Hellenic journal of Nursing Science

Volume 3, Issue 3, July-September 2010

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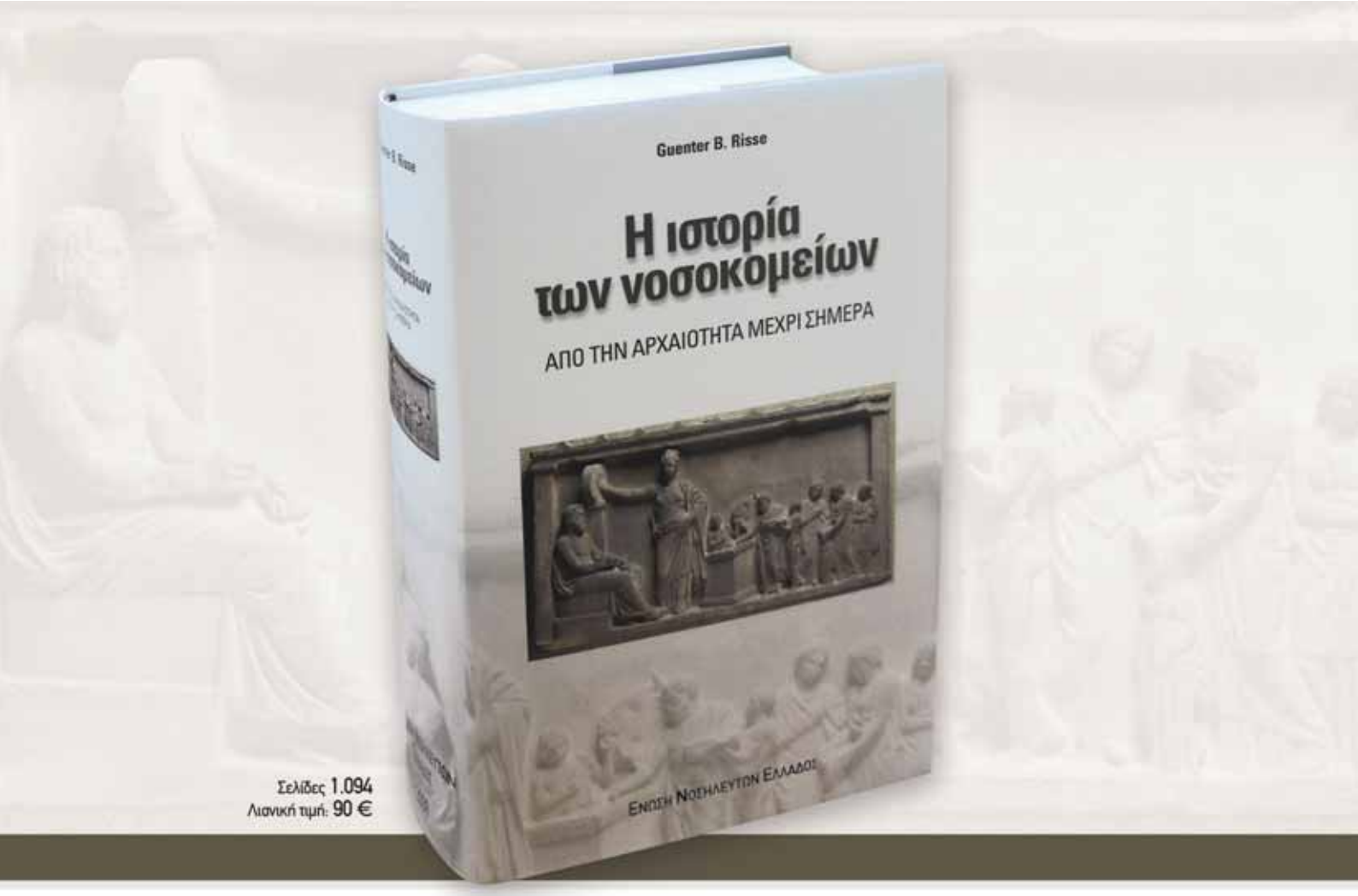
The Scientific Journal of the
Hellenic Regulatory Body of Nurses

ISSN 1791-9002



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Η ιστορία των νοσοκομείων

ΑΠΟ ΤΗΝ ΑΡΧΑΙΟΤΗΤΑ ΜΕΧΡΙ ΣΗΜΕΡΑ

Το βιβλίο αυτό, απεικονίζοντας το χρονικό της μεταμόρφωσης των νοσοκομείων από οίκους ελέους σε δομές εγκλεισμού ασθενών, από χώρους αποκατάστασης σε χώρους κλινικής διδασκαλίας και έρευνας και από δωμάτια τοκετών και θανάτων σε ιδρύματα επιστήμης και τεχνολογίας, μας προσφέρει μια ιστορική οπτική στην κατανόηση των νοσοκομείων της εποχής μας. Η ιστορία ξετυλίγεται σε δώδεκα επεισόδια τα οποία απεικονίζουν τα νοσοκομεία σε συγκεκριμένα μέρη και χρονικές περιόδους, καλύπτοντας σημαντικά θέματα και εξελίξεις στην ιστορία της ιατρικής και της θεραπευτικής, από την αρχαία Ελλάδα ως την εποχή του AIDS. Το βιβλίο αυτό προσφέρει μια μοναδική και εκ των έσω ματιά στον κόσμο των νοημάτων και των συναισθημάτων που συσχετίζονται με τη ζωή στα νοσοκομεία και την περίθαλψη των ασθενών, περιλαμβάνοντας αφηγήσεις τόσο των ασθενών, όσο και των θεραπευτών τους. Εάν θεωρήσουμε τα νοσοκομεία οίκους «αποκατάστασης της τάξης», ικανούς να δαμάσουν το χάος που συσχετίζεται με τα δεινά, τις ασθένειες και το θάνατο των ανθρώπων, μπορούμε να καταλάβουμε καλύτερα και τη σημασία των τελετουργικών τους ρουτινών και κανόνων. Από τις απαρχές τους, τα νοσοκομεία αποτέλεσαν μέρη πνευματικής και σωματικής ανάρρωσης. Θα πρέπει να συνεχίσουν να ανταποκρίνονται σε κάθε ανθρώπινη ανάγκη. Ως παραδοσιακοί μάρτυρες της ανθρώπινης συμπόνιας και φιλανθρωπίας, τα νοσοκομεία πρέπει να συνεχίσουν να αποτελούν χώρους ίασης.

ΜΙΑ ΣΗΜΑΝΤΙΚΗ ΠΡΟΣΦΟΡΑ ΑΠΟ ΤΗΝ Ε.Ν.Ε.

Η Ένωση Νοσηλευτών Ελλάδος, στοχεύοντας στη συνεχή επιμόρφωση των Νοσηλευτών θα διαθέσει ΔΩΡΕΑΝ το βιβλίο «Η Ιστορία των Νοσοκομείων» σε όλους τους επί πτυχίω φοιτητές της Νοσηλευτικής.

Όλοι οι υπόλοιποι Νοσηλευτές μπορούν να προμηθευτούν το βιβλίο στην ειδική τιμή των 45 €.

Αναλυτικές πληροφορίες για τον τρόπο και τη διαδικασία προμήθειας του βιβλίου θα ανακοινωθούν προσεχώς από την Ε.Ν.Ε..

Hellenic journal of Nursing Science

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ISSN 1791-9002

Robotics Surgery: the new Challenge for the Medical and Nursing Staff at the 21st century

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ABSTRACT

The aim of the present research work is to study the utilisation of robotics in surgical science. We discuss the functionality of the daVinci robotic system , its advantages and disadvantages, as well as the specialities in which robotics surgery is applied. The daVinci robotic system is worldwide the first and unique system of robotics surgery so far used for performing surgical operations. Its advantages are multiple, including endoscopic execution of microsurgical operations, stability and detail in execution of surgical movements etc. Nevertheless, there are important disadvantages as well, including high cost, which are further examined in the present work. Indeed, robotics surgery is applied in a lot of specialities of medical science. An essential requirement for the correct application of robotics surgery is the continuous education and training of medical and nursing staff.

Keywords: laparoscopic surgery, daVinci robotic system , robotics surgery, surgical console, surgical field, technology Endo-Wrist.

INTRODUCTION

Twenty years ago, an experiment started. Its aim was the execution of surgical operations without injury, namely with a laparoscope. Its success was so great that it changed the course of contemporary medicine and created a new speciality, the one of minimally invasive surgery. With the laparoscopic surgery, incisions of the abdomen were not necessary and the hospitalisation of a surgical patient dramatically changed. Complete surgical operations are performed through small apertures not exceeding in size one centimetre. Postsurgical pain, loss of blood and complications almost vanished. Operations requiring in the past many days of hospitalisation, now can be performed in one day (Susan C. deWit, 2009).

Laparoscopic surgery was an enormous technological and medical innovation, but in the attempts of generalising its utilisation, certain weaknesses emerged, limiting its development. During the laparoscopic operation, the surgeon is guided by video-image without directly contacting the patient. The limited operating space and optical field and the downgrading of surgeon's natural senses create serious obstacles in the development of technological applications. Some laparoscopic

Picture 1: Depiction of the daVinci robotic system.

operations, like the one for the inflammation of the gall-bladder, developed easily and fast. However, this was not the case with some most demanding operations, like removal of the spleen, intestine, stomach, etc. All studies agreed in the conclusion that advanced laparoscopic surgery requires time-consuming education and certain surgical abilities. Two solutions were proposed in order to overcome these difficulties: technological assistance of surgeons in order to improve their abilities or replacing them for an automatic machine free of the human weaknesses. Research has been done to both directions (Sejal P., 2008).

As a result, after numerous studies and much research, we now observe a revolution in the domain of surgery, with the approval of robotics surgery, which led to the use of robotics systems within human body under the guidance of computers. These robotic systems require operation and control by a surgeon. They are remotely controlled and they are activated by voice (Chatzidimitriou S., 2008).

In the present report, we examine the operation of robotics surgery, the surgical system daVinci, its advantages and disadvantages, as well as the specialities in which it can be applied. Continuous education and training of the medical and nursing staff is essential for the correct application of robotics surgery science.

HISTORICAL RETROSPECTION

Robotics surgery is a reality thanks to the robotic technology and tele-surgery. The development of digital analysis provides the possibility to transfer information in distance, promoting tele-surgery. Until recently, it was unimaginable to perform an operation from a distance, especially without having the patient and the surgeon in the same room. This restriction led NASA to begin research, in order to create a medical method for operating astronauts by doctors working on the ground. The same concept is investigated for its applicability in soldiers, whose life is in danger in the field of battle, operated by doctors remaining in safe and distance (Konstantinidis K. et. al., 2009).

In 1985, the robotic system PUMA 560 was used to perform a brain biopsy under guidance with computed tomography. In 1988, the system PROBOT, which was developed in the Imperial College of London, was used in urological operations of the prostate. The system ROBODOC of Integrated Surgical Systems was launched in 1992 for precise resurfacing during arthroplasty and replacement of the hip. Further development of robotic systems took place from Intuitive Surgical with the manufacturing of daVinci system and from Computer Motion with the AESOP robot and ZEUS robot. Intuitive Surgical bought Computer Motion in 1994 and they interrupted development of ZEUS. At the same time, the daVinci system was getting approval from FDA for a broad range of surgical operations including complete operation for prostate cancer, hysterectomy and restoration of mitral valve, and it is used in more than 800 hospitals in America and Europe. In May 1988, Dr. Friedrich-Wilhelm Mohr performed the first robotic aorto-coronary by-pass in Leipzig Heart Centre, Germany, using the daVinci system. In 2001, J. Marescaux performed from New York an operation for inflammation of the gall-bladder, on a patient in Strasbourg, France (Howe RD. et. al., 1999).

