Ένας πρόσθετος αλλά σημαντικός λόγος που οδήγησε τον Ιεροδιακόνου στη γνωριμία με τον Αριστοτέλη, ήταν η σχέση του έργου του τελευταίου με την ψυχολογία και την ψυχανάλυση. Σε πολλά από τα βιβλία του Αριστοτέλη γίνεται ευρύς και λεπτομερειακός λόγος για τα αντικείμενα αυτά και είναι σημαντική η προσφορά του Ιεροδιακόνου στο ότι συγκέντρωσε στο βιβλίο του «The Psychology of Aristotle the Philosopher» όλες τις συναφείς προς την ψυχολογία πληροφορίες από όλες τις πηγές του Αριστοτελικού έργου. Έτσι ο αναγνώστης έχει τη δυνατότητα να βρει συγκεντρωμένες, στοιχειοθετημένες, σχολιασμένες και αναλυμένες όλες τις πληροφορίες για τη συλλογή των οποίων θα χρειαζόταν ενδεχομένως να αφιερωθούν όσα χρόνια χρειάστηκε ο Ιεροδιακόνου για να μελετήσει σε βάθος το έργο του Αριστοτέλη.

Το βιβλίο, λοιπόν, αποτελεί μια πολύτιμη πηγή πληροφοριών για τις απόψεις του φιλοσόφου για την ψυχή του ανθρώπου σε όλες της τις εκφάνσεις. Εντύπωση προκαλεί η ισορροπία ανάμεσα στις βιολογικές προσεγγίσεις και τις ψυχολογικές θεωρήσεις καθώς και η χρησιμοποίηση παραδειγμάτων από το ζωικό βασίλειο που δείχνει την ευρεία επιστημονικότητα του Αριστοτέλη αλλά και την παρατηρητικότητά του. Δεν αντιστέκομαι στον πειρασμό να αναφερθώ στο φαινόμενο της αλλαγής του ρόλου του κόκορα όταν χάνεται η κότα από το κοτέτσι και οι νεοσσοί χρειάζονται προστασία και φροντίδα. Αυτό το φαινόμενο εντυπωσίασε τον Αριστοτέλη, επιλέχθηκε για καταγραφή από τον Ιεροδιακόνου και (όπως βλέπετε) επιλέχθηκε και από εμένα ώστε να επισημάνω την επιλογή των δύο προηγούμενων. Το παράδειγμα δείχνει τη σημασία του περιβάλλοντος στη διαμόρφωση της συμπεριφοράς των έμβιων όντων, συγχρόνως όμως, τουλάχιστον κατά τη δική μου αντίληψη, και την βιολογικώς καθοριζόμενη και εξωγενώς ενισχυόμενη επιλογή προτεραιοτήτων.

Φυσικά, το βιβλίο του Ιεροδιακόνου δεν ασχολείται τόσο με τις παρατηρήσεις του Αριστοτέλη για τη συμπεριφορά των ζώων. Υπάρχουν άλλα θέματα που αναδεικνύει με μεγαλύτερη έμφαση και σε μεγαλύτερο βάθος, κυρίως αυτά που θα μπορούσαν να θεωρηθούν ως προπομποί της σύγχρονης ψυχανάλυσης. Η αυθεντία του Ιεροδιακόνου στα θέματα αυτά είναι η καλύτερη εγγύηση της ερμηνευτικής εγκυρότητας του έργου του Αριστοτέλη σε ένα θέμα διαχρονικής σημασίας όπως είναι η ανθρώπινη ψυχή.

Συμπερασματικά, θεωρώ το βιβλίο αυτό εξαιρετικά χρήσιμο, όχι μόνο για τους λειτουργούς ψυχικής υγείας αλλά και για το ευρύτερο κοινό.

Ευχαριστούμε Καθηγητά Ιεροδιακόνου γι’ αυτό το σημαντικό και χρήσιμο βιβλίο.

