Consortium PSYCHIATRICUM

2024 | Volume 5 | Issue 1 | www.consortium-psy.com | ISSN 2712–7672 (Print) | ISSN 2713-2919 (Online)

Self-Stigma in Patients with Endogenous Mental Disorders: A Cross-Sectional Comparative Study Page 13

Consortium
PSYCHIATRICUM

Consortium Psychiatricum
Peer-reviewed quarterly medical journal

Editor
Aleksander B. Berdalin (Moscow, Russia)

Assistant Editor
Teona G. Chanturiya (Moscow, Russia)

Director of Marketing & Communications
Elena A. Makova (Moscow, Russia)

Publisher
Eco-Vector
Address: 3A, Aptekarskiy lane, Saint Petersburg, Russia 191186
Phone: +7 (812) 648-83-66
E-mail: info@eco-vector.com
WEB: www.eco-vector.com

Editorial office
Address: 2, Zagorodnoe shosse, Moscow, Russia 117152
Phone: +7 (495) 952-88-33 (ex. 16213)
E-mail: editor@consortium-psy.com
WEB: www.consortium-psy.com

Indexation
Scopus
PubMed Central
RSCI
PsycInfo
DOAJ Seal

Volume 5 Issue 1
ISSN 2712-7672 (Print)
ISSN 2713-2919 (Online)
Frequency: 4 times a year. Signed for printing: 25.03.2024 Printing House: Mediacolor LLC, 19, Signalny proesd, Moscow, Russia, 127273

Consortium
PSYCHIATRICUM

Consortium Psychiatricum
Научный медицинский журнал

Редактор
Александр Бердалин (Москва, Россия)

Менеджер редакции
Теона Чантурия (Москва, Россия)

Директор по маркетингу и связям с общественностью
Елена Макова (Москва, Россия)

Издатель
Эко-Вектор
Адрес: 191186, Россия, Санкт-Петербург, Аптекарский пер. д.3
Телефон: +7 (812) 648-83-66
E-mail: info@eco-vector.com
Сайт: www.eco-vector.com

Контакты редакции
Почтовый адрес: 117152, Россия, Москва, Загородное шоссе, 2
Телефон: +7 (495) 952-88-33 (доб.16213)
E-mail: editor@consortium-psy.com
Сайт: www.consortium-psy.com

Индексация
ВАК
Scopus
PubMed Central
PsycInfo
DOAJ Seal

Том 5 Выпуск 1
ISSN 2712-7672 (Print)
ISSN 2713-2919 (Online)
Журнал зарегистрирован Федеральной службой по надзору в сфере связи, информационных технологий и массовых коммуникаций
Свидетельство о регистрации ПИ No ФС 77-78122 от 13 марта 2020 г. Периодичность: 4 раза в год. Дата выхода в свет: 25.03.2024.
Типография: ООО “Медиаколор“, 127273, г. Москва, Сигнальный проезд, д. 19 . Тираж: 350 экз. Распространяется бесплатно.

Table of contents

Suicide Attempt Violence: Gender Differences, Diagnosis and Psychiatric Care Seeking in Mexico City

Суицидальные попытки с использованием насильственных способов: гендерные различия, диагностика и частота обращения людей за психиатрической помощью в Мехико

doi: 10.17816/CP13457

Original research

Danae Alejandra Juárez-Domínguez[1], Karen Michelle Arteaga-Contreras[2], Héctor Cabello Rangel[2]

[1] National University Autonomous of Mexico, Mexico City, Mexico

[2] Psychiatric Hospital "Fray Bernardino Álvarez", Mexico City, Mexico

Данаэ Алехандра Хуарес-Домингес[1], Карен Мишель Артеага-Контрерас[2], Эктор Кабельо Ранхель[2]

[1] Национальный автономный университет Мексики, Мехико, Мексика

[2] Психиатрическая больница "Fray Bernardino Álvarez", Мехико, Мексика

ABSTRACT

BACKGROUND: Suicide cases in Mexico have increased during the last two years and are the second-leading cause of death in the young adult population.

AIM: To describe gender differences in violent suicide attempts as relates to diagnosis and the seeking of psychiatric care.

METHODS: A descriptive retrospective study was conducted. The referral forms of 241 patients who had attempted suicide were analyzed.

RESULTS: The mean age of the patients was 29.1 (SD=10.8) years, *n*=140 (58.1%) of the sample were women. Affective disorders were the most frequent diagnoses for both sexes. Women were more likely to delay seeking psychiatric care: 60 days versus 30 days of delay for men (*p*=0.009). Men were shown to more frequently resort to violent suicide methods. Both women and men who used violent suicide methods were shown to delay by more days the seeking of psychiatric care than those who were found to have used non-violent suicide methods.

CONCLUSION: We found that patients who use more violent methods of suicide took longer before seeking psychiatric care. This delay in accessing psychiatric care can be thought to contribute to the fact that completed suicides are more frequent within that category of patients. The majority of suicide attempts occurred in the 17–24 years age group; therefore, it seems reasonable to analyze the existing barriers to seeking psychiatric care, mainly in the young adult population, and to design strategies to bring mental health services closer to this population group.

АННОТАЦИЯ

ВВЕДЕНИЕ: За последние 2 года в Мехико увеличилось число суицидов, которые, таким образом, стали второй по значимости причиной смерти среди взрослого населения молодого возраста.

ЦЕЛЬ: Описать гендерные различия суицидальных попыток с использованием насильственных способов с учетом диагностики психических расстройств и частоты обращения за психиатрической помощью.

МЕТОДЫ: Было проведено описательное ретроспективное исследование. Проанализированы анкеты 241 пациента, совершившего суицидальную попытку.

РЕЗУЛЬТАТЫ: Средний возраст пациентов составил 29,1 (SD=10,8) года. Женщины составили 58,1% выборки (*n*=140). У пациентов обоих полов чаще всего диагностировали аффективные расстройства. Женщины с большей вероятностью откладывали обращение за психиатрической помощью по сравнению с мужчинами (задержка в обращении составила 60 дней по сравнению с 30 днями, соответственно, *p*=0,009). Установлено, что мужчины чаще прибегают к совершению суицида с использованием более травматичного способа. Также отмечено, что и женщины, и мужчины, использовавшие насильственный способ совершения суицидальной попытки, откладывали обращение за психиатрической помощью на большее число дней, чем те, которые применяли менее травматичные способы.

ЗАКЛЮЧЕНИЕ: Мы пришли к выводу о том, что пациентам, которые использовали насильственные способы совершения суицидальной попытки, требовалось больше времени для принятия решения об обращении за психиатрической помощью. Можно предположить, что позднее обращение за психиатрической помощью способствует тому, что среди этой категории пациентов чаще регистрируют завершенные суициды. Большинство случаев суицидальных попыток зарегистрировано в возрастной группе 17–24 лет, поэтому представляется целесообразным проанализировать существующие препятствия к обращению за психиатрической помощью, в основном среди молодых взрослых, а также разработать стратегии по повышению доступности служб охраны психического здоровья для этой группы населения.

Keywords: *suicide; violent suicide attempt; mental disorders; psychiatric emergencies; self-harm*
Ключевые слова: *суицид; суицидальная попытка с использованием насильственного способа; психические расстройства; экстренная психиатрическая помощь; самоповреждение*

INTRODUCTION

According to the World Health Organization (WHO), 700,000 people commit suicide each year, which translates into a rate of 11.4 per 100,000 inhabitants.[1] In various regions of the world, suicidal behavior has increased in recent years; in the United States, emergency room visits for suspected suicide attempts have increased by 50.6% among girls aged 12–17 years compared to the same period in 2019 [1]. Since 2014, the suicide rate has decreased in older adults and increased in adolescents and young adults in the Americas, making it the second-leading cause of death in the 15–29 age group (with a rate of 13.8 per 100,000 population), after road traffic accidents.[2] In Greece, an increase of 10.40% was documented compared to the pre-pandemic period [2]. In New Zealand, an increase in suicidal ideation was observed in 18- to 34-year-olds who had lost their jobs or faced the prospect of reduced income [3]. In Mexico, according to data from the National Institute of Statistics and Geography (INEGI by Spanish acronym), during 2020 673 more deaths by suicide compared to the previous year were recorded, an increase from 5.4 to 9.9 per 100,000 inhabitants.[3]

Suicide is defined by the WHO as the deliberate act of taking one's own life; its prevalence and the methods used vary by gender; for men, asphyxia was the most commonly used method in the Central American, Hispanic Caribbean, and Mexico subregions, while in South America and North America firearms were the main method used. For

[1] WHO (World Health Organization) [Internet]. Suicide; 2021 [cited Jul 2022]. Available from: https://www.who.int/es/news-room/fact-sheets/detail/suicide

[2] Pan American Health Organization. Suicide Mortality in the Americas. Regional Report 2010–2014. Washington, DC; 2021.

[3] National Institute of Statistics and Geography [Internet]. Population and Housing Census; 2021 [cited Apr 2023]. Available from: https://www.inegi.org.mx/app/tabulados/interactivos/?pxq=Salud_Mental_07_f6061818-d620-4269-adbb-d4376cc22c0d

women, poisoning was the most frequently used method in North America (36.5%) and in the non-Hispanic Caribbean (57.4%).[1] In Mexico, amongst men, in order of frequency, hanging comes fist followed by firearms and poisoning, while the hierarchy for women is hanging, poisoning, and firearms [4]. The choice of method when attempting suicide depends on factors such as accessibility and cultural acceptability, as well as physical availability and cognitive accessibility [5]. Another factor affecting suicidal behavior is people's living conditions, which was affected by the pandemic caused by the SARS-CoV-2 virus; in particular, restrictions on movement resulted in an increase in mental disorders such as anxiety and depression, as well as substance use.

According to data from the National Health and Nutrition Survey of 2022 in Mexico, the prevalence of suicidal behavior at some point in life in adolescents stands at 6.5%, while that for adults is at 3.5%. Some 13% of adolescents who attempted suicide were hospitalized, while the remainder were denied hospitalization [6]. It remains unknown whether those who were denied hospitalization had received any psychiatric or general medical care, which is of concern since people with suicidal ideation face a 10-fold increased risk of death by suicide [7]. Likewise, the lack of access to health care aggravates the situation since the likelihood of committing suicide after a suicide attempt stands at 2.8% after one year, 5.6% after five years, and 7.4% at 10 years. This indicator is closely tied to the psychiatric diagnosis [8]; therefore, individual follow-up of such patients is essential in preventing a new attempt. The recent COVID-19 pandemic has perturbed the scenario of suicidal behavior. Various works by researchers have reported broadly divergent results. These range from those that have uncovered an increase in suicidal ideation during the pandemic to studies that have recorded no movement in that parameter compared to previous years [9–12]. Still other studies have reported a decrease in suicidal behavior [13–15]. Contrarily, in Mexico the number of completed suicides is shown to have increased during 2020, particularly in the young adult population, accompanied by an increase in depressive and anxiety disorders [16].

The most affected age group was the 18- to 24-year-old range, and the Hispanic population exhibited a higher prevalence rate of these symptoms [17]. It was also documented that school confinement and stress associated with issues around school contributed to the prevalence of suicide [18]. Suicidal ideation was more prevalent in young adults, women, and people experiencing economic hardship, chronic illnesses and mental disorders [19, 20].

In Mexico, the methods used in completed suicides are known but data is limited on the time it takes to seek psychiatric care between the onset of symptoms and the emergence of suicidal behavior. Our purpose was to study gender differences in violent suicide attempts, as well as diagnosis and psychiatric care seeking in patients that visited a psychiatric emergency room because of suicidal behavior. We hypothesized that there are statistically significant gender differences in patients with suicidal behavior who seek psychiatric care; the degree of violence that accompanies a particular suicide attempt seems to have something to do with gender and the severity of one's mental condition (number of diagnoses).

METHODS

Study design

This study was based on a descriptive, retrospective, and cross-sectional design.

Sample

The sample was composed of the reference forms of patients who had been attended for in the emergency ward of Psychiatric Hospital "Fray Bernardino Álvarez" (PHFBA) for suicidal behavior. The finite sample formula was used to calculate the sample size with the following parameters: confidence level Z=1.96, percentage of the population with the desired attribute p=11%, percentage of the population without the desired attribute q=89%, maximum accepted estimation error (e)=4%, and universe size (N)=11800. Calculated size n=241. To collect the sample, we selected 15 bundles of referral forms by the simple random method, from which 241 referral forms of patients with suicidal behavior were obtained.

Data source

The reference forms of patients treated in the emergency department of PHFBA in the period March-December 2020 were used for the purposes of the study. The forms contain the following variables: a) age; b) sex; c) suicide attempt defined as self-harming behavior with a non-fatal outcome, accompanied by evidence (either explicit or implicit) that the person intended to die [21]; d) psychiatric diagnosis according to the International Classification of Diseases, 10th revision (ICD-10); e) time elapsed from the onset of symptoms for the current episode to the seeking

of psychiatric care; f) number of health establishments visited before receiving psychiatric care in the current episode; g) severity of the suicide method used, classified into violent methods (hanging, strangulation, suffocation, gunshot, jumping from a high altitude, or throwing oneself against a moving vehicle) and non-violent methods (blunt or sharp injuries, substance poisoning); and h) number of diagnoses (one, more than one) [22].

Data analysis

Descriptive statistics was used for the qualitative variables absolute and relative frequencies, as well as for the quantitative variables measures of main tendency and dispersion. The distribution was tested using the Kolmogorov-Smirnov test. The Mann–Whitney U test was used as the hypothesis test. The Chi-square test was applied for categorical variables. The variables (sex and the presence of more than one psychiatric diagnosis) that showed p <0.05 were included in the binary logistic regression analysis. The analysis was carried out using the SPSS version 26 statistical software.

Ethical approval

In accordance with the provisions of the Regulations of the General Health Law on Health Research, the research was deemed without risk. The Research and Research Ethics Committees of PHFBA approved the project (registration CI-955 of January 23, 2023).

RESULTS

We collected 241 referral forms of patients who had sought care after a suicide attempt between March and December 2020. We found a similar percentage of men and women patients, 41.9% (n=101) and 58.1% (n=140), respectively. The mean age of the sample was 29.1 years (SD=10.8). For women it was 29.0 years (SD=11.5); and 29.2 years (SD=9.8) for men. No statistically significant difference in the Mann–Whitney U test was uncovered (Table 1).

For 214 cases (88.4%), it was the first case of psychiatric care consumption since the onset of the current episode, with statistically significant differences by gender (χ^2=4.737, p=0.030). In addition, 111 (46.3%) patients reported having visited two health institutions before they could secure

Table 1. Parameters of psychiatric care seeking by gender

	Men N=101	Women N=140	*P**
Age (years)	29.2 (±9.8)	29.0 (±11.5)	(U=6637) 0.417
Time elapsed from the onset of symptoms to the seeking of psychiatric care (days) Me [Q1;Q3]	30 [14; 180] (min 7 – max 7565)	60 [6; 365] (min 7 – max 6570)	(U=4893) 0.009
Number of health institutions visited before receiving psychiatric care (n=128) Me [Q1;Q3]	2 [1; 2] (min 1 – max 4) n=57	2 [1; 2] (min 1 – max 5) n=71	(U=7943) 0.027

Note: * Mann–Whitney U test, significance level p <0.05.

Table 2. Percentage and frequency of main diagnoses by gender (N=241)

Diagnosis	Main diagnosis		χ^2	df	*p*
	Men N=101 (%)	Women N=140 (%)*			
Organic mental disorders	2 (1.98)	1 (0.7)	0.765	1	0.382
Substance use disorders	12 (11.8)	3 (2.1)	9.533	1	0.002
Schizophrenia, schizotypal, and delusional disorders	14 (13.86)	1 (0.7)	17.375	1	0.001
Mood (affective) disorders	36 (35.6)	55 (39.5)	0.331	1	0.565
Stress-related disorders	10 (9.90)	13 (9.35)	0.026	1	0.873
Personality disorders	23 (22.7)	62 (44.6)	11.894	1	0.001
Intellectual disability	4 (3.96)	2 (1.4%)	1.549	1	0.213
Somatic diseases	0 (0.0)	2 (1.4%)	-	-	-

Note: * The diagnosis was not recorded in the reference form in one case.

psychiatric care, while 17 (7%) had visited more than two health institutions, with gender-based statistically significant differences (U=7943, p=0.027) (Table 1).

Women delayed the seeking of psychiatric care from the time of onset of symptoms longer compared to men by a median of 60 versus 30 days (U=4893, p=0.009) (Table 1).

In both men and women, personality and mood (affective) disorders were the most frequent diagnoses, but stress-related disorders were more recurrent in women, as well as primary psychotic disorders in men. There were statistically significant differences for the latter (χ^2=17.37, p=0.001) (Table 2).

We found that 76.7% of the patients had some comorbid psychiatric diagnosis (74 men and 111 women). The most frequent were substance use disorders (12%), personality disorders (31.9%), affective disorders (15.3%), and stress-related disorders (7.4%), respectively. The least frequent comorbid disorders were eating disorders (one case), pervasive developmental disorders (two cases), intellectual disability (eight cases), and somatic disorders (three cases).

The majority of the suicide attempts fell on young people aged 17–24 years. In this group, the most frequent main diagnosis was personality disorders n=46 (43.8%), while in the groups aged 25–40 and 41–59 years the most frequent diagnosis was mood disorders: n=40 (41.2%) and n=14 (42.4%), respectively. The chi-square tests showed statistically significant differences for organic disorders and personality disorders. The older adult population group constituted five (2%) patients of the sample; two cases related to cognitive impairment (Table 3).

Regarding the methods used to attempt suicide, poisoning was the most frequent for both sexes, while hanging or strangulation was significantly more frequent in men compared to women (χ^2=47.784, p <0.05).

Regarding the methods, men used more violent suicide methods (hanging, jumping from the heights or using a moving vehicle) than women, with statistically significant differences (χ^2=22.210, p <0.05) (Table 4).

Patients with more than one psychiatric diagnosis used more violent suicide methods (χ^2=7.940, p <0.05).

Table 3. Main diagnoses by age group (N=241)

Diagnosis	Age group *n* (% by column) [years]				Chi-square test		
	17–24	25–40	41–59	>60	χ^2	df	*p*
Total in column	105 (100%)	97 (100%)	33 (100%)	4 (100%)	-	-	-
Organic disorders	0 (0.0%)	0 (0.0%)	1 (3.0%)	2 (40.0%)	64.50	3	<0.001
Substance use disorders	3 (2.9%)	9 (9.3%)	3 (9.1%)	0 (0.0%)	4.31	3	0.23
Schizophrenia, schizotypal, and delusional disorder	5 (4.8%)	9 (9.3%)	1 (3.0%)	0 (0.0%)	2.76	3	0.43
Mood (affective) disorders	36 (34.3%)	40 (41.2%)	14 (42.4%)	1 (20.0%)	1.91	3	0.59
Stress-related disorders	13 (12.4%)	4 (4.1%)	5 (15.2%)	1 (20.0%)	6.20	3	0.10
Personality disorders	46 (43.8%)	33 (34.0%)	6 (18.2%)	0 (0.0%)	10.41	3	0.02
Intellectual disability	2 (1.9%)	1 (1.0%)	3 (9.1%)	0 (0.0%)	7.07	3	0.07
Somatic diseases	0 (0.0%)	1 (1.0%)	0 (0.0%)	1 (20.0%)	-	-	-

Table 4. Frequency of suicide methods and the methods of violence by sex (N=241)

Method [ICD-10]		Men *n* (%)	Women *n* (%)
Non-violent methods	Intentional self-poisoning by and exposure to antiepileptic, sedative, hypnotic, antiparkinsonian, or psychotropic drugs [X60–X69]	34 (14.1)	86 (35.7)
	Intentional self-harm by sharp or blunt object [X78–X79]	32 (13.3)	41 (17.0)
Violent methods	Intentional self-harm by hanging, strangulation and suffocation [X70], by drowning and submersion [X71]	25 (10.4)	10 (4.1)
	Intentional self-harm by jumping from a high place [X80], by jumping or lying before moving object [X81], by crashing of motor vehicle [X82]	9 (3.7)	3 (1.2)
Intentional self-harm by unspecified means [X84]		1 (0.4)	-
Total*		101 (41.9)*	140 (58.1)*

Note: * χ^2=22.210, p <0.05.

Table 5. Regression analysis of the violence of the suicide attempt (N=241)

	B	Standard error	Wald	gl	Sig.	Exp(B)	95% C.I. EXP(B)	
							Inferior	Superior
Sex (men)	-1.577	0.364	18.745	1	0.0001	0.207	0.101	0.422
Diagnosis (>1)	-0.919	0.372	6.111	1	0.013	0.399	0.192	0.827

The regression model had a good fit according to the Hosmer-Lemeshev test p=0.971. Being male and having more than one psychiatric diagnosis increased the risk of violent suicide attempts (Exp(B)=0.207 CI 95%: 0.101-0.402 and Exp(B)=0.399, 95% CI 0.192-0.827 p <0.05) (Table 5).

The mean time from symptom onset for the current episode to the reception of psychiatric care for patients who had attempted violent suicide was longer than that for patients who had attempted non-violent suicide, but the difference was not statistically significant (705 versus 493, U=2377.0, p=0.765). The median time from symptom onset to psychiatric care for both groups was 135 days (min=7, max=7665). The median number of health institutions visited within the current episode was the same between patients who chose violent and non-violent suicide attempts (median 2, min=1, max=5, U=4821.0, p=0.294).

DISCUSSION

We studied the gender differences in the methods used to attempt suicide and the time gap in seeking psychiatric care. We found that women displayed a higher frequency of suicide attempts, that the most affected age group was the 17–24 years, which is consistent with the study by Benke et al. (2020), who noted that depressive symptoms and perceived loneliness are increased in young adults, as well as in people in that age group with mental disorders [23].

Regarding the methods of suicide, we uncovered statistically significant differences in terms of gender; men used methods that are more violent, while women used poisoning more frequently. This is in line with the data reported in France, where deliberate poisoning was more frequent in women and men who used methods related to a high likelihood of death [24]. In that study, the most frequent diagnoses were substance use and mood disorders. In our case, personality and mood disorders were more frequent, since in our results, patients who used more lethal methods of suicide were diagnosed with some category of psychosis (schizophrenia, schizotypal, or delusional disorders).

