STUDY GUIDE:

WORLD HEALTH ORGANIZATION

CANKMUN'20

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LETTER FROM SECRETARY-GENERAL

Dear Delegates,

It is my utmost pleasure to welcome you all to the CankMUN'20. I am happy to say that it is an honor for me to serve you as Secretary General in the first ever official conference of CankMUN.

I can assure you all that our conference will be unforgettable in every single way possible. Our organization Team, led by Ms. Sıla Güler, has put up so much effort to plan every single detail of the organization to give you the best experience possible.

It is my utmost pleasure to welcome you all to the CankMUN'20's World Health Organization.

Our distinguished Under Secretary General Rabia Eryılmaz has prepared this study guide for you to understand the concept of this committee as well as the questions to be addressed recommend you read the Rules of Procedures of CankMUN'20 since it will be the main course of our procedures.

This committee is well thought and prepared. Get ready for the fun and the crisis all along the conference. There will be lots of surprises among the 3 days ahead of you

Both our organization team and academic team has been working so hard to make this experience unique and unforgettable.

Get ready to enjoy this committee to its finest. Let's #BeeInTheFuture to create a better future from now on.

Sincerely

Enzel Ege Sarı

Secretary General of CankMUN'20

LETTER FROM UNDER-SECRETARY GENERAL

Most distinguished participants,

It is an honor for me to welcome you all to the first edition of Çankaya University Model United Nations Conference. As the Under Secretary-General of CANKMUN 2020, I would like to start with introducing myself shortly. My name is Rabia ERYILMAZ and a sophomore student in

Çankaya University department of Psychology. I have been participating a MUN program last year with being delegate of the Netherlands on Diplomatic Day'19 with CANKMUN and took part in one conference ever since but I didn't leave it because it is very enjoyable and including many information for all topics. Also, I got an award about my writing and it supports me to join there.

Therefore, I would gladly say that CANKMUN has a very special place in my heart and I am more than happy to serve you as the Under Secretary-General of such a prestigious conference.

I hope every single one of you will enjoy your times the fullest during the upcoming 3 days and widen your view on world problems while making life-long friendships. I cannot wait to see how you will shape the reality with your ideas.

Kindest Regards,

Rabia ERYILMAZ

Under Secretary-General of CANKMUN 2020

1.INTRODUCTION TO WORLD HEALTH ORGANIZATION

The World Health Organization (WHO) is a specialized agency of the United Nations that is concerned with international public health. It was established on 7 April 1948, and is headquartered in Geneva, Switzerland. The WHO is a member of the United Nations

Development Group. Its predecessor, the Health Organization, was an agency of the League of Nations.

The constitution of the WHO has been signed by 61 countries (all 51 member countries and 10 others) on 22 July 1946, with the first meeting of the World Health Assembly finishing on 24 July 1948. It incorporated the Office International d'Hygiène Publique and the League of Nations Health Organization. Since its establishment, it has played a leading role in the destruction of smallpox. Its current priorities include communicable diseases, in particular HIV/AIDS, Ebola, malaria and tuberculosis; the mitigation of the effects of non-communicable diseases such as sexual and reproductive health, development, and aging; nutrition, food security and healthy eating; occupational health; substance abuse; and driving the development of reporting, publications, and networking.

The WHO is responsible for the World Health Report, the worldwide World Health Survey, and World Health Day. The current Director-General of the WHO is Tedros Adhanom.

The WHO is trying to build a better, healthier future for people all over the world. Together they strive to combat diseases – communicable diseases like influenza and HIV, and noncommunicable diseases like cancer and heart disease.

They help mothers and children survive and thrive so they can look forward to a healthy old age and ensure the safety of the air people breathe, the food they eat, the water they drink – and the medicines and vaccines they need. It could be psychological or physical problem nothing changes for us.

WHO's six official languages - Arabic, Chinese, English, French, Russian and Spanish - were established by a 1978 World Health Assembly resolution. The official language for CankMUN'20 is English so even though WHO has 6 official languages they will use English only.

WHO works worldwide to promote health, keep the world safe, and serve the vulnerable? Our goal is to ensure that a billion more people have universal health coverage, to protect a billion more people from health emergencies, and provide a further billion people with better health and well-being.

WHO began when their Constitution came into force on 7 April 1948 – a date they now celebrate every year as World Health Day? They are now more than 7000 people from more

than 150 countries working in 150 country offices, in 6 regional offices and at our headquarters in Geneva.

For universal health coverage, they: focus on primary health care to improve access to quality essential services, work towards sustainable financing and financial protection, improve access to essential medicines and health products, train the health workforce and advise on labor policies

- support people's participation in national health policies
- improve monitoring, data and information.

For health and well-being, they:

- address social determinants
- promote intersectoral approaches for health
- prioritize health in all policies and healthy settings.

Through our work, they address:

- human capital across the life-course
- noncommunicable diseases prevention
- mental health promotion
- climate change in small island developing states
- antimicrobial resistance
- elimination and eradication of high-impact communicable diseases.

2. INTRODUCTION TO THE FIRST AGENDA ITEM: INCREMENT OF THE MENTAL ILLNESSES AMONG THE YOUTH AND ITS CORRELATION WITH SCHOOL ENVIRONMENT

Humans are developing frequently, and it continues until death. The development could cause some of problems either physical or mental. Also, they are weaker to protect their body and feelings from illnesses in development process. Because they are trying to get used to changes in their body and thoughts. Especially young people have mental illnesses nowadays and it creates a question about the relation between school environment and having mental illness?

Adolescence, which is accepted as the transition period from childhood to adulthood, is one of the most dynamic periods of life in which physical, psychological and social maturity is completed. In this period of rapid changes and developments, adolescents are more vulnerable to mental problems and adjustment disorders due to rapid growth, increase in sex drive, lack of accepting their maturing period and not yet having a definite place in society, and continued dependence on the family. Mental problems are among the major causes of morbidity and mortality in the youth and the rate of psychiatric disorders in the adolescent population varies between 8-22%. Personality disorders, conversion disorders, schizophrenia, depression and suicidal thoughts are among the psychological problems of adolescents. The prevalence of depression, which is a common problem during normal emotional fluctuations of adolescents, has been reported to range between 8.6-12%. Found that the prevalence of depression was 35.0%. In the research conducted in Ankara in the 15-18 age group in 1996, it was determined that female students had higher depression scores than male students.[1]

Adolescents' mental problems are brought into adulthood negatively affects family, social and school life. Therefore, mental health of young people should be evaluated carefully.

The pressures of the school environment combined with psychiatric symptom management have made mental illness in postsecondary institutions an increasingly common concern. In 2000, the U.S. Department of Education, National Center for Education Statistics (NCES) reported that an estimated 428,280 students with disabilities were enrolled at 2-year and 4-year postsecondary education institutions. Of this number, 33,260 students were reported to have mental illness. It is estimated that 25 to 50 percent of individuals with severe mental illnesses have some university experience.