Βιβλιογραφία

Ιεροδιακόνου Χ. 6 θέματα στον Αριστοτέλη από ψυχολογικής σκοπιάς. *Σύναψις*, 2, 2015:70–71

Γιώργος Χριστοδούλου
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S. Stylianidis et al
Social and Community Psychiatry. Towards a critical patient-oriented approach. Springer, 2015

The recent edition in English of this book is a proof of quality. The references in the principles and guidelines of the international organisms in parallel with good practices offers a solid framework for a critical approach of different branches of social psychiatry. Also, the historical approach of the different models of mental health services in Europe.

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Σύγχρονα θέματα κοινωνικής και κοινοτικής ψυχιατρικής. Για μια κριτική ανθρωποκεντρική ψυχιατρική Εκδ. Τόπος, Αθήνα 2014

Κυκλοφόρησε το 2015 και η αγγλική έκδοση από τις εκδόσεις Springer. Η ανάπτυξη μονάδων κοινοτικής ψυχιατρικής αποτελεί κεντρικό διακύβευμα , καθώς επιτρέπουν την διαβίωση ασθενών με σοβαρά ψυχοπαθολογικά προβλήματα στη κοινότητα. Οι κατευθυντήριες αρχές και οδηγίες των διεθνών οργανισμών για τους τομείς της Κοινωνικής ψυχιατρικής αναπτύσσονται διεξοδικά στα αντίστοιχα κεφάλαια, μαζί με παραδείγματα άσκησης τους, από τις βιωμένες εμπειρίες των συγγραφέων. Αυτό είναι μια σημαντική συμβολή, καθώς έχουμε, γενικά, μια αποσπασματική γνώση για αρχές και οδηγίες που έχει συνυπογράψει η χώρα μας και η διαρκής μείωση των πόρων κινδυνεύει να κενώσει από την ουσία τους.

Ο Στ. Στυλιανίδης και πολλοί συγγραφείς με καθιερωμένη συμβολή στο χώρο της κοινωνικής ψυχιατρικής υπογράφουν τα διάφορα κεφάλαια. Η Μ.Amering στο πρόλογο της τονίζει ότι τα κρίσιμα ζητήματα που αφορούν την κοινωνική ψυχιατρική είναι αλληλένδετα με αυτά που αφορούν και άλλους κοινωνικούς θεσμούς, όπως τα σχολεία, τις υπηρεσίες υγείας, την στέγαση, την εργασία και το πως οι ανθρώπινες κοινότητες και οι διεθνείς οργανισμοί τα αντιμετωπίζουν. Η κοινωνική ψυχιατρική τοποθετείται στο πλαίσιο της ιστορικής πορείας της ψυχιατρικής, της φροντίδας ή και των εγκλεισμών , που έχουμε γνωρίσει. Αναπτύσσονται οι φιλοσοφικές και κοινωνιολογικές της βάσεις . Η πολυδιάσπαση της οικογένειας στις μέρες μας έχει ως συνέπειες την μικρή ανοχή στις ματαιώσεις, την βία , αλλά και την κοινωνική απόσυρση. Προσεγγίζεται επίσης η ιντερνετική διαμεσολάβηση των ανθρώπινων σχέσεων.

Το κεφάλαιο για τις αρχές και τους στόχους της επιδημιολογίας υπογραμμίζει την σημασία αυτών των εργαλείων για την δημοσιοποίηση ερευνητικών και κλινικών δεδομένων. Το κεφάλαιο για την Παγκόσμια Ψυχική Υγεία αναφέρεται στους κύριους άξονες δράσης του ΠΟΥ, στις διεθνείς διακηρύξεις και οδηγίες, αλλά και σε πίνακες που συνοψίζουν τις διεθνείς μελέτες. Η αναφορά σε αυτές τις γενικές αρχές μπορεί να αποτελέσει εργαλείο υπεράσπισης της ψυχικής υγείας από την αποψίλωση της από πόρους.