In Greece, daVinci surgical system is used since 2006 in Medical Centre of Athens, while in 2008, a second system was placed in "Ygeia" Hospital. The use of daVinci robotic system began in September 2006, and during the first year, more than 250 absolutely successful surgical operations have been performed. The person behind this initiative is Mr. Konstantinos Konstantinidis, Assistant Professor, who successfully performed the first robotic surgical operations in collaboration with other doctors (Konstantinidis K. et. al., 2009). The surgical operations that have been performed include:

- Surgical operation Heller-Dorr for the management of achalasia of the oesophagus.
- Restoration of diaphragm's hernia at Nisssen.
- Appendicectomies and operations for the inflammation of the gall-bladder.
- Ectoperitonial excision of inguinal hernia and abdominal hernia with the insertion of a plexus.
- Insertion and removal of gastric balloon for pathogenic obesity.
- Excision of pancreatic tumours and renal cysts.
- Excision of the adrenal glands.
- Excision of the ovaries and hysterectomy.

At the same time, A. Ploumidis, N. Pardalidis, V. Poulakis and E. Panagiotou, urologists, performed a broad range of complete prostate surgeries using the daVinci robotic system, sparing the nerves of the area and erectile function, as well as nephrectomies, pelvic operations and total excision of cysts (Diamantes Th., 2009).

OPERATION OF THE SYSTEM OF ROBOTICS SURGERY DA VINCI

Robotic surgery is the most recent and revolutionary development in the field of minimally invasive surgery. It is performed by the daVinci robotic system, which is worldwide the first and unique system of its kind at the moment, and it was approved by the Food and Drug Administration (FDA) for performing surgical operations. It is a product of Intuitive Surgical, combining the surgeon's skills with robotic technology, enhanced by a computer (Muhlmann G. et. al., 2003).

It consists of three compartments: the robot with the special arms, the endoscopic tower and the surgical console (Picture 1).

The surgeon controls the system through the surgical console, having in front an enlarged three-dimensional image of the surgical field. The surgical console includes handles, where the surgeon places his fingers and moves the levers as if he uses his hands. Each surgeon's movement is reproduced with absolute precision and stability in the surgical field from the surgical arms of the robot, which is usually placed to the left of the patient, with the surgical team. The robot's surgical arms use the Endo-Wrist technology, which involves flexible wrists, bendable by the surgeon like his own, but with even more flexibility. The endoscopic control tower includes two video cameras, a system of automatic picture adjustment, a high definition video recorder and other necessary components (Morino M. et. al., 2006).

Designing of the daVinci surgical system began in 1995 and since 2000 it is used in more than 350 hospitals worldwide. Its use has expanded rapidly during the past years, due to its important advantages, such as the ability of endoscopic microsurgical operations, its big stability and its precision in surgical movements execution, the three-dimensional views and the availability of more degrees of freedom in comparison to laparoscopic tools.

However, the daVinci robotic system presents the following disadvantages:

- High cost (one million US dollars).
- Big weight resulting in a slow moving ability.
- Time for preparation before the surgical operation requiring at least 30 minutes.
- Necessity of assembling all the tools before their usage.
- Regulation of the system (Link RE. et. al., 2006).

ADVANTAGES OF ROBOTICS SURGERY

There are multiple advantages of robotic surgery in comparison to the conventional surgical operations (Rocco B. et. al., 2006):

- It is a minimally invasive and minimally traumatic method, due to the precision of the surgical movements.
- It provides for a minimum loss of blood.

Picture 2: Depiction of execution of surgical movements by the surgical tools of robotic arms.

- It minimizes pain and malaise after the surgical operation.
- It minimizes the probability of complications during and after the surgery.
- It considerably decreases the time and cost of hospitalisation.
- It provides rapid recovery and return in daily activities.
- It provides better aesthetic result, with the absence of scars.
- It provides the surgeon with three-dimensional (3D) view of surgical field in high enlargement.
- It ensures higher precision of surgical movements. While the surgeon's operations on the console are transformed to movements of the surgical arms, the physiologic hand tremor is eliminated and as a result, an unprecedented surgical dexterity is achieved.
- It provides the opportunity to perform difficult surgical operations. The surgical tools of robotic arms can perform all movements of the human hand (7 degrees of freedom for movement), with greater dexterity and precision, and they can turn almost at 360o in the surgical field (Picture 2).
- It provides greater comfort for the surgeon during the operation. Contrary to the conventional surgical method, robotic surgery allows the surgeon to perform operations while seated, in a carefully designed and ergonomically excellent environment. By this way, the surgeon's tiredness is decreased, with very important benefits, particularly for the cases of challenging and long-lasting operations.
- It provides the opportunity to prepare the operation on the computer, using images of internal organs of the patient derived from their laboratory work-up. The surgeon can also recall these images during the operation and be supplied with useful images.
- The surgeon derives the sense that his eyes and hands are into the patient's body. He is able to see perfectly in places with poor optical accessibility until recently.
- It provides for less duration of anaesthesia and decreased risk of infection.

IMPLEMENTATION OF ROBOTIC SURGERY

Robotics is implemented in various surgical specialities, including general surgery, bariatric surgery, cardiac surgery, thoracic surgery, vascular surgery, paediatric surgery, urological surgery, pelvic surgery, kidney's transplantation for graft taking and endocrine surgery (Vassiliades, 2006).

Presently, most frequently performed robotic laparoscopic operations, include bariatric indications, inflammation of the gall-bladder, management of diseases of the small intestine, management of gastro-oesophageal reflux disease, surgical management of pelvic disease, prostate's surgery, kidney excision, endocrine surgery etc., thus providing important benefits to the patient (Nikiteas N., 2008).

CONCLUSION

According to the present discussion, it is obvious that robotic surgery is an innovation of the 21st century, with multiple benefits for patients, and medical and nursing staff. The speed of the continuous development in robotic surgery requires continuing training and education of the medical and nursing staff. Important factors for the development of a robotic surgery unit include the experience of the surgical team in laparoscopic operations, as well as the institution's infrastructure (Patel VR., 2006).

On the other hand, nursing is in front of a new challenge. Nurses are charged with new responsibilities, targeting to provide a high quality clinical care to the patients that will be subjected to this new surgical technique. Importantly, nursing staff will still be irreplaceable for the patient, because nurses bridge the gap between technology and science, confronting human pain with human hope.

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Help-seeking as a threat to self-reliance and self- esteem of an individual with mental health problems: a questionnaire survey

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ABSTRACT

Background: Individuals differ whether they are healthy or not. They have different personalities and lifestyles, so that consequences of an illness are perceived in individual ways. Therefore, they use to seek different types of help.

Aim: To explore the way in which self-reliance and self-respect affect help-seeking behaviour of individuals suffering from mental health problems.

Method: A self-report questionnaire was administered and completed by a total of 290 participants who sought help from the Community Mental Health Centre (CMHC) during 2003-2007.

Participants: The total sample was divided into those who had sought help from other mental health care service prior to their visit to CMHC (former visitors: group A) and those who visited a mental health care service for the first time in their live (first-time-visitors, group B).

Results: Subjects who totally believed that help-seeking is an acknowledgment of one's insufficiency and inability, had the most positive attitudes towards help- seeking from a mental health professional, the most positive orientation towards the utilization of social support network and the greatest fear for mental health interventions, in both groups A and B. Moreover, in group B, the aforementioned acknowledgement was directly related with subject's positive opinions about psychiatry, but these patients would also wait for longer until they ask for help for their first time.

Conclusions: Exploring the factors affecting the process of help-seeking may offer useful information to the mental health professionals, enabling them to detect the individuals with mental health problems and to intervene in earlier stages.

Key- words: help-seeking, mental health, self- esteem, self-reliance

INTRODUCTION

Despite the availability of mental health services, a great number of individuals don't cope with their needs and problems or they deal with them much later, when their symptoms are more severe. The continuously increasing focus of psychiatry on early intervention underscores the importance of identifying delays in help-seeking and providing appropriate and sufficient mental healthcare, as well as the significance of early referral of those with mental health problems to specialized services.

People are different, either in health or in illness. They belong to different cultures and they have different personalities and personal histories, all of which make them perceive their diseases in a specific manner. They cope with the consequences of diseases in individual ways and thus they require different types of help. Some of them do not want anyone to help them; others want more help than could sensibly be expected for a certain degree of impairment or suffering that their disease produces.

The exploration of some personality traits which possibly influence help- seeking behaviour from a Community Mental Health Centre (CMHC) or other specialized mental health service may help health professionals understand the factors affecting the process of help-seeking.

Only a small percentage of individuals seek professional psychological help (Cui & Vaillant, 1997; Horwitz, 1987). If this phenomenon is not due to a lack of the actual need, it should highly concern community members and health professionals.

This body of literature related to help-seeking pathways examine the concept of individual's "need" in the context of other factors affecting the utilization of health services. This study is a part of an effort to examine other dimensions of help-seeking behaviour of community residents with mental health problems, beyond individuals' needs, as well as the factors contributing to an individual's unmet need. Better knowledge of the contributing factors will help mental health professionals to understand the factors that may inhibit or promote early detection of individuals suffering from mental health problems and early intervention in order to meet their needs.

REVIEWING THE LITERATURE: PERSONALITY CHARACTERISTICS AND HELP-SEEKING

There are many personality traits that affect help-seeking behaviour and attitudes (Feldman et al., 1999). The characteristics that have been extensively studied in this body of literature are: self-respect, self-esteem, locus of control, shyness and authoritarianism, autonomy, dominance, introversion, secrecy, need for success, dependency, conservatism, rigidity and individuality. Personal factors leading to higher rates of help-seeking or more positive attitudes towards receiving specialized help include greater academic performance and achievement (Berdie & Stein, 1966; Kirk, 1973), older age, female gender (Sharp & Kirk, 1974; Tracey et al., 1984), internal locus of control (Fischer & Turner, 1970; Robbins, 1981) and low self-esteem (Nadler, 1986; Raviv et al., 1991).

Individuals may believe that they control all situations in their lives (internal locus of control) or that these situations are controlled by others (external locus of control). Persons may believe that they can control the status of his health (e.g. "I am directly responsible for my health"), or that their health depend on fate (e.g. "Whether I am healthy or not is a matter of luck") or they may consider their health as being controlled by some other serious circumstances (e.g. "I can do only what my doctor tells me") (Halter, 2004). All of these beliefs seem to influence whether a person may try to change his behaviour or not, as well as the type of communication the individual may require from health professionals. For example, if a health professional encourages a person -who seems to believe in an overall external locus of control- to change his lifestyle, that person is difficult to cooperate (Ogdenn, 2004).

Individuals who don't seek help are likely to believe that they are able to change things they don't like and solve their problems on their own (Simoni et al., 1991). Halgin and Weaver (1986) and Halgin, Weaver and Donaldson (1985) examined the advantages and disadvantages of receiving psychotherapy. Many researchers concluded that college students and patients perceived similar advantages and disadvantages in psychotherapy. The perceived benefits of psychotherapy were: improved self- knowledge, relief from anxiety and problem-solving. The disadvantages were: the time and money required, coping with painful issues, and the belief that help-seeking is an admission of weakness.