2.1. Major Mental Disorders

Personality disorder

Personality disorders (PD) are a class of mental disorders characterized by enduring maladaptive patterns of behavior, cognition, and inner experience, exhibited across many contexts and deviating from those accepted by the individual's culture. These patterns develop early, are inflexible, and are associated with significant distress or disability. The definitions may vary somewhat, according to source.[2][3][4] Official criteria for diagnosing personality disorders are listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the fifth chapter of the International Classification of Diseases (ICD).

Types of Personality Disorders

Antisocial personality disorder: a pattern of disregarding or violating the rights of others. A person with antisocial personality disorder may not conform to social norms, may repeatedly lie or deceive others, or may act impulsively.

Avoidant personality disorder: a pattern of extreme shyness, feelings of inadequacy and extreme sensitivity to criticism. People with avoidant personality disorder may be unwilling to get involved with people unless they are certain of being liked, be preoccupied with being criticized or rejected, or may view themselves as not being good enough or socially inept.

Borderline personality disorder: a pattern of instability in personal relationships, intense emotions, poor self-image and impulsivity. A person with borderline personality disorder may go to great lengths to avoid being abandoned, have repeated suicide attempts, display inappropriate intense anger or have ongoing feelings of emptiness.

Dependent personality disorder: a pattern of needing to be taken care of and submissive and clingy behavior. People with dependent personality disorder may have difficulty making daily decisions without reassurance from others or may feel uncomfortable or helpless when alone because of fear of inability to take care of themselves.

Histrionic personality disorder: a pattern of excessive emotion and attention seeking. People with histrionic personality disorder may be uncomfortable when they are not the center of attention, may use physical appearance to draw attention to themselves or have rapidly shifting or exaggerated emotions.

Narcissistic personality disorder: a pattern of need for admiration and lack of empathy for others. A person with narcissistic personality disorder may have a grandiose sense of self-importance, a sense of entitlement, take advantage of others or lack empathy.

Obsessive-compulsive personality disorder: a pattern of preoccupation with orderliness, perfection and control. A person with obsessive-compulsive personality disorder may be overly focused on details or schedules, may work excessively not allowing time for leisure or friends, or may be inflexible in their morality and values. (This is NOT the same as obsessive compulsive disorder.)

Paranoid personality disorder: a pattern of being suspicious of others and seeing them as mean or spiteful. People with paranoid personality disorder often assume people will harm or deceive them and don't confide in others or become close to them.

Schizoid personality disorder: being detached from social relationships and expressing little emotion. A person with schizoid personality disorder typically does not seek close relationships, chooses to be alone and seems to not care about praise or criticism from others.

Schizotypal personality disorder: a pattern of being very uncomfortable in close relationships, having distorted thinking and eccentric behavior. A person with schizotypal personality disorder may have odd beliefs or odd or peculiar behavior or speech or may have excessive social anxiety. [5]

Conversion disorder

Conversion disorder (CD), or functional neurologic symptom disorder, is a diagnostic category used in some psychiatric classification systems. It is sometimes applied to patients who present with neurological symptoms, such as numbness, blindness, paralysis, or fits, which are not consistent with a well-established organic cause, which cause significant distress, and can be traced back to a psychological trigger. It is thought that these symptoms arise in response to stressful situations affecting a patient's mental health or an ongoing mental health condition such as depression. Conversion disorder was retained in DSM-5 but given the subtitle functional neurological symptom disorder. The new criteria cover the same range of symptoms but remove the requirements for a psychological stressor to be present and for feigning to be disproved. ICD-10 classifies conversion disorder as a dissociative disorder while DSM-IV classifies it as a somatoform disorder.[6]

Schizophrenia

Schizophrenia is a chronic brain disorder that affects less than one percent of the U.S. population. When schizophrenia is active, symptoms can include delusions, hallucinations,

trouble with thinking and concentration, and lack of motivation. However, with treatment, most symptoms of schizophrenia will greatly improve.

While there is no cure for schizophrenia, research is leading to new, safer treatments. Experts also are unraveling the causes of the disease by studying genetics, conducting behavioral research, and using advanced imaging to look at the brain's structure and function. These approaches hold the promise of new, more effective therapies.

The complexity of schizophrenia may help explain why there are misconceptions about the disease. Schizophrenia does not mean split personality or multiple personality. Most people with schizophrenia are not dangerous or violent. They also are not homeless, nor do they live in hospitals. Most people with schizophrenia live with family, in group homes or on their own.

Research has shown that schizophrenia affects men and women about equally but may have an earlier onset in males. Rates are similar around the world. People with schizophrenia are more likely to die younger than the general population, in part because of high rates of co-occurring medical conditions, such as heart disease and diabetes.[7]

Depression

Depression (major depressive disorder) is a common and serious medical illness that negatively affects how you feel, the way you think and how you act. Fortunately, it is also treatable. Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home.

Depression symptoms can vary from mild to severe and can include:

- Feeling sad or having a depressed mood
- Loss of interest or pleasure in activities once enjoyed
- Changes in appetite — weight loss or gain unrelated to dieting
- Trouble sleeping or sleeping too much
- Loss of energy or increased fatigue
- Increase in purposeless physical activity (e.g., handwringing or pacing) or slowed movements and speech (actions observable by others)
- Feeling worthless or guilty

- Difficulty thinking, concentrating or making decisions
- Thoughts of death or suicide

Symptoms must last at least two weeks for a diagnosis of depression.

Also, medical conditions (e.g., thyroid problems, a brain tumor or vitamin deficiency) can mimic symptoms of depression so it is important to rule out general medical causes.

Depression affects an estimated one in 15 adults (6.7%) in any given year. And one in six people (16.6%) will experience depression at some time in their life. Depression can strike at any time, but on average, first appears during the late teens to mid-20s. Women are more likely than men to experience depression. Some studies show that one-third of women will experience a major depressive episode in their lifetime.[8]

Suicidal Ideation

Suicidal ideation, also known as **suicidal thoughts [9]**, is thinking about, considering, or planning suicide.[10] The range of suicidal ideation varies from fleeting thoughts, to extensive thoughts, to detailed planning.

Most people who have suicidal thoughts do not go on to make suicide attempts, but suicidal thoughts are considered a risk factor. [9] During 2008–09, an estimated 8.3 million adults aged 18 and over in the United States, or 3.7% of the adult U.S. population, reported having suicidal thoughts in the previous year. An estimated 2.2 million in the U.S. reported having made suicide plans in 2014.[11] Suicidal thoughts are also common among teenagers.[12]

Suicidal ideation is generally associated with depression and other mood disorders; however, it seems to have associations with many other mental disorders, life events, and family events, all of which may increase the risk of suicidal ideation. For example, many individuals with borderline personality disorder exhibit recurrent suicidal behavior and suicidal thoughts. One study found that 73% of patients with borderline personality disorder have attempted suicide, with the average patient having 3.4 attempts.[13] Currently, there are a few treatment options for those experiencing suicidal ideation.