Τα δύο κεφάλαια για την ψυχιατρική μεταρρύθμιση στην Ευρώπη και την Ελλάδα τοποθετούν την πορεία των μεταρρυθμίσεων στο πλαίσιο που ορίζουν τα θεμελιώδη κείμενα και οι διακηρύξεις της Ευρωπαϊκής Ένωσης, πλαίσιο που ίσως δεν είχαμε επαρκώς αντιληφθεί στην Ελλάδα σε ποιό βαθμό καθορίζει το πρακτέο. Το ιστορικό πλαίσιο της μεταρρύθμισης αναφέρεται στα κύρια παραδείγματα της Γαλλίας, Αγγλίας, Ιταλίας, Γερμανίας, Ισπανίας και Πορτογαλίας. Σε ότι αφορά την Ελλάδα επιχειρείται μια ευρεία σύνθεση ιστορικών, νομικών και κοινωνιολογικών κειμένων. Μια εκτεταμένη συζήτηση που καταλήγει σε πρόταση 12 σημείων για ένα σύγχρονο σύστημα παροχής ψυχιατρικών υπηρεσιών.

Το κεφάλαιο για την Ψυχαναλυτική πρακτική αναφέρεται σε συγκεκριμένες θεραπευτικές προσεγγίσεις, αλλά και στη κεντρική συνεισφορά της στην δυναμική των θεραπευτικών ομάδων. Αναφορές στην Προαγωγή της Ψυχικής Υγείας, τόσο με αυτόνομες δράσεις πρόληψης και κοινωνικής ένταξης, όσο και με την ένταξη τέτοιων δράσεων στον κορμό της θεραπευτικής φροντίδας. Η αξιολόγηση δεν υπάρχει μόνο από μια εξωτερική εργαλειακή σκοπιά, αλλά δίνει επίσης την δυνατότητα της ενσωμάτωσης της μελέτης των αναγκών του πληθυσμού αναφοράς και του προσωπικού. Η ενδυνάμωση και τα δικαιώματα των χρηστών αναπτύσσονται ολοκληρωμένα και με σχετικά παραδείγματα. Δίκην Επιλόγου, αναφέρεται στην οικονομική κρίση, το σύγχρονο πλαίσιο, προτείνοντας δράσεις σε διάφορους τομείς. Η επιτυχία του βιβλίου έγκειται στη σύνθεση των κοινωνικών και θεραπευτικών δεδομένων,ακριβώς, στη συγκυρία του σήμερα.

Δ. Πλουμπίδης
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G. Stefanatos
Psychoanalysis and Adolescence -
Clinical and Theoretical Aspects,
Hestia, Athens 2013

The psychiatrist and psychoanalysist Gerasimos Stefanatos is an expert in the psychoanalytic study of puberty with a special interest on disorders occurring in adolescence. He has directed the Gennimatas Hospital's Adolescent Unit. His book "Psychoanalysis and Adolescence" is mainly addressed to the greek psychiatric and psychoanalytic community and is a systematic collection of key texts on adolescence. Freud, Winnikot, Anna Freud, Kestemberg, Blos, Laufer and Olagnier are some of the authors whose texts are included in this elegant book

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Ψυχανάλυση και Εφηβεία-
Κλινικά και Θεωρητικά Ορόσημα,
Βιβλιοπωλείον της Εστίας, 2013