Raviv, Raviv and Arnon (1991) point out that help-seeking from mental health professionals may lead to the feeling of embarrassment. It is possible that the extent to which an individual's self-respect is threatened by help-seeking is a crucial element of this process (Wills & De Paulo, 1991).

There is a correlation between dependency and likelihood of an individual to seek help (Dawkins et al., 1980; O'Neill & Bornstein, 1970). The dependent people feel helpless and seek guidance and support from others (Bornstein, 1992; Bornstein et al., 1993; Roy-Byrne et al., 2000).

Students who seek counselling and those who don't differ as far as autonomy and self-efficacy are concerned (Anderson et al., 2006; Apostal, 1968). The clients who seek help are less judgemental, more intuitive, introspective and sensitive. Also, they

are more likely to internalize their problems and feel they have less control over them, compared to non-clients (Mendelsohn & Kirk, 1962; Simoni et al., 1991). They also indicate greater knowledge of their emotions and reactions (Rickwood & Braithwaite, 1994). Self-reliance is one of the barriers that delay help-seeking. Denial, repression and control of emotions are key features of stoicism, leading people to believe they should cope with their problems alone and suffer silently, so they are more likely to delay help- seeking until symptoms become more severe (Tang et al., 2007).

West et al (1991) reported that one of the major barriers is that individuals don't feel comfortable to reveal their

TABLE 1: Sociodemographic characteristics of groups A and B (N=290)

	GROUP A		GROUP B		
	N	%	N	%	P
Gender					
Male	35	26.1	30	19.2	0.204
Female	99	73.9	126	80.8	
TOTAL	134	100.0	156	100.0	
Marital status					
Single	66	49.3	78	50.0	0.063
Married	40	29.9	60	38.5	
Divorced / widowed	28	20.9	18	11.5	
TOTAL	134	100.0	156	100.0	
Education					
Elementary	17	12.7	31	19.9	0.128
High school	50	37.3	44	28.2	
College /university graduates	67	50.0	81	51.9	
TOTAL	134	100.0	156	100.0	
Lifestyle					
Parental family & With relatives	42	31.3	46	29.5	0.942
Own family	58	43.3	69	44.2	
Lives alone	34	25.4	41	26.3	
TOTAL	134	100.0	156	100.0	
Occupation					
Professionals	31	24.4	52	33.3	0.438
Medium/small business owners/ clerks Skilled workers	37	29.1	41	26.3	
Pensioners & housekeepers	36	28.3	38	24.4	
Students	23	18.1	25	16.0	
TOTAL	127	100.0	156	100.0	
Employment					
Full time	45	33.6	74	47.4	0.000
Part time	21	15.7	26	16.7	
None	53	39.6	56	35.9	
None / for psychiatric reasons	15	11.2	0	0.0	
TOTAL	134	100.0	156	100.0	

TABLE 2: Diagnostic categories in group A & B

		GROUP A		GROUP B		TOTAL	
		N	%	N	%	N	%
Diagnostic categories	Affective disorders	71	53.0%	72	46.1%	143	49.3%
	Neurotic stress related & somatoform disorders & Personality disorder	43	32.1%	50	32.1%	93	32.1%
	Relationship problems & Schizophrenia and delusional disorder	20	14.9%	34	21.8%	54	18.6%
	TOTAL	134	100.0%	156	100.0%	290	100.0%
		P=0.284				df = 2	

personal problems to a stranger. Emotional openness is another variable related to personality traits and associated to help-seeking attitudes.

Neuroticism is a personality trait that affects individuals' perceptions about their vulnerability to the symptoms and the seriousness of their health status (Brown & Moskowitz, 1997; Costa & McCrae, 1987; Katon & Walker, 1998; Neitzert et al., 1997). Individuals may experience tension, anxiety, and agitation. These feelings are reflected in their tendency to exaggerate minor symptoms. They are more likely to complain about symptoms and consider themselves vulnerable to diseases (Brownhill, 2003; DiMatteo & Martin, 2006; McClure et al., 1982). Other people experiencing the same symptoms may fail to notice them at all.

The meaning that individuals attribute to each of their symptoms may be a crucial factor. All individuals do not react to a disease in the same way. While some patients are willing to seek help even for minor symptoms, others are unwilling to do so even for life-threatening diseases (Mechanic, 1982). Indeed, people with the same illness may have a completely different experience of the situation and a completely different attitude, especially regarding the degree to which the cause of the disease is involved.

People who seek help are likely to have also sought help in the past for emotional problems (Dew et al., 1988). This finding indicates that an individual tends to seek help all of the times (Henderson et al., 1992). These individuals don't accept living in situations they don't like and they tend to talk to others (Sorgaard et al., 1999), including health professionals (Sherbourne, 1988), about their problems.

MATERIALS AND METHODS

This research was conducted in the Community Mental Health Center (CMHC), the last of its kind, which was established in 2000 to serve a borough of the broader area of Athens, 21 years after establishment of the first Community Mental Health Centre. The CMHC is administered by the University of Athens and it includes the Open Psychosocial Care Clinic, the Outreach Program and the Day Care Centre. A multiprofessional team staffs the CMHC.

The purpose of the present study was to explore the way in which self-reliance and self-respect affect help-seeking behaviour of individuals with mental health problems.

Two hundred and ninety individuals who sought help from the CMHC during a 4-years period, from 1/1/2003 to 12/31/2007, who agreed to participate in the survey and completed a questionnaire. The participants were informed about the purpose of our research. The questionnaires administered took 35 to 50 minutes to complete. The participants were told that there are no right or wrong answers. The researcher was available to answer any question. Participation in this study was voluntary and the participants were free to withdraw at any point. The data were strictly confidential and no names, codes, or any means that could reveal the identity of the participants were used. Only the researcher had access to the data. The participants completed an informed consent sheet.

The researcher conducted a pilot study before the actual distribution of the questionnaires. Twenty volunteers participated in the pilot study. Feedback and comments were obtained from each participant so that the final version of the instrument should be of appropriate length, clear, and free from biased language. The questionnaire was translated from English to Greek and back to English. The final version was checked by two bilingual professionals for possible inaccuracies in translation.

The population was divided in two groups: individuals who had sought help from other mental health care services before visiting our Centre (group A: former visitors) and individuals whose visit to the Centre was the first contact with a mental health service in their

lives (first-time-visitors, group B). The variables included in the questionnaire are presented below:
Demographic Data: The demographic questionnaire consisted of questions regarding the participant's gender, educational level, occupation, marital status, lifestyle, and employment.
Duration of untreated disorder: The untreated period for each individual was defined as the time (in months) between the onset of psychopathological symptoms and the time when the suffering individuals first contacted a mental health service or a professional.
Diagnostic categories (information taken from medical records): Organic brain syndrome, Schizophrenia and delusional disorders, Affective disorders, Neurotic stress related & somatoform & Personality disorders, Relationship problems, Certificates and information, Substance abuse.
Attitudes toward Seeking Professional Psychological Help scale (ATSPPHS) is developed by Fischer & Turner (1970). ATSPPH scale consists of 29 items that are related to the Recognition of Personal Need for Professional Help, the Tolerance of Stigma Associated with seeking Psychological Help, and the Interpersonal Openness and Confidence in Mental Health Professional. Factor analysis in the population of community residents who sought help from the C.M.H.C during 2003-2007 (Zartaloudi, 2008), resulted in 4 factors/subscales; FACTOR 1: Assertiveness toward help-seeking; FACTOR 2: Isolation; FACTOR 3: Ambivalence toward help-seeking; FACTOR 4: Stigma. Higher scores represent more positive attitudes toward seeking professional help for psychological problems.
Orientation toward Utilization of Social Resources Scale (OTUSRS) is a 20-item scale developed by Vaux, Burda & Stewart (1986). OTUSRS is designed to measure people's orientation to having a social network, by assessing their feelings about advisability or usefulness of seeking social help, their past history of having actually sought social help, and the extent to which they feel that others cannot be trusted. Factor analysis in the population of the community residents who sought help from the C.M.H.C during 2003-2007 (Zartaloudi, 2008) resulted in 3 factors/subscales; FACTOR 1: Interpersonal communication; FACTOR 2: Distrust; FACTOR 3: Isolation. A higher score was indicative of a positive social-network orientation, and a lower score was indicative of a negative one.
Thoughts about Psychotherapy Survey (TAPS) is a 19-item scale developed by Kushner & Sher (1989). This measure assesses fears about therapist competence, stigma concerns and fear of change. Factor analysis in the population of the community residents who sought help from the CMHC during 2003-2007 (Zartaloudi, 2008) resulted in 2 factors/subscales; FACTOR 1: Fear of change; FACTOR 2: Fear about therapist competence. Low scores indicate fewer concerns about therapy while higher scores indicate greater concerns.
Opinions about Psychiatry is a 20-item scale, on which factor analysis was conducted (Zartaloudi, 2008). The 20 items were divided into three subscales/factors; FACTOR 1: Effectiveness of Psychiatry; FACTOR 2: Ineffectiveness of Psychiatry; and FACTOR 3: Stigma. Lower score is indicative of more positive opinions about Psychiatry.
The participants were asked about their opinion regarding the statement "I then believed that help-seeking was an admission of insufficiency, weakness and inability to solve my problems on my own" with possible answers 1=totally disagree, 2= disagree, 3= not agree or disagree, 4= agree and 5=totally agree.

STATISTICS

A statistical analysis was performed by the use of the Statistical Package for Social Sciences XIII (Norusis, 2005). Student's t-test was performed to examine whether significant differences existed between means. Chi square tests were used for comparisons between the groups on several categorical variables. Statistical procedures included descriptive statistics, t-test, ANOVA, Mann Whitney test, Kruskal-Wallis test, and Fisher's Exact test.

RESULTS

The social demographic and clinical characteristics of all individuals completing the questionnaire (n: 290) were analysed. Group A included 35 men (26.1%) and 99 women (73.9%) and Group B included 30 men (19.2%) and 126 women (80.8%). Significant differences were noticed in one out of six variables. The first-timers (group B) were full-time employed more often than individuals of group A. In group A, individuals were not employed due to psychiatric reasons to a greater extent in comparison to individuals of group B. No difference was noticed between the two groups regarding educational level, marital and occupational status and lifestyle. The results are shown in Table 1.
The current diagnostic categories of group A and B by gender are presented in Table 2. There is no significant difference between diagnostic categories and groups. A proportion of 88% of group A and 76.3% of group B agreed or totally agreed with the statement "I then believed that help-seeking was an admission of insufficiency, weakness and inability to solve my problems on my own". In group A, there was a significant correlation between the individual's acknowledgement of insufficiency and incapability and his/her attitude toward seeking professional psychological help (p=0.000; Kruskal Wallis test), his/her fear about therapy (p=0.001; Kruskal Wallis test) and his/her orientation toward Utilization of Social Resources Scale (p=0.000; ANOVA). In group B, there was a significant correlation between the individual's acknowledgements of insufficiency

and incapability and his/her attitude toward seeking professional psychological help (p=0.000; Kruskal Wallis test), his/her fear about therapy (p=0.001; Kruskal Wallis test), his/her orientation toward Utilization of Social Resources Scale (p=0.045; Kruskal Wallis test), his/her Opinions about Psychiatry (p=0.000; Kruskal Wallis test) and the duration of untreated disorder (p=0.034; Kruskal Wallis test).