Current treatment methods often work in mental disorders. Your treatment depends on the type of mental illness you have, its severity and what works best for you. In many cases, a combination of treatments works best.

If you have a mild mental illness with well-controlled symptoms, treatment from your primary care provider may be enough. However, often a team approach is appropriate to make sure all your psychiatric, medical and social needs are met. This is especially important for severe mental illnesses, such as schizophrenia. There are several treatment ways that can be encountered.

Firstly, your support is very important at this point. Your treatment team may include your family or primary care doctor, nurse practitioner, physician assistant, psychiatrist, a medical doctor who diagnoses and treats mental illnesses, psychotherapist, such as a psychologist or a licensed counselor, pharmacist, social worker and family members.

Furthermore, medications sometimes feel good. Although psychiatric medications don't cure mental illness, they can often significantly improve symptoms. Psychiatric medications can also help make other treatments, such as psychotherapy, more effective. The best medications for you will depend on your situation and how your body responds to the medication.

Some of the most used classes of prescription psychiatric medications include:

- **Antidepressants.** Antidepressants are used to treat depression, anxiety and sometimes other conditions. They can help improve symptoms such as sadness, hopelessness, lack of energy, difficulty concentrating and lack of interest in activities. Antidepressants are not addictive and do not cause dependency.
- **Anti-anxiety medications.** These drugs are used to treat anxiety disorders, such as generalized anxiety disorder or panic disorder. They may also help reduce agitation and insomnia. Long-term anti-anxiety drugs typically are antidepressants that also work for anxiety. Fast-acting anti-anxiety drugs help with short-term relief, but they also have the potential to cause dependency, so ideally, they'd be used short term.
- **Mood-stabilizing medications.** Mood stabilizers are most used to treat bipolar disorders, which involves alternating episodes of mania and depression. Sometimes mood stabilizers are used with antidepressants to treat depression.

- **Antipsychotic medications.** Antipsychotic drugs are typically used to treat psychotic disorders, such as schizophrenia. Antipsychotic medications may also be used to treat bipolar disorders or used with antidepressants to treat depression.

Third one is psychotherapy**.** Psychotherapy, also called talk therapy, involves talking about your condition and related issues with a mental health professional. During psychotherapy, you learn about your condition and your moods, feelings, thoughts and behavior. With the insights and knowledge, you gain, you can learn coping and stress management skills.

There are many types of psychotherapy, each with its own approach to improving your mental well-being. Psychotherapy often can be successfully completed in a few months, but in some cases, long-term treatment may be needed. It can take place one-on-one, in a group or with family members.

When choosing a therapist, you should feel comfortable and be confident that he or she is capable of listening and hearing what you have to say. Also, it's important that your therapist understands the life journey that has helped shape who you are and how you live in the world.

Also, hospital and residential treatment programs can help. Sometimes mental illness becomes so severe that you need care in a psychiatric hospital. This is generally recommended when you can't care for yourself properly or when you're in immediate danger of harming yourself or someone else.

Options include 24-hour inpatient care, partial or day hospitalization, or residential treatment, which offers a temporary supportive place to live. Another option may be intensive outpatient treatment.

If there is a problem related to substance misuse, before it should be prevented and cure. Problems with substance use commonly occur along with mental illness. Often it interferes with treatment and worsens mental illness. If you can't stop using drugs or alcohol on your own, you need treatment. Talk to your doctor about treatment options.

The last one is participating in your own care. Working together, you and your primary care provider or mental health professional can decide which treatment may be best, depending on your symptoms and their severity, your personal preferences, medication side effects, and other factors. In some cases, a mental illness may be so severe that a doctor or loved one may need to guide your care until you're well enough to participate in decision-making.

2.2. Mental Illnesses in Youth

Mental illnesses are common in the United States. Nearly one in five U.S. adults live with a mental illness (46.6 million in 2017). Mental illnesses include many different conditions that vary in degree of severity, ranging from mild to moderate to severe. Two broad categories can be used to describe these conditions: Any Mental Illness (AMI) and Serious Mental Illness (SMI). AMI encompasses all recognized mental illnesses. SMI is a smaller and more severe subset of AMI.

Definitions according to 2017 National Survey on Drug Use and Health (NSDUH) by the Substance Abuse and Mental Health Services Administration (SAMHSA).[14][15]

- **Any mental illness (AMI)** is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below). There are causes of any mental illnesses such as heredity, infections, brain defects or injury, prenatal damage, substance abuse and other factors.

Genetics (heredity): Mental illnesses sometimes run in families, suggesting that people who have a family member with a mental illness may be somewhat more likely to develop one themselves. Susceptibility is passed on in families through genes. Experts believe many mental illnesses are linked to abnormalities in many genes rather than just one or a few and that how these genes interact with the environment is unique for every person (even identical twins). That is why a person inherits a susceptibility to a mental illness and doesn't necessarily develop the illness. Mental illness itself occurs from the interaction of multiple genes and other factors -- such as stress, abuse, or a traumatic event -- which can influence, or trigger, an illness in a person who has an inherited susceptibility to it.

Infections: Certain infections have been linked to brain damage and the development of mental illness or the worsening of its symptoms. For example, a condition known as pediatric autoimmune neuropsychiatric disorder (PANDA) associated with the Streptococcus bacteria has been linked to the development of obsessive-compulsive disorder and other mental illnesses in children.

Brain defects or injury: Defects in or injury to certain areas of the brain have also been linked to some mental illnesses.

Prenatal damage: Some evidence suggests that a disruption of early fetal brain development or trauma that occurs at the time of birth -- for example, loss of oxygen to the brain -- may be a factor in the development of certain conditions, such as autism spectrum disorder.