It was found that men inclined to use violent suicide attempts delayed the seeking of psychiatric care. We believe that the delay in seeking psychiatric care had the potential to contribute to the marked differences in the number of completed suicides. In Mexico, the man:woman ratio is 8:2, and high-fatality suicide attempts accounted for 90% of the deaths by suicide in Mexico City in the year 2020.[4] Unfortunately, for México there is a complete lack of studies that provide data on the number of people with completed suicide that had access to psychiatric or psychological care.

The procrastination in seeking psychiatric care may be due to barriers of geographic, administrative, or human resources nature. In that perspective, it has been established that the main barriers to accessing mental health care are due to a lack of information on where to obtain it, long waiting times, shortage of professionals, cultural and geographical factors, as well as stigma and cost [25]. Barriers to accessing psychiatric care widen the treatment gap for mental disorders in Latin America to a high 80% [26]. In our study, patients were found to have visited a median of two general medical care institutions before they could receive psychiatric care. One strategy would be to bolster human resources. For example, in Japan the increase in psychiatrists per resident was reflected in a reduction in the number of suicides [27].

The availability of human and material resources for mental health care is crucial in securing timely medical attention: however, in our study the delay in seeking psychiatric care and accessing it was considerable; so, it is paramount to analyze the causes behind the gap in seeking psychiatric care. It has been documented that in the young population, the predisposition to handle the problem by oneself or with friends and family constitutes

[4] National Institute of Statistics and Geography [Internet]. Population and Housing Census; 2021 [cited Apr 2023]. Available from: https://www.inegi.org.mx/app/tabulados/interactivos/?pxq=Salud_Mental_07_f6061818-d620-4269-adbb-d4376cc22c0d

the main barrier to accessing psychiatric care, to a greater extent than costs and difficulties of transportation. Also, having more than one psychiatric diagnosis is a predictor of delay in seeking psychiatric care [28].

In our study, a high percentage of patients had more than one psychiatric diagnosis, mainly affective disorders co-occurring with personality disorders, and patients between 25 and 40 years of age displayed high comorbidity with substance use disorders. Patients with more than one psychiatric diagnosis displayed a higher probability of attempting violent suicide. There is confirmation that having a psychiatric diagnosis with co-occurring mental or behavioral disorders is a predictor of high expectation of fatality when committing suicide, particularly in men [29].

The present work has limitations rooted in the fact that it proved impossible to conduct a structured interview to confirm the psychiatric diagnosis, since the diagnosis was established through a clinical interview in the emergency ward; it proved impossible to measure the magnitude of the harm or the intentionality of the suicidal behavior. The variables were limited to those contained in the reference form of the general medical care unit that referred the patient to the PHFBA.

CONCLUSION

As we have stated, suicide is a public health problem that affects the entire population and, particularly, the young. In conclusion, given the increase in suicidal behavior, the Mexican health system must adopt strategies that would allow prompt identification of patients at risk of committing suicide and timely provision of care to them. In particular, it is reasonable to assume that the availability of health resources significantly affects the possibility of receiving care. It also appears necessary to conduct an analysis of the causes behind the delay in seeking psychiatric care and, in addition, design strategies to detect those at a higher risk, particularly men with more than one psychiatric diagnosis.

Article history

Submitted: 21.07.2023
Accepted: 19.01.2024
Published Online: 04.03.2024

Authors' contribution: Juárez-Domínguez DA contributed to the original idea and development of the work. Cabello-Rangel H contributed to the development and conceptualization of the results. Arteaga-Contreras KM contributed to the analysis of results and critical review of the document. All authors contributed to the final version of the work.

Funding: The research was carried out without additional funding.

Conflict of interest: The authors declare no conflicts of interest.

For citation:
Juárez-Domínguez DA, Arteaga-Contreras KM, Cabello-Rangel H. Suicide attempt violence: gender differences, diagnosis and psychiatric care seeking in Mexico City. *Consortium Psychiatricum*. 2024;5(1):CP13457. doi: 10.17816/CP13457

Information about the authors

Danae Alejandra Juárez-Domínguez, psychiatrist, Faculty of Medicine, National University Autonomous of Mexico;
ORCID: https://orcid.org/0009-0002-5586-7747
Karen Michelle Arteaga-Contreras, Master in Public Health, Psychiatric Care Services, Psychiatric Hospital "Fray Bernardino Álvarez";
ORCID: https://orcid.org/0000-0002-5227-1916
*__Héctor Cabello Rangel__, Doctor of Science, psychiatrist, Head of Research at the Psychiatric Hospital "Fray Bernardino Álvarez";
ORCID: https://orcid.org/0000-0002-0421-4351
E-mail: hector19.05.19.05@gmail.com

*corresponding author

References

1. Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency department visits for suspected suicide attempts among persons aged 12–25 years before and during the COVID-19 pandemic — United States, January 2019–May 2021. MMWR Morb Mortal Wkly Rep. 2021;70(24):888–94. doi: 10.15585/mmwr.mm7024e1
2. Fountoulakis KN, Apostolidou MK, Atsiova MB, et al. Self-reported changes in anxiety, depression and suicidality during the COVID-19 lockdown in Greece. J Affect Disord. 2021;279:624–9. doi: 10.1016/j.jad.2020.10.061
3. Every-Palmer S, Jenkins M, Gendall P, et al. Psychological distress, anxiety, family violence, suicidality, and wellbeing in New Zealand during the COVID-19 lockdown: A cross-sectional study. PLoS One. 2020;15(11):e0241658. doi: 10.1371/journal.pone.0241658
4. Romero-Pimentel AL, Mendoza-Morales RC, Fresan A, et al. Demographic and clinical characteristics of completed suicides in Mexico City 2014–2015. Front Psychiatry. 2018;9:402. doi: 10.3389/fpsyt.2018.00402
5. Florentine JB, Crane C. Suicide prevention by limiting access to methods: a review of theory and practice. Soc Sci Med. 2010;70(10):1626–32. doi: 10.1016/j.socscimed.2010.01.029. Erratum in: Soc Sci Med. 2010;71(11):2046

6. Valdez-Santiago R, Villalobos Hernández A, Arenas-Monreal L, et al. Conducta suicida en México: análisis comparativo entre población adolescente y adulta [Suicidal behavior in Mexico: comparative analysis between adolescent and adult population]. Salud Publica Mex. 2023;65:s110–s116. doi: 10.21149/14815 (Spanish)
7. Ross E, Murphy S, O'Hagan D, et al. Emergency department presentations with suicide and self-harm ideation: a missed opportunity for intervention? Epidemiol Psychiatr Sci. 2023;32:e24. doi: 10.1017/S2045796023000203
8. Demesmaeker A, Chazard E, Hoang A, et al. Author reply to Letter to the Editor regarding 'Suicide mortality after a nonfatal suicide attempt. A systematic review and meta-analysis'. Aust Amp New Zeal J Psychiatry. 2022;56(12):1676–7. doi: 10.1177/00048674221136458
9. Ambrosetti J, Macheret L, Folliet A, et al. Impact of the COVID-19 pandemic on psychiatric admissions to a large swiss emergency department: An observational study. Int J Environ Res Public Health. 2021;18(3):1174. doi: 10.3390/ijerph18031174
10. McDowell MJ, Fry CE, Nisavic M, et al. Evaluating the association between COVID-19 and psychiatric presentations, suicidal ideation in an emergency department. PLoS One. 2021;16(6):e0253805. doi: 10.1371/journal.pone.0253805
11. Ferrando SJ, Klepacz L, Lynch S, et al. Psychiatric emergencies during the height of the COVID-19 pandemic in the suburban New York City area. J Psychiatr Res. 2021;136:552–9. doi: 10.1016/j.jpsychires.2020.10.029
12. Rømer TB, Christensen RHB, Blomberg SN, et al. Psychiatric admissions, referrals, and suicidal behavior before and during the COVID-19 pandemic in denmark: A time-trend study. Acta Psychiatr Scand. 2021;144(6):553–62. doi: 10.1111/acps.13369
13. Smalley CM, Malone DA Jr, Meldon SW, et al. The impact of COVID-19 on suicidal ideation and alcohol presentations to emergency departments in a large healthcare system. Am J Emerg Med. 2021;41:237–8. doi: 10.1016/j.ajem.2020.05.093
14. Hernández-Calle D, Martínez-Alés G, Mediavilla R, et al. Trends in psychiatric emergency department visits due to suicidal ideation and suicide attempts during the COVID-19 pandemic in Madrid, Spain. J Clin Psychiatry. 2020;81(5): 20113419. doi: 10.4088/JCP.20l13419
15. Reif-Leonhard C, Lemke D, Holz F, et al. Changes in the pattern of suicides and suicide attempt admissions in relation to the COVID-19 pandemic. Eur Arch Psychiatry Clin Neurosci. 2023;273(2):357–65. doi: 10.1007/s00406-022-01448-y
16. Cabello Rangel H, Santiago Luna J. Demand for care in a public psychiatric hospital in México City in the context of the COVID-19 pandemic. Archivos Neurociencias. 2022;27(4). doi: 10.31157/an.v27i4.372
17. Czeisler MÉ, Lane RI, Petrosky E, et al. Mental health, substance use, and suicidal ideation during the COVID-19 pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(32):1049–57. doi: 10.15585/mmwr.mm6932a1
18. Manzar MD, Albougami A, Usman N, Mamun MA. Suicide among adolescents and youths during the COVID-19 pandemic lockdowns: A press media reports-based exploratory study. J Child Adolesc Psychiatr Nurs. 2021;34(2):139–46. doi: 10.1111/jcap.12313
19. Iob E, Steptoe A, Fancourt D. Abuse, self-harm and suicidal ideation in the UK during the COVID-19 pandemic. Br J Psychiatry. 2020;217(4):543–6. doi: 10.1192/bjp.2020.130
20. Tanaka T, Okamoto S. Increase in suicide following an initial decline during the COVID-19 pandemic in Japan. Nat Hum Behav. 2021;5(2):229–38. doi: 10.1038/s41562-020-01042-z
21. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Am J Psychiatry. 2003;160(11 Suppl):1–60. Erratum in: Am J Psychiatry. 2004;161(4):776.
22. Isometsä ET, Henriksson MM, Aro HM, et al. Suicide in major depression. Am J Psychiatry. 1994;151(4):530–6. doi: 10.1176/ajp.151.4.530
23. Benke C, Autenrieth LK, Asselmann E, Pané-Farré CA. Lockdown, quarantine measures, and social distancing: Associations with depression, anxiety and distress at the beginning of the COVID-19 pandemic among adults from Germany. Psychiatry Res. 2020;293:113462. doi: 10.1016/j.psychres.2020.113462
24. Corbé J, Montout C, Fares A, et al. A comprehensive study of medically serious suicide attempts in France: incidence and associated factors. Epidemiol Psychiatr Sci. 2023;32:e2. doi: 10.1017/S2045796022000774
25. Moroz N, Moroz I, D'Angelo MS. Mental health services in Canada: Barriers and cost-effective solutions to increase access. Healthc Manage Forum. 2020;33(6):282–7. doi: 10.1177/0840470420933911
26. Kohn R, Levav I, de Almeida JM, et al. Los trastornos mentales en América Latina y el Caribe: asunto prioritario para la salud pública [Mental disorders in Latin America and the Caribbean: a public health priority]. Rev Panam Salud Publica. 2005;18(4–5):229–40. doi: 10.1590/s1020-49892005000900002 (Spanish)
27. Nakanishi M, Endo K. National suicide prevention, local mental health resources, and suicide rates in Japan. Crisis. 2017;38(6):384–92. doi: 10.1027/0227-5910/a000469
28. Ebert DD, Mortier P, Kaehlke F, et al. Barriers of mental health treatment utilization among first year college students: First cross national results from the WHO World Mental Health International College Student Initiative. Int J Methods Psychiatr Res. 2019;28(2):e1782. doi: 10.1002/mpr.1782
29. Rozanov VA. Psychosocial and psychiatric factors associated with expected fatality during suicide attempt in men and women. Consortium Psychiatricum. 2022;3(2):48–59. doi: 10.17816/CP161

Self-Stigma in Patients with Endogenous Mental Disorders: A Cross-Sectional Comparative Study

Самостигматизации у пациентов с эндогенными психическими расстройствами: кроссекционное сравнительное исследование

doi: 10.17816/CP15485

Original research

Tatiana Solokhina, Dmitry Oshevsky, Aleksandra Barkhatova, Marianna Kuzminova, Galina Tiumenkova, Leyla Alieva, Alisa Shteinberg, Anna Churkina

Mental Health Research Center, Moscow, Russia

Татьяна Солохина, Дмитрий Ошевский, Александра Бархатова, Марианна Кузьминова, Галина Тюменкова, Лейла Алиева, Алиса Штейнберг, Анна Чуркина

ФГБНУ «Научный центр психического здоровья», Москва, Россия

ABSTRACT

BACKGROUND: Self-stigma remains one of the most vexing issues in psychiatry. It complicates the treatment and social functioning of patients with endogenous psychiatric disorders. Identifying the specific features of self-stigma depending on the type and duration of the endogenous mental illness can help solve this problem.

AIM: The aim of this study was to establish the level and specific features of self-stigma in patients with various types of chronic endogenous psychiatric disorders at different disease stages and to establish the correlation between the level of self-stigma and the attitude of the patient to his/her disease and treatment.

METHODS: Clinical psychopathology assessment, psychometric scales and questionnaires: "Positive and Negative Syndrome Scale" (PANSS), "Questionnaire for Self-Stigma Assessment in Mentally Ill Patients", and Russian versions of the "Insight Scale for Psychosis" (ISP), and "Drug Attitude Inventory" (DAI-10). The cross-sectional study included 86 patients with endogenous mental illnesses (bipolar affective disorder and schizophrenia spectrum disorders.

RESULTS: The analysis of the results of the "Questionnaire for Self-Stigma Assessment in Mentally Ill Patients" showed that at the initial disease stages the highest level of self-stigma is observed in patients with bipolar affective disorder (M±σ=1.22±0.73; Me [Q1; Q3]=1.10 [0.83; 1.60]), while the lowest level was observed in patients with schizophrenia spectrum disorders (M±σ=0.86±0.53; Me [Q1; Q3]=0.77 [0.31; 1.25]). Patients with schizophrenia and schizoaffective disorder and a disease duration more than five years participating in a long-term comprehensive psychosocial rehabilitation program also demonstrated high rates of self-stigma (M±σ=1.20±0.57, Me [Q1; Q3]=1.26 [0.89; 1.47]). The study groups showed differences in terms of the structure of components of self-stigma and their severity; significant correlations were uncovered between the self-stigma parameters and the attitude of patients to their disease and therapy.

CONCLUSION: The results of this study contribute to a better understanding of the specific features of self-stigma in patients with various endogenous disorders at different stages of the disease. These data can be used as part of a comprehensive psychosocial treatment program for this patient cohort, as well as for future research.

АННОТАЦИЯ

ВВЕДЕНИЕ: Самостигматизация остается одной из актуальных проблем современной психиатрии, которая затрудняет лечение и социальное функционирование пациентов с эндогенными психическими расстройствами. Решению этой проблемы может способствовать определение особенностей и специфики самостигматизации в зависимости от формы и длительности эндогенного психического расстройства.

ЦЕЛЬ: Установить уровень и особенности самостигматизации у пациентов с различными формами эндогенных хронических психических расстройств на разных этапах болезни и выявить связь выраженности самостигматизации с отношением к своему заболеванию и лечению.

МЕТОДЫ: Клинико-психопатологический, психометрические шкалы и опросники («Опросник для оценки феномена самостигматизации психически больных», «Шкала позитивных и негативных симптомов — «Positive and Negative Syndrome Scale» (PANSS), русскоязычные версии опросников «Осознание болезни» — «Insight Scale for Psychosis» (ISP), «Отношение к лекарственным препаратам» — «Drug attitude inventory» (DAI-10). Проведено кроссекционное исследование 86 пациентов с эндогенными психическими заболеваниями (биполярное аффективное расстройство и расстройства шизофренического спектра).

РЕЗУЛЬТАТЫ: С помощью «Опросника для оценки феномена самостигматизации психически больных» установлено, что на начальном этапе заболевания наибольший уровень самостигматизации характерен для пациентов с биполярным аффективным расстройством (M±σ=1,22±0,73; Me [Q1; Q3]=1,10 [0,83; 1,60]), наиболее низкий выявлен у пациентов с расстройствами шизофренического спектра (M±σ=0,86±0,53; Me [Q1; Q3]= 0,77 [0,31; 1,25]). Пациенты с шизофренией и шизоаффективным расстройством и длительностью заболевания более 5 лет, участвующие в долгосрочной комплексной программе психосоциальной реабилитации, также продемонстрировали высокие показатели самостигматизации (M±σ=1,20±0,57, Me [Q1; Q3]= 1,26 [0,89; 1,47]). В изученных группах обнаружены различия в структуре компонентов самостигматизации пациентов и их выраженности и получены достоверные корреляционные связи между показателями самостигматизации, отношением пациентов к имеющемуся психическому расстройству и получаемому лечению.

ЗАКЛЮЧЕНИЕ: Результаты проведенного исследования уточняют и расширяют имеющиеся знания об особенностях самостигматизации у пациентов с различными эндогенными расстройствами на разных этапах заболевания. Полученные данные могут послужить основой для дальнейших исследований, а также для использования в комплексном психосоциальном лечении таких пациентов.

Keywords: *self-stigma; schizophrenia; schizoaffective disorder; bipolar affective disorder; first episode psychosis*
Ключевые слова: *самостигматизация; шизофрения; шизоаффективное расстройство; биполярное аффективное расстройство; первый психотический эпизод*

INTRODUCTION

An analysis of publications in international scientific databases (PubMed, Cochrane, Researchgate, Google Scholar) related to stigma and self-stigma in mentally ill patients showed that over the past 10 years (from 2013 to 2023), more than 2,000 papers were published, i.e. almost as many as in the previous 50 years, after the concept of "stigma" was first introduced in the psychiatry lexicon in 1963 [1]. This increase is quite understandable and indicates the relevance and importance of the notion, since the negative consequences associated with the stigma of mentally ill persons cause significant damage not only to the patients themselves, but also to their families, society, and the state. Traditionally, the WHO has considered the fight against stigma and self-stigma in mentally ill patients to be one of the most important areas of modern psychiatry.[1]

[1] World Health Organization (WHO) [Internet]. Comprehensive Mental Health Action Plan 2013–2030. Available from: https://www.who.int/publications/i/item/9789241506021

As a result of stigma (social "ostracism" and social rejection due to existing myths, prejudices, and stereotypes), mentally ill patients tend to develop distrust toward psychiatric services, raise barriers to seeking help, which can result in a deterioration of their clinical state, non-compliance, and adversely affect their social functioning [2]. There are problems with work and studies, social life; the quality of life suffers, while the risk of substance abuse, suicide, and other consequences increases [3, 4]. The response to the disease, related transformations, and a feeling of being "mentally ill" may result in a complex psychological phenomenon known as self-stigma, which is a combination of negative responses, experiences, assessments, and personality changes [2].

Some researchers have stated that patients with endogenous mental illnesses (e.g. schizophrenia, schizoaffective disorder, bipolar affective disorder [BAD], etc.) are more stigmatized and predisposed to self-stigma compared to patients with other psychiatric disorders [5, 6, 7]. All over the world, increased attention is directed at organizing comprehensive care for such patients as early as at the initial stages of their disease [8, 9]. For patients with schizophrenia spectrum disorders, the first five years from the disease onset are considered the most significant in terms of prognosis, treatment efficacy, and outcomes. During this period, despite the intensity of the psychopathology processes, there exists a tendency towards their recurrence and towards the development of chronic disorders, and they are at their highest stage of plasticity and curability [10]. Similar data were obtained in relation to BAD [11]. However, our observations have shown that the patients at the initial disease stages may underestimate the seriousness of their condition and possible social life limitations (due to the lack of criticality), and, consequently, they may be at a higher potential risk of developing stigma and self-stigma. Moreover, changes over time in self-stigma in a patient with a developing mental illness is also of interest. In chronically ill patients, the self-stigma becomes part of clinical manifestations, it worsens their condition, and it leads to more pronounced maladaptation [12].

Self-stigma has been shown to have complex, yet close, links to motivation as regards treatment [13]. The inclusion of elements of a fight against the stigma in psychosocial rehabilitation (PSR) activities increases compliance in patients [14], allows to achieve good adherence to treatment, and helps to avoid many other negative clinical, psychological, and social consequences associated with the disease [15, 16]. However, in terms of the biopsychosocial approach, it is advisable to consider sociodemographic, as well as the clinical and psychological features of self-stigma in order to develop effective, patient-centered medical and rehabilitation programs.

Thus, the relevance of the issue is conditioned by the need for an in-depth study of the problem of self-stigma in patients with various types of endogenous mental illnesses at both early and later stages of the disease and its connection with the specific features of the attitude to their psychiatric disorder and therapy.

This study was based on a general hypothesis holding that the severity and structure of self-stigma are specific, depending on the type of mental illness and its duration. According to a particular hypothesis, there are associations between self-stigma and the patterns of attitudes toward the mental illness and treatment.

The aim of this study was to establish the level and specific features of self-stigma in patients with various types of chronic endogenous psychiatric disorders at different disease stages and to determine the correlation between the level of self-stigma and patient attitude to his/her disease and treatment.

METHODS

Study design

This was an observational comparative cross-sectional study of three groups of patients with endogenous psychiatric disorders.

Setting

The study was conducted at the Mental Health Research Center, mental health facilities in Moscow (Mental-health clinic No. 1 named after N.A. Alexeev, Mental-health clinic No. 4 named after P.B. Gannushkin), as well as at the Regional Charitable Public Organization "Family and Mental Health", between January and November 2023. In order to ensure a high-quality assessment of patients mental state, a clinical psychopathology assessment was conducted by psychiatrists. The assessments using psychometric scales were carried out once beyond the exacerbation period by clinical psychologists, together with psychiatrists.

Patients were recruited to the study in a continuous manner.

The inclusion criteria were as follows: verified diagnosis of bipolar affective disorder (F31.xxx according to the

ICD-10), or schizophrenia spectrum disorder (F20.xxx, F23.xxx, F25.xxx according to the ICD-10); mental illness duration less than five years and a history of three and less hospitalizations for patients with recent disease; disease duration more than five years for chronically ill patients; written voluntary consent of the patient to participate in the study.

The exclusion criteria were as follows: refusal to participate in the study; acute symptoms that prevent any assessment (for patients with schizophrenia spectrum disorders, five and more PANSS scores on each item); concomitant structural brain disorders, and substance abuse.

The patients were allocated to three groups according to their diagnosis and duration of their mental illness.