Individuals, who totally believed that help-seeking is an acknowledgment of insufficiency and inability had the most positive attitudes towards help- seeking from a mental health expert, the most positive orientation towards the utilization of a social support network and the greatest fear about therapy. Those who neither agreed nor disagreed achieved the next higher scores in these scales both in group A and group B. Moreover, in group B, the participants with a stronger he belief that help-seeking is an acknowledgement of weakness, were more positive in their opinions about psychiatry, but they waited longer before seeking help for the first time.

DISCUSSION

Psychic therapy is often related to "lunacy or madness" or it is perceived as an element of mental or personality weakness, decreasing individual's self-respect. Most explanations given for the individual's unwillingness to ask for help are related to the fact that the person wants to consider himself as independent and self-sufficient. In general, help-seeking is perceived as an acknowledgment of an individual's weakness and inability, an admission that leads to severe cognitive and emotional consequences for the person who asks for help (Franklin, 1992).

The individuals who totally believed that help-seeking is an acknowledgment of insufficiency and inability had the most positive attitudes towards seeking help from a mental health specialist, the most positive orientation towards utilization of a social support network and the greatest fear for mental treatment due to their insecurity and low self-confidence. Those individuals were feeling vulnerable, not being able to control their lives. Moreover, in group B, the participants' with a stronger belief that help-seeking is an acknowledgement of weakness were more positive in their opinions about psychiatry but they showed prolonged delay in seeking help for their first time. People who need help often fail to utilize the appropriate resources because help-seeking is a direct admission of insufficiency (Simmons, 2000). This means that the individuals were "open" to professionals' and non-professionals' interventions and opinions because they felt insufficient and believed that their inadequacy was the cause of their problems. They also looked for "a way out" but at the same time their self-respect was threatened and these feelings delayed them from making the final step and actually ask for help. Negative judgments from others may inhibit individuals from seeking help, despite that they could benefit from receiving appropriate specialized services.

Many studies have shown that moral values like competitiveness, self-reliance and independence, that are dominate in western culture, don't promote help-seeking that can be regarded as a sign of dependence. From this point of view, help- seeking can be regarded as "an act of immaturity, passivity, even inability" that must be "avoided". This happens despite the fact that help-receiving is sometimes acknowledged as useful and necessary. According to this model, the individual's willingness or unwillingness to ask for help depends on his personal beliefs and self image. By asking for help, the individual acknowledges his inability to manage a failure and his self-esteem is wounded. A person considers help-seeking to be a threatening or supportive experience, depending on his/her personal and social characteristics. Women are expected to be more willing than men to realize and admit that they need help (Cepeda-Benito & Short, 1998; Halgin et al, 1987; Kelly & Achter, 1995).

When the individual makes the decision to seek (or receive) help from a mental health specialist, he/she has previously formed the intention of doing this. There is a positive relationship between attitudes towards help-seeking and help- seeking intentions (Kelly & Achter, 1995). Intention is the most important factor affecting the appearance of a certain behavior. Attitudes towards help-seeking were the most significant factor influencing the intentions to seek help from a mental heath specialist (Mackenzie, Gekoski & Knox, 2007). An intention is serious when it is accompanied by a clear understanding of the problem, an organized action plan and a high degree of self-efficiency (Stretcher et al., 1995). Self-efficiency is the individual's subjective evaluation of the self regarding personal abilities (e.g., especially regarding his/her ability to behave in certain ways or to achieve his/her goals) (DiMatteo & Martin, 2006).

Self-reliance (when a person prefers to solve his problems on his own) is one of the barriers of help-seeking. The development of the individual's intention to seek help can be influenced by personal factors (e.g. duration of the problem, feelings of loss of self-reliance, the belief that persons who solve their problems on their own are more worthy). Receiving help affects a person's self-esteem and self-respect (Wills & De Paulo, 1991). According to Fischer, Winer and Abramowitz (1983), help-seeking can be "a threatening experience because it creates a superiority-inferiority relationship between the one giving and the one receiving help and conflict with values like self-reliance and independence reinforced during the whole process of our socialization". A source of

help can also be supportive. People are more likely to seek help if they regard the source of help as supportive and less likely if they regard it as threatening for their self-esteem.

Help-seeking behaviors depend on whether individuals attribute their need for help to internal or external factors. In the first case, when the need for help is attributed to internal factors (e.g. I need help because I am incompetent), people are less likely to seek help depending on the extent to which their self-esteem is threatened. On the other hand, if they attribute the need for help to external factors (e.g. I need help because this is a difficult decision) they are more likely to seek help as their self-esteem is not wounded. Being expressive about personal inabilities, vulnerability, emotions, familiarity or personal need for help and support is an element of weakness (O'Neil, 1981). Raviv, Raviv and Arnon (1991) point out that help-seeking from experts can lead to embarrassment. It is possible that the extent to which the individual's self-respect is threatened is a central point in the help-seeking process. People with high self-respect are more sensitive, feel more threatened and seek help less often compared to people with low self-respect, who are more likely to seek help (Wills & De Paulo, 1991).

STUDY LIMITATIONS

Our results cannot be invariably generalized to other populations and other social settings. The study sample had specific socio-economical characteristics and the results cannot be generalized to populations with other socio-economical conditions.

Given the delay that certain patients apparently showed in visiting the Community Mental Health Centre (which is especially true for group A, where individuals had previously visited other mental health services) and the self-report nature of the answers given by the participants when they complete a questionnaire, there are limitations regarding recall and accuracy of certain information which is retrospectively collected. In individuals of group A there is also a limitation regarding their previous experience of treatment, possibly influencing the recall and accuracy of information. A future study could use interviews with the family members so that collected data can be duplicated.

CONCLUSION

A great number of people are being identified in epidemiological studies as fulfilling the criteria for a mental disorder but not receiving treatment.

The decision to seek treatment is a complex matter driven by a number of factors, such as the severity and chronicity, the disability produced by the disorder, the perception that treatment will be effective or not and some personality traits. A better understanding of the contributing factors that promote treatment seeking will help health professionals to adopt more effective intervention strategies.

Exploring the influence of self-reliance and self-esteem of an individual with mental health problems to his/her pathway towards the appropriate therapeutic interventions may help mental health professionals to understand the obstacles towards the early detection and intervention regarding mental disorders.

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The phenomenon of infant abandonment in Europe and in United States of America and the way to deal with it

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SUMMARY

From Oidipodas' time, whose parents abandoned him in Kithairona Mountain so that Pythia's oracle would not be true, up to the Moses myth, whose Israeli mother placed him on a papyrus on the Niles' edges so that the Pharaoh's of Egypt daughter could find him, history has shown that the phenomenon of infant abandonment has been a repeating reality. The practice of infant abandonment right after their birth is a phenomenon involving a variety of motives depending on several socio-economic factors. Nevertheless, in the recent years there has been a rising interest in illustrating the reasons for the persistence of this phenomenon in contemporary society, despite changes in its structure and norms.

Aim: The aim of the present study is to investigate the infant abandonment phenomenon, the factors leading a mother to abandon her infant, as well as the available ways to deal with this issue, within European countries and United States of America.

Methods: The study methods included the evaluation of published retrospective and research studies on infant abandonment, causes of this phenomenon, factors leading to abandonment and possible solutions within European countries and United States of America. We also included a literature review in MEDLINE and CINAHL databases (1990-2009).

Results: Infant abandonment is a complicated issue involving parental and children rights. It involves the fundamental children's right to live with their families and know their roots of origin. Mothers abandoning their children are under great psychological distress, they possibly suffer from mental disorders or they are often victimized both in their personal and social life. In the fight against infant abandonment, it is essential to secure a woman's right to freely choose the time to become a mother and to provide all the social and financial support needed for a new mother and her child.

Key words: abandoned infants, infant abandonment in Europe and the United States of America.

INTRODUCTION

Data in international literature regarding newborns abandonment by their mothers are scarce, as research on this subject is limited. Research shows that there will always be desperate mothers who feel that there are important reasons to abandon their children soon after birth (Cesario 2003 & Oberman 2008). Studies also show that these women belong to different social classes or they live in a state of social isolation. They may also be living in family with a different structure comparing to the standard conventional family.

Factors such as unemployment, poverty, women abuse of any kind (financial or sexual), incest, parental alcoholism, drug abuse, HIV infection, etc (Mousourou 2005) seem to be responsible for these situations. Other researches indicate that women capable of abandoning their children are even capable to commit child murder (Oberman 1996). Some women experience more fear in losing their mate rather than their child. As a result, they take desperate measures to save their affair without knowing that they bear a child; when suddenly the baby arrives, they get into panic and simply wish to "get rid of it" (Williams-Mbengue 2001 & Oberman 1996). Reasons for negative acts behaviors towards the infant may include negative childhood experiences, emotionally poor parental relationships, unfulfilled interpersonal relationship with the child's father, negative or adverse environmental and financial situations, poor living conditions, etc (Riga and at, 1990).

Infant abandonment in Europe

In Western Europe most cases of infant abandonment involve very young women deprived of some kind of freedom (illegal immigrants, prostitutes, socially isolated groups). Nongovernmental organizations indicate that mothers in risk have no knowledge of their rights or have no access to social or heath services. As a consequence, they become vulnerable to exploitation and they abandon their children without having a choice (Doctors of the World, 2007). Both in Europe and in the rest of the world, there is much controversy about the re-introduction of the so-called baby drop box system, used in Europe during Medieval times. In the 12th century, Pope Innocentios the 3rd urged women to leave children that were not able to raise on the stairs of a church. At a monastery in Florence during the 14th century there was a specially adjusted wooden rolling barrel (la ruota) where unwanted newborns were left. Throughout Europe, till the 19th century and in Greece till 60's, in nurseries where unwanted infants were abandoned there were special admissions in use (Pediatric Society Minute Archives, 2006).

In many countries, child abandonment in public place is considered as a crime and the measure of baby drop box is considered by many as a crime motivation whilst mothers carry the overall responsibility. Those measures often have no legal basis, as it happens in Belgium. Recently, in Germany, permission was granted for a campaign, while in Italy, an unwanted pregnancy is still considered as a sin and a social stigmatization (Williams – Mbengue, 2001). Experts suggest that the establishment of a baby drop box system is expected to reduce abortions, child murders, child abuse and infant abandonment in public place (Boyes R., 2007). The first electronic baby drop boxes were introduced in Germany in 2000 (presently, there exist in many countries all over the world). The places where baby drop boxes are usually placed are out of public view with no surveillance cameras placed around. The infant is put in a reception surface – through a "window" in a specially adjusted area of the wall of a building– which gradually gets lower leading the infant in a heated small bed. A special alarm notifies health professionals for an infant arrival, and the child's birth is officially recorded in birth registries. Usually, there is enough time for the mother to leave the area without being noticed, and in case she changes her mind, she is provided with a three months time to request her child back (Poggioli, 2007).

Dealing with the phenomenon in Europe and in United States of America

In 2007, the European Council, in order to collect opinions and deduct some conclusions, conducted a research regarding ways of dealing with the infant abandonment phenomenon, in twenty countries of the European Union. Among results of this research, it was found that in some of the countries, national statistical data on the percentages of abandoned infants are rarely collected or they do not exist at all. With the assumption that the situation in Ukraine (1549 cases of baby abandonment in 2004, but only 998 in 2006) might be useful as an example for a thorough analysis, the introduction of an electronic database was decided, aiming to exchange conclusions between the affiliated countries (Hancock M., 2007).

