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Gender Roles by the Sambal-Bolinao in Their Traditional Herbal Healing in Bolinao, Pangasinan, Northern Philippines

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Abstract

Transmission of ethnobotanical knowledge is needed for cultural preservation and biodiversity conservation. Nowadays, this is seriously threatened by globalization which is evident in tropical areas due to influence of Western culture leading to rapid change in indigenous individual and the community. Several factors were attributed and associated with the use of plants in the indigenous communities which includes biological, ecological and socio-cultural with the inclusion of techniques, practices, religion and age. Moreover, gender influences the ethnobotanical knowledge and the structure of local medical systems. The study aimed to assess the gender roles, sanitation practice, and lifestyle of Sambal-Bolinao in their traditional herbal healing. Specifically, it sought to determine the traditional herbal healers' profile, gender roles; and sanitation practice and lifestyle. Descriptive research technique was employed in gathering data. All traditional herbal healers in the municipality of Bolinao were interviewed using semi-structured questionnaire. A total of 19 *managtambal*; 11 males and 8 females. The Sambal-Bolinao Roman Catholic believers appreciated the practice of traditional herbal healing. They extended their roles as plant gatherers, keepers of the plant parts gathered, washers of the plant parts prior to treatment, managers of the plant parts wastes and as plant conservationist either through plant propagation and personal campaign on plant conservation. Majority of women traditional herbal healers did not transmit their ethnobotanical knowledge to their children and relatives due to their multiple burden case and perceived economic difficulty for their children. Men traditional herbal healers were the one transmitting their ethnobotanical knowledge to their family members.

Keywords*:* Gender roles, managtambal, traditional healers

Introduction

The World Health Organization recognized that 80% of people from developing countries rely mainly on traditional medicine for primary health care. Healing using medicinal herbs or plants has been part of the Filipino culture and a tradition by the Sambal-Bolinao in Bolinao, Pangasinan, Northern Philippines. Herbal healing is also called botanical or phytomedical healing using a plant's seeds, fruits, flowers, roots, leaves, barks, and other plant parts for medicinal purposes. Although modern health facilities and healing exist nowadays, herbal healing by the Sambal-Bolinao still prevail revealing the value of herbal medicine and the tradition of treating and preventing diseases.

The Sambal-Bolinao people origin were Austronesian inhabitants of the province of Zambales. The Sambals in the province of Pangasinan are found in the municipality of Bolinao and Anda. The Sambals of Bolinao still believe in superstitions, mysteries and herbal healing. The word Sambal was originally called sambali by Spanish and coined from the Malay word, sembah meaning "to worship". Today, herbal healing is predominantly practiced by the Sambal-Bolinao men and women. They are called *managtambal* in the spoken dialect, Sambal. The *managtambal* have unusual healing practices and roles in the pre-treatment, treatment and post treatment of diseases.

In the 12th century, the province of Pangasinan was ruled by a warrior princess called Urduja. During those times, women were given importance. They held high positions like healers, priestesses and even handle leadership roles and fight as warriors. The healer was called Babaylan and usually performed by a woman. When an occasion arises that a man would take this role, he needs to dress up as a woman. Women were looked up to because of their wisdom and knowledge. When problems arise and there were no other means to fix it, the *Babaylan* is the one to be called and perform rituals and chants to drive away the spirits that caused turmoil.

Fojas (2012) described Miguel de Loarca, a conquistador that gave a graphic description of the supernatural beliefs and religious practices of ancient Filipinos in *Relacion de las Yslas Filipinas,* a treatise on the Philippine islands that was published in Arevalo, Spain in June 1582. The priestesses or *Babaylan* cure diseases with medicinal herbs. They have a remedy for every kind of poison using antidotal herbs. They were very superstitious people.

As Saldua (2012) mentioned that glorious years of the women were destroyed when the Spanish arrived during the 16th century. They brought with them their own idea of what a woman is and where she is supposed to be placed in society. Women were turned into objects of suppression. Men and women's role especially in traditional herbal healing had been altered. This was furthered by the coming of Americans, Japanese, and technologies brought by globalization. Yet, the supernatural beliefs and practices in herbal healing of their ancestors still exert a major influence in the daily lives of modern Filipinos. This is evident in the Sambal-Bolinao folk, hence, this study was made.

Objectives

Today, there are still remnants of the past though quite different from its origin. Traditional herbal healing still exist and performed by the native men and women of Sambal-Bolinao in Bolinao, Pangasinan, Northern Philippines.This study aimed to assess the gender roles, sanitation practice, and lifestyle of Sambal-Bolinao in their traditional herbal healing.

Specifically it sought to determine the traditional herbal healers':

1. general information or profile;
2. gender roles; and
3. sanitation practice and lifestyle

Methodology

Study Area

The study was conducted in eleven barangays of the municipality of Bolinao in the province of Pangsinan. These barangays were Arnedo, Binabalian, Cabuyao, Culang, Goyoden, Lucero, Pilar, Samang Norte, Sampaloc, Tara, and Victory. These barangays were found to have existing traditional herbal healers. Bolinao is one of the blooming and first class municipalities of the province of Pangasinan. Bolinao has thirty (30) barangays with a total area of 197.22 km^2. Bolinao lies in the coordinates of 6°20′N 119°53′E.

The study sites were selected based on the following criteria: presence of active traditional herbal healers, traditional herbal healers willing to be interviewed and sites were accessible and peaceful. Primary and secondary data gathering were gathered from March 2016 to January 2017.

Figure 1 shows the map of the municipality of Bolinao, province of Pangasinan relative to the position of nearby provinces such as Benguet, La Union, Zambales, Tarlac, Nueva Ecija and Nueva Viscaya. It could be seen that Zambales is near the town of Bolinao.

Figure 1. Map of the municipality of Bolinao, Pangasinan

Research Design

This study focused on the gender roles, sanitation practice and lifestyle of Sambal-Bolinao traditional herbal healers in Bolinao, Pangasinan, Northern Philippines. Descriptive research techniques was employed in gathering the needed data and information for the study. All traditional herbal healers existing in the municipality of Bolinao were interviewed using semi-structured questionnaire.

Research Instrument and Data Collection Technique

Gathering of Secondary Data and Information

Before the start of data collection, the researchers secured permission from the mayor of Bolinao, and local barangay officials. Also, endorsements from local Department of Interior and Local Government, Local Department of Health and Social Welfare were solicited.

Data Collection

The nineteen traditional herbal healers were individually interviewed using semi-structured questionnaires. The respondents were purposively chosen based on the abovementioned criteria. The questionnaire was divided into 3 sections, namely: section 1, personal data or profile of the respondent; section 2, gender roles in drug preparation, its pre-treatment, treatment, post treatment, plant conservation, and transmission of traditional ethnobotanical knowledge; and section 3, sanitation practice and lifestyle of traditional herbal healers. Key informant interviews were done to seek advance information about the traditional herbal healing and the healers. Focused group was also employed to seek a view from different perspectives about the topic. This approach facilitated a sort of rapid appraisal assessment and allowed unanticipated data and information to emerge.

Respondents

The respondents of the study were the identified traditional herbal healers in Bolinao, Pangasinan, Northern Philippines. All the identified traditional herbal healers by the local government of Bolinao were interviewed. Hence, a total of 19 traditional herbal healer respondents including non Sambal blooded ones underwent in this study's survey. Replacement (usually by a family member) was considered when identified respondents were not available.