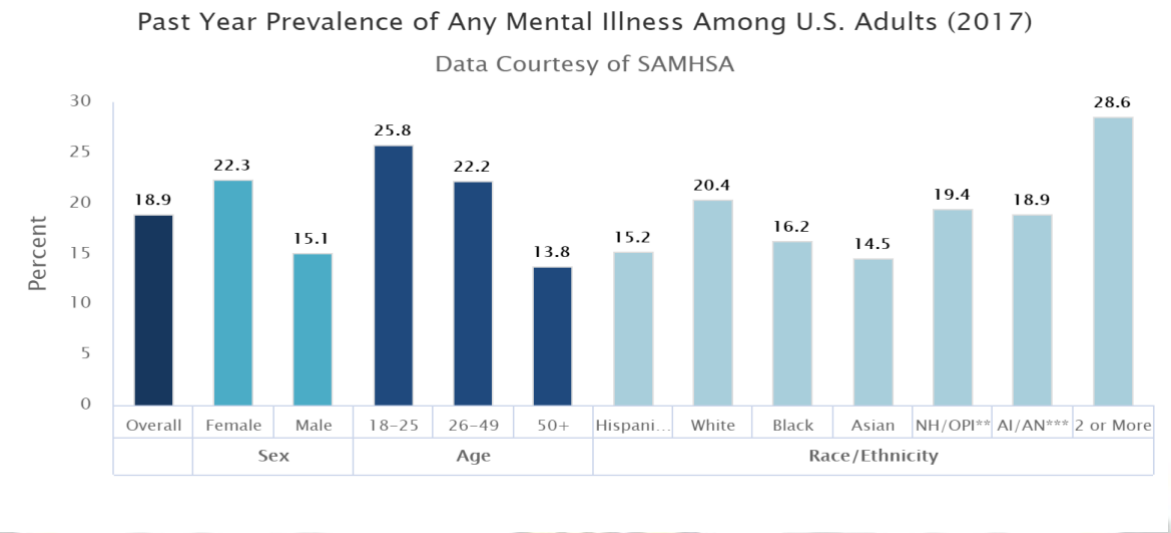
Substance abuse: Long-term substance abuse, in particular, has been linked to anxiety, depression, and paranoia.

Other factors: Poor nutrition and exposure to toxins, such as lead, may play a role in the development of mental illnesses.[16]

- **Serious mental illness (SMI)** is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.

Prevalence of Any Mental Illness (AMI)

- Figure 1 shows the past year prevalence of AMI among U.S. adults.
    - In 2017, there were an estimated 46.6 million adults aged 18 or older in the United States with AMI. This number represented 18.9% of all U.S. adults.
    - The prevalence of AMI was higher among women (22.3%) than men (15.1%).
    - Young adults aged 18-25 years had the highest prevalence of AMI (25.8%) compared to adults aged 26-49 years (22.2%) and aged 50 and older (13.8%).
    - The prevalence of AMI was highest among the adults reporting two or more races (28.6%), followed by White adults (20.4%). The prevalence of AMI was lowest among Asian adults (14.5%). [17]



2.3. Source of Mental Illnesses in Youth

Adolescence is a crucial period for developing and maintaining social and emotional habits important for mental well-being. These include adopting healthy sleep patterns, taking regular exercise, learning to manage emotions and developing coping, problem-solving, and interpersonal skills. Supportive environment with the family, at school and in the wider community are also important. An estimated 10–20% of adolescents globally experience mental health conditions, yet these remain underdiagnosed and undertreated *[18]*.

Multiple factors determine mental health outcomes. The more risk factors adolescents are exposed to, the greater the potential impact on their mental health. Factors that can contribute to stress during adolescence include a desire for greater autonomy, pressure to conform with peers, exploration of sexual identity, and increased access to and use of technology. Media influence and gender norms can exacerbate the disparity between an adolescent's lived reality and their perceptions or aspirations for the future. Other important determinants include the quality of their home life and relationships with peers. Violence (including harsh parenting and bullying) and socioeconomic problems are recognized risks to mental health. Children and adolescents are especially vulnerable to sexual violence, which has a clear association with detrimental mental health.

Some adolescents are at greater risk of mental health conditions due to their living conditions, stigma, discrimination or exclusion, or lack of access to quality support and services. These include adolescents living in humanitarian and fragile settings; adolescents with chronic illness, autism spectrum disorder, an intellectual disability or other neurological condition; pregnant adolescents, adolescent parents, or those in early and/or forced marriages;

orphans; and adolescents from minority ethnic or sexual backgrounds or other discriminated groups.

Adolescents with mental health conditions are in turn particularly vulnerable to social exclusion, discrimination, stigma (affecting readiness to seek help), educational difficulties, risk-taking behaviors, physical ill-health and human rights violations.

According to mentioned above there are several reasons to have mental illnesses in young age and it affects their school life.

2.4. Relationship between School and Mental Illnesses

The earlier a young person can access mental health care, the more effective it can be. Early treatment can help keep youth in school and on track to achieving their life goals. But, far too often, there are long delays between when a young person first experiences symptom and when they get help. Fortunately, our schools can play an important role in identifying the early warning signs of an emerging mental health condition and in linking students with effective services and supports.

NAMI (National Alliance on Mental Illnesses) supports funding to allow schools to train faculty and staff on the early warning signs of mental health conditions and how to link students to services. And, NAMI believes that every school should also be able to provide school-based and/or school-linked mental health services. School-based mental health services bring trained community mental health professionals into schools, where school-linked mental health services link families to resources in the community. Schools should also have the funding necessary to coordinate school-based mental health services with the community mental health system, so children and young adults do not fall through the cracks. Investing in children's mental health improves the lives of children and families. When children get the right care at the right time, we can prevent negative outcomes like school failure, hospitalization and even suicide.

Therefore, these consequences underlie some topics which is important to students' life. For instance, teen suicides. Suicide is when a teen causes his or her own death on purpose. Before trying to take their own life, a teen may have thoughts of wanting to die. This is called suicidal ideation. He or she may also have suicidal behavior. That's when a teen is focused on doing things that cause his or her own death. The teen years are a stressful time. They are filled with major changes. These include body changes, changes in thoughts, and changes in feelings.

Strong feelings of stress, confusion, fear, and doubt may affect a teen's problem-solving and decision-making. He or she may also feel a pressure to succeed. For some teens, normal developmental changes can be very unsettling when combined with other events, such as:

- Changes in their families, such as divorce, siblings moving out, or moving to a new town
- Changes in friendship
- Problems in school
- Other losses

These problems may seem too hard or embarrassing to overcome. For some, suicide may seem like a solution. So, what should they do and how could they find a solution which is logical? These questions should be covered.

There is another condition related to school environment which is being educated at home. Home education, also known as homeschooling, is the education of children at home or a variety of places other than school. Home education is usually conducted by a parent, tutor, or an online teacher. Many families use fewer formal ways of educating. "Homeschooling" is the term commonly used in North America, whereas "home education" is commonly used in the United Kingdom, Europe, and in many Commonwealth countries. Home education is preferred to solve some problems or contribute to lessons. Students are getting tired enough at school and retraining at home does not affect their physical and mental health well. Not only is this a problem, besides, great difficulties begin to come to terms with the tutor, conflict with the family and devote time. The house is not different for them from school anymore. In this case, young people seek escape and behave home. This plays a big role in their getting bad habits. Outsiders quickly meet drugs and want to try. The circle of friends is also the facilitator of this situation. The reason why one cannot cope with these demands is the weakening of their bonds. As the enemy to the concept of family moves away from their tightest bond, they become interested in other things. So, the fact that these young people who need support from the family are away from the family is one of the major factors in acquiring mental disorders. Another view is the policy of abstracting the child from the bad environment of the school in this way. but the same thing exists here, if one is isolated from his peers, he starts to feel lonely. Loneliness is the strongest reason that pushes people to these mental problems.