France has established a privacy system for the mother who abandons an infant and this country, as well as United States of America, is the only where this system is used. Five hundred cases of unknown births are recorded yearly in France, in comparison to 10.000 a year in 60's, when contraception and abortions were still illegal. Law allows a mother to give birth to a baby reserving full anonymity not recording her identity to any official data (http://assembly.coe.int, 2008). In Germany, in 2003, the annual recorded number of abandoned newborns was more than 70, and within the first trimester of 2007, at least 23 infants were recorded as murdered. Experts have expressed their concern that the actual number is much higher. A relevant campaign was started to illuminate the importance and length of the problem and to promote wider use of the baby drop box (Poggioli, 2007).

In Italy, more than 30 children were abandoned during the last two years, especially in the rundown neighborhoods of Rome, due to the rise of the immigrants' population. Multilingual campaign posters were used calling them not to abandon newborns and at the same time, public education campaigns were undertaken regarding the right to have access to health and social services. Additionally, a high tech baby drop box was placed in a central hospital of Rome (Boyes R., 2007).

In United Kingdom, programs of foster parenting for the abandoned children are promoted, along with the implementation of strict rules for the procedure of foster families' choice, in order to avoid baby jamming in the institutions. The aforementioned practice is known in this country since 19th century and it was supported by a volunteer spirit of wealthy families.

In Central and in East Europe, there is still in place a strong tendency of parents to leave their children's care in institutions. This practice is in use especially in Romania, a country which is still influenced by the heritage of its old political status involving measures by the state in order to take care of abandoned children. In Ukraine, the suggested reasons for this phenomenon include the parental family pressure on teenage mothers, the limited financial sources, the case where the mother herself has been a victim of abandonment and a number of other problems related to drug and alcohol addiction(Hancock M., 2007).

In many counties, legislation requires investigating for the family of the abandoned child. In general, due to differences in legislation and family practices at each country, a consensus for dealing with this phenomenon is difficult to reach (Hancock M., 2007).

United States of America voted a new legislation in 1999, which was implemented in pilot manner in Texas. According to this, parents can anonymously leave their baby to safe places (hospitals, police departments, fire stations) without the risk of being prosecuted. During hospitalization, care of the baby is assigned to a member of the personnel (Rosner, 1997 & Cesario, 2003). Written guidelines based on a certain protocol are provided to the personnel of these services, which include the steps they need to take from the moment they find an abandoned infant (Buckley, 2007). In many circumstances, a letter is sent to the mother of the infant – when her identity is known- giving her information for available services where she could ask for support for her and her baby in case she changes her mind (Williams – Mbengue, 2001). By this way, the risk of abandoning a child in an unsafe area where its life could be in danger is reduced. This also protects the parents who feel that they have no other choice than abandoning their child and offers them a chance to leave their newborn in a safe place (Drescher – Burke, 2004). The people in charge claim that this legislation is a positive step but it should be part of a wider effort to the improvement of health services and related social services (Cesario, 2001 & Buckley, 2007).

In Greece, from the very first years of the constitution of the Hellenic State, care was provided for the orphans and the abandoned children, in the capital of the country. In 1883, the first baby drop box was established at the Community Nursery of Athens and remained in use until 1960 (Korasidou, 1992). In Greece, as in the other countries, there was much controversy regarding its purposes, since many believed that its use would encourage birth of children outside marriage and abandonment as a consequence (Pediatric Society Minute Archives, 2006). In the present, there are only isolated cases of infant abandonment, since family bonds are still very strong. Infants found in pavements or trash bins were transferred to a public hospital by the police, where they were hospitalized and as soon as a vacancy existed in the Centre of Child Care, they are transferred. At the same time, an investigation starts with the aim of identifying the mother. Data from the Registry of Underage Care show that the percentage of Greek and Immigrant women abandoning their children is similar. In 2005, 13 abandoned children were found, 9 in 2006, 10 in 2007 and 5 in the first semester of 2008 (Eleutherotypia Newspaper – 05/07/2008). Today there are thirteen Centers of Child Care in Greece, with a total capacity for 600-700 children, along with six Child City Centers where another 200-250 children are hosted. These centers aim to offer medical treatment, education and professional training to the children that are unprotected and deprived of family care.

CONCLUSIONS

Child abandonment after birth is a complicated issue which is related to both the parental and the child rights. Nevertheless, in Europe and especially in Central and Eastern Europe, financial and social factors including poverty, social class and adolescent motherhood deprived of financial support from the parental families are responsible (Bloch, 1998). In Greece, a survey regarding the views of Greek nurses for the phenomenon of child abandonment indicated that the great majority believe that adolescent mothers belong to low socio-economic class, they do not have financial sources and that they are more prone to abandon their infants (83.5%, 70,9% and 73,8%, respectively) (Athanasopoulou, 2008). Health policies, effective social and health services, accessibility to those services and in particular, accessibility for socially isolated groups play an important role in a woman's decision, especially when she confronts an unwanted pregnancy and she has limited choices for dealing with the situation (Rosner, 1997 & Green, 1999). Pregnancy is unwanted in most such cases, whereas information on contraception issues is inadequate. These women have a fear for the health services or they don't know how to effectively use them, before or during their pregnancy

(Cesario, 2003 & Oberman, 2008). Psychological changes and stressors, as well, are causes for abandoning an infant in public places (Bonnet, 1993 & Oberman, 1996). Studies from international literature verify that those women are importantly under significant stress, they suffer from mental disorders and they are often victimized, in personal and in social level, as well (Cesario, 2003). Newborn abandonment raises the issue of accessibility to special information services for young people and mostly for women's sexual rights and reproductive health. Abortion has not yet been legal to most of the countries. Even when it is allowed, it is usually subjected to many bureaucratic procedures that inhibit many women. In some of the cases and in some of the countries there are strict time limits for the procedure of an abortion, so that in everyday practice, the right of abortion is of no value (Athanasopoulou & Kouta, 2009). Beyond of a doubt, there is a need for family planning which would take into account the demographic pressures created by the birth of a child as well as the need of young mothers to be followed up and supported. All suggested measures should focus on the fundamental principle of respect for the children's rights and most importantly, for the utmost human right of a child to live with its family and to know its origin. Special attention should be provided to socially vulnerable women coming from minorities. Another important issue is the de-institutionalization of the abandoned infants. Another necessity is that these children are provided with alternatives so that they are able to obtain a family through adoption (Rosner D. et al, 1997).

A mother's failure to take care of her child is expressed through abandoning of the child to a midwifery or elsewhere. In Greece, cases like these are inconsistently treated. On one hand, the state is having difficulty in breaking the privacy of a family and on the other hand, it is obliged to force the constitutional law for protection of children and youth. As a result, whenever there is a case of child abandonment or child abuse, in the face of these difficulties, the state intervenes and only temporarily offers to the child the choice of a foster family or an institution (Mousourou, 2005). The responsibility of effective care under the broader issue of child protection from its parents is expressed in a close emotional bond. A mother's failure to respond to this need could be a result of personal irresponsibility and deficiency. A similar failure could also be attributed to adverse socio-economic conditions combined with the crisis that the institution of family is facing in our days.

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Research in occupational stress among nursing staff - a comparative study in capital and regional hospitals

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SUMMARY

Background: In European Union, occupational stress is second in frequency as a health problem related with occupation affecting 28% of employees. Occupational stress is a psychosocial risk factor in occupational field and it is present when occupational demands overcome the ability to address or control the situation.

Objectives: Research of occupational stress in the nursing staff of a General University Hospital of Athens and identification of any differences in factors related with stress in both samples under investigation.

Thesis plan: The population sample consisted of nurses and nursing assistants working in a General University Hospital of Athens and a regional General University Hospital.

Participants: The study sample consisted of 140 nurses and nursing assistants, selected with a randomization technique.

Methods-Results: In order to collect the scientific data we used the following methods:

1) The occupational stress scale of Kahn et al (1964).

2) A general information questionnaire.

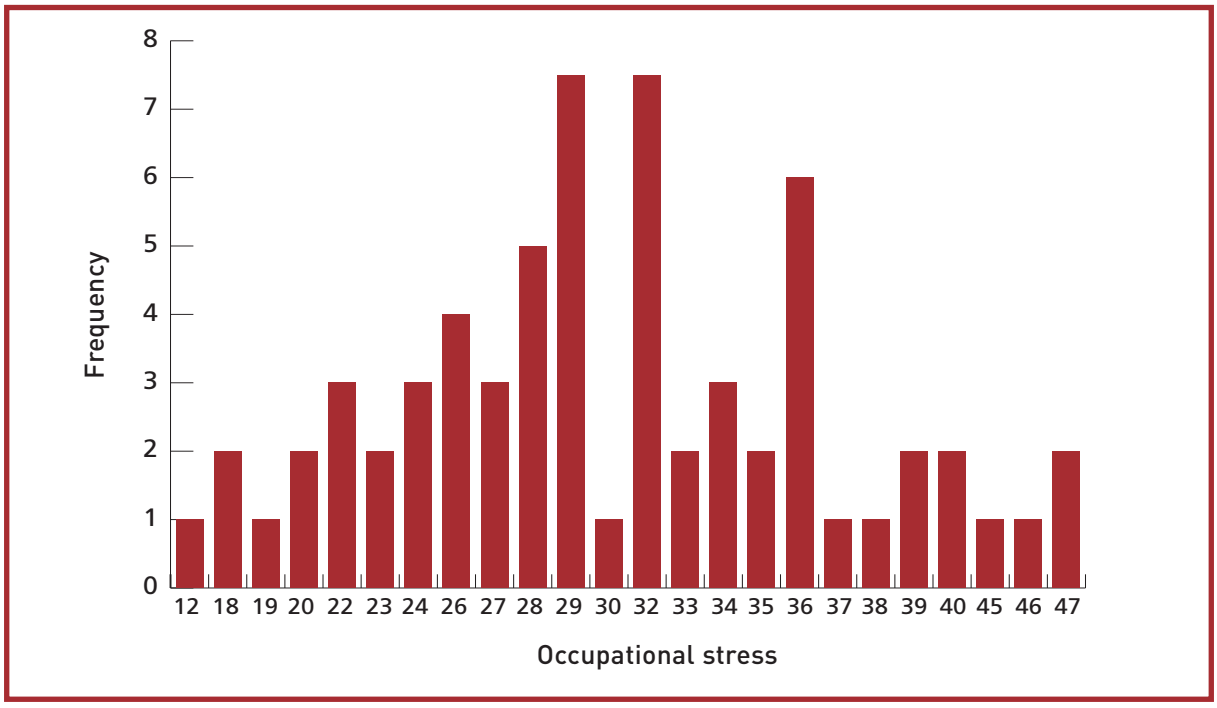
The statistical tool SPSS Version 15 was used for analysis. According to the findings of the present study, nurses suffer from occupational stress without any significant differences between the two samples. Increased work overload and conflict between professional and family roles contribute to the development of stress.

Conclusions: The evaluation of occupational conditions and the search for factors which potentially harm employees' health is essential for effective prevention. Preventing occupational stress and occupational health in general, as well as dealing with safety hazards should be an integral part of management policies and of provisional and safeguarding procedures for improvement of health care quality.

KEYWORDS

Nursing staff, occupational stress

TABLE 1. Occupational stress scale at the regional hospital



INTRODUCTION

Stress is the second in frequency health problem regarding the occupational environment. It is estimated that 28% (about 1 in 3 people) of employees within European Union experience occupational stress (Andoniou, 2007).