Data Analyses

In addition to information obtained from the interview questionnaires, information through observation and video/photo documentation were sought. Answers in every interview question were tabulated and calculated employing frequency distribution method. WPS Spreadsheet software program was used in encoding data and processing of information. Descriptive analysis was used for the interpretation of the data gathered.

Results and Discussions

General Information about the Respondents

Table 1 shows the general information about the traditional herbal healers as respondents in the eleven barangays of Bolinao, Pangasinan, Northern Philippines. Results showed that barangay Victory had three female and one male traditional herbal healers. Barangay Culang had one female and two male traditional herbal healers. Barangays Arnedo, Binabalian, and Sampaloc had each one female and one male traditional herbal healers. Barangays Cabuyao, Goyoden, Lucero, Pilar, and Samang Norte, had one each male traditional herbal healer. Barangay Tara had one female traditional healer. All respondents were married and only one widowed female. Among the 8 female respondents, seven were Sambal blooded and only one female respondent was not. Among the eleven male traditional herbal healers, seven were Sambal blooded while four of them were not Sambals. Among eight female respondents, five were Roman Catholic believers, the three were non-Roman Catholic believers. Nine of the eleven male respondents were Roman Catholic believers and the two were non-Catholic believers.

Fojas(2012) described that most of the priestess or Babaylan were Roman Catholic believers. Roman Catholicism reinforced the pre-hispanic herbal healing practice. It could be inferred that most of the traditional herbal healers were Roman Catholic believers.

Table 1. General Information about the traditional healer respondents

Name of the barangay where the respondents came	Sex		Civil Status				Ethnicity				Religion			
			Married		Widowed		Sambal		Not Sambal		Roman Catholic		Others	
	Female (F)	Male (M)	F	M	F	M	F	M	F	M	F	M	F	M
Arnedo	1	1	1	1			1	1			1	1		
Binabalian	1	1	1	1			1	1			1	1	1	
Cabuyao		1		1				1						1
Culang	1	2	1	2			1	1		1	1	2		
Goyoden		1		1				1						1
Lucero		1		1				1				1		
Pilar		1		1						1		1		
Samang Norte		1		1						1		1		
Sampaloc	1	1	1	1			1			1	1	1		
Tara	1		1											
Victory	3	1	2	1	1		3	1	1		2	1	1	
Total	8	11	7	11	1		7	7	1	4	6	9	2	2

Gender *Roles in Traditional Herbal Healing*

Shown in Table 2 is the gender roles in traditional herbal healing by the Sambal-Bolinao. At least five gender roles were described by the traditional herbal healer respondents. Six out of eight female respondents did plant gathering as part of the healing preparation. The two female respondents depend either from family member or relative to gather the plant parts. Among the male respondents, seven did by themselves the plant gathering while four relied from their spouses and sometimes from their patients. In storing plant parts prior to pre-treatment and treatment, six of the female respondents did it themselves while the two depended from their family members. Washing the plant parts in the pre-treatment, and disposal of used or left over plant parts in the post treatment, six female respondents did by themselves and two female respondents asked their family members to do it. Three female respondents propagated by themselves the plants being used in healing as part of plant conservation. The other three female respondents requested or asked their family member to propagate the plants. Other conservation measure was to tell people to conserve the plant as done by two female respondents. Of all eight female respondents, only one was willing to transmit her ethnobotanical knowledge to her family members. Most of the reasons mentioned by the female respondents why they do not like to transmit their ethnobotanical knowledge was economic difficulty. Majority of these female respondents did not have regular source of income. Neither herbal healing was their means of income. On the transmission of ethnobotanical knowledge to their family members or relatives, only one female respondent was found out transmitting her knowledge to anyone of her family members. The rest of female respondents did not.

The male respondents, on the other hand, seven of them did gathering and storing of plant parts. The other four male respondents requested their patients or wives to gather and store the plants for them. In the pre-treatment or washing the plant parts, only one of the male respondents did not do it by himself. In the disposal of plant parts, seven male respondents did the disposal of the used or left over plant parts. The other four male respondents, sought their patients or wives to dispose the left over or used plant parts. In plant conservation, only one male respondent did the propagation of plant. The other male respondent requested a family member to do the propagation while three of male respondents did not mind the plant's propagation. Moreover, one male respondent did protect the plant wildlings and two male respondents did not bother to protect the plant wildlings. One male respondent told the people to conserve the plant used for healing. Two male respondents requested either their patients or family members to conserve the plant. Six out of eleven male respondents do not like to transmit their ethnobotanical knowledge. Like female respondents, their main reason was economic difficulty. Three of the male respondents primary occupation was carpentry, two were into fishing, the rest were senior citizens. Five out of eleven male respondents were already transmitting their

ethnobotanical knowledge to their family members or relatives while six of them were not.

Sahibzada (2005) studied that the plant collectors or gatherers of medicinal plants in Roringar Valley, Swat, Pakistan include women (34%) , children (47%), and men (19%). Howard (2001) claimed that across the globe, and particularly in tropical regions rich in biodiversity, in villages, on farms, in homesteads, forests, common pastures, fields and borders, it is women who manage the majority of all plant resources that are used by humans. They also hold the majority of all local plant knowledge and are those who are mainly responsible for the in situ conservation and management of useful plants, whether they are domesticated or wild. The simple explanation for this is that, throughout history, women's daily work has required more of this knowledge. Across the globe, it is women who predominate as wild plant gatherers, homegardeners and plant domesticators, herbalists, and seed custodians. The study of Hunde et al (2015) concluded that Ethopian women were the major players in the conservation and managing medicinal plants. One of the gender biases being faced by Filipino women is multiple burden. They do all the household chores and extra living activities and almost have no time to mentor. These could be one of the reasons why female respondents did not transmit their ethnobotanical knowledge. Not wanting their children experience economic difficulty in the near future was one of the reasons for not transmitting their knowledge.

Both men and women traditional healers performed other roles like plant gatherer, keeper of left over plant parts, washer of the plant parts before treatment. They even disposed used plant parts in their post - treatment. All of the above roles were directly associated with their nature of work in herbal healing. In the conservation of plants being used for herbal healing, female respondents tend to do this role compared to male respondents. It can be deduced that women hold local plant knowledge as a result of their daily work, hence, they felt responsible for the conservation and management of herbal or useful plants. Male respondents were active in transmitting their ethnobotanical knowledge to their family members or relatives. One possible reason was that they have extra time to do it especially the senior citizens. Unlike female respondents, they were facing multiple burden, hence, less time for ethnobotanical knowledge transmission.

Table 2. Gender Roles in Traditional Herbal Healing

Gender Roles in Traditional Herbal Healing	Female			Male		
	Self	Others	No	Self	Others	No
Plant Gatherer	6	2		7	4	
Storer of plant parts	6	2		7	4	
Washer of plant parts (pre-treatment)	6	2		10	1	
2Disposer of left over plant parts (post treatment)	6	2		7	4	
Plant Conservation						
Propagator	3	3		1	1	

Protector of wildlings				1		2
Teller or reminder of plant conservation	2				1	2
Transmitter of traditional ethnobotanical knowledge	1		7	5		6

Sanitation Practices of Traditional Herbal Healers

Pretreatment

Four out of eight female respondents washed plant parts with water as their sanitation practice before treatment. Two used alcohol in disinfecting their hands before treatment while the rest no sanitation pre-treatment practice.