2.5. Questions to be Addressed

- What should be done to understand the relation between the school environment and mental illnesses?
- What could be the procedure for a student who has a mental illness?
- Who could be the responsible person in school environment to help with diagnosing or transferring the subjects with possible mental illness?
- What should be the responsible person do in other to avoid the teenage suicides?
- What would be the possible approach for all students of the school
- Is bullying contribute a significant amount in the increase of the mental illnesses?
- Is the homeschool approach a solution to the decreasing the mental illness rate?
- Can this issue have eliminated with usage of medicine?
- Can usage of depression medicines cause a different problem such as addiction etc.?

3. Introduction To The Second Agenda: Psychological Effects Due To Sexual Assault And Life-Long Implications

Sexual assault is a serious problem that needs to be solved immediately for every country. Solving this problem, which has recently increased all over the world, will both reduce the number of victims and give people a fearless living environment. So, what kind of judicial system do countries provide in this regard and how much benefit do these systems provide to the victim? Sexual assault is a problem that even non-victim people get stressed when they just hear it. This shows us what a terrible problem we are facing. More importantly, it is the people who live it, namely victims. The pre-event and the moment of the event are also very important, but the real time to intervene is after the event. When victims return to their lives, they suffer great adaptation difficulties and need great support at this point. In cases where support cannot be provided, the risks of acquiring serious lifelong psychological disorders are very high, even suicidal thoughts are included in these problems.

There is also another important point to be addressed in this regard. this is whether there is a correlation between people's gender identity and the risk of sexual assault. There are more news that women are sexually assaulted on the agenda, but the number of men who are sexually assaulted is considerably higher. People with many different sexual orientations may be victims of sexual assault, men and women are just two examples that can be given here. In this case, one of the priorities is to investigate this situation without any gender discrimination and to find suitable solutions for every sexual identity.

3.1. Definition

Sexual assault is an act in which a person intentionally sexually touches another person without that person's consent or coerces or physically forces a person to engage in a sexual act against their will. It is a form of sexual violence, which includes rape (forced vaginal, anal or oral penetration or drug facilitated sexual assault), groping, child sexual abuse or the torture of the person in a sexual manner.[19][20][21]

There are many types of sexual assault but in here, elderly and sexual assault is going to be discussed. Also, its vital effects on people's lives are going to be mentioned with wide aspects.

Elderly and Adult Sexual Assault

Elderly sexual assault is victimization of persons over the age of 60, most of whom suffer from decreased functionality, frailty and weakness, and therefore are reliant on caretakers. Only 30 percent of people age 65 or older who are victimized report the assault to the police. The most common assailants are caretakers, adult children, spouses and fellow facility residents. Signs that an elder is being assaulted include increased vaginal tearing, bleeding, bruising, infection, pelvic injury, soft tissue or bone injury. Also, an altered mood might be an indication of sexual assault. These symptoms include extreme agitation, post-traumatic stress disorder, withdrawal, panic attacks, STDs, exacerbation of existing illness, sleep disturbances and longer recovery times.[22]

Sexual assault on adults affects business life more intensely because it leads to lack of self-confidence, to think badly, and to feel weak. These situations lead to the failure of adults to be successful in their jobs, to fulfill their responsibilities in a timely manner, and therefore to embarrassment and hiding behaviors. this order is followed by the fear of being fired and not being hired, and the person is now deprived of most activities. These successive traumatic events lead the person to a period of severe depression. Unless proper diagnosis and treatment are made, the person experiences different psychological problems while also suffering great financial losses. Also, the behavior of self-comparison with peers and the question of why these events occur only on their own puts a person in a deadlock that he cannot solve on his own.

3.2. Psychological Effects of Sexual Assault

A large body of research suggests that sexual assault has severe and long-lasting mental health consequences. Studies of persons seeking treatment or other assistance have reported that those who have been sexually assaulted experience high rates of sexual dysfunction, depression, anxiety, and substance abuse. Reports of female sexual dysfunction after adult sexual assault are common, with rates for problems such as fear of sex, arousal dysfunction, and decreased sexual interest ranging from 50%-60%. Men assaulted by men have reported similar problems. Female victims of child sexual assault have also evidenced sexual disturbances such as sexual dysfunction, sexual maladjustment, and infrequent orgasms. Similar symptoms have been reported among male child assault victims. Other studies suggest that adult women experience a variety of depressive symptoms immediately after an assault, such as sleep or loss of appetite, loss of interest in normal activities, and decreased concentration.

In one study, about one fourth of recently assaulted subjects met Research Diagnostic Criteria for major depressive disorder. Longitudinal studies have reported that sexual assault victims were significantly more depressed than control subjects immediately after the assault through more than a year after the assault

Otherwise, sexual assault on children and adolescents has become a common topic of study, but there has been little research into the specific characteristics of the population of male victims. A national survey representative of school-age adolescents in France enabled us to study 465 adolescents reporting sexual assault (121 boys, 344 girls; mean age 15.4, SD 2.5 years). Girls were shown to be more frequently affected by certain medico-psychological symptoms: nightmares, multiple somatic complaints and some items concerning mood disorders. On the other hand, behavioral symptoms were much more frequently expressed in boys, in particular: repeated suicide attempts, running away, fits of violence and substance use. Boys presenting these symptoms should be questioned as a matter of routine concerning a history of sexual assault.

There are some facts about results of number of sexual assaults. Firstly,3 times more likely to suffer from depression and 6 times more likely to suffer from post-traumatic stress disorder. Secondly,13 times more likely to abuse alcohol and 26 times more likely to abuse drugs. The final and most dangerous result is that 4 times more likely to contemplate suicide. [23]

The reporting of sexual assault says that on average 68% of sexual assaults go unreported and 98% of rapists will not spend time in jail.[24]

The assailants:
According to the U.S. Department of Justice 1997 Sex Offenses and Offenders Study,

- A rapist's age on average is 31 years old
- 52% of offenders are white
- 22% of rapists imprisoned report that they are married
- Juveniles accounted for 16% of forcible rape arrestees in 1995 and 17% of those arrested for other sex offenses

According to the U.S. Department of Justice 2005 National Crime Victimization Study

- About 2/3 of rapes were committed by someone known to the victim

- 73% of sexual assaults were perpetrated by a non-stranger
- 38% of rapists are a friend or acquaintance
- 28% are an intimate partner
- 7% are a relative [25]

3.3. Types of Effects

Three crucial effects are emphasized such as emotional, physical and economical. examine them one by one, considering the emotional effects beside from physical traumas, rape and other sexual assault often result in long-term emotional effects, particularly in child victims. These can include, but are not limited to denial, learned helplessness, genuphobia, anger, self-blame, anxiety, shame, nightmares, fear, depression, flashbacks, guilt, rationalization, mood swings, numbness, promiscuity, loneliness, social anxiety, difficulty trusting oneself or others, difficulty concentrating. Being the victim of sexual assault may lead to the development of posttraumatic stress disorder, addiction, major depressive disorder or other psychopathologies. Family and friends experience emotional scarring including a strong desire for revenge, a desire to "fix" the problem and/or move on, and a rationalization that "it wasn't that bad".[26]