Η ψυχανάλυση έχει συμβάλλει αποφασιστικά στην κατανόηση των ψυχολογικών μεταβολών που συμβαίνουν στην εφηβεία. Μάλλον πρέπει να την θεωρήσουμε ως την κύρια κλινικο-θεωρητική πηγή ιδεών που έχει διευρύνει τις γνώσεις μας για την ψυχολογία του εφήβου και έχει βοηθήσει να κατανοήσουμε τις κρίσεις της εφηβείας και την ιδιαίτερη ψυχοπαθολογία της. Από την άλλη, είναι γεγονός ότι αυτές οι γνώσεις δεν έχουν φθάσει στους Έλληνες ψυχιάτρους, ίσως γιατί έχει υποτιμηθεί η σημασία τους στη διάρκεια της εκπαίδευσης στην ψυχιατρική. Το σεμινάριο «Εφηβικής Ψυχιατρικής» που γινόταν στο Αιγινήτειο είχε ατονήσει για πολλά χρόνια, αλλά την τρέχουσα χρονιά (ευτυχώς) επανεργοποιήθηκε. Άλλα σεμινάρια πράγματι γίνονται σε Μονάδες του Δημοσίου Τομέα, πιθανολογώ με μικρή συμμετοχή ψυχιάτρων, και σε όλα η ψυχαναλυτική οπτική κρατάει μια σημαίνουσα θέση.

Ο παιδοψυχίατρος ψυχαναλυτής Γεράσιμος Στεφανάτος έχει γεμάτες αποσκευές από την πορεία του στην ψυχανάλυση της εφηβείας. Διεύθυνε για πολλά χρόνια την Μονάδα Εφήβων του Νοσοκομείου Γ. Γεννηματάς, ασχολείται κλινικά και γράφει για την εφηβεία και σε γενικές γραμμές είναι ένας από τους πιο σταθερούς και αξιόπιστους Έλληνες ψυχαναλυτές που δουλεύουν με εφήβους. Αυτές οι εμπειρίες του εξηγούν, νομίζω, και την απόφασή του να επιμεληθεί μια τέτοια πανοραμική έκδοση και να την προσφέρει στο Ελληνικό αναγνωστικό κοινό.

Το βιβλίο «Ψυχανάλυση & Εφηβεία» απευθύνεται κυρίως στην Ελληνική Ψυχιατρική και Ψυχαναλυτική κοινότητα και αποτελεί μια συστημική συλλογή κειμένων οροσήμων (όπως λέει και ο υπότιτλος) για την εφηβεία. Φρόιντ, Βίννικοτ, Άννα Φρόιντ, Κεσταμπεργκ, Μπλός, το ζεύγος Λόφερ, Ωλανιέ είναι μερικά από τα ονόματα που κείμενά τους, κλασικά πλέον, περιλαμβάνονται σε αυτή την καλαίσθητη έκδοση.

Το βιβλίο ξεκινά με την πραμάτεια του Σίγκμουντ Φρόιντ για τους «Μετασχηματισμούς της ήβης», την Τρίτη από τις περιβόητες «Τρεις Μελέτες για την Σεξουαλική Θεωρία» του 1905. Τόσο μακρινή χρονικά αλλά και τόσο εντυπωσιακά ευκολοδιάβαστη και συναρπαστική –για τα πεπρωμένα της λίμπιντο στην εφηβεία. Μόνο το θέμα της ανδρικής ομοφυλοφιλικής τάσης στην εφηβεία προσεγγίζεται με έναν, για τα σημερινά δεδομένα, μονοδιάστατο τρόπο, καθώς αποδίδεται στη «μειωμένη προσωπική φροντίδα των μητέρων» (σελ. 83). Τα κεφάλαια του Μπλος (από τις ΗΠΑ) και του Καν (από τη Γαλλία), παρότι ξεκινούν από διαφορετικές θεωρητικές βάσεις, δίνουν πολύ διεισδυτικές εικόνες των διαδικασιών ταύτισης και εξατομίκευσης που συμβαίνουν στην εφηβεία και αποτελούν, ως εργασίες ψυχαναλυτικής έρευνας, πρότυπα για την μελέτη της εφηβείας. Το ίδιο θα έλεγα και για το σύντομο κείμενο της Κεσταμπέργκ, που ονομάζει και διερευνά την κρίση τη εφηβείας ως μια ψυχολογική διαδικασία που μπορεί να είναι άλλοτε απόλυτα φυσιολογική και άλλοτε να συνδέεται με μια παθολογική εξέλιξη.