Four of the eleven male respondents washed plant parts with water as their sanitation practice while one male respondent washed hands only. The remaining two male respondents showed no sanitation practice before treatment.

Majority of female and male respondents were observant of their pre-treatment sanitation practice particularly on washing plant parts with water. However, washing of plant parts does not guarantee that patient is free from infection.

Treatment

In observance of health treatment procedure, two out of eight female respondents used alcohol and warm water in applying affected human part, and use of washed or clean plant parts during treatment. Two female respondents use washed or clean plant parts during treatment. The rest of female (4) respondents had no sanitation practice during treatment.

Five out of eleven male respondents used washed or clean plant parts as part of their sanitation treatment. Two male respondents both used alcohol and warm water to apply onto affected human part, and used washed or clean plant parts as sanitation practice during treatment. Two male respondents used alcohol and warm water and apply onto affected human part. The other two male respondents had no sanitation practice during treatment.

Half of the female respondents observed used alcohol and warm water in applying affected human part and washing or cleaning plant parts during treatment as their sanitation practice. Majority of male respondents observed washing or cleaning plant parts as their sanitation practice during treatment. Few used alcohol and warm water in applying affected human part. It can be deduced that male respondents were more conscious on treatment sanitation.

Post of After Treatment

Two out of eight female respondents disposed waste materials (from human and plants) onto a pit. Two female respondents disposed waste materials onto garbage

bin for truck collection. The four female respondents had no sanitation practice after treatment.

Seven out of eleven male respondents disposed waste materials (from human and plants) onto a pit. One male respondent observed sanitation practice by waste burning while one let his patient bring the waste materials used in healing. Two of the male respondents had no sanitation practice after treatment.

Half of female respondents were conscious of their waste disposal either onto pit or garbage bin. Moreover, male respondents were more conscious of their waste disposal after treatment compared to female respondents.

Few studies have been conducted on the sanitation practice by the traditional herbal healers in the Philippines. Though herbal healing were being promoted by and among the community people, its sanitation side is being neglected. The practice of sanitation before, during and after treatment play a big role in the outcome of healing and health of the patient. The main objective of sanitation practice is to protect and promote human health by providing a clean environment and breaking the cycle of disease.

The Medical Evidence, online book. (1999) claimed that the sanitation practice saved countless lives of Israelites by protecting them against infection caused by unseen germs. The medical instructions given by Moses to the Israelites some 3500 years ago were not only far superior to the practices of contemporary cultures, they also exceeded medical standards practiced as recently as 100 years ago. The Israelites were instructed to wash themselves and their clothes *in running water* if they had a bodily discharge, if they came in contact with another person's discharge, or if they had touched a dead human or animal carcass. They were also instructed to wash any *uncovered* vessels that were in the vicinity of a dead body, and if a dead carcass touched a vessel it was to be destroyed. Items recovered during war were also to be purified through either fire or running water. In addition, the Israelites were instructed to bury their human waste outside of camp, and to burn the waste of their animals.

Sambal-Bolinao particularly women traditional herbal healers were not really conscious of sanitation practice before, during and after treatment. They presumed and felt not to wash hands before and during treatment because they usually stayed at home. Men, on the other hand, usually coming from work outside home, tended to wash hands before and during treatment.

Conclusion

The Sambal-Bolinao that were Roman Catholic believers appreciated the practice of traditional herbal healing. They extended their roles as plant gatherer, keeper of the plant parts gathered, washer of the plant parts prior to treatment, manager of the plant parts wastes and as plant conservationist either through plant propagation and personal campaign on plant conservation. However, majority of them especially

women traditional herbal healers did not transmit their ethnobotanical knowledge to their children and other relatives for their multiple burden case and perceived economic difficulty for their children or family members. Men traditional herbal healers were the ones transmitting their ethnobotanical knowledge to their family members.

The nature of work of men which was outside home made them conscious to observe sanitation practice by washing the plant parts with hands and by disinfecting the hands with alcohol or warm water. Women traditional herbal healers which usually stay at home presumed that their hands were already clean and no need of sanitation practice.

Recommendations

Further validation or study on transmission of ethnobotanical knowledge to the family members of the traditional herbal healers should be conducted. Support in perpetuating the ethnobotanical knowledge particularly from local government and other government agencies should be initiated.

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Mental Images and Postpartum Depression: Case Study

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Abstract

Imagination and images refer jointly ability to imagine. Imaginative therapies operate all within an almost real context. In therapeutical experience, the individual goes through almost real experiences before going through the events in reality, acts before acting in reality and this provokes changes in somatic level. The almost real dimension, namely the imaginative dimension, influences the individual, or rather the individual, starting from the imagination changes himself, his beliefs and perceptions. Imagination as therapeutic intervention is sometimes more efficient and more valuable than other therapies. It is also effective in treating a range of psychological symptoms such as insomnia, depression, obesity, cronich pain, various phobias, anxiety and panic , somatic problems. Given the fact that the images are effective in treating a range of psychological symptoms, including depression we want to see if imaginative techniques help improve symptoms of postpartum depression. This case was treated at University Hospital for Obstetric and Gynecology "Koco Gliozheni" Tirane (Albania). A 35 years young mother showed depressive symptoms associated with post-partum condition, as determined by semi-structured interviews and relevant test EDPS, also by psychiatric consultations. Besides the daily psychological support I proposed some imaginative techniques like self-watching, flooding, guided imagery. Imaginative activity in general, in the case in question, was a valid instrument of the difficulties in everyday life. The patient learned to visualize problematic elements of each situation and this resulted an efficient approach. Imagination helped identify schematic components that have contributed to the formation of inappropriate thoughts and exaggerated ideas. It helped in recognition of the patient's emotional reality and modifying this emotional reality. The patient uses images to manage situations different daily life even by telephone follow up. This case study shows that imagery techniques, elaborated through images, facilitate recovery and provide us with a functional interpretation of the event and its consequences. Working with images intended to make the patient able to withstand and manage the pain that bring different situations and to integrate it in the history of personal life.

Keywords: imaginative techniques, post-partum depression.

Introduction

1. Background

The imagination, images and imaginative techniques have always raised great interest. Imagination and images refer jointly the ability to imagine. Imagination is action (Widman 2004). It is the ability to shape mental images, to transform them, to develop them and to deform them. In Psychological terminology it is a form of thinking that does not follow fixed rules, nor logical relationships but is presented as a reproduction and elaboration of current or past sensory data associated with a certain affective stage. The imagination allows the combination of memories, perceptions, aspirations and real context by creating in mind something new, transformed and re-elaborated thanks to the fantasy. Images are the basis of psychic life. The approach that is used by some orientations and imaginative psychotherapies lies on the fact that some imaginative experiences take on the colors of reality and it is precisely this almost real dimension that acts in changing the individual. The ability to imagine allows the experimentation in this almost real dimension. The almost real dimension, namely the imaginative dimension, succeeds in influencing the individual, or to be more precise, the individual starting from the imagination changes himself, his own beliefs and perceptions. The process that is followed by most of the therapies is from the fantasy to reality.