Occupational stress is defined as the adverse emotional state experienced when the demands due to occupational factors overcome the ability of an employee to address or control the situation. There is a subjective aspect in occupational stress, since a certain factor may be the cause of stress for some individuals but not for others (Lazarus, Folkman, 1984). The triggers usually connected with stress are physical, physiological and behavioral. In particular, physical symptoms include increased arterial pressure, allergies, ulcer, heart conditions and general symptoms concerning the employee's health, while psychological symptoms involve lack of concentration, increased tension, boredom and low work consistency. Finally, the behavioral symptoms are evident in the employee's performance and satisfaction. Three basic strategies are recommended:

1. Reduction or modification of stressors or moving the individual away from them
2. Adjusting occupational environment to the individual.
3. Improving the individual's coping through exercising, meditation, relaxation techniques and social support (Pandazopoulou-Fotinea, 2003).

Nurses are one of the most vulnerable professional groups to occupational stress, as they often encounter stressful situations due to the special demands of their profession (Papageorgiou, etc, 2007).

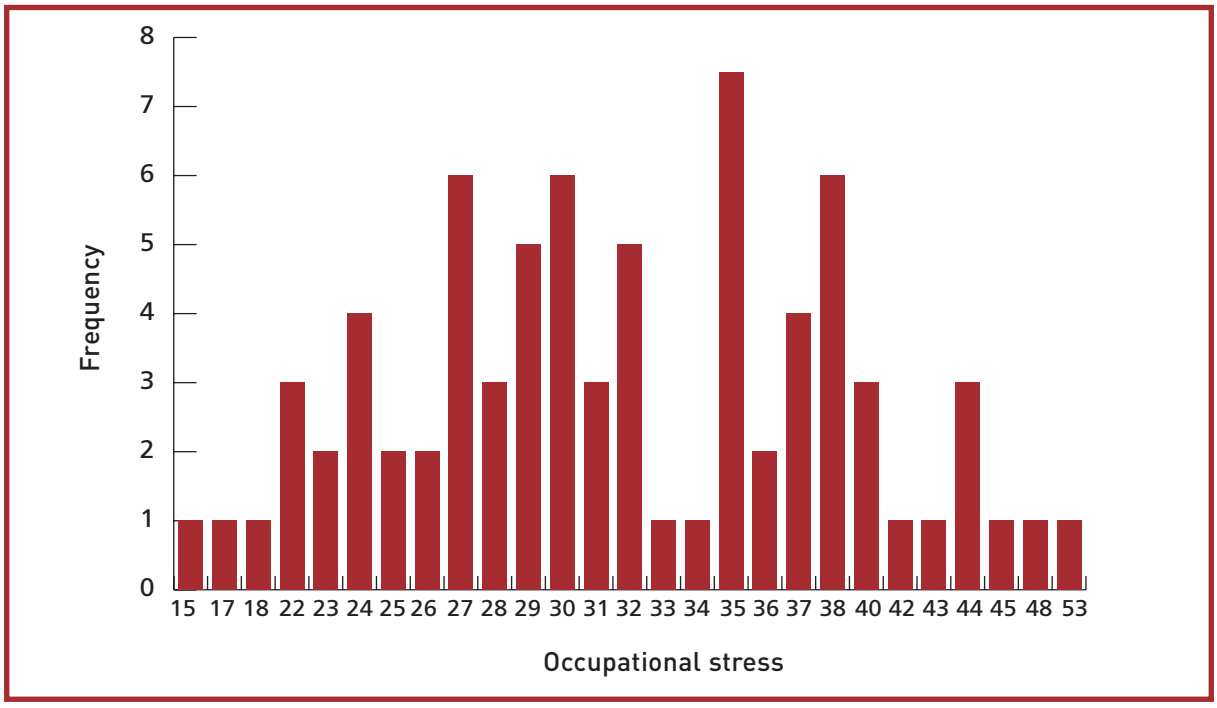
During the last two decades, the interest in stress producing factors that contribute to nurses' psychological state has increased (Pagapeorgiou, etc, 2007).

The study of occupational stress is an imperative need since it has been shown that stress has negative impact both on nurses' health and on the health organization they are occupied, with absenteeism and low quality of health care being the most frequent consequences (Ouzouni, 2005). The major stress producing factors in nurses are:

1. Frequently or rapidly alternating timeshifts, bad occupational conditions
2. Role conflict
3. Constant communication with a variety of people
4. Work overload and severity of incidents
5. Routine dealing with death
6. The lack of individual's role in the occupational environment (role ambiguity-lack of duties specification) (Papamichael, 2005).

Another important factor is the lack of support and positive feedback to the nursing staff by the administrative

TABLE 2. Occupational stress scale at the capital hospital



executives in the nursing services (Ouzouni, 2005). Clinical nurses work under conditions of intense stress with limited autonomy in decision making, since they often work under policies defined by others (Marvaki, etc, 2007).

In the bottom line, the important one who will be harmed due to nurses' stress is the patient. A nurse under stress will care for patients in a cold, indifferent and depersonalized way, with apathy and disappointment (Papageorgiou, etc, 2007). Moreover, it is possible that a nurse under stress withdraws, behaves negatively and has a short-temper, is often absent from work, and performs in a less effective manner comparing to her best and she has often wishes to quit the profession (Papageorgiou, etc, 2007).

OBJECTIVE

The objective of the present study is to evaluate the level of nurses' occupational stress and to identify any differences between the two samples.

MATERIAL AND METHODS

The questionnaire was distributed to a total of 250 nurses and nursing assistants. In detail, it was distributed to 150 nurses and nursing assistants of the regional University Hospital and to another 100 of the capital Hospital, during a time period of one month (November 2006). Sixty four questionnaires were returned completed (response rate 42,6%) from the first hospital, while in the latter hospital, the response rate was 76%. Eighty five per cent of the sample was of female gender (15% males). The gender in the two hospitals ranged as follows: regional University Hospital, 6% females, 9,4% males; capital General Hospital, 80,3% females, 19,7% males. The average age of the sample was 37,19 years, with a standard deviation of 6,5 and a range of 33, minimum age 24 years and maximum 57 years. The average age was 37,17 years for the regional hospital and 37,21 for the capital hospital.

Data collection was conducted by a subgroup of the researchers' team after in person brief guidance from departmental supervisors, on receiving of the sealed envelopes with the completed questionnaires.

An anonymous self-completed questionnaire was used. The first section contained questions about socio-demographic factors such as age, gender, marital status, degree, further education, as well as work factors like department of work, years of work, work hours, type of service, average night shifts per month, department selection.

The second section in included in the occupational stress questionnaire developed by Kahn and associates (1964). The stress evaluating scale regarding occupation (in the form of role conflict, role ambiguity and overload) contains 11 items and participants respond by choosing one among five answers: Never, rarely, sometimes, often, and almost always. These responses are scored with 1, 2, 3, 4, and 5, respectively. The total score

TABLE 3. How often do you experience emotions due to excessive overload mostly when you feel that you cannot finish your work during a normal shift?

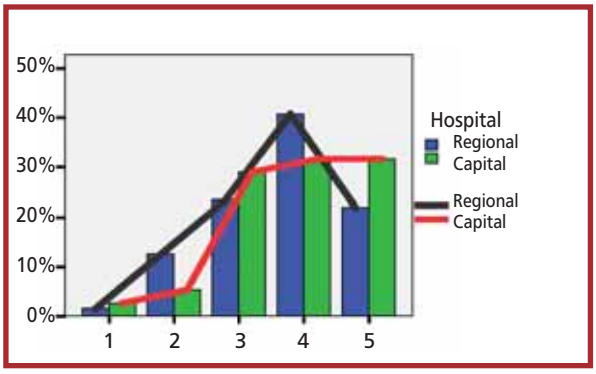


TABLE 4. How often do you feel unqualified for your job?

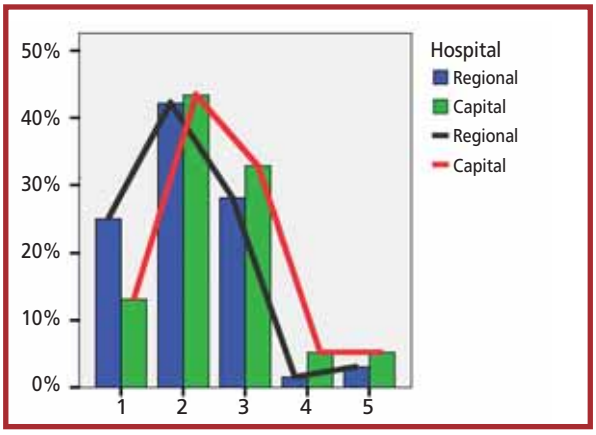


TABLE 5. How often are you affected by your decisions which have an influence on your fellow human beings and particularly on those that you are acquainted with?

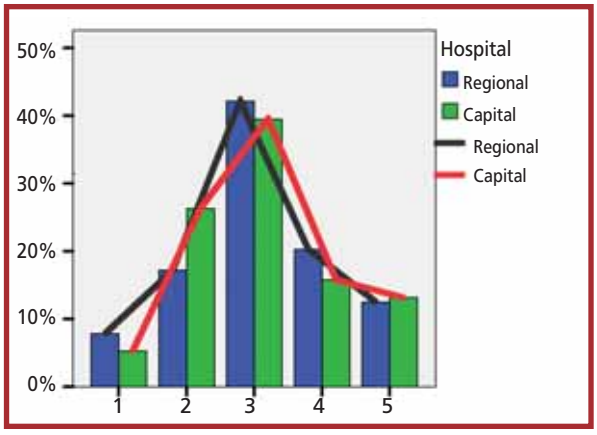
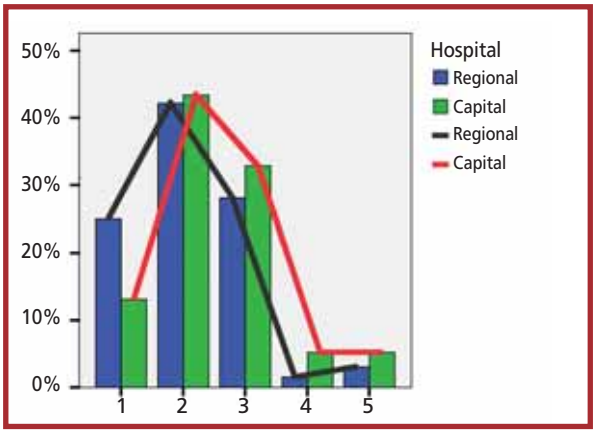


TABLE 6. How often do you feel that you are unable to influence your supervisor's decisions and actions that concern you?



represents the occupational stress level of each individual. A high score means high level of occupational stress. Consequently, the scores of occupational stress range between 11 and 55.

RESULTS

In the first part of the questionnaire: 60,9 % of nursing personnel in Regional Hospital were graduates of Technological Institutions and 39,1% had 2 years of education in Nursing. In the Capital Hospital, these proportions were 59,2% and 40,8%, respectively.

The mean of years on duty was 13.68 years [standard deviation (SD) 7,7] ranging from 1 to 30 years. In detail, in the Regional Hospital, the mean of years on duty was 13,6 (SD, 8,9) and 13,74 (SD, 6,6) in the Capital Hospital.

In the Regional Hospital, the mean score in stress scale was 30,39 (SD, 7,27) ranging from 12 to 47. In the Capital Hospital, the mean score in stress scale was 31 (SD, 7,29), ranging from 15 to 53.

The following graphs represent the frequencies of scores in stress scale in each hospital.

There was no significant difference except in the items regarding "work pressure" and "conflict between family roles and professional roles.

DISCUSSION

According to the study findings, occupational stress of nurses does not differ significantly between the two samples.

Increased work overload along with conflicts regarding work and family roles result in increasing stress.