Group 1 "Schizophrenia spectrum disorders, first episode psychosis" (SSD FEP), (*n*=39) included patients with psychotic schizophrenia spectrum disorders (F20.xxx, F23.xxx, F25.xxx according to the ICD-10) in accordance with the criteria of the first episode psychosis used in this study (duration of illness five years and less, history of three hospitalizations and less). The patients were treated in a daycare department at mental-health clinic No. 1 and No. 4 in Moscow, or as inpatients in the Mental Health Research Center.

Group 2 (BAD) included patients with the F31.xxx diagnoses according to the ICD-10 (*n*=17) at the initial stages of the disease (disease duration five years and less; a history of three hospitalizations and less). The patients were receiving outpatient and inpatient treatment at the Mental Health Research Center.

Group 3 "Schizophrenia spectrum disorders, psychosocial rehabilitation" (SSD PSR), (*n*=30) included patients with schizophrenia spectrum disorders (F20.xxx, F25.xxx according to the ICD-10) at advanced stages of the disease duration of more than five years. Patients in this group were members of the Regional Charitable Public Organization "Family and Mental Health" and participants of a long-term comprehensive psychosocial rehabilitation program conducted by this organization in the community.

Measures

The socio-demographic characteristics of the patient (sex, age, marital status, education level) were analyzed during the study. The data obtained were recorded on a research form for subsequent frequency analysis. Moreover, clinical psychopathology assessment and assessments using clinical psychometric scales and questionnaires were conducted.

Psychometric assessments included the use of the following techniques.

The Positive and Negative Symptom Scale (PANSS) [17] was applied to evaluate the severity of psychopathology symptoms in patients with schizophrenia spectrum disorders; other questionnaires were used with patients from all three groups.

"Questionnaire for Self-Stigma Assessment in Mentally Ill Patients" [18, 19]. The method is aimed at revealing the severity of the self-stigma and determining its structure based on 83 statements related to various areas of a person's psychological and social functioning. They form nine scales: "Overestimation of self-actualization"; "Impairment of self-identity"; "Readiness to be labeled 'mentally ill' as relates to work adaptation"; "De-identification from others in the society"; "Distancing from mentally ill persons in the area of internal activity"; "Readiness to distance oneself from mentally ill persons in the society"; "Overestimation of internal activity"; "Acceptance of the role of a mentally ill person in the area of self-actualization"; and "Mirror self of a mentally ill person in the area of internal activity". The method allows one to investigate the general degree of self-stigmatization, as well as its individual components. The statements are rated by the subject on a direct scale from 0 to 3 with an interval of one, where "0" corresponds to complete disagreement and "3" implies complete agreement. The higher the score, the higher the level of self-stigmatization and its individual components. Furthermore, the following types of self-stigma were assessed: *auto-psychic* (idealization of the period before the onset of the disease, less severe requirements towards oneself); *compensatory* (partial ignoring of mental illness-associated symptoms and exaggerated attribution of failure to "mentally ill" subjects; and *socio-reversive (*associated with changes in personal position and distancing from society).

The *"Insight Scale for Psychosis" (ISP) scale* [20] allows one to assess the illness perception based on the patient's self-reporting. The scale consists of 8 questions, the highest score for each subscale is three, and it corresponds to a high level of agreement with the statements, indicating good illness awareness. The assessment is based on three parameters: the patient's ability to recognize the disease manifestations as symptoms of mental illness; the patient's awareness of mental illness; and the patient's acceptance of the need for treatment.

"Drug Attitude Inventory" (DAI-10) consists of 10 questions and is a shortened version of DAI-30 [21]. The scale includes

five direct and five reverse statements the patient needs to agree or disagree with. The positive and negative scores are summarized. If the resulting total score is positive, this indicates acceptance of the need for drug therapy; the higher the total score, the higher the level of acceptance of the need for treatment.

Statistical analysis

The mathematical and statistical methods implemented in the STATISTICA 12.1.rus software and Excel office package were used to verify and objectify the data. The minimum sample size for the significance level (p=0.05) was determined using the method of Otdelnova KA [22]. The Bonferroni correction (α adjusted=α baseline/3) was applied; and the critical significance level for such comparisons was 0.017 to adjust the estimate of the reliability of the differences in multiple comparisons of three samples. The analysis conducted using the Shapiro-Wilk test showed that the obtained data were not normally distributed; therefore, nonparametric tests were applied. The Mann-Whitney nonparametric test (U-test) was used in the comparative study of quantitative values in two groups, and the Kruskal-Wallis nonparametric test (H-test) (ANOVA) was used for the comparison of three groups. The study results are presented as median values with indication of interquartile ranges; i.e., first (lower) and third (upper) quartiles (Me [Q1; Q3]), the mean value of the parameter taking into account the standard deviation M±σ. The Fisher's exact test (F-test) was used to compare the frequency of categories of qualitative variables between study groups. The strength of possible correlation between qualitative and ordinal variables was assessed using the nonparametric Spearman rank correlation coefficient (r-Spearman).

Ethical approval

The study was conducted in compliance with the principles of the Declaration of Helsinki of the World Medical Association "Ethical Guidelines for Health-related Research Involving Humans" of 1964 (revised in October 1975 — October 2013) and was approved by the local ethics committee of Mental Health Research Center (minutes No. 914 of November 21, 2023). All the patients included in the study had provided written voluntary informed consent for participation in the study and processing of their personal data.

RESULTS

Sample characteristics

The analysis of socio-demographic parameters (see Table 1) showed that younger persons prevailed among patients at the initial disease stages (H=28.93; df=2; p=0.0001). Among patients with SSD PSR, there were older subjects ($U_{SSD\ FEP\ vs\ SSD\ PSR}$=134.50; p=0.00011; $U_{BAD\ vs\ SSD\ PSR}$=18.00; p=0.0001). However, a comparative analysis of age subgroups in the SSD FEP and BAD groups showed no significant differences (U=245.00; p=0.2020), which allowed us to assign the subjects at the initial disease stages to one age category.

The analysis of the percentages of male and female subjects, depending on the duration of the mental illness, did not demonstrate any differences at the level of the statistical significance calculated by the F-test ($p_{SSD\ FEP\ vs\ BAD}$=0.6296; $p_{SSD\ FEP\ vs\ SSD\ PSR}$=0.4965; $p_{BAD\ vs\ SSD\ PSR}$=0.3417).

The patients in all groups had quite a high level of education, with no differences in terms of this parameter ($p_{SSD\ FEP\ vs\ BAD}$=0.2413; $p_{SSD\ FEP\ vs\ SSD\ PSR}$=0.7138; $p_{BAD\ vs\ SSD\ PSR}$=0.3809).

Before the onset of a psychiatric disorder, patients with SSD FEP and BAD were more likely to be involved in a qualified occupation and studies than patients

Table 1. Patient sociodemographic characteristics

Parameter	Patient groups		
	SSD FEP ***n*=39**	**BAD** ***n*=17**	**SSD PSR** ***n*=30**
Age (years) m±σ Me [Q1; Q3]	 25.53±4.56; 25 [22; 29]	 28.95±8.53; 29 [22; 35]	 42.21±10.36; 40 [34; 50]
Sex			
male, *n* (%)	16 (41.02%)	5 (29.41%)	16 (53.33%)
female, *n* (%)	23 (58.98%)	12 (70.59%)	14 (46.67%)
University education/undergraduate, *n* (%)	16 (41.03%)	10 (58.82%)	14 (46.67%)
Married/has a partner, *n* (%)	6 (15.38%)	2 (11.76%)	3 (10.00%)
Work/studies before the onset of a psychiatric disorder, *n* (%)	19 (48.72%)	11 (64.71%)	5 (16.67%)

Table 2. PANSS scores in patients with schizophrenia spectrum disorders with different disease durations

Parameter	Patients SSD FEP (*n*=39) m±σ; Me [Q1; Q3]	Patients SSD PSR (*n*=30) m±σ; Me [Q1; Q3]	U	*p*
P-1 Delusions	2.08±0.87 2 [1; 3]	1.09±0.11 1 [1; 1]	132.0	0.000002
P-2 Judgement disorders (conceptual disorganization)	2.26±1.02 2 [1; 3]	1.17±0.48 1 [1; 1]	177.5	0.000041
P-3 Hallucinatory behavior	1.69±0.69 2 [1; 2]	1.13±0.34 1 [1; 1]	255.0	0.002633
P-4 Excitement	1.64±0.78 1 [1; 2]	1.11±0.07 1 [1; 1]	252.0	0.002288
P-5 Grandiosity	1.51±0.64 1 [1; 2]	1.12±0.2 11 [1; 1]	253.0	0.004489
P-6 Suspiciousness	2.08±1.01 2 [1; 3]	1.13±1.33 1 [1; 1]	205.5	0.000209
P-7 Hostility	1.46±0.60 1 [1; 2]	1.04±0.25 1 [1; 1]	294.5	0.014344
Composite score, “Positive symptoms” subscale	12.72±4.22 12 [10; 15]	7.42±0.93 7 [7; 7.5]	100.5	0.000001
N-1 Blunted affect	2.54±0.91 3 [2; 3]	2.96±0.62 3 [3; 3]	342.0	0.075691
N-2 Emotional withdrawal	2.51±1.05 2 [2; 3]	2.75±0.89 3 [2; 3]	401.5	0.350238
N-3 Poor rapport	2.10±1.12 2 [1; 3]	3.00±0.88 3 [2.5; 3.5]	253.0	0.002398
N-4 Passive/apathetic withdrawal	2.49±1.02 2 [2; 3]	2.88±0.85 3 [2;3]	362.0	0.135388
N-5 Difficulty in abstract thinking	2.00±0.79 2 [1; 3]	3.25±1.29 3 [2.5; 4]	199.5	0.000149
N-6 Lack of spontaneity conversation	1.82±0.82 2 [1;2]	2.95±1.42 3 [2; 4]	243.5	0.001523
N-7 Stereotyped thinking	1.83±0.76 2 [1; 2]	3.20±1.47 3 [2; 4.5]	210.5	0.000275
Composite score, “Negative symptoms” scale	15.28±5.38 15 [12; 19]	21.00±5.05 21 [16.5; 24.5]	201.5	0.000167
G-1 Somatic concern	2.05±0.92 2 [1; 3]	2.45±0.97 2 [2; 3]	354.5	0.109746
G-2 Anxiety	2.74±0.82 3 [2; 3]	2.52±0.86 2 [2; 3]	421.5	0.515009
G-3 Guilt feelings	2.18±1.10 2 [1; 3]	1.38±0.57 1 [1; 2]	262.5	0.003715
G-4 Tension	2.74±0.88 2 [1; 3]	2.58±0.77 2.5 [2; 3]	411.0	0.423902
G-5 Mannerisms and posturing	1.85±0.74 2 [1; 2]	1.46±0.76 1 [1; 1.5]	315.0	0.030897
G-6 Depression	2.41±1.12 2 [2; 3]	2.12±0.85 2 [1.5; 3]	415.5	0.461743
G-7 Motor retardation	2.03±0.99 2 [1; 3]	1.67±0.85 1 [1; 2]	352.0	0.102108
G-8 Uncooperativeness	1.64±0.99 1 [1; 2]	1.33±0.64 1 [1; 1.5]	397.0	0.318368
G-9 Unusual thought content	2.33±1.13 2 [1; 3]	2.67±1.13 3 [2; 3]	357.5	0.119500
G-10 Disorientation	1.59±0.68 1 [1; 2]	1.09±0.12 1 [1; 1]	240.0	0.001282
G-11 Poor attention	2.13±1.03 2 [1; 3]	2.91±0.83 3 [2; 3.5]	258.0	0.003026

Parameter	Patients SSD FEP (*n*=39) m±σ; Me [Q1; Q3]	Patients SSD PSR (*n*=30) m±σ; Me [Q1; Q3]	U	*p*
G-12 Lack of judgement and insight	2.00±1.00 2 [1; 3]	3.21±1.06 3.5 [2.5; 4]	195.5	0.000118
G-13 Disturbance of volition	2.21±0.83 2 [2; 3]	3.37±0.76 3 [3; 4]	156.0	0.000010
G-14 Poor impulse control	1.64±0.74 1 [1; 2]	2.87±0.89 3 [2; 3.5]	163.0	0.000016
G-15 Preoccupation	2.44±1.07 2 [2; 3]	2.83±1.19 3 [2; 3]	353.5	0.106638
G-16 Active social avoidance	2.26±0.97 2 [2; 3]	1.87±1.06 1.5 [1; 3]	355.0	0.111326
Composite score, "General psychopathology" scale	34.23±10.41 33 [27; 40]	36.51±5.821 35 [33.5; 40]	372.5	0.178762
PANSS total score	62.23±18.28 60 [49; 74]	64.19±9.91 63.5 [58; 71]	389.0	0.266549

with SSD PSR ($p_{SSD\ FEP\ vs\ BAD}$=0.1181; $p_{BAD\ vs\ SSD\ PSR}$=0.0371; $p_{SSD\ FEP\ vs\ SSD\ PSR}$=0.060). Family relationships were rare in patients from all three groups, and no significant difference was noted for this parameter ($p_{SSD\ FEP\ vs\ BAD}$=0.6943; $p_{SSD\ FEP\ vs\ SSD\ PSR}$=0.5913; $p_{BAD\ vs\ SSD\ PSR}$=0.3718).

Assessment using the PANSS (see Table 2) and clinical assessment by a psychiatrist during the study showed that residual productive symptoms prevailed at the initial stages of schizophrenia spectrum disorders (SSD FEP).

The above-mentioned symptoms included incompletely reduced delusional concepts, judgment disorders, some hallucinatory phenomena, agitation, mild delusions of grandeur, suspiciousness, and hostility, which was also reflected in higher scores in all seven subscales (P1-P7) of the PANSS in patients with SSD FEP.

In patients with SSD PSR, negative symptoms prevailed. Poor rapport (N-3), difficulty with abstract thinking (N-5), lack of spontaneity in conversation (N-6), and stereotyped thinking were observed (N-7).

Among general psychopathology symptoms, SSD PSR patients showed more pronounced disorientation (G-10), attention deficit (G-11), lack of judgement and insight (G-12), significant disruption of volition (G-13), and poor impulse control (G-14).

Characteristics of self-stigma in the study groups

The results of the analysis of the structure of self-stigma and the severity of its components in the study groups are shown in Table 3.

The most elevated general level of self-stigma was observed in patients with BAD, which was significantly different compared to those with SSD FEP. In this group, the following components were found to be the most pronounced: "De-identification", "Overestimation of self-actualization", "Overestimation of internal activity", and "Readiness to distance oneself from mentally ill persons in the society". This combination was characterized by the predominance of the auto-psychic self-stigma type.

Patients with SSD FEP had a relatively low level of self-stigma in general and its structural components, in particular. The lowest severity of self-stigma was observed in the following scales: "Mirror self of a mentally ill person in the area of internal activity", "Acceptance of the role of a mentally ill person in the area of self-actualization", "De-identification from others in the society", "Distancing from mentally ill persons in the area of internal activity", and "Restriction of work adaptation of mentally ill persons". Different forms of self-stigma, autopsychic, compensatory, and socio-reversive forms, were mild.

Patients with SSD PSR were shown to have an elevated level of self-stigma. The leading components in its structure were "Overestimation of self-actualization", "Readiness to distance oneself from mentally ill persons in the society", "Distancing from mentally ill persons in the area of internal activity", and "Impairment of self-identity". The auto-psychic form of self-stigma was the most pronounced in them, as well as in patients with BAD; however, the levels of compensatory and socio-reversive forms were also high.

Correlation between the level of self-stigma and patients' attitude toward the disease and treatment

The results of the assessment of patients attitudes toward the disease and treatment received are shown in Table 4.

No significant differences were found in all 3 groups in terms of the ISP parameter "Need for treatment awareness".

Table 3. Comparison of the severity of self-stigma structural components in the study groups according to the data of "Questionnaire for Self-Stigma Assessment in Mentally Ill Patients"

Parameter	Patients SSD FEP (*n*=39) m±σ; Me [Q1; Q3]	Patients BAD (*n*=17) m±σ; Me [Q1; Q3]	Patients SSD PSR (*n*=30) m±σ; Me [Q1; Q3]	U, *p* (Mann-Whitney)			H at df=2; *p* (Kruskal-Wallis)
				SSD FEP vs BAD	SSD FEP vs SSD PSR	BAD vs SSD PSR	
Component 1. Overestimation of self-actualization	1.05±0.74 1.00 [0.36; 1.55]	1.84±0.81 1.82 [1.27; 2.45]	1.48±0.78 1.50 [1.00; 2.00]	139.50 0.00212	139.00 0.012942	185.50 0.126197	11.2254 0.0037
Component 2. Violation of self-identity	0.82±0.65 0.67 [0.22; 1.44]	1.37±0.77 1.33 [0.78; 2.00]	1.17±0.59 1.17 [0.89; 1.56]	179.50 0.012901	379.50 0.056384	228.00 0.556294	6.5312 0.0382
Component 3. Restriction of work adaptation of mentally ill persons	0.80±0.57 0.86 [0.29; 1.29]	1.07±0.83 1.00 [0.43; 1.57]	1.13±0.61 1.14 [0.71; 1.29]	229.00 0.018467	377.00 0.052264	232.00 0.616728	4.3466 0.1144
Component 4. De-identification from others in the society	0.74±0.56 0.83 [0.22; 1.11]	0.93±0.76 0.72 [0.17; 1.28]	1.09±0.68 1.08 [0.61; 1.50]	271.50 0.618884	369.00 0.040735	215.50 0.387369	3.9412 0.1394
Component 5. Distancing from the mentally ill persons in the area of internal activity	0.78±0.49 0.78 [0.44; 1.00]	0.97±0.76 0.78 [0.33; 1.22]	1.20±0.52 1.22 [0.89; 1.56]	265.00 0.532477	284.50 0.001588	175.00 0.076554	10.0796 0.0065
Component 6. Readiness to distance from the mentally ill persons in the society	1.21±0.57 1.17 [0.83; 1.67]	1.24±0.75 1.33 [0.67; 1.50]	1.44±0.72 1.50 [1.17; 1.83]	293.50 0.945567	405.00 0.115835	203.50 0.257271	2.7554 0.2522
Component 7. Overestimation of internal activity	1.21±0.74 1.27 [0.45; 1.91]	1.96±0.87 2.18 [1.45; 2.64]	1.61±0.67 1.73 [1.09; 2.18]	139.50 0.002124	351.00 0.022426	177.50 0.087781	11.8829 0.0026
Component 8. Acceptance of the role of a mentally ill person in the area of self-actualization	0.60±0.48 0.57 [0.14; 1.00]	0.82±0.73 0.71 [0.43; 1.00]	0.81±0.61 0.79 [0.29; 1.29]	266.50 0.551865	419.00 0.165053	240.50 0.755289	1.8538 0.3958
Component 9. "Mirror self of a mentally ill person in the area of internal activity"	0.30±0.40 0.00 [0.00; 0.60]	0.31±0.82 0.00 [0.00; 0.20]	0.54±0.61 0.30 [0.00; 1.00]	255.00 0.412615	432.00 0.223525	187.00 0.104518	3.4201 0.1809
Auto-psychic type	1.13±0.72 1.05 [0.45; 1.64]	1.90±0.82 1.91 [1.45; 2.50]	1.55±0.68 1.61 [1.23; 2.00]	134.50 0.001525	349.00 0.020921	183.50 0.115717	12.1452 0.0023
Compensatory type	0.93±0.46 0.92 [0.46; 1.34]	1.09±0.72 1.00 [0.59; 1.49]	1.25±0.57 1.30 [0.95; 1.56]	258.00 0.446789	336.50 0.013365	205.00 0.273074	5.9742 0.0504
Socio-reversive type	0.62±0.49 0.42 [0.17; 1.02]	0.85±0.73 0.77 [0.38; 1.11]	0.90±0.55 0.91 [0.43; 1.20]	237.00 0.241829	370.00 0.042046	221.00 0.458229	4.5119 0.1048
Total score	0.86±0.53 0.77 [0.31; 1.25]	1.22±0.73 1.10 [0.83; 1.60]	1.20±0.57 1.26 [0.89; 1.47]	209.00 0.086048	357.50 0.027981	248.00 0.885566	5.7806 0.0556

Table 4. Attitudes toward drug therapy and illness in patients with endogenous chronic disorders depending on the type of mental illness and treatment duration (using the ISP and DAI-10)

Parameter	Patients SSD FEP (*n*=39) m±σ; Me [Q1; Q3]	Patients BAD (*n*=17) m±σ; Me [Q1; Q3]	Patients SSD PSR (*n*=30) m±σ; Me [Q1; Q3]	U, *p* (Mann-Whitney)			H at df=2; *p* (Kruskal-Wallis)
				SSD FEP vs BAD	SSD FEP vs SSD PSR	BAD vs SSD PSR	
Need for treatment awareness (ISP)	2.94±0.91 3.00 [2.00; 4.00]	3.03±0.70 3.50 [2.50; 3.50]	3.17±0.79 2.25 [2.50; 4.00]	320.50 0.848772	379.5 0.514655	405.50 0.369974	0.8943 0.6394
Symptom attribution (ISP)	2.59±1.19 3.00 [2.00; 4.00]	3.35±0.79 4.00 [3.00; 4.00]	3.20±0.78 3.00 [3.00; 4.00]	208.50 0.016431	333.50 0.047519	182.00 0.538054	7.0838 0.0290
Illness awareness (ISP)	2.31±0.97 2.00 [1.00; 3.00]	3.59±0.61 4.00 [3.00; 4.00]	3.21±1.14 4.00 [3.00; 4.00]	128.00 0.000193	265.00 0.003028	174.00 0.442831	17.5539 0.0002
Drug attitude (DAI-10).	1.44±3.46 2.00 [-2.00; 4.00]	3.88±3.27 3.50 [2.50; 3.50]	3.25±4.36 4.00 [1.00; 7.00]	202.00 0.015291	288.50 0.016228	196.00 0.840198	7.7980 0.01653

Note: ISP — Insight Scale for Psychosis; DAI-10 — Drug attitude inventory.