The imagination as an intervention technique has yielded results in various fields. Most clinicians use imaginative techniques to promote relaxation, to reduce stress, to regain control of unwanted behaviors and to improve health.

They are effective in treating a variety of psychological symptoms such as depression, different phobias, anxiety and panic, sleeplessness, somatic problems.

Imaginative techniques are incorporated into psychoanalytic, psychodynamic and cognitive behavioral theories as supplementary therapeutic methods.

2. Case Study

Our patient is transferred to the obstetric-gynecological university hospital 'Koco Gliozheni' Tirana (Albania) from Berat maternity. It is 30-31 week pregnancy and the patient is diagnosed with preeclamsia. She is 35 years old, married and in her first pregnancy. She gives birth to a girl with a weight of 1100 grams, who starts a treatment at the intensive therapy unit at the “Koco Gliozheni” maternity hospital.

The first psychological counseling is requested by the gynecologist and then by the pediatrician who is curing the patient's daughter. The latter asks for the consultation because of the lack of interest shown by the mother to the child.

The patient complains of persistent headaches, chest pain and breathing difficulties. After examinations with the specialized doctors, the room physician requests a psychological counseling. The first consultation is done about one month after the baby's birth. The patient complains of headaches, breathing difficulties and persistent anxiety that does not allow her to sleep but is trying to suffocate her. She goes very rarely to see the girl because she does not feel good, according the declaration of the patient. She is always accompanied by her mother-in-law and husband who are present at almost all meetings with the patient and they refuse to leave her alone through consultations.

In the upcoming hours and days the situation appears alternately, there are days when she is quiet and other days when she only cries because she does not feel physically fit.

3. Methodology

The patient started to follow the consultation regularly every day. During the consultations, there were constantly present either the husband or the mother-in-law of the patient who with all the insistence of the psychologist refused to leave, moreover by taking the approval of the patient. This aspect was counterproductive because it did not allow us to obtain additional information on the patient's family problems. In the presence of the family, the patient complained continuously of physical problems but not for psychological problems. The psychologist noted sleep disorders, fatigue and lack of energy, anxiety, guilt feelings, thoughts of death and suicide.

With the cooperation of the maternity staff we tried to find time when the patient could be consulted alone in order to explore her thoughts and emotions.

Initially I conducted semi-structured interviews that consisted of cognitive questions. These questions are proposed by the National Institute for Health and Clinical Excellence (United Kingdom) (Nice 2007), and are important in screening postpartum.

- Did you feel very sad and hopeless during the last month?

- Did you have little interest or little pleasure in daily activities during the last month?

If the above questions result positive then the third question is raised

- Taking in consideration this situation, do you feel the need for help?

After the answers to the questions were all positive we applied the Edinburgh test for postnatal depression.

The Edinburgh Postnatal Depression Scale (EDPS) is a valuable and effective way of identifying patients at risk for perinatal depression. The EDPS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are

likely to be suffering from a depressive disease of varying severity. The scale indicates how the mother has felt during the previous week.

From the interviews we made and from the respective tests we identified depressive symptoms.

We sought a psychiatric consultant, who based on the assessments made, confirmed the diagnosis of postpartum depression and proceeded with the respective pharmacological therapy.

In addition to pharmacological therapy, the patient continued to have constant psychological support.

But since the communication with the patient was difficult and we reached a point without way out, we thought to use the imagination, starting from the fact that the patient's imagination was quite alive (at least from the description of the scenes of death and suicide which she imagined and outlined).

Self-Watching Technique: This technique uses self-observation to change compulsive behaviors. It is taught to the patient to identify the factors that support and associate compulsive behavior, also are taught the techniques that modify this situation. The patient should keep a behavioral diary in which he should note any compulsive behavior and the circumstances in which this behavior occurs. This helps in identifying events, ideas and feelings that influence the behavior. The patient is assisted in creating the strategies to face and not avoid them. Important in this technique is the identification of alternative satisfaction based on the fact that it is easier to resist to compulsive behaviors when they are anticipated from alternative positive behaviors.

Flooding Tech: Polin (1959) has named it as a shocking therapy. It consists in the imagination of an anxiety situation that is experienced with the maximum intensity including all the emotional dyeing that it causes. This image pushes the patient to the limit of patience and aims to avoid strategies that the patient usually uses in similar situations such as avoiding or leaving.

The directive images were used to build a future-oriented identity. To re-imagine or re-live changes the patient's point of view regarding the reality of the pain.

4. Discussions And Conclusions

The period of pregnancy and birth are important events that contribute not only to the birth of a human being such as a child but also to the birth of a new identity of the next mother, particularly from the psychological point of view. Pregnancy is configured as a fundamental process in shaping of the female identity. Like all phases of identity crisis, this stage also has its own conflicts because the mother's personality is tested and faces constant changes and adjustments. The woman can withstand with difficulty this process, and the birth of the baby may worsen the situation, causing humorous disorders from the easiest to the worst.

The post-partum depression phenomenon in Albania is highly underestimated. There are no good statistics for this phenomenon. Medical staff are not trained to identify these cases and refer them to relevant institutions. The psychological service in maternity is regularly implemented since 5 years.

Patients are still not happy about the psychological support. There is still the mentality that asking for psychological help means being crazy. And these prejudices become even more distinct among the people living in the city and those living in the village.

On top of these limitations, adds the fact that a child's birth is a joyful event and should not bring any kind of problem, and therefore new mothers have difficulty in expressing and showing their problems.

Even when maternity personnel faced such problems, is the mother herself or her family members who try to minimize the problem, not pay attention, even to refuse psychological support or even when they accept it they are not at all cooperative.

Such problems are also encountered in our case. The husband of the patient and her family wanted to be in consultation, and this limited the confession of the woman.

Since verbal communication was blocked at a point without a way out, I decided to use the imagination and the imaginative techniques to understand the problems, motivations and behaviors of the patient, starting from the fact that the imagination helps to face daily difficulties and improve the lifestyle

Images are always associated with emotion. It is a bidirectional relationship. If images produce emotions the latter together with feelings and affections produce imaginative activity, which is used to recognize the individual's cognitive-emotional reality and to modify it if necessary.

Imaginative exposure is used as an alternative to the real-life difficulties. These images are capable of provoking a positive or negative emotional state, transforming some aspects of the external and internal reality, facilitating the identification and analysis of emotional states, cognitive processes, to identify and modify the distorted and irrational beliefs of patients through a change in the degree of anxiety stimulus risk or through a change in the way of assessing the ability to confront.

The directive images used with our patient helped us discover new areas of exploration, such as a depressive episode that occurred six years ago and treated with medicines. Or the conflicting relationship with her husband and her family, or fear of having a child who would have a life full of suffering like her, so she preferred to die together with the baby.

The images helped us to modify the irrational beliefs that led to the appearance of inappropriate emotions.

The directive images helped us to start the creation of a future-projected identity, a future that includes her child.

The patient began to approach and stay more with her child, and one month later, after daily psychological consultations and psychiatric support, came out of the hospital in a better state.

In a telephone follow-up with the patient, the patient referred us to be better, changed some things in her life. She had been divorced from her husband and had gone to live with her daughter at her parents, she had started a new job. She was happy with the new life she had created, and she continued to consult periodically with mental health institute.

This clinical case is a positive example, which indicates that work with imagery and imaginative techniques is more effective where words are lacking, and where barriers and protective mechanisms are very obvious.