When looking at the physical effects one condition could be seen that while sexual assault, including rape, can result in physical trauma, many people who experience sexual assault will not suffer any physical injury.[27] Rape myths suggest that the stereotypical victim of sexual violence is a bruised and battered young woman. The central issue in many cases of rape or other sexual assault is whether or not both parties consented to the sexual activity or whether or not both parties had the capacity to do so. Thus, physical force resulting in visible physical injury is not always seen. This stereotype can be damaging because people who have experienced sexual assault but have no physical trauma may be less inclined to report to the authorities or to seek health care.[28] However, women who experienced rape or physical violence by a partner were more likely than people who had not experienced this violence to report frequent headaches, chronic pain, difficulty sleeping, activity limitation, poor physical health, and poor mental health.[29]

Finally, some economic effects could be mentioned, due to rape or sexual assault, or the threat of, there are many resulting impacts on income and commerce at the macro level. Each sexual assault (excluding child abuse) costs $5,100 in tangible losses (lost productivity, medical and mental health care, police/fire services, and property damage) plus $81,400 in lost quality of life.[30] This issue has been addressed in the Supreme Court. In his dissenting opinion of the

U.S. Supreme Court case U.S. v. Morrison, Justice Souter explained that 75% of women never go to the movies alone at night and nearly 50% will not ride public transportation out of fear of rape or sexual assault. It also stated that less than 1% of victims collect damages and 50% of women lose their jobs or quit after the trauma. The court ruled in U.S. v. Morrison that Congress did not have the authority to enact part of the Violence Against Women Act because it did not have a direct impact on commerce. The Commerce Clause of Article I Section VII of the U.S. Constitution gives authority and jurisdiction to the Federal government in matters of interstate commerce. As a result, the victim was unable to sue her attacker in Federal Court.

Sexual assault also has adverse economic effects for survivors on the micro level. For instance, survivors of sexual assault often require time off from work.[31] Sexual assault is also associated with numerous negative employment consequences, including unpaid time off, diminished work performance, job loss, and inability to work, all of which can lead to lower earnings for survivors.[32][33]

3.4. Judicial System of Countries

Australia

Within Australia, the term sexual assault is used to describe a variation of sexual offences. This is due to a variety of definitions and use of terminology to describe sexual offences within territories and states as each territory and state have their own legislation to define rape, attempted rape, sexual assault, aggravated sexual assault, sexual penetration or intercourse without consent and sexual violence.

In the State of New South Wales, sexual assault is a statutory offence punishable under s 61I of the Crimes Act 1900. The term "sexual assault" is equivalent to "rape" in ordinary parlance, while all other assaults of a sexual nature are termed "indecent assault".

To be liable for punishment under the Crimes Act 1900, an offender must intend to commit an act of sexual intercourse while having one of the states of knowledge of non-consent. But note that law is an objective standard which only require the person has no reasonable grounds for believing the other person is consenting.[34] The maximum penalty for sexual assault is 14 years imprisonment.[35]

Aggravated sexual assault is sexual intercourse with another person without the consent of the other person and in circumstances of aggravation. The maximum penalty is imprisonment for 20 years under s 61J of the Crimes Act.

In the state of Victoria, rape is punishable under s 38 of the Crimes Act 1958, with a maximum penalty of 25 years imprisonment.[36]

In the state of South Australia, rape is punishable under s 48 of the Criminal Law Consolidation Act 1935 (SA) with a maximum term of life imprisonment.[37]

In the state of Western Australia, sexual penetration is punishable under s 325 the Criminal Code Act 1913 with a maximum sentence of 14 years imprisonment.[38]

In the Northern Territory, offences of sexual intercourse and gross indecency without consent are punishable under s 192 of the Criminal Code Act 1983 and punishable with a maximum sentence of life imprisonment.[39]

In Queensland, rape and sexual assault are punishable under s 349, Chapter 32 of the Criminal Code Act 1899 with a maximum penalty of life imprisonment.[40]

In Tasmania, rape is punishable under s 185 of the Criminal Code Act 1924 with a maximum punishment of 21 years under s389 of the Criminal Code Act 1924.[41]

In the Australian Capital Territory, sexual assault is punishable under Part 3 of the Crimes Act 1900 with a maximum punishment of 17 years.[42]

Sexual assault is considered a gendered crime which results in 85% of sexual assaults never coming to the attention of the criminal justice system according to the Australian Bureau of Statistics.[43] This is due to low reporting rates, treatment of victims and distrust of the criminal justice system, difficulty in obtaining evidence and the belief in sexual assault myths.[44]

However, once a person is charged, the public prosecutor will decide whether the case will proceed to trial based on whether there is sufficient evidence and whether a case is in the public interest.[45] Once the matter has reached trial, the matter will generally be heard in the District Court. This is because sexually violent crimes are mostly categorized as indictable offences (serious offences), as opposed to summary offences (minor offences). Sexual offences can also be heard in the Supreme Court, but more generally if the matter is being heard as an appeal.

Once the matter is being heard, the prosecution must provide evidence which proves "beyond reasonable doubt" that the offence was committed by the defendant. The standard of proof is vital in checking the power of the State.[46] While as previously stated that each jurisdiction (State and Territory) has its own sexual offence legislation, there are many common elements

to any criminal offence that advise on how the offence is defined and what must be proven by the prosecution in order to find the defendant guilty.[47]

Canada

Sexual assault is defined as sexual contact with another person without that other person's consent. Consent is "*the voluntary agreement of the complainant to engage in the sexual activity in question*".[48]

Consent

The absence of consent defines the crime of sexual assault. Section 1 defines consent, section 2 outlines certain circumstances where "no consent" is obtained, while section 3 states that subsection "a" does not limit the circumstances where "no consent" is obtained (i.e. subsection "a" describes some circumstances which deem the act to be non-consensual, but other circumstances, not described in this section, can also deem the act as having been committed without consent). In 2011, the Supreme Court of Canada in R. v. J.A. interpreted the provisions below to find that a person must have an active mind during the sexual activity in order to consent, and that they cannot give consent in advance.[49][50]

Meaning of "consent"

"Consent" means, for the purposes of sections 271, 272 and 273, *the voluntary agreement of the complainant to engage in the sexual activity in question*.

Where no consent obtained;

No consent is obtained where the agreement is expressed by the words or conduct of a person other than the complainant; the complainant is incapable of consenting to the activity; the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority; (d) the complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or (e) the complainant, having consented to engage in sexual activity, expresses, by words or conduct, a lack of agreement to continue to engage in the activity.