These findings are consistent with those of previous studies that classify the nursing profession as the most stressful one compared with other health professions (Adali, et al, 2000).

The work overload (1st item) and the conflict between work and family roles (11th item) influence more,

TABLE 7. How often do you feel that during your work you have to do things that contradict your convictions?

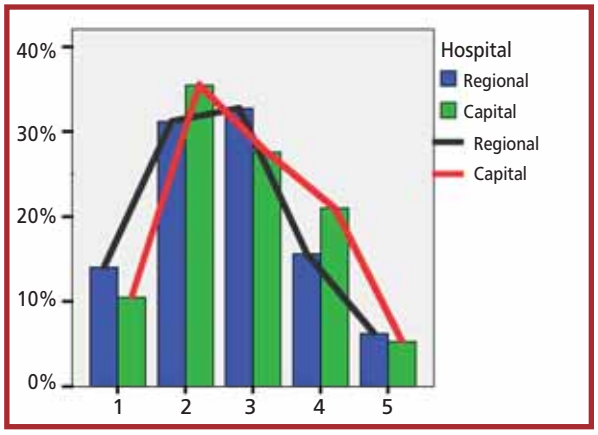
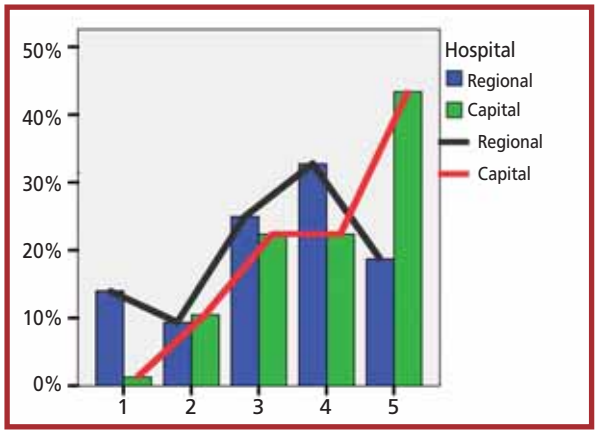


TABLE 8. How often do you feel that your work interferes with your family and personal life?



comparing to other items, the score in Kahn's scale. The conflict between work and family roles contributes to occupational stress development because fulfilling the work role may adversely affect fulfilling a role within the family and vice versa. In detail, according to Thoits (1991), a key concept to identify stressors for each individual is the role he identifies with. As role-identities, we define the ways of self awareness as part of social living (e.g. a father, a husband/wife, a member, a professional etc.). These roles offer an identity, as well as behavioral rules. When an individual fulfills the demands of his/her role-identity, self-awareness is enhanced. In case of failure, self awareness is reduced and stress is increased. The real stressors are the facts (positive or negative), depending on the extent that they affect these roles-identities and interact with our perception for them. In fact, Gruen, Folkman and Lazarus (1988) showed roles and commitments of individuals relate directly to the major every day problems and the way they are perceived.

A study conducted on 282 nurses and nursing assistants in Greek hospitals has shown that occupational roles in a hospital influence personal, family and social live of the nursing staff, and in particular, the life of women and of people employed for more than 10 years (Marvaki, et al, 2007). According to other studies, the nursing staff's family life can be influenced by their work, through frequent shifts, which are a main feature of nursing occupation. (Weiss, 2004, Michalacopoulou, 2003) and night shifts (PD Dr. Med. Hm Hasselhorn, 2007).

A study conducted on 89 mental health nurses has shown that among the most frequent sources of occupational stress for nursing staff is the role conflict between family and work (Ouzouni, 2005). Another study on mental health of nurses had contradictory findings, where conflict between family and work had a low score in the stress scale that was used, interpreted as role conflict not being a major source of stress in that particular nursing staff (Ouzouni, 2005).

The increased workload as a stressor has been confirmed by many studies (Callaghan, 1991, Chiriboga, 1986). According to Pines (1982), workload has a negative impact on the relationships among nurses, as they have no time for social contact, interpersonal interaction and positive feedback, discussions on professional issues, determination of the healthcare unit targets and assurance on the importance of their work. In other studies, a moderate statistical significance between occupational burnout syndrome and environmental factors has been found (Stone, 1984, Constable, 1986).

CONCLUSIONS-SUGGESTIONS

Increased workload, in combination with the sense that the work role contradicts the family one, lead to development of occupational stress.

Two levels of intervention are recommended in order to prevent and manage occupational stress:

1 The primary level, where the focus is the organization itself. The targets include the identification and evaluation of the existing stressors, as well as corrective measures. A part of the primary level for occupational stress management is to take preventive measures on all levels in order to avoid stressors (Psychargos 2nd phase, 2005).

To control the potential factors that contribute to the development of occupational stress, we recommend the following:

- Evaluation of occupational stress risk factors and management of these risks, taking preventive measures for the employees (ICN).

- Reduction of work overload with rational management of human recourses regarding nursing staff (Adali, Lemonidou, 2001) establishes a balance between work demands and capabilities of the nursing staff (ICN).

2 The secondary level focuses on persons and includes an individual guided training, by organizations for occupational stress management.

- Support groups. These groups of nurses, which may be coordinated by a psychologist or psychiatrist focus a) on identifying all sources of occupational stress, b) on exchanging experiences and realizing that many nurses also face similar situations in their work, c) on self-awareness and analysis of emotions and responses of nurses, d) on reassessment of the ways of managing certain stressors (Pateraki, et al, 1995).
- Time to relax between work and home.

As mentioned above, occupational stress can negatively influence a nurse's personal and family life. Introducing a time interval between work and return to home, as well as having leisure activities helps a nurse relax and block carrying stress in family life (Pateraki, et al, 1995). Of particular interest would be a program, during the nurse's shift, provided by hospital management, with the aim to help nurses relax before returning home.

To implement all of aforementioned suggestions, executives should coordinate with nursing staff and promote employees' health and safety. Therefore it is necessary that executives specialized in such fields will be recruited in hospital departments of Health and Safety.

Consequently, mechanisms for prevention and management of occupational stress should act in coordination and focus early on minimizing the stressors, on one hand, and on enhancing psychophysical stability of nurses, on the other (Pateraki, et al, 1995).

It is essential to reorganize work environment (in its broad sense) and remove as many as possible stressors, along with training of staff in ways with which they can manage stress and achieve better adjustment. All these should be coordinated by employers and take place within the workplace. This interest from employers' part should be sincere and visible, in order to promote employees' health and safety.

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Hellenic journal of Nursing Science

INSTRUCTIONS FOR AUTHORS

The Greek Journal of Nursing Science (EPNE) is the official journal of the HELLENIC NURSES' ASSOCIATION. It is a peer-reviewed, cross-disciplinary journal with the purpose of promoting nursing science in Greece. The Greek Journal of Nursing Science provides opportunity for the publication of academic articles presenting research conclusions, research based reviews, discussion articles and commentaries of interest to an international readership of professionals, educators, administrators and researchers in all the fields of nursing, and health care professionals.

TYPE OF ARTICLES

EPNE publishes articles which fall into three main categories:
- Editorial articles
- Editorial articles which are relatively brief (200 words maximum)
- Original articles – research work

- Full articles relating to primary research can have up to 5000 words.
- Clinical trials protocols should not exceed 2.500 words. Authors must state the trial registration number (where available), as well as the timing of the presentation of the conclusions.

Reviews and brief presentations (2000 words maximum)

- Reviews that contain:
- systematic reviews, meta-analysis
- book reviews
- political reviews
- other type (e.g. socio-economic)

- Book reviews: Should not exceed 1000 words.

ARTICLE SUBMISSION

Authors must submit manuscripts via the journal email address: journal@enne.gr. All correspondence, including the editorial decision statement and re-review requests, will be carried out online. An article is submitted on the condition that it has not been previously published, that it is not under consideration for publication elsewhere and that if accepted it will not be published elsewhere, either in English or in any other language, without the written consent of the publisher.

REVIEW PROCESS

All articles are initially evaluated by the editorial team and are thematically assigned to the reviewers. Subsequently they are admitted for publication following a double-blind review by at least two anonymous reviewers. Reviewers decide whether the article is:
(a) Accepted for publication without alterations.
(b) Accepted for publication after minor modifications.
(c) Accepted for publication after extensive revision.
(d) Rejected for publication in its present form

PREPARATION OF MANUSCRIPT

General Guidelines: All submitted work should be suitable for an international audience and authors should not limit their work to national and political practices and to legislation specific to their country. Each article must be accompanied by a cover letter, an example of which can be found on the journal website: www.enne.gr
The cover letter must provide the following:
- Statement that the work has not been published in whole or in part in another journal.
- Statement that the final version has been acknowledged and approved by all the authors.
- Written permission (registration number of approval) for the research from the ethics committee of the institution where the work was carried out.
- Full name, postal address, email address and telephone number of the author responsible for correspondence.

Detailed information about online submission of manuscripts can be found on our website.

ORGANIZATION OF MANUSCRIPT

Organize your manuscript in the following order: article title, title page, acknowledgements, abstract and keywords, text, references, tables, figures, supplements (Font: TIMES NEW ROMAN size12, 1.5 line spacing). Please number the pages of your manuscript.

Title: The title must describe the topic of the article,

participants where relevant, clinical problem and research method used.

Title page: The title page contains:
- Full name, full article title (maximum 90 characters), academic and professional qualifications and institute for every author.
- Email address of every author.
- Submission date of article.

Acknowledgements: Basic contributors to the work are thanked in the acknowledgements.

Abstract: Abstracts should be no more than 250 words and should not include any references or abbreviations.
Abstracts of research work should be structured under the following headings, where possible: (a) Introduction, (b) Materials and Methods, (c) Results, (d) Discussion, (e) Research limitations and (f) Conclusions, which must have a bearing on the objectives and the context of the study, and provide recommendations for clinical implementation of the results.
Abstracts of reviews should come under the following headings, where possible: Introduction, purpose, secondary aims, references: data bases, review methods, results, conclusions.
Abstracts of book reviews should provide a brief summary of the rationale and conclusions.

Keywords: Up to six keywords in alphabetical order should be included, stating clearly the context of the article, objective and method used.
Use the medical title thesaurus (MeSH®) and (CINAHL) where possible.

Text: The text introduction must refer to what is already known on the topic and what this article has to add to nursing science. Depending on the type of article, it should be set out as follows:
Reviews should carry: (a) Introduction, (b) Purpose, (c) Materials and Methods, (d) Results, (e) Discussion, (f) Conclusions, and must expand in detail on the summary.
Research works must follow a specific structure: (a) Introduction, (b) Materials and Methods, (it is necessary to state the time period for the collection of data, data source, sample sizes and sample selection methods, details of how they were chosen, selection and exclusion criteria, number of new participants or dropouts, relevant clinical and demographic characteristics, data collection methods, data collection device and permission and approval process for its use, response rates, statistical methods used for analysis (c) Results along with accurate rates of statistical importance (d) Discussion, (e) Research limitations and (f) Conclusion, which must have a bearing on the objective and the context of the review, and provide recommendations for clinical implementation of the results.
Interesting cases are divided into: (a) Introduction, (b) Case reports, (c) Comments.
Prolonged publications are separated into: (a) Introduction, (b) Materials and Methods, (c) Results, (d) Discussion.

Tables/figures: Tables and figures are printed only when presenting further supporting data not provided by text. Tables should be numbered consecutively, given a concise title and must each be typed on a separate page.