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Circumstances Related to the Reporting of Bad News in the Medical Profession

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Abstract

In the medical profession, communicating bad news about a malignant formation is often associated with experience, obstacles, and problems faced by the medical professionals and related to the communication with the patient. Our survey included 232 medical specialists - doctors and nurses with diverse internship in the profession and working in Bulgarian healthcare facilities. It aimed to find: (i) the most common difficulty in communicating the bad news to cancer patients, (ii) the most difficult aspects of that information, and (iii) the specific words the medical professionals prefer to avoid when communicating the bad news. Also, the medical specialists were asked about the factors with the largest interference with the disclosure of the bad news to the patients. The survey results show that only 66% of the medical professionals are ready to respond directly and definitively to the question from the patient if he/she has cancer. Almost all of the surveyed medical specialists believed that the most difficult part of communicating the bad news was related to the prognosis of the disease and the survival expectancy; many of the medical professionals preferred to avoid the word "cancer", and the fatality of the disease was the most common barrier in communicating bad news, followed by the relatives' negative position towards bringing up the bad news to the patient, and the low level of patient's education and the short life expectancy. The study shows the need for support and training of the medical professionals in addressing bad news situations and the importance of the protocols with guidelines and steps to be performed during that communication.

Keywords: bad news, health care professionals, cancer patients

Introduction

Communicating bad news in medicine is a challenge for all healthcare professionals and they are often poorly prepared for such moments. This process includes not only skills that medical professionals have acquired in their training and experience with

patients, but also personal viewpoints, e.g., the professionals' perceptions of life and death in general, specific life experience and identification with the patient and his/her situation, and transfer of emotions related to situations in their own life, associations with relatives and close friends.

The patients with their problems and emotions present an important party in the process of communicating bad news. At the same time the healthcare professionals with their experience, emotions and personal background are also an intrinsic part of this process. Some healthcare professionals will bring up the bad news to many patients, and they must maintain their own mental balance and emotional state in order to be available to help the patients.

Perceiving some news as bad usually relates to consideractions about the changes that could occur after bringing up the news. How bad the news is for the patient depends to a great extend on the patients' expectations, the nature of the illness, and whether or not the patient suspects the diagnosis (Buckman, 1984).

There are many factors which interfere with the health professionals' attempts to disclose the bad news in a clear and calm way, e.g. the professionals' own anxieties and fears especially hinder the start of the conversation or who is taking the responsibility for managing disease and the treatment (Buckman, 1984). This probably is related to insufficient followup statement about the true patient's health status as well as attempts to avoid certain words.

Among the most common potential areas of improvement of the perception of the bad news are the knowledge of the patient expectations, the speed and timing of presenting the news to the patient, the incremental presentation of the information, sharing of troublesome information warning, allowing the patients to express their emotions and worries (Ellis & Tattersall, 1999), following the patient's pace, avoidance of medical jargon and euphemism and answering of the patient's questions (VandeKieft, 2001). The medical professionals should give enough time for the conversation, they must insure high quality of the information and facilitate the patient's understanding, provide emotional support and allowing expression of emotions (Fujimori et al., 2005).

When receiving the bad news, the patients usually expect both empathy and complete information (Munoz Sastre at al., 2011) and this process is an important part of the adaptation of the patient, Phipps, Cuthill, 2002). Patients often state they want their doctors to provide them with realistic information, to include them in the discussion of the prognosis, and to give them clear answers to their questions. Raising the hope of the patient depends on the possibilities to have modern methods of treatment, more clever and well informed doctor, and a promise to keep the pain under control. Most patients worry that doctors feel nervous about reporting the bad news, or give the prognosis to the family first and use euphemisms. As a result, the patients feel less hopeful about the outcome of the treatment (Hagerty et al. 2005). Also, the medical professionals must be careful, because the patients' preferences for inclusion in the

process could be unstable and the situational factors may alter the needs for information (Butow et al., 1997).

A review of several studies in the field indicates that the patients' preferences to communicating bad news includes four components: setting, manner of communication, emotional support, type and completeness of information. The review also finds that patients' preferences are associated with their age, gender and educational level. Younger patients, female patients and highly educated patients want to have detailed information and they are expecting more emotional support (Fujimori & Uchitomi, 2009).

Many medical professionals believe that delivering bad news is related to skills that are of great importance, the ability to respond to the patients' verbal and non-verbal signals (Bennett, Alison, 1996), and to manage their own reactions to death and dying (Fields, Johnson, 2012). The medical professionals need to be trained and taught in communicating the bad news in addition to training in diagnostics and therapy in medicine in general. Thus, training courses in communication skills are recommended to enhance the perception of information and the patients' satisfaction (Monden, et al. 2016, Rabow & McPhee, 1999). In addition, the competency in the bad news communication skills should be included in the core curriculum for the health care training and education (Minichiello et al., 2007). Important personality characteristics include reflection skills and the ability to show empathy and to care.

Participants and methods

The study included 232 health specialists /144 doctors and 88 nurses/ with different professional experience from healthcare facilities in Bulgaria – demografic data table 1. The participants were asked to fill in a survey with questions related to bad news disclosure. It aimed to find: (i) the most common difficulty in communicating the bad news to cancer patients, (ii) the most difficult aspects of that information, and (iii) the specific words the medical professionals prefer to avoid when communicating the bad news.

Table 1 Demographic data

The results present the number of answers provided by each participant and the distribution of those answers as a percentage. Every health care professional had the opportunity to give more than one answer to the questions included in tables 3, 4 and 5 and the percentages have been calculated based on the total number of participants.

Results

The first question of our survey attempts to find the most common answers that the healthcare professionals give to cancer patients in response to the direct question "Do I have cancer?". This question is of a great importance to the communication with the patient, because after hearing it the doctor clearly understands that the patient wants to know the truth about his/her diagnosis. Also, the Bulgarian Health Law states that

every patient is entitled to clear and accessible information about his/her health and the methods of treatment and every patient must have an access to the medical records related to his or her diagnosis and treatment (Bulgarian Health Law, 2018). Therefore, the question checks what types of responses the healthcare professionals give to the cancer patients when they are sure that the patients want to know their diagnosis and the situation requires an honest answer.

Table 2 Survey question: How do you usually answer a patient who has cancer when he/she asks you, "Do I have cancer?"

The next survey question is related to the separate parts of the information needed to be disclosed after the definitive answer about the diagnosis. The assumptions include the prognosis and life expectancy, the meaning of the word cancer itself, the existence of metastasis that is associated with the prognosis and the possibility of complete cure, the need for heavy and/or painful treatment, in this case chemotherapy. These topics often generate communication difficulties and health professionals would like to avoid them. /Every health professional had the opportunity to give more than one answer and the percentages have been calculated based on the total number of participants/.

Table 3 Survey question: If your patient has cancer, what part of the information is most difficult to share?

The next survey question is related to the frequent complaints from patients that the healthcare professionals often use euphemisms and difficult words when communicating the bad news. The question is related to the most difficult words and the attempts of the healthcare professionals to avoid them and try to cope with their own emotions and the transfer of their personal experience to the current situation. /Every health professional had the opportunity to give more than one answer and the percentages have been calculated based on the total number of participants/.

Table 4 Survey question: If the patient has cancer, which words do you prefer to avoid?