Table 5. Correlation matrix of the results obtained using the DAI-10 and ISP scales according to the data of "Questionnaire for Self-Stigma Assessment in Mentally Ill Patients"

Spearman correlation coefficient (*r*)												
	Drug Attitude Inventory (DAI-10)			Symptom attribution (ISP)			Illness awareness (ISP)			Need for treatment awareness (ISP)		
Parameter/Group	**SSD FEP**	**BAD**	**SSD PSR**	**SSD FEP**	**BAD**	**SSD PSR**	**SSD FEP**	**BAD**	**SSD PSR**	**SSD FEP**	**BAD**	**SSD PSR**
Component 1. Overestimation of self-actualization	-0.16	-0.18	-0.45*	0.01	0.22	-0.13	0.58*	0.54*	0.22	0.14	0.02	-0.21
Component 2. Impairment of self-identity	-0.12	-0.31	-0.31	-0.12	0.32	-0.17	0.47*	0.64*	0.10	0.05	-0.03	-0.23
Component 3. Restriction of work adaptation of mentally ill persons	-0.03	-0.21	-0.21	-0.07	0.27	-0.01	0.33	0.16	0.36	-0.05	0.03	0.07
Component 4. De-identification from others in the society	-0.11	-0.32	-0.46*	-0.04	0.08	-0.09	0.61*	0.37	0.11	0.06	0.12	-0.33
Component 5. Distancing from the mentally ill persons in the area of internal activity	0.10	-0.18	-0.41*	-0.17	0.28	0.00	0.44*	0.41	0.23	-0.07	0.10	-0.15
Component 6. Readiness to distance from the mentally ill persons in the society	0.03	-0.26	-0.03	-0.19	0.28	0.12	0.22	0.47	0.43*	-0.20	0.06	0.26
Component 7. Overestimation of internal activity	-0.25	-0.39	-0.36	0.08	0.19	-0.10	0.52*	0.54*	0.23	0.19	0.05	-0.07
Component 8. Acceptance of the role of a mentally ill person in the area of self-actualization	-0.04	-0.25	-0.41*	-0.08	0.11	-0.09	0.45*	0.20	-0.04	-0.06	0.05	-0.42*
Component 9. "Mirror self of a mentally ill person in the area of internal activity"	-0.06	-0.44	-0.65*	-0.05	0.06	-0.10	0.27	0.28	-0.08	-0.11	-0.10	-0.57*
Auto-psychic type	-0.23	-0.29	-0.45*	0.08	0.24	-0.11	0.57*	0.61*	0.22	0.17	0.02	-0.18
Compensatory type	0.06	-0.25	-0.19	-0.16	0.25	0.05	0.55*	0.36	0.33	-0.13	0.16	-0.46*
Socio-reversive type	-0.06	-0.27	-0.58*	-0.08	0.18	-0.17	0.26	0.32	0.01	0.01	0.10	0.28
Total score	-0.09	-0.28	-0.43*	-0.02	0.18	-0.08	0.56*	0.46*	0.12	0.06	0.09	-0.42*

Note: * r-Spearmen's at $p \leq 0.01$.

However, patients with SSD FEP tended to possess lower Drug Attitude Inventory (DAI-10) scores, which set a distinction between them and the patients in the BAD and SSD FEP groups. A similar tendency was observed for the ISP parameter "Illness awareness". Patients with SSD FEP showed significantly lower results compared to patients in the BAD and SSD FEP groups.

The correlation analysis between the scales of "Questionnaire for Self-Stigma Assessment in Mentally Ill Patients" and the ISP and DAI-10 parameters showed moderate direct and inverse correlations (see Table 5).

Patients with SSD FEP demonstrated multiple, significant direct moderate correlation between the parameters of "Disease awareness" of the ISP and self-stigma parameters. Patients with BAD tended to show less such correlation. There were only a few of those in the SSD PSR group.

SSD PSR group patients demonstrated multiple, significant moderate reverse correlations between the ISP parameter of "Need to treatment awareness", as well as the "Drug Attitude Inventory" (DAI-10) scores, with the parameters of the "Questionnaire for Self-Stigma Assessment in Mentally Ill Patients". No such correlations were reveled in the BAD and SSD PSR groups.

DISCUSSION

The results of the study confirmed the general hypothesis that there are differences in the level and structure of self-stigma in patients with endogenous chronic mental illnesses, depending on their type and disease duration.

The most elevated general level of self-stigma was observed in the BAD group. The most pronounced structural components of self-stigma in these patients included idealization (overestimation) of their own activity and realization of their abilities before the onset of the disease. Patients believed that, because of their mental illness, they had lost the opportunity to engage in pleasurable experiences, activity, and productivity, and their prospects for success in learning and professional activities were

significantly reduced. The assessment of their interpersonal relationships showed that the patient has doubts in their ability to keep friendship or maintain family relationships. Idealization of the pre-disease period of life in patients with BAD and underestimation of their own actual capabilities led to a pessimistic view of their future, identity disorders, low expectations on themselves, and secondary decrease in activities, which, apparently, was no longer directly related to affective symptoms. This combination was characterized by the predominance of the auto-psychic self-stigma form.

Our results correlate with the data of meta-analyses, which have shown that high levels of self-stigma are typical of BAD patients as early as at the initial stages of the disease [24; 25]. At the same time, these publications emphasize the fact that patients' intense experiences and ongoing changes are associated not only with the severity of depressive symptoms and decreased quality of life, but also with an overly critical attitude towards their altered internal and external life conditions.

Patients with initial stages of schizophrenia (SSD FEP group) had a relatively low level of self-stigma in general, and its structural components in particular. Those patients believed that their mental illness and related changes would not noticeably affect their perception of the external world, limit their creative, professional, and social activities, or act as an obstacle to self-actualization. These patients tended to distance themselves from the image of "a mentally ill person", without accepting the restrictions that are associated with a mental illness and with underestimation of possible social and interpersonal problems, and they demonstrated a desire to distance themselves from mentally ill persons.

Various forms of self-stigmaautopsychic, compensatory, and socio-reversive forms in patients with schizophrenia spectrum disorders at the initial stages of the disease were mild.

It was noteworthy that patients with schizophrenia spectrum disorders at the late stages of the disease (SSD PSR group), despite their long-term psychological and social rehabilitation, as well as patients with BAD, demonstrated an elevated level of self-stigma. The leading components in its structure were idealization and overestimation of their internal activity and self-actualization before the disease onset. In such a mechanism, maintaining relatively adequate self-esteem is possible only by justifying one's failure solely by the effects of their mental illness. In addition, this patients cohort tends to have a generalized projection of their failure on all mentally ill persons and the perception of such subjects as people who are not capable of self-realization in interpersonal relationships, as well as in the professional or social spheres.

Changes in the self-identity and development of restrictive behavior resulted in a secondary benefit from the mental illness, obviating the need for adequate activity. The auto-psychic form of self-stigma was the most pronounced in them, as well as in patients with BAD; however, the level of compensatory form was also high.

In general, the results obtained in patients with schizophrenia spectrum disorders depending on the disease are consistent with the literature data [25–27] and demonstrate that compensatory and self-limiting types of self-stigma tend to increase at later stages of the disease.

As for the particular hypothesis, the study showed that the patients were aware of the need for treatment regardless of the type and duration of the psychiatric disorder. However, patients with BAD and chronically ill patients with schizophrenia spectrum disorders (SSD PSR group) tended to have a more positive attitude toward drug therapy compared to those in the initial stages of schizophrenia (SSD FEP group), for whom the expressed agreement with the necessity of treatment came with a generally negative attitude towards drug therapy and poor understanding of the need to accept it. These results indicate that patients with BAD and chronically ill patients with schizophrenia spectrum disorders have a better awareness of their mental illness symptoms and understanding of the changes in their life activities associated with it compared to patients in the early stages of mental illness, for whom greater awareness of mental illness symptoms leads to increased self-stigma. It is possible that the perception of the generalized image of a "mentally ill person" as a person who is unsuccessful in various spheres of life, has lost activity, is not capable for self-realization, as well as the fear of being socially "ostracized" by the mere fact of having a mental illness, leads to the denial of the disease in general, as it plays a compensatory role and prevents the emergence of internal tension. A similar tendency was observed in BAD patients. Chronically ill patients with schizophrenia spectrum disorders (SSD PSR group) showed a reverse correlation between an adequate attitude towards drugs and self-stigma. Acceptance of the position of "a mentally ill person" with the development of a socio-reversive type of self-stigma, changes in the personal station, and distancing

from society lead to an increasing distortion of perceptions related to the possibilities of receiving psychiatric care. Some observational studies also reached similar results [28, 29], which emphasizes the need to fight stigma at all stages of endogenous mental illnesses.

Strengths and limitations

The strength of the study is the identification of the level of severity and structure of self-stigma in patients with endogenous psychiatric disorders, depending on their type and disease duration using reliable assessment tools. Correlations between self-stigma and patients attitude to their mental illness and their treatment were identified.

However, this study had a number of limitations that need to be taken into account when interpreting the data, as well as when planning further research. Moreover, it is advisable to use large samples and strive for greater sample homogeneity, taking into account the socio-demographic and clinical parameters of the subjects included in the comparative studies. Thus, a subgroup with the diagnosis F23.xxx can be distinguished from the group of patients at the initial disease stages. When comparing groups of patients with schizophrenia spectrum disorders depending on disease duration, a cohort with a diagnosis of F25 can be considered. BAD patients can be classified as BAD-1 and BAD-2 subgroups, which makes the results more differentiated. It is reasonable to expand the study with a sample of patients with BAD at late stages of the disease. In order to make the data representative, it is advisable to envisage collecting data from various mental health facilities. Since the exploratory study evaluated a significant number of parameters for a comprehensive self-stigma assessment, a possible adjustment for multiple comparisons should be considered.

CONCLUSION

The results of this study contribute to a better understanding of the specific features of self-stigma in patients with various endogenous disorders at different stages of the disease. The highest level of self-stigma was observed in patients with BAD; the lowest level, in patients at the initial stages of schizophrenia spectrum disorders. Patients with schizophrenia spectrum disorders and a disease duration of more than five years participating in a long-term comprehensive psychosocial rehabilitation program also demonstrated high rates of self-stigma. The study revealed differences in the structure and severity of self-stigma in the studied cohorts; the correlations with the specific features of patients' attitudes towards the mental illness and drug therapy were also evaluated.

The elevated level of self-stigma demonstrated in this study in patients with BAD and schizophrenia spectrum disorders makes it relevant, on the one hand, to increase (through psychological education) awareness of the disease and the possible reasonable limitations associated with it, to improve our understanding of the need for treatment, and, on the other hand, to prevent self-stigma and self-labeling as "mentally ill" for patients at initial stages of endogenous mental illnesses. The results of this study may serve as a basis for a further thorough search for the specific features of self-stigma development in mentally ill patients and contribute to the development of techniques to combat the stigma.

Article history

Submitted: 17.12.2023
Accepted: 15.03.2024
Published Online: 26.03.2024

Authors' contribution: Tatiana Solokhina — development of the idea, setting research objectives, discussion of results and drawing conclusions, review of publications on the topic of the article, analysis of obtained data, writing the manuscript; Dmitry Oshevsky — development of the research design, setting research objectives, discussion of results and drawing conclusions, review of publications on the topic of the article, obtaining data for analysis, analysis of obtained data, statistical processing, writing the manuscript; Aleksandra Barkhatova — organisation of the study, discussion of results and drawing conclusions. All authors contributed significantly to the study and preparation of the article, read and approved the final version of the manuscript before publication.

Funding: The research was carried out without additional funding.

Conflict of interest: The authors declare no conflicts of interest.

For citation:
Solokhina TA, Oshevsky DS, Barkhatova AN, Kuzminova MV, Tiumenkova GV, Alieva LM, Shteinberg AS, Churkina AM. Self-Stigma in patients with endogenous mental disorders:

a cross-sectional comparative study. *Consortium Psychiatricum.* 2024;5(1):CP15485. doi: 10.17816/CP15485

Information about the authors

*__Tatiana Aleksandrovna Solokhina__, MD, Dr. Sci (Med.), Head of the Organisation of psychiatric services department, chief researcher, Mental Health Research Center; ORCID: https://orcid.org/0000-0003-3235-2476, e-Library SPIN-code: 7292-6023, Scopus Author ID: 6602118347, Researcher ID: F-9923-2019
E-mail: tsolokhina@live.ru

Dmitry Stanislavovich Oshevsky, MD, Cand. Sci (Med.), Chief Researcher, Organisation of mental health services department, Mental Health Research Center; ORCID: https://orcid.org/0000-0001-5234-5877, e-Library SPIN-code: 6432-9814, Scopus Author ID: 35773701100, Researcher ID: rid67377

Aleksandra Nikolaevna Barkhatova, MD, Dr. Sci (Med.), Professor, Chief Researcher, Head of the Endogenous mental disorders and affective states research unit, Mental Health Research Center; ORCID: https://orcid.org/0000-0003-3805-332X, Scopus Author ID: 23491525300, Researcher ID: C-3636-2016

Marianna Vladimirovna Kuzminova, MD, Cand. Sci (Med.), Chief Researcher, Organisation of mental health services department, Mental Health Research Center; ORCID: https://orcid.org/0000-0001-5234-5877, e-Library SPIN-code: 6446-5426

Galina Viktorovna Tiumenkova, MD, Cand. Sci (Med.), Chief Researcher, Organisation of mental health services department, Mental Health Research Center; ORCID: https://orcid.org/0000-0003-1567-2814, e-Library SPIN-code: 1672-1211, Scopus Author ID: 6504538761, Researcher ID: S-8998-2019

Leyla Musaferovna Alieva, Junior Researcher, Organisation of mental health services department, Mental Health Research Center; ORCID: https://orcid.org/0000-0002-9037-6065

Alisa Sergeevna Shteinberg, Junior Researcher, Endogenous mental disorders and affective states research unit, Mental Health Research Center; ORCID: https://orcid.org/0009-0002-7273-3046

Anna Mikhailovna Churkina, MD, Cand. Sci (Med.), Researcher, Endogenous mental disorders and affective states research unit, Mental Health Research Center; ORCID: https://orcid.org/0000-0002-7453-3155, e-Library SPIN-code: 8021-1574, Researcher ID: ADU-8410-2022

*corresponding author

References

1. Goffman E. Stigma: Notes on the management of spoiled identity. Englewood Cliffs, N. J.: Prentice-Hall; 1963. 147 p.
2. Yastrebov VS, Solokhina TA. [Stigmatization in psychiatry]. Mental health: social, clinical, organizational and scientific aspects. Proceedings of scientific and practical conference; October 31, 2016, Moscow. G.P. Kostyuk, editor. Moscow: KDU publisher; 2017. 524–531 p. Russian.
3. Yu B, Chio F, Mak W, et al. Internalization process of stigma of people with mental illness across cultures: a meta-analytic structural equation modeling approach. Clinical Psychology Review. 2021;87:102029. doi: 10.1016/j.cpr.2021.102029
4. Thornicroft G, Sunkel C, Aliev AA, et al. The Lancet Commission on ending stigma and discrimination in mental health. Lancet. 2022;400(10361):1438–1480. doi: 10.1016/S0140-6736(22)01470-2
5. Latalova K, Kamaradova D, Prasko J. Perspectives on perceived stigma and self-stigma in adult male patients with depression. Neuropsychiatric Disease and Treatment. 2014;10:1399–1405. doi: 10.2147/NDT.S54081
6. Rayan A, Aldaieflih M. Public stigma toward mental illness and its correlates among patients diagnosed with schizophrenia. Contemp Nurse. 2019;55(6):522–532. doi: 10.1080/10376178.2019.1670706
7. Solokhina TA, Oshevsky DS, Barkhatova AN, et al. Self-stigmatization and targets of psychosocial intervention in patients with bipolar affective disorder. Mental Health. 2023;18(8):86–90.
8. Neznanov NG, Shmukler AB, Kostyuk GP, Sofronov AG, et al. The first psychotic episode: Epidemiological aspects of care provision. Social and Clinical Psychiatry. 2019;28(3):5–11.
9. Murru A, Carpiniello B. Duration of untreated illness as a key to early intervention in schizophrenia: A review. Neuroscience Letters. 2018;669:59–67. doi: 10.1016/j.neulet.2016.10.003
10. Schizophrenia: Current science and clinical. 1st ed. Gaebel W, editor. Publishing house: John Wiley & Sons, Ltd; 2011. 272 p. doi: 10.1002/9780470978672
11. Ratheesh A, Cotton SM, Davey CG, et al. Ethical considerations in preventive interventions for bipolar disorder. Early Intervention Psychiatry. 2017;11(2):104–112. doi: 10.1111/eip.12340
12. Corrigan PW, Rao D. On the self-stigma of mental illness: Stages, disclosure, and strategies for change. Canadian Journal of Psychiatry. 2012;57(8):464–469. doi: 10.1177/070674371205700804
13. Sorokin MY, Lutova NB, Bocharova MO, et al. Computational psychiatry approach to stigma subtyping in patients with mental disorders: Explicit and implicit internalized stigma. Consortium Psychiatricum. 2023;4(3):13–21. doi: 10.17816/CP6556
14. Babin SM, Shlafer AM, Sergeeva NA. Compliance therapy for patients with schizophrenia. Medicinskaâ psihologiâ v Rossii. 2011;2. Available from: http://mprj.ru/archiv_global/2011_2_7/nomer/nomer11.php. Russian.
15. Yastrebov VS, Trushchelev SA. Social images of psychiatry. S.S. Korsakov Journal of Neurology and Psychiatry. 2009;6(109):65–68.
16. Yanos PT, Lysaker PH, Silverstein SM, et al. A randomized controlled-trial of treatment for self-stigma among persons diagnosed with schizophrenia-spectrum disorders. Social Psychiatry and Psychiatric Epidemiology. 2019;54(11):1363–1378. doi: 10.1007/s00127-019-01702-0
17. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. Schizophrenia Bulletin. 1987;13(2):261–276. doi: 10.1093/schbul/13.2.261
18. Mikhailova II. Self-stigmatization of mentally ill patients: description and typology. Psychiatry. 2004;2(8):23–30. Russian.
19. Yastrebov VS, Enikolopov SN, Mikhailova II. Self-stigmatization of patients with major mental illnesses. S.S. Korsakov Journal of Neurology and Psychiatry. 2005;105(11):50–54.
20. Birchwood M, Smith J, Drury V, et al. A self report Insight Scale for psychosis: Reliability, validity and sensitivity to change. Acta Psychiatrica Scandinavica. 1994;89(1):62–67. doi: 10.1111/j.1600-0447.1994.tb01487.x
21. Hogan TP, Awad AG, Eastwood RA. Self-report scale predictive of drug compliance in schizophrenics: Reliability and discriminative validity. Psychological Medicine. 1983;13(1):177–183. doi: 10.1017/s0033291700050182
22. Otdel'nova KA. Determination of the required number of observations in social and hygienic studies. Sb. trudov 2-go MMI. 1980;150(6):18–22. Russian.
23. Favre S, Richard-Lepouriel H. Self-stigma and bipolar disorder: A systematic review and best-evidence synthesis. Journal of Affective Disorders. 2023;335(15):273–288. doi: 10.1016/j.jad.2023.05.041

24. Perich T, Mitchell PB, Vilus B. Stigma in bipolar disorder: a current review of the literature. Australian and New Zealand Journal of Psychiatry. 2022;56(9):1060–1064. doi: 10.1177/00048674221080708
25. Gerlinger G, Hauser M, De Hert M, et al. Personal stigma in schizophrenia spectrum disorders: a systematic review of prevalence rates, correlates, impact and interventions. World Psychiatry. 2013;12(2):155–164. doi: 10.1002/wps.20040
26. Karidi MV, Vassilopoulou D, Savvidou E, et al. Bipolar disorder and self-stigma: a comparison with schizophrenia. Journal of Affective Disorders. 2015;184:209–215. doi: 10.1016/j.jad.2015.05.038
27. Vasilchenko KF, Drozdovskii YuV. Internalized stigma and social adaptation levels among patients with first episode schizophrenia. Siberian Herald of Psychiatry and Addiction Psychiatry. 2018;1(98):30–35. doi: 10.26617/1810-3111-2018-1(98)-30-35
28. Feldhaus T, Falke S, von Gruchalla L, et al. The impact of self-stigmatization on medication attitude in schizophrenia patients. Psychiatry Research. 2018;261(3):391–399. doi: 10.1016/j.psychres.2018.01.012
29. Novick D, Montgomery W, Treuer T, et al. PMH10 — Relationship of insight with medication adherence and the impact on outcomes in patients with schizophrenia and bipolar disorder: results from a 1-year European outpatient observational study. BMC Psychiatry. 2015;15:189. doi: 10.1186/s12888-015-0560-4

Cannabis Hyperemesis Syndrome in a Recently Abstinent Chronic User: Assessment and Intervention

Синдром каннабиноидной гиперемезии у хронического потребителя каннабиса на фоне воздержания: диагностика и лечение

doi: 10.17816/CP15473

Case report

Yasmine ElSherif[1], Sariah Gouher[1,2], Mutaz Mohsin Abualhab[2], Joseph El-Khoury[3,4]

[1] American Hospital Dubai, Dubai, UAE

[2] University of Sharjah, Sharjah, UAE

[3] The Valens Clinic, Dubai, UAE

[4] United Arab Emirates University, Al Ain, UAE

Ясмин Эль-Шериф[1], Сария Гухер[1,2], Мутаз Мохсин Абульхаб[2], Джозеф Эль-Хури[3,4]

[1] Американская больница в Дубае, Дубай, ОАЭ

[2] Университет Шарджи, Шарджа, ОАЭ

[3] Клиника Валенса, Дубай, ОАЭ

[4] Университет Объединенных Арабских Эмиратов, Эль-Айн, ОАЭ

ABSTRACT

BACKGROUND: Cannabis Hyperemesis Syndrome (CHS) is a condition characterized by episodic bursts of vomiting and abdominal pain linked to cannabis use. The clinical picture mimics an acute abdomen and is often misdiagnosed, especially when the patient avoids reporting their cannabis use for legal reasons.

CASE REPORT: We report on the case of a 33-year-old man that was brought to the emergency room with a history of 3 days of non-bloody, non-projectile, and non-bilious brownish vomit, coupled with severe epigastric and left hypochondriac pain, and a slight fever. He was a daily cannabis user for several years and had stopped using a week or so before the onset of the symptoms, as he was traveling to a country with more restrictive cannabis laws. His condition deteriorated rapidly, followed by emergency room attendance, thorough diagnostic work-up, and unsuccessful interventions, including intravenous treatment with the anti-emetic Ondansetron. The patient was referred to a psychiatrist after a suspected psychogenic etiology by the medical team. The history was suggestive of CHS and also included anxious, depressed mood with 'brain fog'. The abdominal pain was the most severe complaint. A combination of tramadol, promethazine, and mirtazapine given on an outpatient basis led to full recovery within 10 days.