Subsection not limiting

Nothing in subsection shall be construed as limiting the circumstances in which no consent is obtained.

Consent

For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of a the application of force to the complainant or to a person other than the complainant; threats or fear of the application of force to the complainant or to a person other than the complainant; fraud; or the exercise of authority.

In accordance with 265 (4) an accused may use the defense that he or she believed that the complainant consented, but such a defense may be used only when "a judge, if satisfied that there is sufficient evidence and that, if believed by the jury, the evidence would constitute a defense, shall instruct the jury when reviewing all the evidence relating to the determination of the honesty of the accused's belief, to consider the presence or absence of reasonable grounds for that belief"; furthermore according to section 273.2(b) the accused must show that he or she took reasonable steps in order to ascertain the complainant's consent, also 273.2(a) states that if the accused's belief steams from self-induced intoxication, or recklessness or willful blindness than such belief is not a defense.[49]

Germany

Before 1997, the definition of rape was: "*Whoever compels a woman to have extramarital intercourse with him, or with a third person, by force or the threat of present danger to life or limb, shall be punished by not less than two years' imprisonment*."

In 1997, a broader definition was adopted with the 13th criminal amendment, section 177–179, which deals with sexual abuse. Rape is generally reported to the police, although it is also allowed to be reported to the prosecutor or District Court. [55]

The Strafgesetzbuch reads:

Sexual assault by use of force or threats; rape

A. Whosoever coerces another person

1. by force;
2. by threat of imminent danger to life or limb; or
3. by exploiting a situation in which the victim is unprotected and at the mercy of the offender,

to suffer sexual acts by the offender or a third person on their own person or to engage actively in sexual activity with the offender or a third person, shall be liable to imprisonment of not less than one year.

B. In especially serious cases the penalty shall be imprisonment of not less than two years. An especially serious case typically occurs if

   1. the offender performs sexual intercourse with the victim or performs similar sexual acts with the victim, or allows them to be performed on himself by the victim, especially if they degrade the victim or if they entail penetration of the body (rape); or
   2. the offence is committed jointly by more than one person.

Subsections (3-4-5) provide additional stipulations on sentencing depending on aggravating or mitigating circumstances.

Section 178 provides that "*If the offender through sexual assault or rape (section 177) causes the death of the victim at least by gross negligence the penalty shall be imprisonment for life or not less than ten years*."[56][57]

Republic of Ireland

As in many other jurisdictions, the term sexual assault is generally used to describe non-penetrative sexual offences. Section 2 of the Criminal Law (Rape) Act of 1981 states that a man has committed rape if he has sexual intercourse with a woman who at the time of the intercourse does not consent to it, and at that time he knows that she does not consent to the intercourse or he is reckless as to whether she does or does not consent to it. Under Section 4 of the Criminal Law (Rape Amendment) Act of 1990, rape means a sexual assault that includes penetration (however slight) of the anus or mouth by the penis or penetration (however slight) of the vagina by any object held or manipulated by another person. The maximum penalty for rape in Ireland is imprisonment for life.[58]

South Africa

The Criminal Law (Sexual Offences and Related Matters) Amendment Act created the offence of sexual assault, replacing a common-law offence of indecent assault. "Sexual assault" is defined as the unlawful and intentional sexual violation of another person without their consent. The Act's definition of "sexual violation" incorporates several sexual acts, including any genital contact that does not amount to penetration as well as any contact with the mouth

designed to cause sexual arousal. Non-consensual acts that involve actual penetration are rape rather than sexual assault.

Unlawfully and intentionally inspiring the belief in another person that they will be sexually violated also amounts to sexual assault. The Act also created the offences of "compelled sexual assault", when a person forces a second person to commit an act of sexual violation with a third person; and "compelled self-sexual assault", when a person forces another person to masturbate or commit various other sexual acts on themselves. [59]

United Kingdom

England and Wales

Sexual assault is a statutory offence in England and Wales. It is created by section 3 of the Sexual Offences Act 2003 which defines "sexual assault" as when a person (A)

1. intentionally touches another person (B),
2. the touching is sexual,
3. B does not consent to the touching, and
4. A does not reasonably believe that B consents.

Whether a belief is reasonable is to be determined having regard to all the circumstances, including any steps A has taken to ascertain whether B consents.

Sections 75 and 76 apply to an offence under this section.

A person guilty of an offence under this section is liable—

1. on summary conviction, to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both;
2. on conviction on indictment, to imprisonment for a term not exceeding 10 years.[60]

Consent

Section 74 of the Sexual Offenses Act explains that "a person consents if he agrees by choice and has the freedom and capacity to make that choice".

Section 75 clarifies what consent means

75 Evidential presumptions about consent

(1)If in proceedings for an offence to which this section applies it is proved— (a)that the defendant did the relevant act, (b)that any of the circumstances specified in subsection (2) existed, and (c)that the defendant knew that those circumstances existed, the complainant is to be taken not to have consented to the relevant act unless sufficient evidence is adduced to raise an issue as to whether he consented, and the defendant is to be taken not to have reasonably believed that the complainant consented unless sufficient evidence is adduced to raise an issue as to whether he reasonably believed it.

(2)The circumstances are that— (a)any person was, at the time of the relevant act or immediately before it began, using violence against the complainant or causing the complainant to fear that immediate violence would be used against him; (b)any person was, at the time of the relevant act or immediately before it began, causing the complainant to fear that violence was being used, or that immediate violence would be used, against another person; (c)the complainant was, and the defendant was not, unlawfully detained at the time of the relevant act; (d)the complainant was asleep or otherwise unconscious at the time of the relevant act; (e)because of the complainant's physical disability, the complainant would not have been able at the time of the relevant act to communicate to the defendant whether the complainant consented; (f)any person had administered to or caused to be taken by the complainant, without the complainant's consent, a substance which, having regard to when it was administered or taken, was capable of causing or enabling the complainant to be stupefied or overpowered at the time of the relevant act.

(3)In subsection (2)(a) and (b), the reference to the time immediately before the relevant act began is, in the case of an act which is one of a continuous series of sexual activities, a reference to the time immediately before the first sexual activity began.

Northern Ireland

Sexual assault is a statutory offence. It is created by article 7 of the Sexual Offences (Northern Ireland) Order 2008. Sexual assault is defined as follows: [61]

Sexual assault

(1) A person (A) commits an offence if—

(a) he intentionally touches another person (B),

(b) the touching is sexual,

(c) B does not consent to the touching, and

(d) A does not reasonably believe that B consents.

Scotland

Sexual assault is a statutory offence. It is created by section 3 of the Sexual Offences (Scotland) Act 2009. Sexual assault is defined as follows: [62]

Sexual assault

(1) If a person ("A")—

(a) without another person ("B") consenting, and

(b) without any reasonable belief that B consents,

does any of the things mentioned in subsection (2), then A commits an offence, to be known as the offence of sexual assault.