The last survey question probes the factors that interfere with the communication of the bad news. The expectation here was related to the common problems with the patient's relatives in Bulgaria who play an important role in such communication. Often, the relatives believe that the bad news disclosure will shorten the patients' life, because he will not be able to overcome the illness if he knows his life expectancy. /Every health professional had the opportunity to give more than one answer and the percentages have been calculated based on the total number of participants/.

Table 5 Survey question: What is most interfering with communicating bad news?

Discussion

Only 66% of the health professionals tend to respond directly to the question of the cancer patients "Do I have cancer?" and definitely say „Yes" when answering it . About

¼ of them give vague answers that they are not able to say the definite “Yes”. It is important to notice that answering the patient’s question it is not a matter of examining of the patient's wishes, his/her emotional state, and the willingness to hear the answer. Here, the health professionals are asked only about their answer to the the patient’s question "Do I have cancer?" However, only 66% of healthcare professionals in this group are able to give a definite answer to this clear question.

The most difficult part of the information is related the prognosis and life expectancy. Traditionally, it is difficult for Bulgarians to talk about death. Many of them also believe that talking about death makes a prophecy for a short life and the only way to overcome a serious illness is to think and talk positively. Probably, many healthcare professionals also experience identification with the patient and have difficulties in communicating the facts about the short life expectancy due to projections to their own experience and the idea that every human life is limited.

The most commonly avoided word is “cancer”, followed by “formation” and “tumor”. This is probably related to the healthcare professionals' attempts to avoid direct communication related to the diagnosis and the idea that the word "cancer" brings extreme anxiety and tension in the patient and his/her relatives.

The most difficult part of the communication is the fact related to the fatality of the disease, and the conversation about imminent terminal prognosis followed by the problem that is often generated by the relatives, the request to the healthcare professionals not to report the diagnosis to the patient. This obviously is related to the fatality of the potential outcome and the other difficulties that the healthcare professionals enlist to be associated with the short life expectancy. Other difficulties identified by the healthcare professionals are related to the low level of education of the patients and their poor cognitive abilities.

Conclusions

Many healthcare professionals in our study report problems in communicating directly the diagnosis and naming the illness with the proper words. The most important part of this process relates to the prognosis, life expectancy, and terminal outcome. The information concerning the diagnosis and its sharing in response to direct questions is an interesting aspect of this study especially in the context of the regulations and laws in the country. According to the law, the patient has the right to know and be completely informed about his/her medical problems. The situation is exactly the same, even if the relatives want the patient not to be informed about the diagnosis, the life expectancy and the upcoming therapy.

The survey makes clear that the healthcare professionals need adequate knowledge and skills to talk clearly and openly with the patients, complying with their emotions and desires, while keeping their own capabilities to reflect without accumulating additional negative feelings about themselves from any conversation related to the bad news.

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Tables

Table 1 Demographic data	nurses	doctors	total
Gender			
men	4	74	78
women	84	70	154
Age			
20-30	9	16	25
31-40	18	25	43
41-50	31	24	55
51-60	20	61	81
over 65	10	18	28
Working experience			
1-5 years	30	37	67
6-10 years	14	28	42
11-15 years	4	16	20
16-20 years	16	25	41
over 20 years	24	38	62

Table 2 Survey question: How do you usually answer a patient who has cancer when he/she asks you, "Do I have cancer?"

Answers	N	%
Probably you don't have	24	10,3%
You probably have	42	18%
I am afraid - Yes	154	66,4%
At present the results suggest that diagnosis	2	0,9%
You should ask your doctor	4	1,7%
There is a high probability	2	0,9%
You have a formation that needs to be treated	2	0,9%
I don't have the right to give you an answer	2	0,9%
Total number of	232	

answers		

Table 3 Survey question: If your patient has cancer, what part of the information is most difficult to share?

Answers	N	%
I don't have difficulties	2	0,9%
Prognosis and life expectancy	196	84%
The existence of malignant neoplasm	78	34%
Metastases	75	32%
The need of Chemotherapy	24	10%
Total number of answers	376	

Table 4 Survey question: If the patient has cancer, which words do you prefer to avoid?

Answers	N	%
Atypical cells	41	18%
Inflammation	20	9%
Lesion	30	13%
Tumor	45	19%
Formation	112	48%
Cancer	169	73%
Neoplasm	40	17%
Lump	29	12,5%
Shadow	20	9%
	640	

Table 5 Survey question: What is most interfering with communicating bad news?

Answers	N	%
Relatives who have negative position towards braking the bad news to the patient	108	46,5%
The short life expectancy	92	40%
Fatality of the disease	134	58%
The age of the patient	75	32%

Small treatment effect	80	34%
Poor social status	67	29%
Poor family status	57	24,5%
Poor physiological status	68	29%
Low education	94	40,5%
Poor cognitive abilities	91	39%
Poor professional status	34	15%
	900	

Sense of Defeat, Social Status and Oral Health among Forensic Psychiatric Patients

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Abstract

Aims: The aim was to examine how sense of defeat and social status are related to perceived oral health, tooth brushing, and oral health-related quality of life among Dutch male forensic psychiatric patients.**Methods:** The sample consisted of 40 hospitalized forensic psychiatric patients participated. The questionnaire included five questions about moments of tooth brushing, scales for sense of defeat and subjective social status, a scale from 1 to 10 for perceived oral health and a Dutch version of the Oral Health Impact Profile-14 (OHIP-14).**Results:** The results showed that on the basis of a factor analysis of the OHIP-14, three meaningful scales could be constructed, i.e., functional limitations, social discomfort, and psychological inhibitions. The major results revealed that sense of defeat correlated negatively with tooth brushing after breakfast and before going to sleep, positively with social discomfort because of one's teeth, mouth, or dentures, not with functional limitations, and negatively with self-perceived oral health. Social status correlated positively with tooth brushing before going to sleep, with psychological inhibitions, but not with social discomfort, and neither with functional limitations.**Conclusions and implications:** The major conclusion is that sense of defeat and social status have theoretically meaningful relations with oral self-care and oral health. Oral health professionals working with male forensic psychiatric patients should be sensitive to the sense of defeat these patients may experience, and to the fact that this may be associated with problems with their oral health and with a lack of oral self-care.

Keywords: Defeat, Social Status, Oral Health, Forensic psychiatric patients, oral health-related quality of life

1. Introduction

According to the theory of involuntary subordinate strategies, as in many other social animals, humans compete with each other for status and prestige in groups. Status can be based on power and dominance, but also on what has been referred to as social attention holding potential (Allan & Gilbert, 1995; Buunk & Brenninkmeyer, 2000), the ways in which one can attract attention and appreciation from others. More specifically, the sense of *subjective status* or subjective rank includes a perception of how well one is doing in comparison to others with respect to one's strength and power (i.e., the ability to win conflicts and meet challenges), one's social attractiveness and talent (i.e., the ability to be chosen by others for a team, as a friend or lover), and the extent to which one ´fits in the group´. In the evolution of status in human groups, humans became less oriented towards attaining physical dominance, but more towards attaining a sense of symbolic dominance (Barkow, 1989; Buunk & Ybema, 1997). A low subjective status is associated with a low well-being, and becomes particularly problematic –and can involve important mundane costs for oneself and one's family– when no escape is felt to be possible. According to the theory of involuntary subordinate strategies, such blocked escape may induce a *sense of defeat*, and may bring individuals in a 'giving up' state of mind (Gilbert & Allan, 1998; Buunk, Peíró, Rodríguez, & Bravo, 2007), feeling like a loser, feeling unsuccessful and having low self-confidence.