CONCLUSION: CHS can occur soon after the interruption of chronic cannabis use and overlap with withdrawal symptom. A combination of anti-histaminergic, opioid-based medication, and antidepressant mirtazapine seemed an effective treatment of CHS, which resulted in a relatively quick recovery.

АННОТАЦИЯ

ВВЕДЕНИЕ: Синдром каннабиноидной гиперемезии (СКГ) — состояние, связанное с употреблением каннабиса, характеризующееся эпизодическими приступами рвоты и болью в животе. Клиническая картина имитирует синдром острого живота. Зачастую ставится ошибочный диагноз, особенно если пациент по юридическим причинам избегает раскрытия информации об употреблении им каннабиса.

КЛИНИЧЕСКИЙ СЛУЧАЙ: Представлен случай СКГ у 33-летнего мужчины, которого доставили в отделение неотложной помощи с жалобами на рвоту в течение трех дней (не «фонтаном», без примеси крови, желчи,

коричневатого цвета). Также отмечались сильная боль в эпигастрии и левом подреберье, небольшое повышение температуры тела. Из анамнеза известно, что пациент на протяжении нескольких лет ежедневно употреблял каннабис. Примерно за неделю до появления вышеуказанных симптомов пациент прекратил употребление из-за нахождения в стране со строгими законами в отношении каннабиса. В связи с быстрым ухудшением состояния пациент обратился в отделение неотложной помощи, где было проведено всестороннее обследование, а также предприняты неудачные попытки купировать симптомы. Внутривенное назначение ондансетрона (противорвотный препарат) также не дало эффекта. Врачебная бригада заподозрила психогенную природу состояния, в связи с чем пациент был направлен на консультацию к психиатру. Анамнестические сведения указывали на вероятность СКГ, кроме того у пациента наблюдались тревога, подавленность, ощущение «тумана в голове», хотя основной жалобой являлась выраженная боль в животе. Пациенту в амбулаторных условиях была назначена комбинация трамадола, прометазина и миртазапина. Спустя 10 дней лечения вся симптоматика купировалась.

ЗАКЛЮЧЕНИЕ: СГК может возникнуть вскоре после прекращения длительного употребления каннабиса и совпадать с синдромом отмены. Комбинированное лечение с использованием антигистаминных, опиоидных препаратов и антидепрессанта миртазапина было эффективным в отношении СКГ и привело к относительно быстрому улучшению состояния пациента.

Keywords: *cannabis; cyclic vomiting; tetrahydrocannabinol; cannabis hyperemesis syndrome*
Ключевые слова: *каннабис; циклическая рвота; тетрагидроканнабинол; синдром каннабиноидной гиперемезии*

INTRODUCTION

Cannabinoid Hyperemesis Syndrome (CHS) has been a rare presentation, mostly in the context of clinical encounters in emergency settings over the past 20 years. The syndrome, first formally reported in 2004, is characterized by sudden abrupt cyclic vomiting with no underlying organic pathology and a history of chronic ongoing cannabis use [1]. The course of the disease is divided into three phases (prodromal, emetic, and recovery phase). Most patient understandably seek medical attention in the emesis phase. The prodrome can last for months, characterized by morning nausea and abdominal epigastric discomfort. Interestingly in this phase, the individual may increase their cannabis consumption, believing to be dealing with a form of withdrawal. Yet the symptoms are not relieved by such a strategy. The emetic phase is often dramatic, with severe resistant nausea, frequent intense vomiting, flushing, diaphoresis, and diffuse abdominal pain. Loss of appetite and weight is also reported. A prolonged untreated course of the illness can have severe consequences associated with dehydration and cachexia. Recovery is often complete, with cessation of cannabis consumption, but that commitment is not always adhered to by patients [2].

The condition can easily go underdiagnosed as research into best practices for diagnosis and treatment is scant. Patients who present the core symptoms of this disorder often do not link them to their use of cannabis, nor do they volunteer such information unless specifically probed. Even then, potential legal ramifications mean that the history is inaccurate or incomplete. In addition, clinicians either omit to inquire about substance use as part of a general medical assessment focused on gastrointestinal symptoms or would also not necessarily make a link between the two. Examination and investigation are usually unremarkable. Electrolyte disturbance and leukocytosis can be present, but possibly as a non-specific finding resulting from the cyclic vomiting. These challenges, in addition to the poor understanding of the pathophysiology of this disorder, mean that most doctors are not equipped to identify and treat the condition.

We present a recent case of suspected Cannabinoid Hyperemesis Syndrome with the unusual characteristic of a patient developing symptoms one week after abruptly interrupting chronic daily cannabis use.

Ethical approval

No formal ethics approval was sought as no clinical research was conducted.

Consent for publication

The nature of the information being presented in this paper was explained to the Patient. This was followed

by a written informed consent for the publication of this case report in an academic journal and for educational purposes.

CASE REPORT

History

We present the case of a 33-year-old single male tourist visiting the United Arab Emirates, with no significant medical history, who was admitted to our hospital complaining of recurrent nausea and vomiting, acute severe upper quadrant abdominal pain constipation lasting three days without relief on over the counter and prescription-based treatments.

The onset of the illness took place on a Friday morning after a workout. The patient initially managed the symptoms at home for a day. On the second day, the pain worsened, and so did the nausea, leading to retching and vomiting up to 10 times within 24 h. Only mild relief came with hot showers and short walks. With the support of family members, the patient agreed to seek emergency medical attention. The first tests included abdominal ultrasound and X ray, which all turned out normal. In the absence of improvement at the first hospital, the patient self-discharged within 48 hours and attended the emergency department at the American Hospital in Dubai, a secondary and tertiary care facility.

The background story only emerged after the second admission, with the patient acknowledging daily cannabis use. He related to have begun smoking cannabis at the age of 19, escalating gradually to daily heavy use estimated at eight "joints" daily (1–1.5 g per day of cannabis). The pattern of consumption had been stable for the past seven years, with interruptions lasting two to three weeks due to travel or other commitments. He denied having any significant withdrawal symptoms whenever he stopped, other than mild insomnia and irritability lasting a few days. He described himself as a functional professional and his personal lifestyle. He denied any substance use outside of nicotine in the form of four cigarettes daily. He also denied consuming alcohol. He reported his last use of cannabis to have taken place in his home country and six days prior to the onset of pain.

Mental state examination

The patient was a tall, medium-build male. He manifested his distress by holding his head in his hands, resting his elbow on his upper thigh and leaning forward. "My head is spinning" he would say, before immediately starting vomiting into a plastic bag. His speech would become slow, monosyllabic, and monotonous. He used relevant and coherent sentences but made no eye contact. He remained fully oriented in time, place, and date. He displayed good short-term memory and no objective cognitive deficit. Yet he would describe his head as feeling heavy and being unable to think clearly and focused. There was no evidence of formal thought disorder, paranoia, or flight of ideas. He denied having any suicidal or homicidal ideas. His insight was preserved. His mood was described subjectively as "okay", and he appeared euthymic despite his physical distress.

Assessment and investigations

A full medical checkup was performed on assessment, even though the patient had already been consulted at another medical facility. The vital signs assessment showed the patient to be mildly febrile at 37.9°C (Oral) with a pulse rate of 66 beats per minute, a regular blood pressure of 133/66 mm Hg, respiratory rate of 20 per minute, SpO2: 98% height: 190 cm, body mass index (BMI): 23.27 kg/m^2. His comprehensive examination was otherwise unremarkable. Blood tests revealed an elevated white cells count of 14.4*10^9L and hemoglobin of 172.0 g/L. Total protein of 74 g/L. Total bilirubin was also increased at bilirubin 27.0 µmol/L with Direct bilirubin 8.0 µmol/L. Creatinine POs was 70 µmol/L. Liver functions were otherwise normal. Blood cultures were negative. A computed tomography (CT) examination of the abdomen and pelvis with intravenous (IV) contrast was also unremarkable.

Management and course of illness

In the emergency department, the patient was initially treated for dehydration using intravenous fluids (normal saline 1,000 ml, IV Al hydroxide/Mg carbonate/alginic acid 10 ml, Soln-Oral, three times a day). Antiemetics, including metoclopramide 10 mg, IV push, injectable, every 8 h, pro re nata. Based on the lack of identifiable etiology and an already failed admission despite extensive intervention a decision was taken to consult the on-duty psychiatrist with the assumption that a psychosomatic cause was behind the presentation. The psychosocial history revealed a chronic pattern of daily and heavy cannabis use that was interrupted due to travel a week prior to the onset of symptoms, consistent with an International Classification of diseases (ICD-11) diagnosis of Cannabis use disorder

unspecified 6C.41Z[1]. This residual category was chosen as the reported use history in a decriminalized social context, and the absence of any psychiatric or physical comorbidities did not justify the harmful qualification. CHS was put forward as the primary differential diagnosis for the acute presentation. This led to the addition of diazepam 5 mg, diphenhydramine 25 mg, and olanzapine (orodispersible) 5 mg to the medical regiment in place. A very small improvement was noted in the nausea and the psychological distress within 24 h, but debilitating acute pain persisted. A shift in treatment was decided, which included an opiate-based painkiller and a stronger antihistamine with an antiemetic property. Other medication was discontinued.

The patient requested early discharge after another 24 h, mainly due to financial reasons and he was sent home under the care of the psychiatrist. An intensive outpatient plan was put in place starting with a review two days later, and at reduced frequencies thereafter, over the following two weeks. At discharge, the treatment protocol consisted of tramadol 100 mg three times daily as needed, in addition to promethazine 50 mg three times daily. As the patient got better, the discussion shifted to his past history, where he revealed he had always been an "anxious" person but had never sought or required medical treatment. This prompted the addition of mirtazapine 30 mg, considering that with the absence of cannabis sleep and anxiety could become a problem once the acute phase of the treatment was completed.

At the second follow-up the following week, the patient mentioned being better in terms of pain and nausea but complained of drowsiness. He also expressed a feeling akin to dissociation. Tramadol was reduced to 50 mg three times a day and promethazine to 25 mg three times a day. He was scheduled for a follow-up five days later. He was significantly better and was advised to gradually stop tramadol within four days while maintaining promethazine at 25 mg three times a day and mirtazapine 30 mg at night.

At the final follow-up, which happened three weeks following his first appearance at our hospital, the patient was symptoms-free and grateful to have recovered. He was due to fly back to his home country and was given a plan to follow until the next review by a local doctor. This included reducing promethazine over two weeks then stopping it. He was encouraged to remain on mirtazapine until further notice. A recommendation was made for absolute abstinence from cannabis. He appeared motivated and convinced of an association between his substance use and his abrupt illness.

DISCUSSION

We have presented a case of CHS after an abrupt discontinuation of regular cannabinoid use.

The possible mechanisms that underlie this condition may be explained by the following features of cannabis metabolism and receptor interactions. Cannabis consists of lipophilic molecules that cross the blood brain barrier and accumulate in the fat of the brain viscera, resulting in inhibition of the hypothalamic-pituitary-adrenal (HPA) axis and sympathetic nervous system response to stress stimuli, causing the calming sensation that accompanies its use. The active substance — delta-9-tetrahydrocannabinol (THC) — attaches to the CB1 (CNS, GIT), CB2 (CNS), and CB3 receptors that are present in the central nervous system and the gastrointestinal (GI) lining. Interestingly, the effect on the GI system includes esophageal sphincter, leading to an antiemetic effect and gastric emptying. Cannabis-based products are a subject of interest in the context of a number of gastrointestinal and hepatic conditions [3].

A comprehensive review of the literature identified a few of the approaches used by doctors to treat CHS. These include minor and major tranquilizers such as benzodiazepines and antipsychotics, coupled with antiemetics such as metoclopramide and ondansetron. Opiates-based painkillers such as morphine and non-steroidal anti-inflammatory drugs (NSAIDS) were also shown to be effective in the acute phase, while tricyclic antidepressants were found useful in the maintenance phase that extends for several months [4]. A case study from Tunisia led credence to the use of antidepressants and anxiolytics, with cognitive behavioral therapy [5]. In another case report, the use of the short acting benzodiazepine lorazepam initially given IV in an inpatient setting followed by a 6-day tapered prescription alleviated both nausea and vomiting [6]. A number of reports highlight the role of hot showers in providing temporary symptomatic relief, which was a strategy that

[1] WHO (World Health Organization) [Internet]. International Statistical Classification of Diseases and Related Health Problems (ICD-11); 2021. Available from: https://www.who.int/standards/classifications/classification-of-diseases

had been adopted by our subject with a good but time-limited effect. There is no clear view of the mechanism of action [7]. One hypothesis is that increasing body temperature corrects an upset of the thermoregulatory system in the hypothalamus, promoting the release of histamine and inducing vasodilation [8].

A more recent review identified capsaicin in topical form and haloperidol as having shown efficacy, although with a lower strength of the evidence [2]. Our choice of treatment was based on the availability of treatments, our own previous experience in treating similar cases, but also reliance on a symptoms-based approach. The most pressing ones experienced by the patients included pain, insomnia, emotional lability, sensory disturbances, and severe distress. Case reports had identified the benefits of the combination of mirtazapine and olanzapine in the treatment of refractory hyperemesis gravidarum [9]. This condition shares some clinical features with cannabis hyperemesis despite the different etiology. Mirtazapine likely affects the central nausea and vomiting circuits through 5-HT3 and H1 blockade and has been used in gastroparesis with significant improvement in nausea and vomiting [10].

Diagnostically, our reported case of cannabis hyperemesis is unusual on two counts. Firstly, in that the patient had stopped using cannabis completely a week prior. Secondly, for the lack of any noticeable prodrome. From the literature, the condition tends to occur while the patient is actually consuming cannabis regardless of the quantity or pattern of use. His presentation was not typical of cannabis withdrawal in the absence of irritability or anxiety. Yet it did include psychiatric elements in the form of brain fog, head tension, and a vague description of dissociation.

CONCLUSION

CHS remains a poorly understood condition that is often missed, misdiagnosed, and with no clear treatment protocol. With the rising consumption of cannabis globally, it is essential that clinicians from various specialties become familiar with its presentation and therapeutic interventions that have shown efficacy even anecdotally. In our case, an early recognition of a history of cannabis use, the establishment of a trusting therapeutic relationship and the rational use of a combination of medications targeting individual physical and psychiatric symptoms allowed ambulatory treatment and full resolution. Emergency doctors, gastroenterologists, neurologists, and psychiatrists should consider CHS in any individual displaying pain, vomiting, and general malaise without an established organic etiology. The use of painkillers, benzodiazepines, antihistamines, and the antidepressant mirtazapine appear to have at least contributed to the recovery. In the absence of international guidelines or an experts consensus, doctors are left to improvise while relying on their clinical judgment. Inclusion of this disorder in the subsequent versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the ICD should be seriously considered to enable better characterization and standardized intervention.

Article history

Submitted: 19.11.2023
Accepted: 22.01.2024
Published Online: 16.02.2024

Authors' contribution: All the authors made a significant contribution to the article, checked and approved its final version prior to publication.

Funding: The research was carried out without additional funding.

Conflict of interest: The authors declare no conflicts of interest.

For citation:
ElSherif Y, Gouher S, Mohsin Abualhab M, El-Khoury J. Cannabis Hyperemesis Syndrome in a recently abstinent chronic user: assessment and intervention. *Consortium Psychiatricum*. 2024;5(1):CP15473. doi: 10.17816/CP15473

Information about the authors

Yasmine ElSherif, MD, Resident in Internal Medicine, American Hospital Dubai; ORCID: https://orcid.org/0000-0002-4933-3354
Sariah Gouher, MD, Consultant in Internal Medicine, American Hospital Dubai
Mutaz Mohsin Abualhab, Medical student, University of Sharjah
* **Joseph El-Khoury**, MD, FRCPsych Consultant Psychiatrist, the Valens Clinic; ORCID: https://orcid.org/0000-0002-4529-6840
E-mail: jkhoury@thevalensclinic.ae

*corresponding author

References

1. Allen JH, de Moore GM, Heddle R, Twartz JC. Cannabinoid hyperemesis: cyclical hyperemesis in association with chronic cannabis abuse. Gut. 2004;53(11):1566–70. doi: 10.1136/gut.2003.036350

2. Senderovich H, Patel P, Jimenez Lopez B, Waicus S. A systematic review on cannabis hyperemesis syndrome and its management options. Med Princ Pract. 2022;31(1):29–38. doi: 10.1159/000520417
3. Izzo AA, Camilleri M. Emerging role of cannabinoids in gastrointestinal and liver diseases: basic and clinical aspects. Gut. 2008;57(8):1140–55. doi: 10.1136/gut.2008.148791
4. Gajendran M, Sifuentes J, Bashashati M, McCallum R. Cannabinoid hyperemesis syndrome: definition, pathophysiology, clinical spectrum, insights into acute and long-term management. J Investig Med. 2020;68(8):1309–16. doi: 10.1136/jim-2020-001564
5. Yacoub H, Hassine H, Kchir H, Maamouri N. Cannabinoid hyperemesis syndrome: A case study in a tunisian young man. Case Rep Med. 2021;2021:6617148. doi: 10.1155/2021/6617148
6. Sun S, Zimmermann AE. Cannabinoid hyperemesis syndrome. Hosp Pharm. 2013;48(8):650–5. doi: 10.1310/hpj4808-650
7. Sorensen CJ, DeSanto K, Borgelt L, et al. Cannabinoid hyperemesis syndrome: diagnosis, pathophysiology, and treatment – a systematic review. J Med Toxicol. 2017;13(1):71–87. doi: 10.1007/s13181-016-0595-z
8. Chang YH, Windish DM. Cannabinoid hyperemesis relieved by compulsive bathing. Mayo Clin Proc. 2009;84(1):76–8. doi: 10.4065/84.1.76
9. Galletta MAK, Tess VLC, Pasotti IM, et al. Use of mirtazapine and olanzapine in the treatment of refractory hyperemesis gravidarum: A case report and systematic review. Case Rep Obstet Gynecol. 2022;2022:7324627. doi: 10.1155/2022/7324627
10. Malamood M, Roberts A, Kataria R, et al. Mirtazapine for symptom control in refractory gastroparesis. Drug Des Devel Ther. 2017;11:1035–41. doi: 10.2147/DDDT.S125743

Lost Self to Present Self: A Case Report of Narrative Therapy for a Woman with Acquired Brain Injury

От потерянного «Я» к новому «Я»: описание клинического случая применения нарративной терапии у пациентки с приобретенной травмой головного мозга

doi: 10.17816/CP15477

Case report

Mrinalini Mahajan, Shantala Hegde[1], Sanjib Sinha[1]

[1] National Institute of Mental Health and Neuro Sciences, Bengaluru, India

Мриналини Махаджан, Шантала Хегде[1], Санджиб Синха[1]

[1] Национальный институт психического здоровья и нейронаук, Бангалор, Индия

ABSTRACT

BACKGROUND: Psychotherapy for people with acquired brain injury (ABI) is considered to be an important component of a holistic neuropsychological rehabilitation approach. This helps in making sense of the loss of the sense of self they experience. Gender, premorbid personality, and socio-cultural discourses guide this process of understanding. Narrative formulation takes these considerations into account and, thus, can be used for formulating therapeutic plans.

AIM: To present a case report which highlights the use of narrative case formulation to understand the psychological, social, and cultural factors forming the dominant discourse of a woman with ABI.

METHODS: Ms. VA, a 43-year-old female, presented herself with a diagnosis of hypoxic ischemic encephalopathy with small chronic infarcts with gliosis in the bilateral cerebellar hemisphere, myoclonic seizures, mild cognitive impairment, depression, generalized dystonia, and bronchial asthma. Along with neuropsychological rehabilitation and cognitive retraining, 25 sessions of psychotherapy using narrative formulation were performed.

RESULTS: Following the therapy, microgains such as a developing strong therapeutic relationship, accommodating vulnerability in her narrative, and finding moments of independence and assertion within the constraints of ABI were observed. Acceptance of her current predicament vis-à-vis her lost self and finding meaning in her new self were facilitated.

CONCLUSION: There is paucity of research detailing psychotherapeutic management of ABI, especially in India. Psychotherapy, particularly using narrative formulation, can be helpful in understanding the intersections of gender role and expectations, premorbid personality and ABI, and aiding the post-ABI rehabilitation and adjustment. Future work in this area can explore the socio-cultural aspects that play an important role in the therapy process.

АННОТАЦИЯ

ВВЕДЕНИЕ: Психотерапия является компонентом нейрореабилитации пациентов с приобретенным повреждением головного мозга (ППГМ). Предполагается значимая роль нарративной психотерапии, которая помогает пациентам осознать серьезные проблемы, обусловленные чувством идентичности больного и безвозвратных потерь, и их связь с хроническими нарушениями функционирования. Этот метод помощи пациентам с ППГМ недостаточно исследован в Индии и других странах. Используемый авторами холистический медицинский подход требует изучения биологических, личностных и психосоциальных факторов, способствующих развитию малоадаптивного дискурса у пациента и неблагоприятному течению заболевания, а также снижающих эффективность терапии.

ЦЕЛЬ: Представить клинический случай применения нарративной психотерапии при реабилитации пациентки с ППГМ с психическими и функциональными нарушениями для изучения ее эффективности с учетом влияния не только клинических, но и личностных, психосоциальных и культурных факторов.

МЕТОДЫ: Проведена диагностика неврологических, психических, когнитивных и личностных нарушений в случае 43-летней женщины с диагнозом гипоксической ишемической энцефалопатии, проявляющейся легким когнитивным расстройством, генерализованной дистонией и миоклоническими судорогами, сопровождающейся депрессией и бронхиальной астмой. В рамках нарративного подхода был определен доминирующий дискурс и его связь с низким уровнем адаптации и восстановления пациентки. Проведены пять сессий нарративной психотерапии наряду со стандартной реабилитацией с нейрокогнитивными тренингами.

РЕЗУЛЬТАТЫ: С помощью нарративного подхода были созданы условия для принятия пациенткой текущих затруднений в связи с потерянной идентичностью и обнаружения смысла в развитии альтернативной идентичности. Показан ряд эффектов этой техники, позволивших выявить уязвимость доминирующего дискурса и изменить нарративное формулирование «Я» пациентки, что привело к повышению активности, самоконтроля пациентки и других психических функций, укреплению терапевтических отношений и результатов лечения в целом. Выявлены ограничения для нарративной терапии в связи с клиническими особенностями случая.