(2) Those things are, that A—

(a) penetrates sexually, by any means and to any extent, either intending to do so or reckless as to whether there is penetration, the vagina, anus or mouth of B,

(b) intentionally or recklessly touches B sexually,

(c) engages in any other form of sexual activity in which A, intentionally or recklessly, has physical contact (whether bodily contact or contact by means of an implement and whether or not through clothing) with B,

(d) intentionally or recklessly ejaculates semen onto B,

(e) intentionally or recklessly emits urine or saliva onto B sexually.

United States

The United States Department of Justice defines sexual assault as "any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape."[63]

Every U.S. state has its own code of laws, and thus the definition of conduct that constitutes a crime, including a sexual assault, may vary to some degree by state. [64][65] Some states may refer to sexual assault as "sexual battery" or "criminal sexual conduct". [66]

Texas

The Texas Penal Code, Sec. 22.011(a) defines sexual assault as [67]

A person commits [sexual assault] if the person:

(1) intentionally or knowingly:

(A) causes the penetration of the anus or sexual organ of another person by any means, without that person's consent;

(B) causes the penetration of the mouth of another person by the sexual organ of the actor, without that person's consent; or

(C) causes the sexual organ of another person, without that person's consent, to contact or penetrate the mouth, anus, or sexual organ of another person, including the actor; or

(2) intentionally or knowingly:

(A) causes the penetration of the anus or sexual organ of a child by any means;

(B) causes the penetration of the mouth of a child by the sexual organ of the actor;

(C) causes the sexual organ of a child to contact or penetrate the mouth, anus, or sexual organ of another person, including the actor;

(D) causes the anus of a child to contact the mouth, anus, or sexual organ of another person, including the actor; or

(E) causes the mouth of a child to contact the anus or sexual organ of another person, including the actor.

3.5. The Consequences of Sexual Assault

Physical force is not necessarily used in rape, and physical injuries are not always a consequence. Deaths associated with rape are known to occur, though the prevalence of fatalities varies considerably across the world. Among the more common consequences of sexual violence are those related to reproductive, mental health and social wellbeing.

Pregnancy and gynecological complications

Pregnancy may result from rape, though the rate varies between settings and depends particularly on the extent to which non-barrier contraceptives are being used. A study of adolescents in Ethiopia found that among those who reported being raped, 17% became pregnant after the rape, a figure which is similar to the 15–18% reported by rape crisis centers in Mexico. A longitudinal study in the United States of over 4000 women followed for 3 years found that the national rape related pregnancy rate was 5.0% per rape among victims aged 12–45 years, producing over 32 000 pregnancies nationally among women from rape each year. In many countries, women who have been raped are forced to bear the child or else put their lives at risk with back-street abortions. Experience of coerced sex at an early age reduces a woman's ability to see her sexuality as something over which she has control. As a result, it is less likely that an adolescent girl who has been forced into sex will use condoms or other forms of contraception, increasing the likelihood of her becoming pregnant. A study of factors associated with teenage pregnancy in Cape Town, South Africa, found that forced sexual initiation was the third most strongly related factor, after frequency of intercourse and use of modern contraceptives. Forced sex can also result in unintended pregnancy among adult women. In India, a study of married men revealed that men who admitted forcing sex on their wives were 2.6 times more likely to have caused an unintended pregnancy than those who did not admit to such behavior. Gynecological complications have been consistently found to be related to forced sex. These include vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infections. Women who experience both physical and sexual abuse from intimate partners are at higher risk of health problems generally than those experiencing physical violence alone.

Sexually transmitted diseases

HIV infection and other sexually transmitted diseases are recognized consequences of rape. Research on women in shelters has shown that women who experience both sexual and physical abuse from intimate partners are significantly more likely to have had sexually transmitted

diseases. For women who have been trafficked into sex work, the risks of HIV and other sexually transmitted diseases are likely to be particularly high.

Mental health

Sexual violence has been associated with a number of mental health and behavioral problems in adolescence and adulthoods. In one population-based study, the prevalence of symptoms or signs suggestive of a psychiatric disorder was 33% in women with a history of sexual abuse as adults, 15% in women with a history of physical violence by an intimate partner and 6% in non-abused women. Sexual violence by an intimate partner aggravates the effects of physical violence on mental health. Abused women reporting experiences of forced sex are at significantly greater risk of depression and post-traumatic stress disorder than non-abused women. Post-traumatic stress disorder after rape is more likely if there is injury during the rape, or a history of depression or alcohol abuse. A study of adolescents in France also found a relationship between having been raped and current sleep difficulties, depressive symptoms, somatic complaints, tobacco consumption and behavioral problems (such as aggressive behavior, theft and truancy. In the absence of trauma counselling, negative psychological effects have been known to persist for at least a year following a rape, while physical health problems and symptoms tend to decrease over such a period. Even with counselling, up to 50% of women retain symptoms of stress).

Suicidal behavior

Women who experience sexual assault in childhood or adulthood are more likely to attempt or commit suicide than other women. The association remains, even after controlling for sex, age, education, symptoms of post-traumatic stress disorder and the presence of psychiatric disorders. The experience of being raped or sexually assaulted can lead to suicidal behavior as early as adolescence. In Ethiopia, 6% of raped schoolgirls reported having attempted suicide. A study of adolescents in Brazil found prior sexual abuse to be a leading factor predicting several health risk behaviors, including suicidal thoughts and attempts. Experiences of severe sexual harassment can also result in emotional disturbances and suicidal behavior. A study of female adolescents in Canada found that 15% of those experiencing frequent, unwanted sexual contact had exhibited suicidal behavior in the previous 6 months, compared with 2% of those who had not had such harassment.

Social ostracization

In many cultural settings it is held that men are unable to control their sexual urges and that women are responsible for provoking sexual desire in men. How families and communities react to acts of rape in such settings is governed by prevailing ideas about sexuality and the status of women. In some societies, the cultural ‘‘solution’’ to rape is that the woman should marry the rapist, thereby preserving the integrity of the woman and her family by legitimizing the union. Such a ‘‘solution’’ is reflected in the laws of some countries, which allow a man who commits rape to be excused his crime if he marries the victim. Apart from marriage, families may put pressure on the woman not to report or pursue a case or else to concentrate on obtaining financial ‘‘damages’’ from the rapist's family. Men may reject their wives if they have been raped and, in some countries, as mentioned previously, restoring lost honor calls for the woman to be cast out – or in extreme cases, murdered.[68]

QUESTION TO BE ADDRESSED

- What kind of a relationship between sexual assault and its lifelong implications?
- Are there any difference between man and woman sexual assault?
- What types of sanctions are existing for each country?
- What could be the procedure for decreasing effects of sexual assault?
- Which ways could be followed to be more sensitive?
- Is gender discrimination a reason for an increase in sexual assault rates?
- Could the trauma of the sexually assaulted person be resolved with drugs?

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