A sense of defeat seems an especially a salient issue among criminal offenders, and will be particularly relevant for males (cf. Cummins, 2007). From an early age, males engage more than females in physical and non-physical forms of competition than females (Campbell, 2002). Indeed, a study in Spain showed that a sense of defeat was related to a low life satisfaction among young male, but not among young female criminal offenders (Buunk, Peiró, Rocabert, & Dijkstra, 2016).

The aim of the present pilot study was to examine how among male forensic psychiatric patients subjective social status and sense of defeat were related to moments of tooth brushing, perceived oral health, and oral health-related quality of life (OH-QoL) (Werkhoven, Spreen, Buunk, & Schaub, 2004). Insight in factors associated with oral self-care practices is of great importance for developing oral health care interventions (Buunk-Werkhoven, Dijkstra, & van der Schans, 2011a; Buunk-Werkhoven, Dijkstra, van der Wal, Basic, Loomans, van der Schans, & van der Meer, 2009a). Oral health is considered as a multi-faceted phenomenon, including the ability to speak, smile, smell, taste, touch, chew, and swallow, as well as the ability to express a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex. Oral health is influenced by the individual's perceptions, expectations and ability to adapt to circumstances (Buunk-Werkhoven et al., 2011a; Glick, Williams, Kleinman, Vujicic, Watt, & Weyant, 2016).

To assess oral health, the short form of the Oral Health Impact Profile (OHIP) (Locker, 1988) is, as its Dutch version, the OHIP-14-NL (Buunk-Werkhoven, Dijkstra, & van der Schans, 2009b; Buunk-Werkhoven, Dijkstra, Schaub, van der Schans, & Spreen, 2010; Buunk-Werkhoven, Verheggen-Udding, & van den Heuvel, 2011b), a self-report instrument aimed at measuring the negative social, psychological, and physical consequences of oral health problems: the more frequent such problems, the lower the OH-QoL. It was expected thatthese aspects of oral health would be lower among forensic patients who experienced a low status, and especially a sense of defeat, as their 'giving up' state of mind would make them less motivated to engage in oral health self-care.

2.Research Methods

Ethical clearance and permission for this study was obtained from the ethical committee of the forensic psychiatric hospital Dr. S. van Mesdag in Groningen, The Netherlands. The study was conducted in accordance with the Declaration of Helsinki; an extensive formal written informed consent was obtained from all the participants. A total of 40 male forensic psychiatric patients participated in this study; the mean age of the participants was 33.70 (SD = 6.40), with a range of 23 to 49 years. They constituted a random sample of the patients of the hospital, including patients with psychotic vulnerability (40%) and patients with personality disorders (60%) (Buunk-Werkhoven et.al., 2011a; Buunk-Werkhoven et al., 2010; Buunk-Werkhoven et al., 2011b).After providing the written informed consent, participants answered voluntarily a paper-and-pencil-questionnaire, which was based on previously validated scales.

2.1. Measures

Oral self-care. Because of the nature of the present sample, five simple questions were asked about moments of tooth brushing, i.e., 'Do you brush your teeth before breakfast?', 'Do you brush your teeth after breakfast´, 'Do you brush your teeth in the afternoon?', 'Do you brush your teeth after evening dinner', and 'Do you brush your teeth before going to sleep?'. These questions were taken from the widely used Dutch index for OHB (Buunk-Werkhoven et al., 2009a; Buunk-Werkhoven et al., 2011a; Brein,Fleenor, Jr., Kim, & Krupat, 2015; Patel, Kulkarni, Doshi, Reddy, Reddy, & Buunk-Werkhoven , in press), and were analyzed separately.

Self-perceived oral health. Participants were asked to indicate on the Cantril ladder (Cantril, 1965) how they valued their own oral health, on a scale from 1 to 10 (i.e., 1 = poor, 5 = not poor/not excellent, 10 = excellent) (Buunk-Werkhoven et al., 2009a).

Oral health-related quality of life. To assess OH-QoL (Locker, 1988) a slightly adapted Dutch version of the widely used Oral Health Impact Profile-14 (OHIP-14) (Werkhoven, et al., 2004) was used. This OHIP-instrument consists of 14 items organized –the original order was shuffled– in seven dimensions of each two items, i.e., function limitation (Q4-Q14), physical pain (Q2-Q5), psychological discomfort

(Q1-Q9), physical disability (Q12-Q10), psychological disability (Q13-Q8), social disability (Q7-Q3), and handicap (Q11-Q6). Responses were scored on a five-point Likert scale (i.e., 0 = never, 1 = sometimes, 2 = regularly, 3 = often,4 = very often) (Werkhoven et al., 2004; Buunk-Werkhoven et al., 2010; Buunk-Werkhoven et al., 2011b). However, because the original OHIP-14 (Locker, 1988) consists of seven subscales of each two items, which is from a psychometric perspective not satisfactory, it was decided to examine if there were a few theoretically and practically meaningful dimensions underlying the scale, and if on this basis reliable scales could be constructed. For this purpose, first, a factor analysis on the present version of OHIP-14 was conducted.

Subjective status. This variable was measured with the Social Comparison Scale (Allan & Gilbert, 1995; Buunk & Brenninkmeyer, 2000); this scale consists of 11 bipolar constructs based upon semantic differential methodology. Participants were asked to complete the sentence `In relationship with others I generally feel .....'. The scale includes constructs such as inferior-superior, incompetent-competent, different-same, untalented-talented, and unattractive-attractive. The reliability of the scale used in the present sample was high, Cronbach's alpha = 0.87.

Sense of defeat. This variable was measured with the validated Sense of Defeat Scale that consists of 16 items (Gilbert & Allan, 1998). Example items are: 'I have the feeling that others don´t respect me enough' and 'I feel that I am basically a winner' (reverse code). Items were assessed on a 5-point scale (i.e., 0 = never to 4 = always). Cronbach's alpha for this scale was 0.91.

2.2 Statistical analyses

The Statistical Package for Social Sciences 22.0 (SPSS, Chicago, Illinois) was used for data analysis. The internal consistency of all validated scales and the new developed scales was computed using Cronbach's alpha. Because of the small sample size, and the explicit predictions, all tests were done one-tailed.

3.Results

3.1 Structure of the OHIP-14.

A factor analysis was conducted over all 14 items of the slightly adapted version of the Dutch OHIP-14, the results of which are presented in Table 1. The results showed three clear, theoretically and practically meaningful factors. The first factor had 5 items loading higher than 0.60 (e.g., painful aching in mouth, uncomfortable to eat any foods, problems with pronouncing any words), and one item with a loading of 0.56 (sense of taste has worsened). This factor can be labeled as *functional limitations*. A scale containing these 6 items (Q2, Q3, Q4, Q5, Q10, Q14) had a coefficient alpha of 0.83, which could not be raised by deleting an item.The second factor had 6 items loading higher than 0.60 (e.g., feeling a bit embarrassed and felt tense because of problems, life in general was less satisfying). This factor can be labeled as *social discomfort*. A scale containing these 6 items (Q7, Q8, Q9, Q11, Q12, Q13) had a

coefficient alpha of 0.82, which could not be raised by deleting an item. The third factor had two items (Q1, Q6) loading higher than 0.70, and all other items loading lower than 0.33 (i.e., self-conscious and totally unable to function). This factor can be labeled as *psychological inhibitions* (Q6 was reverse scored for the factor analysis). A scale was constructed by summing these two items without recoding, $r = 0.40$, $p < 0.001$.