ЗАКЛЮЧЕНИЕ: Представлен новый взгляд на нарративный подход как компонент реабилитации пациентов с ППГМ. Он способствует формированию реальных целей для пациента и психотерапии. Описание нарративного подхода позволяет терапевтам соотносить данный опыт с собственной практикой и внедрять его. Требуются дальнейшие работы для уточнения механизмов влияния психосоциальных и культурных факторов, в том числе современных тенденций в изменении гендерных ролей, на эффективность лечения в сходных случаях.

Keywords: *case report; narrative therapy for ABI; neuropsychological rehabilitation*
Ключевые слова: *клинический случай; нарративная терапия при ППГМ; нейропсихологическая реабилитация*

INTRODUCTION

Acquired Brain Injury (ABI), particularly traumatic brain injuries (TBI), is a prominent contributor to indices of death and disability, especially in the lower and middle-income countries [1]. Published literature regarding overall burden, demographics, and interventions for ABI is limited in India [2, 3]. Within this literature, most of the focus is on the documentation of the neurophysiological aspects of the injuries of TBI and the management processes described center mostly on surgical intervention [4]. Thus, research is even more limited as relates to neuropsychological rehabilitation and psychotherapeutic management for people with brain injuries [5]. Within this subset, research on psychosocial management for women is especially under-represented. There is evidence to suggest that women with TBI exhibit unique trajectories of psychosocial recovery. These include incorporating the effect of brain injuries on the management of the socio-cultural expectations of women, as well as newer identities such as those related to motherhood post injury [6]. The only case report found in the Indian context relating to the psychosocial management of TBI in a woman was by Banerjee et al. in 2021. This work highlighted the importance of a holistic rehabilitation approach emphasizing a coherent self-narrative [7].

Research in the last three decades has highlighted the fact that narrative therapy can lead to significant improvement in restituting the lost sense of self and accepting the newer reality of the client's difficulties following TBI [8]. Narrative therapy recognizes the interface between knowledge, language, and power with the person's life experiences or narratives. These narratives are constructed with the help of societal, familial, and individual cues and influence the problems that an individual faces. It then helps them move away from these narratives and develop newer narratives not entirely consumed by those problems [9]. Post-TBI, people need to deconstruct their view of self and rewrite their identities to be in congruence with their new way of being [10]. Narrative therapeutic formulation may help practitioners by providing theoretical rigor, increasing opportunities for reflection on the factors affecting people's

view of their identities, and encouraging otherwise not obvious intervention strategies [11].

The current case report describes the use of narrative formulation for psychotherapy with a woman with ABI in India. It aims to highlight the unique psychosocial challenges she faced as relates to ABI and how they were incorporated into her newer identity. Written informed consent for publication of data was obtained from the patient.

PATIENT INFORMATION

Ms. VA, a 43-year-old married female with a Bachelor of Technology degree (B. Tech.), employed as a manager in a multinational company, of middle socio-economic status, came with diagnoses of hypoxic ischemic encephalopathy with small chronic infarcts and gliosis in the bilateral cerebellar hemisphere, myoclonic seizures, mild cognitive impairment (MCI), generalized dystonia, and bronchial asthma. The patient was also diagnosed with depression. All diagnoses were made as per the international classification of diseases ICD-11.

She felt apparently well until July 2016, when suddenly she experienced an attack of asthma. When she realized that she needed medical attention, she called her parents to take care of her children, refusing to leave them alone. Her situation deteriorated, and she experienced cardiac arrest at the hospital. Following an emergency surgery, she slipped into a coma that lasted three weeks.

After her stay in the hospital, she spent the next two years recovering and collaborating with medical professionals such as neurologists, cardiologists, pulmonologists, and physiotherapists taking care of her physical health. At the time of referral, she was experiencing difficulty with walking and used a wheelchair. She was unable to carry out her activities of daily living independently and had not been able to return to work. She was referred to the current hospital, which is a tertiary care hospital for mental health, by a friend who had undergone a similar experience and sought treatment from the author at the end of 2018. She consulted the clinical neuropsychology unit at the current hospital primarily for a neuropsychological evaluation and treatment as she was experiencing difficulties with concentration and mood-related concerns, such as lack of motivation, energy, and interest in carrying out the activities of daily living, as well as adjusting to her post-ABI limitation. In January 2019, she underwent a neuropsychological assessment and a cognitive retraining program was initiated.

Personal history

The patient had a history of childhood bronchial asthma. Academically, she was a high achiever. She had chosen mechanical engineering as her major, where she was the only female student in her class. Occupationally, she took on a leadership role at the multinational organization that she was working in after graduation and was in the midst of launching a new product when the attack occurred. She was in a romantic relationship during graduation, which culminated into marriage. She lives with her husband and her two daughters.

Premorbid history

The patient was highly competitive and often compared herself to others. She had type A personality traits [12], was a perfectionist, and had high expectations for herself and others. She would rigidly follow routines, and she seemed to derive her self-worth from her academic performance. Her hobbies included cooking and participating in adventure sports such as sky-diving, where she displayed perfectionist traits as well. She was able to make and maintain long-lasting friendships.

Family history

The patient is the first child, born into a non-consanguineous marriage. Her parents were high achievers and had high expectations for her. The father believed in strict parenting. Switchboard communication was the norm, as she would communicate via her mother to her father.

Medical history

The patient was diagnosed with the following conditions:

1. Bronchial asthma: Currently, she is not taking any medications. She uses an inhaler for emergencies.
2. Hypoxic ischemic encephalopathy with small chronic infarcts with gliosis in the bilateral cerebellar hemisphere, myoclonic seizures, and generalized dystonia: These conditions are managed with medications by the neurology team at another hospital. Details of the medication are currently unavailable. She was also undergoing physiotherapy for gait improvement. She used traditional healing practices such as Ayurveda, as well.
3. Mild cognitive impairment (MCI): Twelve sessions of cognitive retraining were undergone based on the neurocognitive deficits identified through a neuropsychological assessment.

CLINICAL FINDINGS

Her diagnosis when cognitive retraining started was myoclonic seizures, generalized dystonia, and dysarthria. In May 2019, the current psychotherapist started working with her. On further exploration, the patient reported being frustrated with herself, feeling helpless for not being independent in her activities of daily living and experiencing a sense of hopelessness. This led to interpersonal issues with family members as they pushed her to try and then berated her when she could not perform. This added to the feeling of worthlessness. Thus, the diagnosis of depression based on her clinical impression was added. It was decided that narrative psychotherapy would be initiated in her case.

TIMELINE

1. Childhood history of bronchial asthma.
2. Hypoxic brain injury in July 2016; coma until August 2016.
3. First-time interaction with the neuropsychology unit at the end of 2018 led to diagnostic assessments and the beginning of cognitive retraining in January 2019.
4. Current psychotherapeutic journey from May 2019 to June 2020 consisted of 25 sessions ranging from once a week to once a month based on her availability and accessibility.

DIAGNOSTIC ASSESSMENT

Neuropsychological assessment

The neuropsychological assessment was performed in January 2019 across 2 sessions at the neuropsychological unit of the hospital with which the author, Dr Shantala Hegde, has been affiliated with. It was held under the supervision of Dr Shantala Hegde.

Behavioral observations during the neuropsychological assessment are listed below. Her motor functions were compromised as she needed a wheelchair to move. Her overall sensory functions were adequate; she needed spectacles for reading. She was conscious, alert, and oriented in time, place, and person. Her attention could be aroused, but there was difficulty in sustaining it. Her comprehension was adequate. Speech was effortful and slurred. Motor weakness, coordination difficulties, and myoclonic jerks were observed during the assessment.

Table 1. Results of the neuropsychological assessment

Neurocognitive functions in the normal functioning range	
Functions	**Test**
Focused Attention	Color Trails 1
Attention Switching	Color Trails 2
Verbal Working Memory	Verbal N-Back test (1 and 2 Back condition)
Visual Working Memory	Spatial Span
Planning	Tower of London
Set Shifting	Wisconsin Card Sorting
Verbal Fluency	Controlled Oral Word Association (COWA)
Category Fluency	Animal Names test
Facial Recognition	Faces Test (Retention)
Neurocognitive functions in the impaired range (below 15th percentile (%le), based on Indian norms)	
Sustained Attention	Digit Vigilance Test
Mental Speed	Digit Symbol Test
Response Inhibition	Stroop Test
Facial Recognition	Faces Test (Immediate and Delayed Recall)
Verbal Memory	Rey's Auditory Verbal Learning Test
Verbal Learning	Rey's Auditory Verbal Learning Test

Note: Selected tests from the NIMHANS Neuropsychological Battery [13] were administered. The scores were compared with age, education and sex matched Indian normative data.

She was motivated to complete her assessment. The results are presented in Table 1.

Upon clinical neurological examination, there was no evidence of parietal focal signs such as visual object agnosia, form agnosia, color agnosia, finger agnosia, tactile agnosia, ideomotor apraxia, ideational apraxia, or buccofacial apraxia.

THERAPEUTIC INTERVENTION

The following therapeutic interventions were used for the patient:

1. Cognitive Retraining.
2. Narrative Psychotherapy.

Cognitive retraining

Based on the assessment results, cognitive retraining using both traditional cognitive retraining tasks, along with techniques of the Neurologic Music Therapy (NMT) [14], was planned for her. This comprehensive plan included the following elements:

1. Rhythm Speech Cueing for addressing the clarity and prosody of speech.
2. Rhythmic tapping task with one hand and both hands for improving attention and response inhibition.
3. Rhythmic placing blocks using metronome-based tasks on the Minnesota Board for improving attention and response inhibition.
4. Temporal encoding: Starting with a set of 6 words for improving verbal learning and memory.
5. Block construction task for improving visuo-spatial construction; and
6. Writing for enhancing fine motor skills. This also served as a method of therapeutic writing.

The cognitive retraining plan was implemented in 12 sessions starting in January 2019. This work was undertaken by another trainee under the supervision of Dr Shantala Hegde, who had performed the neuropsychological assessment. According to the hospital's policy, the trainee transitioned out of the unit and this cognitive retraining program was handed over to the author Mrinalini Mahajan, who became the primary therapist for Ms. VA. She was supervised by the author. During this time, she noticed symptoms of depression (as mentioned above) and on further discussion with the supervisor led to a decision to begin psychotherapy to address these concerns. Narrative therapy was chosen as the modality of choice, as it appeared that the amotivation, anergia, feelings of hopelessness, helplessness, and worthlessness were conceptualized as a consequence of her inability to reconcile her present self with her past self.

The psychotherapeutic process described below was performed in nearly 25 sessions spread across ten months, with a frequency ranging from once a week to once a month. Sometimes, she missed sessions, because she had other appointments that clashed with sessions or she took breaks to focus exclusively on physical rehabilitation when she experienced falls due to jerks. She also struggled with amotivation and anergia and found it difficult to make the commute for sessions. She had another episode of asthmatic attack during this time, due to which she had to be hospitalized and could not attend therapy. This led to breaks during the therapeutic process. When the reasons were time scheduling difficulties or amotivation, problem-solving was incorporated. However, when the break was due to falls or health-related difficulties, it triggered past traumatic memories, which needed to be addressed. The longer hiatus was caused by the COVID-19 lockdown, as it necessitated precautions for her health. Therapy was terminated in June 2020, while the lockdown continued because the therapist moved away from the site of her training. Author Shantala Hegde had follow-up sessions over the phone and carried out supportive therapy for her primary caregivers.

Narrative psychotherapeutic intervention

Psychotherapy was initiated with the client to help in making sense of the experience for her. A narrative framework was used to guide the therapeutic process, which is delineated further.

It is based on the post-structural narrative model by Meehan and Guilfoyle (2015), which aims to answer the following questions [11]:

1. Who is the client? This relates to the subject positioning of the person within the narrative.
2. How did they learn to construct their particular situation in this way? These refer to the discourses that people adopt to understand themselves.
3. How did the self and other contribute to these discourses? These are related to the normalizing judgments that self and others practice.
4. Which ways in the life of the client did not fit into the discourses, which can then be incorporated into the newer discourses.

Subject position: Narrative therapy emphasizes the belief that people participate in the understanding of their lives

and identities by creating narratives [15]. This "places" the person's identity or sense of self within the narrative constructed by them. This leads to explicit or implicit conclusions for the identity of the person; that is, these are the stories about the person.

The subject position that is used in the present case was that of her *lost self.* She was a superwoman — a person at the top of her game; did well at work, was ambitious, and managed household chores and motherhood with ease and effortlessness. However, her present identity is presented as a "weak, crippled individual" unable to carry out any of her responsibilities. This is so far from her *lost self* that she finds it difficult to accept it as reality.

Discourses: The discourses that people have highlight the way in which they construct the subject's positions. They can, therefore, be considered as coherent crystallizations of the power/knowledge dynamics which society espouses [16]. In turn, this reflects and perpetuates particular dynamics of power.

The discourses in this case that construct, enable, or support the client's problem subject position are encapsulated in the idea of being a high-achieving mother. This discourse has two aspects. One is a *high-achiever*, who is perfect, always successful in her attempts, and has no accommodations for mistakes or vulnerabilities. The other is the *mother* who held herself to these standards even in child-rearing. Currently, Ms. VA is unable to perform her responsibilities of motherhood the way she did prior to the ABI. Without these standards she finds herself floundering. She was once so immersed in this identity that she cannot relinquish it completely. She cannot participate in it nor can she escape it.

Normalizing judgements: Foucault (1977) has highlighted how discourses help to create systems of norms and values that are used to effectively organize people's positions in relation to one another [17]. It allows people to be implicitly rank-ordered relative to each other, based on their perceived value or status (e.g., standards of success, beauty, and so on in society). Such a system guarantees the fundamentally relational nature of people's positions; that is, people being ranked hierarchically. Furthermore, this discourse gets impacted by the alignment of social activities that people engage in so that these values, norms, and positions are maintained [18]. In her story, *lost self* is valued more than the patient's present self from her standards, as well as those of family members. She is constantly reminded of how amazing she was and now is not. The small steps that she takes are not appreciated; rather, they are looked down upon as they are not at the same pedestal as her earlier self. Another source of these judgments comes from her position vis-à-vis her peers, who have retained their high-achiever status. The *lost self* belongs with them. The present self does not; she is excluded from the narrative which she was once a part of.

Lost narratives: Narrative therapy encourages commitment to the idea that people have multiple discourses, and that they are more than the one particular discourse that they have chosen for themselves [16]. Discourses which are saturated with problems can be resisted. These resistances, and instances of being "more than" their problem situations, are the "unique outcomes". In the patient's story two types of unique outcomes were co-constructed. Her *lost self* was characterized by perfection, while the *present self* is riddled with imperfections. Instances where space for learning, making mistakes, and not being the best were created even where perfection was present earlier. At the same time, her present understanding of being riddled with problems started including instances of triumph in her efforts, where she had taken pride in her moving past her imperfections. This has been summarized below in Table 2.

Table 2. Summary of the narrative framework used for the patient

Narrative framework	As seen for the patient
Subject positions	*Lost self* — Superwoman: at the top of her game both in the professional and personal realms. *Current self*: weak, crippled, and unable to carry out her responsibilities.
Discourses	*High-achieving person and mother:* currently, she is neither high-achieving nor an active mother. She cannot participate in these identities completely nor can she escape them.
Normalizing judgments	Valuing *lost self* over the current self both by self and family. She is not who she was. Her peers have retained their positions, but she was not able to do so.
Lost narratives	Creating space for learning, making mistakes, and not being the best where perfection was present. Triumph of her efforts and pride in moving past her imperfections were celebrated.

Translating the formulation into therapeutic journey

A challenge in this case was the way in which her premorbid personality intersected with this framework. She and her family members had high expectations about her. When faced with the inevitability of her inability to do things the way she used to, she gave up on her agency. For example, she did not engage in cognitive retraining sessions, as she was unable to perform these tasks to her satisfaction. Instead, she fell asleep. Similarly, she did not ask for help nor did she acknowledge that something was difficult for her; instead, she withdrew and kept others at a distance, including her therapist. Keeping these challenges in mind, the therapeutic plan for Ms. VA was to use the narrative framework to identify the subject positions and discourses that she used to describe her own self and understand the judgements that she seemed to have normalized for herself.

Certain moments in therapy revealed unique outcomes. The search for unique outcomes that counter the dominant discourse is the first step towards developing an alternate discourse. For example, when, instead of her mother, she was involved as an active, equal agent in preventing sleep, it led to glimpses of herself seen as someone who can manage her time. This was a break away from her story of being riddled with problems without any agency of her own. Similar anecdotes were elicited from the patient. They helped "thicken" the alternate discourse; that is, made the alternate discourse robust and detailed. Another important breakthrough moment was when she left her stoic, blank, and emotionless mask behind and broke down. During a session, she expressed her fear of losing out on crucial years of bonding with her younger daughter because of her coma. She discussed that her elder daughter expects her to be the way she was. She feels disappointed that she cannot live up to her expectations. This culminated in her breaking down and crying over the loss: losing herself, as well as her children losing their mother. She felt especially despondent for her younger daughter as she could not be the mother that she had been with her. She was afraid that her younger daughter saw her as a mother incapable of taking care of her. These narratives represented her memories of being a perfect mother that she no longer was. Thus, reclaiming aspects of her identity of being their mother again were discussed. For example, providing inputs on the design or search for recipes online while the elder daughter bakes. Spending private time with her younger daughter playing games and watching cartoons of her choice were discussed. The younger daughter started making a game of her cognitive retraining exercises. On a difficult day, she looked at the pictures of her playing with her daughters that reminded her that she could still fulfill some of her duties as a mother. Yes, she is a mother with disability, but she is not just a disabled mother. This externalization of her disability as a problem which can be managed helped her reclaim agency.

At the same time, reclaiming her identity beyond her role as a mother was also important. For example, once she forgot her wheelchair and walked to the session with support. This was used as an opportunity to affirm her unique outcome: that she did not need to be limited by her wheelchair. From then onwards, she walked to her sessions. This was used as a "quest metaphor" highlighting her journey of triumph over adversity and helped in constructing an identity of a fighter. Other discussions focused on the feasibility of her work, such as will she be able to go back to the office? Should she teach? Should she focus on walking without support or with some support? Each of these discussions listed the pros and cons of each decision and their sub-goals.

In this way, her subject positions, discourses, and normalized judgements were identified. She moved away from them and constructed her new identity with the unique outcomes she was now noticing using techniques from narrative therapy such as development and thickening of her alternative discourse, externalization of problems, and active efforts to solve them and 'quest metaphors' to highlight her journey through adversity.

FOLLOW-UP AND OUTCOME

Since therapy had to be terminated during the COVID-19 pandemic when the therapist moved away from the site of her training, post therapeutic assessment could not be carried out. However, the supervisor had phone follow-ups with her and remained in touch with family members, thus providing some continuity. A degree of micro gains in therapy helped build a strong therapeutic alliance with the medical team and other clinicians, which helped her in recovery and provided her with a safe space to access her vulnerability and rejigger hope. There were positive changes in her mood (both as observed by others and as per her self-report), more motivation and energy in setting up and achieving realistic goals, increased social interaction, and working remotely. The overall global impression from the

multidisciplinary team, family members, clinical supervisor, and the patient herself was that there was a significant improvement in her socio-occupational functioning. These improvements were attributed to the shift from her illness identity to the alternative discourse created with the help of narrative therapy.

DISCUSSION

This report focuses on the importance of using a narrative formulation in psychotherapy with a woman after ABI as part of a holistic neuropsychological rehabilitation approach. This is unique in the Indian context, as literature on managing TBI in lower and middle-income countries has traditionally focused on surgical interventions and rarely highlights the psychotherapeutic work carried out or the need for such an approach [4]. The psychotherapeutic literature from India has focused more on psychiatric disorders with very few case reports focusing on understanding its effectiveness in the management of ABI. This case report highlights the unique challenges that women with ABI face and on how to ameliorate them by integrating their newer identities into the psychosocial expectations placed on them. An important limitation of this study is the fact that this is a single case study and, hence, generalization of the results could prove difficult. The therapeutic journey was frequently interrupted due to health and accessibility obstacles. Similarly, multiple assessments could not be carried out. Such assessments could have yielded information on the process of change. These are the practical challenges with several neurological and neurosurgical patients. A formal assessment of the outcomes of therapy could not be carried out due to practical concerns. However, as mentioned previously, the supervisor provided some continuity. Lastly, this case report does not include a caregiver perspective, which is important in achieving a holistic understanding of ABI.

Psychotherapy for individuals with ABI emphasizes a collaborative therapeutic alliance in order to improve client awareness and acceptance of their newer identity and create hope and meaning for them [19]. This translates into developing a newer understanding of self within the context of gender, psychosocial expectations, and cultural milieu [20]. Narrative therapy is one way of helping people with ABI deconstruct and co-construct their life stories that can be used in neuro-rehabilitation [21]. It facilitates acceptance of a degree of inevitability, the harsh realities of the client's life, and it allows them to build new narratives to make sense of their experiences, with the understanding that the newer narratives are limited by their injuries but are not defied by them [10].

In the Indian context, gender influences the life stories of individuals [22]. Feminine characteristics represented in skills such as cooking and taking care of others are a part of the socialization process. Motherhood dominates an important discourse in the lives of Indian women [23]. With the advent of industrialization and liberalization, women are also encouraged to aim for success in their careers [24]. Women are thus expected to succeed in these spheres both by themselves and through others. All these identities have the potential to be affected post injury. Hence, psychotherapy with women with ABI recognizes the importance of these societal and cultural expectations. It also acknowledges individual differences, which play a role in how role changes are perceived and how disability affects their lives and interactions with family members [6]. Narrative therapy, with its emphasis on interaction and effect of knowledge, language, and power on the individual's story, is able to incorporate these unique considerations. The underlying philosophy and techniques used in narrative therapy can prevent the individual from becoming completely defined by these discourses [9]. Narrative formulation can serve as an important theoretical construct to understand how these different identities keep the individual trapped in their problem-saturated stories and implement intervention strategies to support unique outcomes for them [11].

Narrative therapy can thus be used in rehabilitation to restore a connection with the former self, acceptance of one's new identity, instill hope and highlight a sense of agency for patients with ABI within their socio-cultural milieu. It is especially advantageous in promoting empowerment, self-determination, independence, and advocacy. However, narrative therapy cannot be used in all situations. Due to its heavy reliance on language, it is not a suitable method for those with severe cognitive impairments and lack of insight.