Units of Measurement: Length, height, weight and volume must be expressed in metric units in accordance with internationally recognized symbols.

Abbreviations: Avoid using abbreviations wherever possible. All abbreviations to be used by the authors must be written in their expanded form along with their abbreviated form in parenthesis at first use. Titles of journals should be abbreviated according to the list of Index Medicus, which is published in January every year in a separate issue (List of Journals Indexed in Index Medicus). There is a relevant list (IATROTEK) with abbreviations of Greek journals.

Statistics: Standardized and internationally approved methods must be used to present statistical material.

Statement of Informed Consent: Authors must ensure that research has been conducted in accordance with the ethical principles clearly laid down in the International Committee of Medical Journal Editors (www. icmje.org) and the World Medical Association Declaration of Helsinki, 2000. In other words it is imperative that authors assure that the results of their studies arise from research work which has obtained informed consent from the participants and approval from the formal ethics committee.

Permissions: Permission to reprint previously published material must be obtained in written form from the copyright holder.

Questionnaires: Non-standard and unfamiliar questionnaires and evaluation programmes used in research work should be applied to supplements.

References: All publications referring to the text must be cited in a reference list. References should be presented according to the style used in «Harvard»

Revised for 2009 version 3.0 editions of: The Coventry University (CU) Harvard Reference Style Guide v3.0,Quickstart Guide v3.0,Glossary v3.0.

Examples

1. Book with one author: Biggs, G. (2000) Gender and Scientific Discovery. 2nd edn. London: Routledge
2. Book with many authors: Ong, E., Chan, W. and Peters, J. (2004) Advances in Engineering. 2nd edn. London: Routledge
3. Chapter or dissertation of specific author in a book: Aggarwal, B. (2004) "Has the British Bird Population Declined?" In a Guide to Contemporary Ornithology. ed by Adams, G. London: Palgrave, 66-99
4. Journal article: Padda, J. (2003) "Creative Writing in Coventry". Journal of Writing Studies 3 (2) 44-59
5. Website: Centre of Academic Writing The List of References Illustrated [online] available from http://home.ched.coventry.ac.uk/caw/harvard/index.htm [Sept 2009]
6. Article in electronic journal: Για ένα άρθρο σε ηλεκτρονικό περιοδικό: Dhillon, B. (2004) "Should Doctors Wear Ties?" Medical Monthly [online] 3 (1) 55-88. available from http://hospitals/infections/latest-advice [20 April 2005]

IMPORTANT NOTE

If submitting an article that has already been reviewed by the editorial team of EPNE, please attach the email message with your response to the comments of the editor and reviewers.

AUTHOR SERVICES

Article progress can be checked ONLY online.

Reprints

Three reprints will be given free of charge to the corresponding author of the article.

Copyright

THE EPITOME OF USEFUL INFORMATION

INCORPORATION OF THE HELLENIC REGULATORY BODY OF NURSES

The Hellenic Regulatory Body of Nurses was constituted by the law 3252/2004 as a form of a Public Body and functions as the official professional body representing the nurses. The enrolment of all nurses is compulsory as is done in corresponding chambers overseeing other professions and functions as a regulatory body and the official counselor of the state (Pan-Hellenic Medical Association, Legal Association of Athens, Technical Chamber of Greece etc.)

MAIN GOALS OF HRBN

In an effort to make the reasons that all nurses should be subscribed to HRBN clear, shown below are the basic goals as presented by the law 3252/2004 and these should be implemented by HRBN:

- The promotion and development of nursing as an independent and autonomous science and art.
- The research, analysis and study of nursing matters and the formulation and submission of scientifically documented studies of the various nursing problems in the country.
- The construction of proposals on nursing matters.
- The continuous training and educating of nursing staff and the materialization and utilization of training programmes.
- The participation in materializing programmes which are funded by the European Union or other international organizations.
- The editing of certificates which are necessary for obtaining a license to practice the nursing profession.
- The evaluation of the nursing care provided.
- The representation of our country at international organizations regarding the nursing department.
- The publication of a journal, an informative bulletin, text books and leaflets so as to inform its members and the public.
- The study of Medicaid matters and the organization of scientific congresses that are independent or in cooperation with other bodies.
- The creation of an ethics committee for the nursing profession.
- The definition and cost assessment of nursing activities.
- The protection and enhancement of the level of health of the Greek population.

MEMBERS OF HRBN

It is compulsory for members of HRBN to be nurses, in other words they should be graduates of the following:

a) University level nursing schools
b) Technical level nursing schools
c) Former higher school for nursing, visiting nurses belonging to the ministry of health, welfare and social security
d) Former nursing school "KATEE"
e) Foreign nursing schools with degrees that are accepted as equivalent to the corresponding Greek schools
f) Military supreme nursing schools

STRUCTURE OF HRBN

HRBN is composed of a central administration, which is located in Athens, and seven peripheral sections, one in each health district of the country.

CENTRAL ADMINISTRATION

The central administration is made up of a 15 member executive council and has its central office in Athens. The address is 47 Vasilisis Sofias Avenue p.c. 10676, tel: 210 3648044-048 and fax: 2103617859 and 210 3648049. HRBN's website is www.enne.gr and email: info@enne.gr.

PERIPHERAL SECTIONS

The peripheral sections correspond to the number of health districts in the country and include:

1. 1st P.S. Attica: 47 Vasilisis Sofias Avenue, p.c. 10676, tel: 210 3648044-048 and fax: 2103617859 and 2103648049
2. 2nd P.S. Piraeus and Aegean: 47 Vasilisis Sofias Avenue, p.c. 10676, tel:210 3648044-048 and fax: 2103617859 and 2103648049
3. 3rd P.S. Macedonia: 11 Mavili St., Thessalonika p.c. 54630, tel: 2310 522229 and fax: 2310 522219
4. 4th P.S. Macedonia and Thrace: 11 Mavili St., Thessalonika p.c. 54630, tel: 2310 522229 and fax: 2310 522219
5. 5th P.S. Thessaly and Mainland Greece: 2 Navarinou St., Larissa p.c. 41223 tel: 2410 284866 and fax: 2410 284871

6. 6th P.S. Peloponnese, Ionian Islands, Epirus, and Western Greece: 1 Ipatis and N.E.O Patra-Athens, Patra p.c. 26441 tel. and fax: 2610 423830
7. 7th P.S. Crete: 116 Menelaou Parlama St., Irakleio p.c. 73105 tel: 2810 310366, 2810 311684 and fax: 2810 310014

MEMBER REGISTRATION AND SUBSCRIPTION

All nurses are obliged to apply for registration at the nearest peripheral section. The application form requires a certified copy of the nurse's degree and official identification, two coloured photographs, the receipt from the bank statement for the amount of 65 €, a simple copy of the license to practice the nursing profession and other titles that the applicant might have are optional (postgraduate degrees, certificates for foreign languages, social activities etc.).

All nurses are obliged to renew their subscription annually, in person or by post (not by fax) till the end of February, by handing in the appropriate statement to the nearest peripheral section. The statement should be handed in simultaneously with the annual subscription fee, which has been assigned to the amount of 45 € by the law 3252/2004.

All nurses who register or renew their subscription to HRBN are given a Nursing Identity Card.

LICENSE TO PRACTICE THE NURSING PROFESSION

The license to practice the nursing profession can be administered at the local prefecture by presenting the necessary documents and certification of registration at their HRBN peripheral section. When receiving the license to practice it is compulsory to present a copy to the peripheral section to which they belong. According to the law 3252/2004, whoever practices the nursing profession without a license to practice will be prosecuted according to the article 458 of the Greek penal code.

Any individual of the peripheral council or the board of directors can file a complaint for illegal practice of the nursing profession and thereafter must notify the judiciary authorities.

In the case of a temporary disciplinary sentence or final disqualification from HRBN the license to practice is automatically suspended.

ADMINISTRATIVE BODIES

HRBN is administered by the assembly of representatives and the executive council. The peripheral sections are administered by the general assembly and the peripheral council.

HRBN'S INTERNATIONAL REPRESENTATION

HRBN is a member of FEPI and has one of the seven positions on the board of directors. England, Italy, Spain, Ireland, Poland, Croatia, Romania and Portugal participate in this European federation. France, Cyprus and Belgium are under consideration for participation. For more information the website is www.fepi.org.

SELECTION AND SERVICE OF ADMINISTRATIVE BODIES

HRBN's board of directors is elected by the assembly of representatives. The representatives are elected separately for each peripheral section by the members of the department's General Assembly. The peripheral councils are elected in a similar way by the members of the peripheral department's General Assembly. These elections take place every 3 years and Nurses that take part are members in good standing (subscription payed).

DISCIPLINARY CHECK

The members of HRBN are initially submitted to a disciplinary check by the peripheral section, which also functions as a disciplinary council. The secondary disciplinary check, as well as the disciplinary check of the members of the board and the peripheral councils is executed by the supreme disciplinary council, whose president is the supreme court judge.

SCIENTIFIC JOURNAL

HRBN created the "Hellenic Journal of Nursing Science" in 2008 which is its official journal. It is a multidimensional journal with an editorial committee which aims at the promotion of the nursing science in Greece.

The "Hellenic Journal of the Nursing Science" is a reliable, modern, quarterly scientific journal which is published in Greek and English and is available in electronic and printed form. A nominal fee is offered to all interested researchers, university teaching staff, students and the entire nursing community in general as well as the tertiary university and technical level schools (Greek or foreign).

Simultaneously it offers young scientists easy access to knowledge and the chance for nursing to progress, as well as a scientific step for the nurses who work in the academic area and the clinical area to publish their work and undergo some constructive criticism. The journal publishes research studies, reviews, original dissertations and book reviews.

The papers that are published, are credited in a manner that is regulated and certified by the Greek legislation according to international standards.

INFORMATIVE JOURNAL

HRBN created a monthly informative journal in 2008 "Rhythm of Health – Ρυθμός της Υγείας", aiming at promoting and demonstrating each nurse as a unified

psychosomatic and professional personality.
The nurses in Greece have the need to solve primary issues that concern their profession as well as the need to express themselves, to communicate, to enjoy themselves and to demonstrate the diverse aspects of their social purpose.
"Rhythm of Health - Ρυθμός της Υγείας" aims at uniting the voice of all nurses in the country and becoming an immediate and dependable form of communication, giving a chance to all voices of the professional community to be heard.

GOALS FOR THE FUTURE

With the collaboration of all its members HRBN aims at materializing and completing some important projects that are requested by the nursing community, some of which have already started being carried out:

- The definition and cost assessment of nursing activities.
- The creation of an open line of communication so as to record and solve the nursing problems.
- The enhancement of international relations between Greek nurses and organizations, for and international institutes.
- The creation of an electronic digital library which can be used free of charge by members of HRBN and to which the whole country will have access.
- Will offer specific training and postgraduate courses.
- The organizing of scientific congresses and day meetings with formal accreditation.
- The formation of specific project committees such as a training committee, a documentation committee, a foreign affairs committee and an informative committee.
- The creation of a network of experts on nursing issues and the provision of legal advice.
- The creation and function of specialization programmes.
- The certification of nursing specialties and nursing adequacy.

CONTACTS

Nurses can contact us:
Tel: 2103648044, 210 3648048 (8:00-15:00)
Fax: 2103648049, 210 3617859
Email: info@enne.gr

- For professional matters
- For training matters
- For legal issues
- For their registration or renewal of subscription
- For general information (congresses, activities, etc)
- Proclamations via the Hellenic public organization for hiring personnel "ΑΣΕΠ"
- For positions in the health sector