Το τρίτο μέρος του βιβλίου απευθύνεται αποκλειστικά σε ψυχαναλυτές θέτοντας το θέμα της αναλυτικής μεθόδου στην εφηβεία. Εδώ συναντάμε τα κεφάλαια κορυφαίων σύγχρονων ψυχαναλυτών, των Μόζες και Εγκλέ Λοφέρ , των Καν και Λαντάμ, του

Ντοννέ και του ίδιου του Στεφανάτου. Το ερώτημα που επικρατεί στα κείμενα αυτά είναι αν ο διαταραγμένος έφηβος μπορεί να περιεχθεί μέσα στο αναλυτικό πλαίσιο ή αν χρειάζεται ένα άλλο θεσμικό πλαίσιο για να συγκρατήσει τις αναπόφευκτες διαδραματίσεις. Το πρόβλημα αυτό έχει πέραν της μιας απάντησης και η εξατομίκευση των προτεινόμενων λύσεων είναι απαραίτητη.

Η όλη έκδοση παρουσιάζει μια αρτιότητα στην επιμέλεια και στην μετάφραση. Οι παρεμβάσεις του Γεράσιμου Στεφανάτου είναι εμφανώς βοηθητικές και ξεκαθαρίζουν τις παρερμηνείες, όπως στην Ελληνική απόδοση των όρων puberty (ήβη) και adolescence (εφηβεία). Είναι εν κατακλείδι μια σημαντική προσθήκη στην Ελληνική μεταφρασμένη βιβλιογραφία που θα βοηθήσει τον ειδικό να δει με μεγαλύτερη εμβάθυνση τα προβλήματα της εφηβείας.

Γρηγόρης Βασλαματζής

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

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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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Tables: They must appear in a separate page, double-spaced. They must be numbered in the order in which they are mentioned on the text, with arabic numbers (table 1). A descriptive concise title should be included. Avoid vertical lines.

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" "

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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.

* Οι οδηγίες προς τους συγγραφείς και το «συνοδευτικό έντυπο υποβολής» υπάρχουν στο 1ο τεύχος κάθε έτους του περιοδικού και στο website της ΕΨΕ: www.psych.gr.