The key takeaway from this case report is the emphasis on the importance of addressing life-altering changes in the physical, cognitive, and social sequelae accompanying ABI. A comprehensive neurorehabilitation program must include the creation of a meaningful life within the constraints of injury. Therapists and medical practitioners need to focus on understanding the grief over the loss of the sense of self while still understanding the individual as a whole, not just

as defined by their problems. It involves acknowledging the strengths of the patient while accepting the new limitations post ABI. Therapists and practitioners must be willing to tolerate the helplessness and despair that may come with working with patients with ABI. Particularly as relates to working in the narrative therapy context, further training is needed to understand the impact of language, an awareness of their own understanding of dominant discourses, and the ability to remain persistent in pursuing unique outcomes. In addition to the need for further training, some of the constraints in the Indian context include the shortage of trained individuals, high caseloads, and the prevalence of high psychosocial barriers for accessing mental health services.

This case report is an attempt to demonstrate how narrative case formulation can be used to understand the psychosocial and cultural factors that contribute to the dominant discourse of a woman with ABI. This framework formed the basis for developing intervention strategies for finding alternate discourses and discovering unique outcomes for her. This allowed for microgains in therapy such as building a strong therapeutic alliance, providing space for vulnerability and promoting independence and assertion within the constraints of ABI. Her acceptance of her newer identity with hope for the future enabled her to make some meaning of her current predicament. Further work on the lines of narrative therapy will involve strengthening resilience and building the strengths of clients. Co-constructing a meaning for the accident and its aftermath, while grieving over the loss of the healthy self by using a special form of narrative therapy called "Narrative Exposure Therapy" developed specially for traumatic events may be considered. Clinical neuropsychologists can focus on a holistic evaluation of people with ABI, focusing on the intersection of premorbid personality and ABI and making individualized psychotherapeutic treatment plans for them. A holistic intervention may also include caregiver perspectives and support for them.

Article history

Submitted: 29.11.2023
Accepted: 12.03.2024
Published Online: 20.03.2024

Acknowledgements: We would like to express our gratitude to Ms. VA and her family for allowing us to share their story with others.

Authors' contribution: All the authors made a significant contribution to the article.

Funding: The research was carried out without additional funding.

Conflict of interest: The authors declare no conflicts of interest.

For citation:
Mahajan M, Hegde S, Sinha S. Lost self to present self: a case report of narrative therapy for a woman with Acquired Brain Injury. *Consortium Psychiatricum.* 2024;5(1): CP15477. doi: 10.17816/CP15477

Information about the authors

Mrinalini Mahajan, M.Phil (Clinical Psychology), MA (Applied Psychology with a specialization in Clinical psychology), Clinical Psychologist (private practitioner); ORCID: https://orcid.org/0000-0002-3779-8437

*__Shantala Hegde__, M Phil (Clinical Psychology), PhD, Associate Professor, Department of Clinical Psychology, and Neuropsychology and Cognitive Neuroscience Centre, National Institute of Mental Health and Neuro Sciences; Wellcome DBT India Alliance Intermediate Fellow, Clinical Neuropsychology and Cognitive Neuro Sciences Center, Music Cognition Laboratory, Department of Clinical Psychology, National Institute of Mental Health and Neuro Science; ORCID: https://orcid.org/0000-0003-3805-3397
E-mail: shantalah@nimhans.ac.in

Sanjib Sinha, Professor of Neurology Department of Neurology, National Institute of Mental Health and Neuro Sciences, Bengaluru, India

*corresponding author

References

1. Rubiano AM, Carney N, Chesnut R, Puyana JC. Global neurotrauma research challenges and opportunities. Nature. 2015;527(7578):S193–7. doi: 10.1038/nature16035
2. Agrawal A, Munivenkatappa A, Shukla DP, et al. Traumatic brain injury related research in India: An overview of published literature. Int J Crit Illn Inj Sci. 2016;6(2):65–9. doi: 10.4103/2229-5151.183025
3. Massenburg BB, Veetil DK, Raykar NP, et al. A systematic review of quantitative research on traumatic brain injury in India. Neurol India. 2017;65(2):305–14. doi: 10.4103/neuroindia.NI_719_16
4. Agrawal A, Savardekar A, Singh M, et al. Pattern of reporting and practices for the management of traumatic brain injury: An overview of published literature from India. Neurol India. 2018;66(4):976–1002. doi: 10.4103/00283886.237027
5. Afsar M, Shukla D, Bhaskarapillai B, Rajeswaran J. Cognitive retraining in traumatic brain injury: experience from tertiary care center in southern India. J Neurosci Rural Pract. 2021;12(02):295–301. doi: 10.1055/s-0041-1722817
6. Mukherjee D, Reis JP, Heller W. Women living with traumatic brain injury: Social isolation, emotional functioning and implications for psychotherapy. Women and Therapy. 2003;26(1–2):3–26. doi: 10.1300/J015v26n01_01

7. Banerjee M, Hegde S, Thippeswamy H, et al. In search of the 'self': Holistic rehabilitation in restoring cognition and recovering the 'self' following traumatic brain injury: A case report. NeuroRehabilitation. 2021;48(2):231–42. doi: 10.3233/NRE-20801
8. Block CK, West SE. Psychotherapeutic treatment of survivors of traumatic brain injury: review of the literature and special considerations. Brain Inj. 2013;27(7–8):775–88. doi: 10.3109/02699052.2013.775487
9. Narrative approaches to brain injury. 1st ed. Todd D, Weatherhead S, editors. Routledge; 2018 Mar 21. 252 p.
10. Morris SD. Rebuilding identity through narrative following traumatic brain injury. Journal of Cognitive Rehabilitation. 2004;22(2):15–21.
11. Meehan T, Guilfoyle M. Case formulation in poststructural narrative therapy. Journal of Constructivist Psychology. 2015;28(Issue 1):24–39. doi: 10.1080/10720537.2014.938848
12. Friedman HS, Booth-Kewley S. Personality, type A behavior, and coronary heart disease: the role of emotional expression. J Pers Soc Psychol. 1987;53(4):783. doi: 10.1037/0022-3514.53.4.783
13. Rao SL, Subbakrishna D, Gopukumar K. NIMHANS neuropsychology battery-2004, manual. National Institute of Mental Health and Neurosciences; 2004. 267 p.
14. Handbook of neurologic music therapy. Thaut MH, Hoemberg V, editors. Oxford University Press: 2014. 384 p.
15. White M, Epston D. Narrative means to therapeutic ends. 1st ed. WW Norton & Company; 1990. 229 p.
16. Foucault M. Power/knowledge. In: Selected interviews and other writings 1972–1977. Gordon C editor. New York: Harvester Wheatsheaf; 1980. 270 p.
17. Foucault M. Discipline and punish: The birth of the prison. London: Penguin; 1977.
18. Rouse J. Power? Knowledge. Gutting G, editor. In: the Cambridge companion to Foucault. Cambridge, UK: Cambridge University Press, 1994.
19. Prigatano GP. Challenges and opportunities facing holistic approaches to neuropsychological rehabilitation. NeuroRehabilitation. 2013;32(4):751–9. doi: 10.3233/NRE-130899
20. Klonoff PS. Psychotherapy after brain injury: Principles and techniques. Guilford Press; 2010 Jun 9.
21. Biggs HC, Hinton-Bayre AD. Telling tales to end wails: Narrative therapy techniques and rehabilitation counselling. Australian Journal of Rehabilitation Counselling. 2008;14(1):16–25. doi: 10.1375/jrc.14.1.16
22. Rao GP, Vidya KL, Sriramya V. The Indian "girl" psychology: A perspective. Indian J Psychiatry. 2015;57(Suppl 2):S212–25. doi: 10.4103/0019-5545.161480
23. Bhambhani C, Inbanathan A. Not a mother, yet a woman: Exploring experiences of women opting out of motherhood in India. Asian journal of women's studies. 2018;24(2):159–82. doi: 10.1080/12259276.2018.1462932
24. Datta S, Agarwal UA. Factors effecting career advancement of Indian women managers. South Asian Journal of Business Studies. 2017;6(3):314–36. doi: 10.1108/SAJBS-07-2016-0062

When Dhat Syndrome is Delusional: A Case Series

Когда синдром Дхат является проявлением бредового расстройства: серия клинических случаев

doi: 10.17816/CP15510

Case report

Debanjan Bhattacharjee[1],
Debanjan Banerjee[2]

[1] Central Hospital Dhori, CCL, Jharkhand, India

[2] Apollo Multispecialty Hospitals, Kolkata, India

Дебанджан Бхаттачарджи[1],
Дебанджан Банерджи[2]

[1] Центральная больница Дхори, Джаркханд, Индия

[2] Многопрофильная больница Аполло, Калькутта, Индия

ABSTRACT

The Dhat syndrome is a culture-bound syndrome associated with anxiety and somatic and mood symptoms related to semen loss. It sometimes occurs in women, in whom it comes with vaginal discharge. Only a single case has been reported whereby Dhat delusion was associated with schizophrenia. In this case report, we dwell on two individuals suffering from a somatic-type delusional disorder with Dhat-like symptoms who had initially presented classical symptoms of the Dhat syndrome. Further studies are needed to explore the intersections of Dhat syndrome and psychoses, as well as the risk factors involved in mutual predisposition.

АННОТАЦИЯ

Синдром Дхат относится к культурально-специфичным синдромам и характеризуется тревожными, соматическими и аффективными симптомами, связанными с потерей спермы. Иногда он встречается у женщин, и его связывают с вагинальными выделениями. В литературе встречается лишь единичное наблюдение пациента с синдромом Дхат с бредовыми идеями в рамках шизофрении. Представлено описание двух пациентов с соматическим подтипом бредового расстройства с симптоматикой, напоминающей синдром Дхат. В инициальном периоде болезни этих больных имели место типичные проявления синдрома Дхат. Необходимы дальнейшие исследования для изучения взаимоотношений между синдромом Дхат и психозами, а также для определения факторов риска, влияющих на возникновение обоих расстройств.

Keywords: *culture-bound syndrome; Dhat syndrome; delusional disorder; psychosis; obsessive-compulsive disorder*
Ключевые слова: *культурально-специфичный синдром; синдром Дхат; бредовое расстройство; психоз; обсессивно-компульсивное расстройство*

INTRODUCTION

The Dhat syndrome is characterized by a preoccupation with vaginal discharge/semen loss, accompanied with lethargy, appetite loss, weakness, difficulty to focus, and frequent loss of memory [1]. Sexual dysfunction and concomitant anxiety or depression are common in some patients and are typically secondary in Dhat syndrome [1]. Typically, patients attribute the passage of semen or a white discharge from the penis to all of their physical and psychological symptoms [1]. Dhat syndrome, in the past, has been linked to Koro syndrome, which likewise is a culture-bound syndrome. Distorted ideas regarding genital organs and their functioning are core to the psychopathology of these two ailments [2, 3]. In addition, these two syndromes have been linked to obsessive-compulsive disorder [2, 3]. Obsessions, obsessive ideas, and delusions can occur on a continuum, while ego-dsytonic obsessions can turn into obsessive ideas and then into ego-syntonic delusions [4]. Also, obsessive-compulsive symptoms can be prodromal manifestations of psychosis [4]. In the past, Dhat and

Koro-like symptoms have been described as consisting of a delusional core [5, 6]. To the best of our knowledge, only one case of Dhat delusion has been reported in the literature [5]. In this case series, we describe two individuals with Dhat syndrome manifesting itself as delusional disorder.

CASE SERIES

All patients, as described below, were diagnosed with delusional disorder of somatic type according to the Diagnostic and Statistical Manual, Fifth Edition (DSM-5)[1]. There was no significant family history or any history of mood, psychotic, or anxiety disorders, substance use, or a chronic medical illness in the past. In both cases, psychoeducation was conducted after the delusions had shown improvement and consisted of 3 sessions, each lasting around 30 minutes. The sessions consisted of physiological exercises involving semen production and vaginal discharge, accompanied with explanations that such acts are not deleterious to health, as well as the idea of mind-body connection and the associated genital changes. The patients reported a satisfactory improvement in their bio-psycho-social functioning. Written informed consent was obtained from the subjects for publication of their data.

Case A

Patient-specific information: 34-year-old single female.

Course of illness and clinical presentation: Gradual onset and continuous course. The patient initially presented herself to a gynecologist with complaints of worry and apprehension, occasional low mood, and fatigue for the previous 5 months, following failure in a college exam. According to her, all this was due to a recent increase in white discharge by the vagina. Upon clinical examination, no abnormality was detected. The patient's blood glucose, liver function test, kidney function test, thyroid function test, lipid profile, complete hemogram, serological tests for sexually transmitted diseases, microscopic examination and culture and odor of the urine and vaginal discharge were within normal boundaries. She was prescribed escitalopram (10 mg) and clonazepam (0.5 mg), which partially relieved her symptoms, and discontinued medication after 2 months. She later presented herself to an internal medicine physician with similar complaints and was prescribed venlafaxine, up to 150 mg, which also partially relieved her symptoms, before she discontinued the medication after 1 month. After a period of around 4 months, she presented herself to another internal medicine physician, with the added symptoms of verbal and physical aggression towards family members whenever a family member tried to reassure her that white vaginal discharge could not result in bodily symptoms and sleeplessness. She was prescribed olanzapine (10 mg), but she discontinued the medication after a week, citing fears of weight gain. When she arrived at our psychiatric outpatient department after around 3 months, she was secure in her belief that her body parts and the food she consumed were gradually "melting away" through the white discharge, which was resulting in a deterioration of her bodily functions, as well as a "drying up" and lumping into one mass of all of her internal organs. To her mind, the result was low mood, body pain, and sleeplessness. All her conversations with family members revolved around this topic. She further reduced her food and water intake believing that consuming food and water would consume energy and thereby increase the amount of white discharge, leading to further deterioration of her physical and mental health and increased aggression towards family members.

Management of the condition: She was diagnosed with delusion disorder (somatic type), and her symptoms significantly improved within 3 weeks with cariprazine (3 mg), and clonazepam (0.5 mg), together with psychoeducation. The patient was concerned about the side effects of many of the antipsychotic options offered, among them the chosen cariprazine. Clonazepam was discontinued after a week, and she held up well on cariprazine (3 mg), for 2 months until the last follow-up without any reported side effects.

Case B

Patient-specific information: 21-year-old single male.

Course of illness and clinical presentation: Gradual onset and continuous course.

Initial episodes of excessive worry, occasional sad mood, fatigue, and decreased attention span and concentration, which he linked to a loss of energy and vitality through semen following masturbation with a frequency of 1–2 times a day for 1 year. His blood glucose, liver function test,

[1] DSM Library [Internet]. Diagnostic and Statistical Manual of Mental Disorders; [cited 2023 Sep 1]. Available from: https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596

kidney function test, thyroid function test, lipid profile, and complete hemogram was within normal boundaries. He underwent psychoeducation and was prescribed fluoxetine (20 mg), but discontinued it after 1 week. Psychoeducation consisted of two brief sessions about building rapport, the physiology of semen production and discharge, and how the phenomenon is not pathological, mind-body link, and the associated changes in genitalia. He then presented himself after around 6 months with a firm belief that his brain and body were melting away along with the semen, which was leading to poor attention, concentration, and fatigue, which, in turn, he linked to his habit of watching sexually explicit videos and eating non-vegetarian food for 2 months. He would constantly seek assurance from his parents and friends about his beliefs and would often become aggressive towards them if they contradicted him. He stopped masturbating and consuming non-vegetarian food as advised by family members, but he continued to be consumed by the same belief during nocturnal ejections. He stopped going to college and would have multiple crying spells in a day.

Management of the condition: The patient was diagnosed with delusional disorder (somatic type), and his symptoms significantly improved within 4 weeks with risperidone (4 mg), along with psychoeducation. He held up well on risperidone (4 mg), for 1 year until the last follow-up, without any reported side effects.

DISCUSSION

In both cases, symptoms of Dhat syndrome existed in the initial period of the illness and the beliefs about vaginal discharge in case A and semen loss in case B were not delusional in nature. Compared to male Dhat syndrome, female Dhat syndrome is comparatively uncommon. Males typically report symptoms related to masturbatory guilt, whereas females typically express symptoms related to vaginal discharge [1].

Over the course of the illness, the beliefs related to semen loss and white discharge emerged as delusional. In both cases, the belief about semen loss and white vaginal discharge was held for more than a month, with strong conviction, effecting the patients' biological and social life. The belief was implausible and illogical nature-wise, and yet the patients remained preoccupied with the thoughts for days. The thoughts came with a sad mood, anxiety, and aggressivity towards family members and friends when contradicted regarding their firmly held beliefs. These characteristics are indication that these beliefs are delusional [7]. The delusions were related to bodily function, persisted for more than one month without any other symptoms of schizophrenia, and were therefore diagnosed as a delusional disorder of the somatic type 1. There is a dearth of data about what factors can play a role in the transition from culture-centered symptoms to delusions. Past research suggests that patients with an at-risk mental status and attenuated psychotic symptoms are susceptible to a transition from obsessions to overvalued ideas, and finally to delusions as part of schizophrenic symptoms, including negative symptoms and hallucinations. Such manifestations in the past have been termed schizo-obsessive disorder [4]. In our cases, the symptoms of Dhat syndrome may be the prodromal symptoms of the delusional disorder, which, along with schizophrenia, falls under the broader classification of non-affective psychotic disorders [8].

Our case differs from a single reported case of Dhat delusion where the patient presented themselves with catatonia, along with concern regarding semen loss and erection-causing weakness [2], whereas in our case, somatic delusions with Dhat syndrome-like content was present. This case also differs from a previously reported case series where classical koro-symptoms were absent before the development of koro-like somatic delusion [6], whereas in our case, classical Dhat syndrome was present before the development of Dhat delusions. What is more, in the previously reported case, the patient failed to improve with treatment and delusions emerged, whereas in our case the delusions emerged when the patient was not on any treatment. There is also a lack of data about the adequate duration of the treatment or dosage of the psychotropics used and about whether, if inadequately treated, the unhinged ideas related to semen loss or vaginal discharge devolved into delusional ideas.

CONCLUSION

Dhat delusion can be considered a distinct phenomenon compared to the Dhat syndrome, as delusional ideas have not been described traditionally in a culture-centered syndrome. Dhat syndrome, though classically described as a culture-rooted syndrome, may present itself as prodromal symptoms of a psychotic illness that needs to be explored further. What is more, future studies need to focus on the course of treatment regarding the adequate duration and dosage of treatment, and on which at-risk individuals

presenting Dhat syndrome symptoms or related culture-rooted syndromes should be followed up adequately and who may develop psychotic features in the future.

Article history

Submitted: 07.02.2024
Accepted: 26.02.2024
Published Online: 13.03.2024

Authors' contribution: All the authors made a significant contribution to the article.

Funding: The research was carried out without additional funding.

Conflict of interest: The authors declare no conflicts of interest.

For citation:
Bhattacharjee D, Banerjee D. When Dhat syndrome is delusional: a case series. *Consortium Psychiatricum.* 2024;5(1):CP15510. doi: 10.17816/CP15510

Information about the authors

Debanjan Bhattacharjee, MBBS, MD (Psychiatry), Medical Specialist, Department of Psychiatry, Central Hospital Dhori, CCL; ORCID: https://orcid.org/0000-0002-7431-0189

*__Debanjan Banerjee__, MD, DM, Consultant geriatric psychiatrist, APOLLO Multispecialty Hospitals, Kolkata; ORCID: https://orcid.org/0000-0001-8152-9798, Scopus Author ID: 57191832268
E-mail: dr.djan88@gmail.com

*corresponding author

References

1. Prakash O, Kar SK. Dhat Syndrome: A review and update. Journal of Psychosexual Health. 2019;1(3–4):241–5. doi: 10.1177/2631831819894769
2. Ghosh S, Chowdhury AN. A case of two culture-bound syndromes (Koro and Dhat syndrome) coexisting with obsessive–compulsive disorder. Indian J Psychiatry. 2020;62(2):221–2. doi: 10.4103/psychiatry.IndianJPsychiatry_298_19
3. Malik MFA, Najeeb B, Nizami AT. The association of symptoms of dhat syndrome with comorbid obsessive-compulsive disorder: A case report. Indian J Psychiatry. 2023;65(7):793–4. doi: 10.4103/indianjpsychiatry.indianjpsychiatry_437_22
4. Scotti-Muzzi E, Saide OL. Transition from obsession to delusion in Schizo-obsessive disorder. Innov Clin Neurosci. 2018;15(7–8):23–6.
5. Patra S, Sidana A, Gupta N. Delusion of dhat: The quandary of the form-content dichotomy! Ind Psychiatry J. 2014;23(2):171–2. doi: 10.4103/0972-6748.151708
6. Chakraborty A, Bhattacharjee D, Bandyopadhyay U. Secondary Koro presenting as delusional disorder: A case series. Journal of Psychosexual Health. 2022;4(4):260–2. doi: 10.1177/26318318221110188
7. Kiran C, Chaudhury S. Understanding delusions. Ind Psychiatry J. 2009;18(1):3–18. doi: 10.4103/0972-6748.57851
8. González-Rodríguez A, Seeman MV. Differences between delusional disorder and schizophrenia: A mini narrative review. World J Psychiatry. 2022;12(5):683–692. doi: 10.5498/wjp.v12.i5.683

Community-Based Psychiatric Care Provision in Hungary: Trends and Steps towards Progress

Внебольничная психиатрическая помощь в Венгрии: история прогресса и тенденции дальнейшего развития

doi: 10.17816/CP15483

Short communication

Tünde Bulyáki[1], Robert Wernigg[2], Péter Kéri[3], Andrea Ács[4], Adrienn Slezák[5], Andrea Bodrogi[4], Judit Harangozó[4]

[1] Eötvös Lóránt University, Budapest, Hungary

[2] National Directorate-General for Hospitals, Budapest, Hungary

[3] Global Alliance of Mental Illness Advocacy Networks — Europe, Brussels, Belgium

[4] Semmelweis University, Budapest, Hungary

[5] Community Outpatient Psychiatric Service for [13]th District, Budapest, Hungary

Тюнде Бульяки[1], Роберт Вернигг[2], Петер Кери[3], Андреа Ач[4], Адриенн Слезак[5], Андреа Бодроги[4], Юдит Харангозо[4]

[1] Университет имени Ло́ранда Э́твёша, Будапешт, Венгрия

[2] Национальное генеральное управление больниц, Будапешт, Венгрия

[3] Всемирное объединение сообществ по защите прав душевнобольных — Европа, Брюссель, Бельгия

[4] Университет Земмельвайса, Будапешт, Венгрия

[5] Общественная амбулаторная психиатрическая служба 13-го округа, Будапешт, Венгрия

ABSTRACT

Psychiatric care has undergone several cycles of profound changes in the past centuries all over the world. In Hungary, community-based outpatient care has been showing signs of evolution since the 1950s. Initially, the system centered on assertive outreach and family involvement, especially for those with serious mental health problems. Such services remain available throughout the country, but the emphasis in the past decades has shifted towards mass care provision. In many places, community-based services are no longer provided, and where they are the approach is biomedical and less asuming of recovery. In other centers, the services provided are conceived with the eventuality of rehabilitation in mind and in close cooperation with community-based care providers.