3.2 Effects

Effects of sense of defeat on oral health. The results further revealed that a sense of defeat wasassociated with less oral health self-care. That is, sense of defeat correlated negatively with tooth brushing after breakfast, $r = -0.31$, $p < 0.05$, and with tooth brushing before going to sleep, $r = -0.27$, $p < 0.05$. For the other three measures of tooth brushing, no significant correlations were found, all $r´s < 0.13$. There was also evidence for an association between sense of defeat and oral health impact. That is, sense of defeat correlated positively with social discomfort because of one's teeth, mouth, or dentures ($r = 0.34$, $p < 0.06$), and negatively with self-perceived oral health, $r = -0.29$, $p < 0.05$, but not with functional limitations, $r = -0.07$, *ns* or psychological inhibitions, $r = 0.07$, *ns.*

Effects of social status on oral health. There was also evidence that a low social status was associated with less oral health self-care. Social status correlated positively with tooth brushing before going to sleep, $r = 0.32$, $p < 0.05$, but not with any of the other moments of tooth brushing, all $r´s < 0.21$. Social status did correlate in a quite different way than sense of defeat with oral health impact. There was only a positive correlation with psychological inhibitions, $r = 0.36$, $p < 0.05$, but not with social discomfort, $r = -0.21$, *ns*, and neither with functional limitations, $r = -0.13$, *ns.* In addition, there was a positive correlation of social status with self-perceived oral health, $r = 0.33$, $p < 0.05$.

4.Discussion

The aim of the study was to examine how among Dutch male forensic psychiatric patients, subjective social status and sense of defeat were related to moments of tooth brushing, perceived oral health, and oral health-related quality of life. The present paper is unique in a number of respects. First, from the theory of involuntary submissive strategies (Allan & Gilbert, 1995; Buunk & Brenninkmeyer, 2000) variables related to oral health were examined in a special sample, i.e., Dutch forensic psychiatric patients. Second, three new, and practically as well as theoretically meaningful scales for oral health impact we constructed, based on a factor analysis of the Dutch Oral Health Impact Profile-14 (OHIP-14; Werkhoven et al, 2004), i.e., functional limitations, social discomfort, and psychological inhibitions. Third, findings showed that subjective social status and sense of defeat were in distinct ways associated with these dimensions. That is, the more one experienced a sense of defeat, the more social discomfort one felt because of one´s teeth, mouth and denture. In contrast, the higher one´s subjective social status, the more one admitted to have

psychological inhibitions in relation to one´s teeth, mouth and denture. Fourth, self-perceived oral health was in a theoretically meaningful way associated with both social status and sense of defeat: the lower one´s sense of defeat, and the higher one´s subjective social status, the better one perceived one´s oral health. Finally, both sense of defeat and subjective social status were associated with the most important aspect of oral self-care: the higher one´s sense of defeat, and the lower one´s subjective social status, the less likely one engaged in tooth brushing before going to bed.

Table 1. Factor analysis of the items for oral health-related quality of life

Items OHIP-14	Factors		
	1th	2nd	3rd
Q1. Have you been self-conscious because of your teeth, mouth, or dentures?	.078	077	.777
Q2. Have you had painful aching in your mouth?	.783	.110	.026
Q3. Have you had difficulty doing your usual jobs because of problems with your teeth, mouth, or dentures?	.754	.331	.131
Q4. Have you had trouble pronouncing any words because of problems with your teeth, mouth, or dentures?	.631	.262	.025
Q5. Have you found it uncomfortable to eat any foods because of problems with your teeth, mouth, or dentures?	.662	.113	.112
Q6. Have you been totally unable to function because of problems with your teeth, mouth, or dentures?	.175	.066	.801
Q7. Have you been a bit irritable with other people because of problems with your teeth, mouth, or dentures?	.236	.827	-.138
Q8. Have you been a bit embarrassed because of problems with your teeth, mouth, or dentures?	.420	.632	.330
Q9. Have you felt tense because of problems with your teeth, mouth, or dentures?	.332	.745	.023
Q10. Have you had to interrupt meals because of problems with your teeth, mouth, or dentures?	.787	.156	.103
Q11. Have you felt that life in general was less satisfying because of problems with your teeth, mouth, or dentures?	-.122	.805	.246
Q12. Has your diet been unsatisfactory because of problems with your teeth, mouth or dentures?	.428	.601	.255
Q13. Have you found it difficult to relax because of problems with your teeth, mouth, or dentures?	.387	.675	-.008
Q14. Have you felt that your sense of taste has worsened because of problems with your teeth, mouth, or dentures?	.564	.197	.156

4.1 Implications

The present findings have a number of theoretical and practical implications. First, the finding that perceived oral health was higher with increasing subjective social status and decreasing sense of defeat is in line with research among young male criminal offenders that showed that life satisfaction was in the same way, and to the same degree (correlations around 0.30), associated with subjective social status and

sense of defeat (Buunk, et al., 2016). Overall, these findings underline the theoretical relevance of the theory of involuntary subordinate strategies (Allan & Gilbert, 1995; Buunk & Brenninkmeyer, 2000) for the psychological situation of law offenders who are confined to criminal institutions. Second, monitoring patients' psychological and psychiatric state with special attention for feelings of low status and defeat may contribute to more adequate oral health related prevention and treatment. The findings suggest that paying attention to such feelings of the patient ('How do you feel about your situation?') may eventually result in taking better care of one's oral health by patients and consequently in less social discomfort because of one's oral health. In general, the present findings underline that the patients' psychological state (e.g., negative emotions and wellbeing) is related to one's perceived oral health and oral health related behavior such as tooth brushing. Acknowledging this is not only essential for a correct diagnosis and applying professional oral health care, but also within forensic health care to support patients' oral self-care by providing information on why and how to practice optimal oral self-care (Buunk-Werkhoven, Dijkstra-le Clercq, de Jong, & Spreen, 2012). In the case of oral pathology, a patient should adapt his or her behavior by complying with a prescribed treatment or care, so called 'health deviation self-care', which may be carried out by mental health nurses in collaboration with dentists and oral hygienists (Dashiff, 1988; Denyes, Orem, & Bekel, 2001; de Mey, Çömlekçi, de Reuver, van Waard, van Gool, Scheerman, & van Meijel, 2016).

Of course, further research on this issue in other forensic institutes is essential, as this pilot study was restricted to male forensic psychiatric patients in one institution. More research is also needed on the association of subjective social status and sense of defeat with oral health related quality of life as measured in the present research, and with self-perceived oral health. It would be particularly important to assess these issues also in samples from the general population. Nevertheless, the present pilot study underlines that oral health professionals and other professionals working with male forensic psychiatric patients should be sensitive to the low status and sense of defeat these patients may experience, and to the fact that this may be associated with problems with their oral health (teeth, mouth and denture) and a lack of oral self-care.

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