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1. : 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).
2. : Ενημερωτικά άρθρα που αφορούν σε κριτική ανάλυση ψυχιατρικών θεμάτων ή θεμάτων συγγενών προς την Ψυχιατρική Επιστήμη. Οι ανασκοπήσεις γράφονται από έναν ή δύο συγγραφείς. Η έκτασή τους δεν πρέπει να υπερβαίνει τις 3.000 λέξεις.
3. : Προοπτικές ή αναδρομικές εργασίες που βασίζονται σε ερευνητικό πρωτόκολλο. Πρέπει οπωσδήποτε να έχει γίνει στατιστική επεξεργασία των αποτελεσμάτων. Οι ερευνητικές εργασίες δεν πρέπει να υπερβαίνουν τις 3.000 λέξεις (έως 8 συγγραφείς).
4. : 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.
5. : Γράφονται μετά από πρόσκληση της Συντακτικής Επιτροπής και αναφέρονται σε θέματα, με τα οποία έχει ιδιαίτερα ασχοληθεί ο συγγραφέας π.χ. θεραπεία συμπεριφοράς, παθολογική ζηλοτυπία, ψυχοθεραπεία μεταιχμιακών καταστάσεων (μέχρι 3.000 λέξεις).
6. : Η κατηγορία αυτή περιλαμβάνει ενδιαφέρουσες αναφορές περιπτώσεων και περιγραφές περιπτώσεων όπου εφαρμόσθηκαν νέες διαγνωστικές ή/και θεραπευτικές μέθοδοι (μέχρι 1.500 λέξεις).
7. : Η δέχεται και άρθρα που εκφράζουν θεωρητικές απόψεις στον χώρο της Ψυχιατρικής, γνώμες για τα συστήματα παροχής ψυχιατρικής περίθαλψης, απόψεις για τους χώρους επαλληλίας μεταξύ Ψυχιατρικής και άλλων επιστημών και άλλα άρθρα ανάλογου περιεχομένου. Τα άρθρα αυτά δεν πρέπει να υπερβαίνουν τις 2.000 λέξεις. Η Συντακτική Επιτροπή μπορεί να προτείνει τη συντόμευση των άρθρων αυτών προκειμένου να δημοσιευθούν ως «Επιστολές προς τη Σύνταξη».
8. : Περιλαμβάνουν σχόλια και κρίσεις πάνω σε ήδη δημοσιευμένες εργασίες, παρατηρήσεις σε επίκαιρα ψυχιατρικά θέματα, πρόδρομα ερευνητικά αποτελέσματα, κ.λπ. Δεν πρέπει να υπερβαίνουν τις 400 λέξεις (συνοδεύεται από σύντομη αγγλική περίληψη).
9. : Η παρουσίαση και κριτική βιβλίων γίνεται μετά από πρόσκληση της Συντακτικής Επιτροπής (μέχρι 600 λέξεις - συνοδεύεται από σύντομη αγγλική περίληψη).
10. : Η θα κυκλοφορεί στην ελληνική γλώσσα πάντα με αγγλική περίληψη των εργασιών. Δύο τεύχη ετησίως θα κυκλοφορούν εξ ολοκλήρου στην αγγλική (με εκτεταμένη ελληνική περίληψη, περίπου 400 λέξεις). Στα τεύχη αυτά θα δημοσιεύονται εργασίες ξένων συναδέλφων, αλλά και Ελλήνων. Οι εργασίες Ελλήνων συναδέλφων μπορούν να υποβάλλονται στην ελληνική ή την αγγλική γλώσσα. Όσες εργασίες προκρίνονται για δημοσίευση και έχουν υποβληθεί στην ελληνική γλώσσα θα μεταφράζονται μετά από συνεργασία του περιοδικού με τους συγγραφείς.
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.

Οι εργασίες υποβάλλονται στο πρωτότυπο και σε τρία φωτοαντίγραφα, στη διεύθυνση:

Ελληνική Ψυχιατρική Εταιρεία,
Παπαδιαμαντοπούλου 11, 115 28 Αθήνα
e-mail: editor@psych.gr

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.).

Όλες οι σελίδες αριθμούνται, αρχίζοντας από τη 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.

: 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.

: 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.

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

: Αριθμούνται με αύξοντα αριθμό, ανάλογα με τη σειρά εμφάνισής τους στο κείμενο (σύστημα Vancouver). Π.χ. *Birley*[1] ..., *Afford*[2] ... 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.*

: 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.

: 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.

: Για λεπτομέρειες, βλ. Ιατρική 1980, 37:139.

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

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FINANCIAL DISCLOSURE

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This corresponding author certifies that:

- all persons who have made substantial contributions to the work reported in this manuscript (eg, data collection, analysis, or writing or editing assistance) but who do not fulfil the authorship criteria are named with their specific contributions in an Acknowledgment in the manuscript. All persons named in the Acknowledgment have provided written permission to be named.

After completing all the required fields above, this form must be sent via fax or e-mail with the submission form and the manuscript at the time of electronic submission.

ΣΥΝΟΔΕΥΤΙΚΟ ΕΝΤΥΠΟ ΥΠΟΒΟΛΗΣ ΕΡΓΑΣΙΑΣ ΣΤΟ ΠΕΡΙΟΔΙΚΟ " "

(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 ....

....

- Ονοματεπώνυμο 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 « »

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

: ,

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 την Συγγραφική Ευθύνη, την Οικονομική Γνωστοποίηση, και την Υποστήριξη Χρηματοδότησης.

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 στην 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 ....

❑ 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:

❑ 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:

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 την 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.