Community-based services providers, as part of the social fabric, offer as many psychiatric and rehabilitation services as possible for those with mental disorders within their communities. The main objective of community-based care is to achieve community re-integration and recovery from mental disorders. Today in Hungary, deinstitutionalisation and the introduction of community-based psychiatric care have been adopted even by large inpatient institutions. The replacement of institutional bed space and the provision of subsidised housing further underscore the importance of community-based psychiatric care provision. There is the opinion that, as a further course of development, the emphasis needs to now shift towards the nurturing of a community of experienced experts and creastion of user-led programs. In this new paradigm, the ability of a person with a mental disorder to make decisions and the bolstering of that ability are seen as vital. In order to achieve these objectives, it is essential that health and social seervices professionals cooperate. Hands-on experience is key in the provision and development of such services.

АННОТАЦИЯ

За последние столетия система оказания психиатрической помощи во всем мире претерпела ряд кардинальных изменений. Внебольничная психиатрическая помощь развивается в Венгрии начиная с 1950-х годов, когда

впервые начали применять ассертивный патронаж и привлечение семьи пациента к лечению, особенно для лиц с серьезными психическими заболеваниями. Такая помощь в настоящее время доступна по всей стране, однако в последние десятилетия ее акцент смещается на массового потребителя. В некоторых местах больше не предоставляют внебольничную помощь с опорой на общество, предпочитая биомедицинский подход, который в меньшей степени ориентирован на возвращения в социум (recovery). В других местах уделяют много внимания реабилитации и успешно взаимодействуют с социальными службами при оказании внебольничной помощи пациентам.

Амбулаторные службы как часть социальной системы предоставляют широкий спектр форм психиатрической помощи и реабилитации по месту жительства для лиц с психическими расстройствами. Основной целью общественно-ориентированной помощи людям с психическими расстройствами является обеспечение их социальной интеграции и достижение восстановления. В настоящее время в Венгрии деинституционализация и открытость внебольничной психиатрической помощи коснулись и крупных интернатов. Замена пребывания в интернате на субсидируемое жилье еще раз подчеркивает важность предоставления внебольничной психиатрической помощи. Существует мнение, что для дальнейшего развития необходимо создание института экспертов, имеющих личных опыт болезни, и программ, которые ведут сами пациенты. В этой новой парадигме жизненно важным является принятие решений человеком с психическим расстройством и развитие его способности принимать решения. Для достижения этих целей необходимо сотрудничество между специалистами системы здравоохранения и социальной сферы. Эксперты с практическим опытом являются ключевым звеном в предоставлении и развитии данного вида помощи.

Keywords: *Hungary; community psychiatry; recovery; multidisciplinary team work; peer support*
Ключевые слова: *Венгрия; амбулаторная психиатрическая помощь; восстановление; междисциплинарная командная работа; поддержка пациентов*

INTRODUCTION

The psychiatric care system has undergone profound changes in the past centuries in many countries. The aim of this review was to identify the main trends in the development of community-based psychiatric care in Hungary, its characteristics and place in the mental health care system, as well as the direction in which the wind blows in the way of progress. Community-based care was provided in a multidisciplinary team (psychiatrist, social worker, nurse), with the involvement of a peer support worker.

IMPORTANT MILESTONES IN THE DEVELOPMENT OF COMMUNITY-BASED PSYCHIATRIC CARE IN HUNGARY

Community-based psychiatry (CP) has a solid tradition in Hungary: most of the inpatient wards have existed in general hospitals. A humanistic tradition has always been part of psychiatry, and, beginning in the 1920s, the first pilot community-based outpatient clinics started to appear. From 1950, these outpatient services providers began multiplying and their best practices included the CP approach.

The comprehensive pilot program of CP was implemented by the Awakenings Foundation, the Community Psychiatry Center of Semmelweis University, Budapest (in short: AF). From 1994, under the leadership of the psychiatrist Judit Harangozó, AF adopted and implemented the Assertive Community Treatment, one of the international best practices, by Leonard Stein [1], and the Optimal Treatment Program by Ian Falloon [2]. We created the principles of community addictology under the leadership of Andrea Bodrogi, MD, head of the addictology team at our center. The Supported Employment Program [3] was adapted by Tünde Bulyáki [4]. We published handbooks and booklets on these topics [4, 5].

Soon after 1994, we launched our community psychiatry and addictology service in Budapest, Hungary. The key characteristics of our service are as follows: recovery-oriented, family involvement, psychoeducation, assertive outreach, monitoring of early warning signs to prevent relapse, optimal and individualized pharmacotherapy, skills training, stress management, assertivity, and supported employment.

Primarily, the rehabilitation plans are based on the personal life goals of patients and family members, before

an assessment is made of the difficulties that interfere with those personal goals and a reaction to these is prescribed, with the involvement of a multidisciplinary team that includes peers support. Emphasis is put on nonviolent means of treatment and rehabilitation by offering to our staff training in communication and negotiation skills and in de-escalation strategies to handle aggression [2]. Great results have been achieved. After one year of community-based care, the employment/learning rate among patients has gone from 15–20% to 55–65% in every diagnostic group.

We have joined efforts with the Antistigma group of the World Psychiatric Association, and Norman Sartorius has provided training for the Antistigma volunteers. We have also joined the research on stigma led by Graham Thornicroft of Kings' College London. There is close cooperation with Agnes Rupp from NIMH (US) in the field of mental health policy and economics. More than 300 of our publications are related to these activities. The staff of the AF participates in graduate and post-gradual training programs for medical professionals, nurses, social workers, and psychologists.

Our mission is to continuously innovate. We have implemented the Hearing Voices approach [6] since 2012, as well as an organizational culture of Coproduction: mental health is a collaboration effort between users and professionals [7]. We train peers as supporters and involve them in every aspect of our action. We offer several online facilities; besides therapy there are online self-help groups, platforms, various applications, and online peer support, as well. Our leader on the professional front is the co-chair of the "Mental Health Economics" panel of the World Psychiatry Association. One of our peer supporters, Peter Kéri, is the board member of the European Psychiatric Association and the President of GAMIAN Europe, an umbrella organization for user-centered organizations.

In the early 2000s, community-based psychiatric care was folded into the renewed Social Act and more than 100 service centers were established by the government, partly for psychiatric and partly for addicted patients, as part of the social services system. The methodological basis of this care is centered on the CP pilot program introduced by the Foundation. Colleagues and peer supporters of the foundation have developed the training programs for the staff of the new services centers, an effort that is also supported by the government.

GENERAL CHARACTERISTICS OF COMMUNITY PSYCHIATRY IN HUNGARY

In Hungary, people living with mental disorders have access to health care and social services. Community-based outpatient services providers and other outpatient facilities and day hospitals constitute community-based psychiatry in the healthcare system (see below), while in the social services system, community-based care and daycare are available and there are a few residential facilities (supported housing) facilities in the community.

There are 91 socially oriented community-based services providers for mental, and 89 for addicted, patients around the country.[1] The former serve 5,003; the latter, 4,435 clients with serious mental disorders that, for the most part, belong on the psychotic to affective continum and require intensive, long-term need-based psychosocial rehabilitation and support.[2] The services are free of charge and non-coersive.

There are also day-centers for mental (*n*=108) and addicted (*n*=95) patients serving 5,583/6,017 clients voluntarily and free of charge in the nation-wide social services system.[3] Patients can use other social services as well; i.e., family support services that are available for everybody in the local community, free of charge. Since 2013, the social services system has been complemented with residential facilities in the community. Unfortunately, this service is not available to everyone in need at the moment and many of these facilities require significant co-pays. The methods utilized in these services are similar to those used in the pilot program of the Awakenings Foundation. Day centers in some instances house self-help facilities and incorporate peers support. They organise cultural, leisure or educational activities, training programs, residential or family programs, meetings, all based on the needs of the clients. The purpose of these establishments is to achieve recovery [8]. The professionals providing these services are mostly social workers and a few psychologists, who must undergo a 350-h community-based psychiatry education program based on our pilot program and run by the National Institution for Social Policy.

THE GENERAL FEATURES OF THE HUGARIAN MENTAL-HEALTH SYSTEM

Within health care system, outpatient care is provided by community-based psychiatric outpatient providers

[1,2,3] Hungarian Central Statistical Bureau. Available at: https://www.ksh.hu/stadat_files/szo/en/szo0025.html

available to the whole population, and outpatient care is available in inpatient wards and special clinics. GPs and other specialists can request a consultation from the outpatient psychiatric services provider. Psychiatric inpatient care is provided in the psychiatric wards of general hospitals, psychiatric clinics, or in a mental hospital. There is still an insuffucient number of professionals in the field of psychiatry and mental health care, and its financing is still institution-based. Speaking of health care over all, there are also day hospitals, mostly organized in hospitals (see Tables 1–3 and Figures 1–2). Health care professionals and patients accept this way of treatment in the country. Peers support workers are not involved in the provision of mental health services.

THE PLACE OF COMMUNITY-BASED MENTAL HEALTH CARE IN HUNGARY

There is an increasing need for CP services in Hungary. Patient turnover in hospital treatment gradually decreases. Professionals and policymakers have insufficient leverage, and not enough resources are vailable in the mostly institutionally financed health care and social services systems to ensure comprehensive, accessible, and acceptable CP care for every patient in need. However,

Table 1. Inpatient psychiatric services providers in Hungary (resource: National Dierctorate General for Hospitals)

Year	Psyhiatric beds (beds per 100,000 inhabitants)	Child and Adolescent Psychiatry beds (beds per 100,000 inhabitants)	Total Psychiatry beds (beds per 100,000 inhabitants)	Psychiatry Average length of stay (days)	Child and Adolescent Psychiatry Average length of stay (days)	Chronic Departments Average length of stay (days)	Rehabilitation Departments Average length of stay (days)
2012	29.62	1.4	31.02	12.95	7.79	33.46	21.73
2013	29.64	1.4	31.04	12.95	7.7	29.89	26.37
2014	29.41	1.4	30.81	13.03	7.66	30.83	26.3
2015	28.8	1.56	30.37	12.92	7.93	30.77	26.62
2016	28.92	1.57	30.49	13.03	8.12	33.45	27.11
2017	28.92	1.57	30.49	12.82	8.09	34.59	27.09
2018	28.67	1.57	30.24	12.61	8.29	36.99	27.27
2019	28.6	1.58	30.18	12.7	8	37.2	27
2020	25.42	1.58	26.99	12.5	6.9	53	30.8
2021	26.53	1.58	28.12	12.5	7.4	39.9	31
2022	26.63	1.79	28.41	12.7	7	39.4	26.6

Table 2. Mental health services providers in Hungary, 2023 (resource: National Directorate General for Hospitals)

	Number of services providers (pieces)	Number of patients treated in the last 12 months	Number treated (cases per 100,000 inhabitants)	Hospital beds / day hospital placements (pieces)	Number of beds (pieces per 100,000 inhabitants)
Outpatient services providers	832	477,864	4,932	-	-
Community-based outpatient services providers	384	135,120	1,394	-	-
Mental hospitals	1	-	-	530	5.47
General hospital units	73 (incl. 35 children and adolescent units)	-	-	2,223 (incl. 489 child and adolescent)	22.94 (incl. 1.78 child and adolescent)
Day hospitals	21 (included in General Hospital count)	-	-	216 (included in General Hospital count)	2.23 (included in General Hospital count)

Table 3. Numbers of professionals in mental health services provision in Hungary, 2023 (resource: National Directorate General for Hospitals)

Profession	Number of professionals per 100,000 inhabitants
Child and adolescent psychiatrists	1.91
Clinical psychologists (incl. Adult or Child and adolescent Clinical and Mental Hygienist Psychologists)	14.54
Psychiatrists	12.16
Mental Health Nurses and Specialised Nurses	10.85

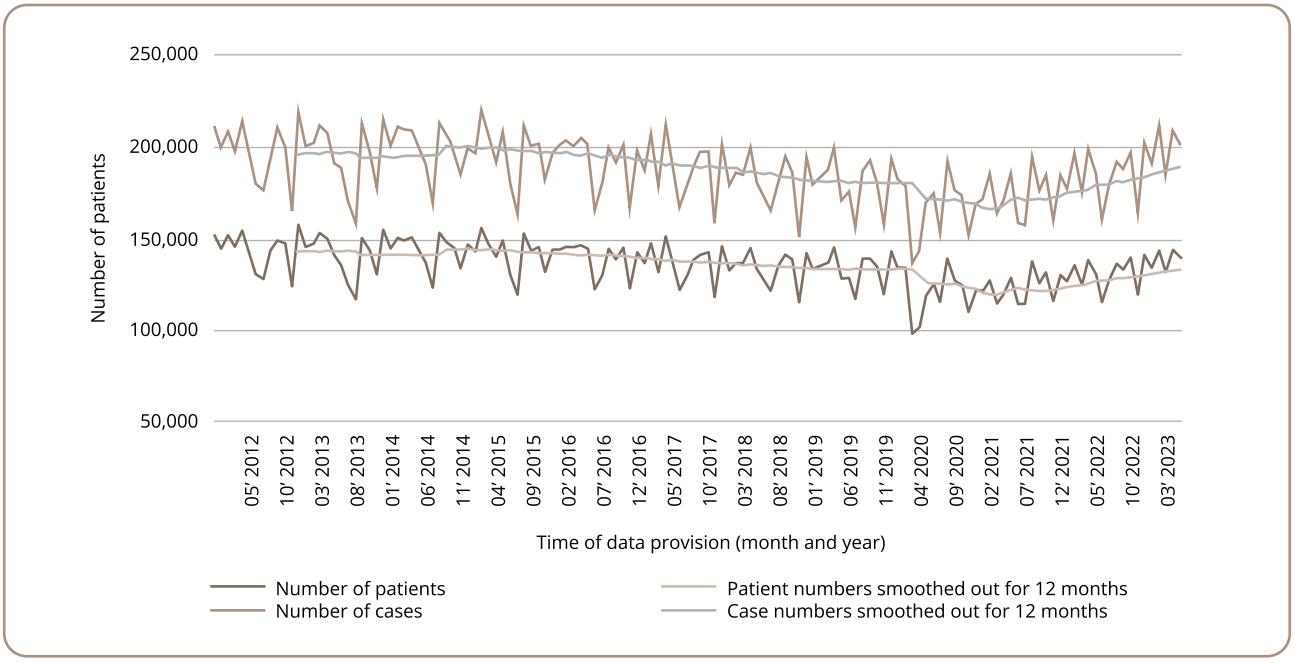

Figure 1. Psychiatric outpatient turnover in the health care system of Hungary: 2012–2023.
Note: These numbers are to be related to the full population of Hungary which changed from 9,931,925 (2012) to 9,689,744 (2023).
Data from Hungarian Central Statistical Office: https://www.ksh.hu/stadat_files/nep/en/nep0001.html

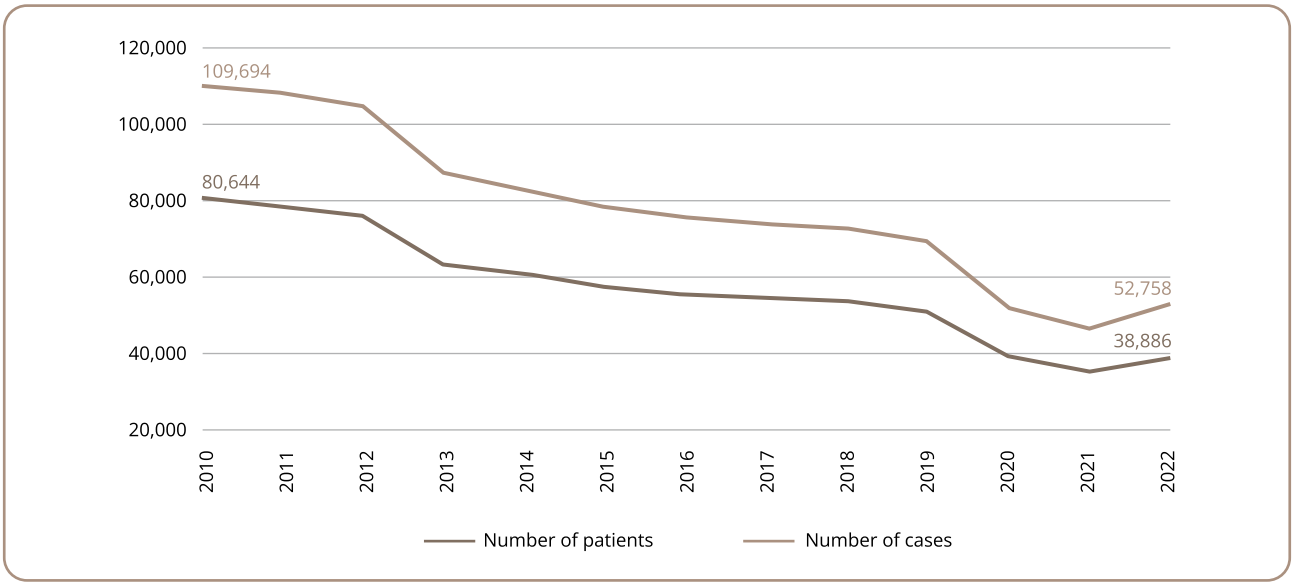

Figure 2. Psychiatric inpatient turnover in the health care system (for 10 million people) of Hungary 2010–2022.

good practices do exist, such as the pilot program at AF, which has yielded a cost-effective model that reduces indirect costs after just one year of optimal care [9]. CP in health care predominantly revolves around medication, but best practices involve cognitive behavior therapies, as well [10]. CP care in the realm of social services provision is only accessible to 10 percent of those with serious mental health problems, while care in boarding-school-type institutions within the community is accessible to just 1% of patients in need who have the resources for co-pays. The quality of care also varies: there are some services which are representative of the quality of the pilot program (Optimal Treatment Project), but others leave much to be desired. Quality assurance is nonexistant, but, on the other hand, there is massive administrative control in the provision of social services. The controls focus mainly on the mandatory documents but not on the professional quality assurance of the services.

THE STRENGTHS AND WEAKNESSES OF COMMUNITY-BASED MENTAL HEALTH CARE PROVISION IN HUNGARY

Most of the existing CP health services provision focuses on symptoms and relapse prevention, while socially oriented CP services in the community are oriented towards recovery, with some application of peer support, as well. That is the strength of socially oriented CP services provision. The system also increases patient access to health care. Achieving this objective requires close cooperation between the professionals working in both sectors [11]. A ministerial professional recommendation issued in 2018 also alludes to close cooperation between the health care and social services sectors in community-based psychiatric care. In addition to the knowledge of one's own profession, effective cooperation requires everyone to remain open to other professions and to tear down the hierarchies between individual professions. In Hungary, the original dominance of the health care approach in the way care is provided to psychiatric patients can be felt even today [12]. Day hospitals that operate according to the medical model are usually part of a health care institution/hospital system and are primarily staffed by medical personnel (doctors, nurses). In these institutions, the nature of daily programs is structured medical therapeutic interventions, with little attention paid to the value of recovery. This can be regarded as a weakness of the mental health system. At the same time, provision of care also exists in the social services sector. It is much less medicalized and is mainly staffed by social services professionals, sometimes supplemented by a number of health professionals: e.g., a psychologist or a psychiatrist [13]. Home-based long-term community-based psychiatric care is usually provided only by social services providers. Communication between providers of health care and social services is often lacking or non-existent when social workers cannot achieve the cooperation of health professionals [14]. Outside of psychiatric professionals in the health care sector, few health care professionals know about community psychiatry. The vast majority of general practitioners do not have contact with community-based care providers in the social services sector. A further weakness is that the majority of doctors, nurses, and other professionals still treat mental illnesses exclusively as a health problem. Although recovery-based service models have appeared in community-based care provision, the willingness to accept changes is slow among the professionals in the health care system. They don't believe in the recovery of the mentally ill. In addition to the differences in approach, insufficient allocation of resources can also be identified as a problem in intersectoral cooperation [14, 15]. The strength of the Hungarian system consists in the good employment opportunities offered to patients. The government provides incentives to employ people with disabilities and funds other initiatives as well. Additional strength is the high quality of the professional trainings received and scientific activities persued by Hungarian mental health care professionals.

THE PERSPECTIVES IN COMMUNITY PSYCHIATRY AND PEER SUPPORT

Personalized care with the involvement of families and other important people is a cornerstone of the future of mental health care provision. Tailoring treatment and therapeutic approaches to the needs and circumstances of individual patients and their families improves the chances of recovery.

Digital technology and artificial intelligence will play a pivotal role in shaping the future of mental health care provision. The widespread adoption of eHealth and technology will facilitate more effective communication between patients and healthcare professionals and empower patients to actively monitor their mental health status.

The progressive steps towards the dissemination of good practices in community-based psychiatry in Hungary are as follows:

- shifting of resources from institutions to quality-controlled CP services provision;
- quality assurance;
- evaluation of good practices and their dissemination using public money;
- subsidized employment for people with a lived experience in the health care and social services sectors, and the education of professionals[4];
- training of managers, leaders, and other staff, as well as peer support and emphasis on a person-centered and value-based approach, including de-escalation of aggression, and organizational development towards a system of cooperation [7];
- training of professionals on ethics and human rights based on CPRD (Convention on the Rights of Persons with Disabilities) and WHO protocols;
- eradicating "violent" practices radically in psychiatry;
- improving public awareness of mental health and mental health institutions;
- involvement of primary care professionals in the prevention and management of noncomplex cases of mental disorders; and
- the integration of digital technology and AI.

In the future, there is great potential for peer support to play a vital role in value-based, cost-effective mental health care provision. As we look ahead, several key factors can shape the future of peer support in the mental health field. Mental health is a coproduction involving users and professionals. The integration of people with lived experience should ensure that peer support workers are valued as equal members of the team, contributing their distinct perspectives towards improving overall care provision. People with lived experience should be involved in the education and training of professionals, as well. Programs involving students offer a glimpse of the potential impact of exposing future mental health professionals to peer support early in their training. Expanding these initiatives and ensuring that they are an integrated part of mental health education can foster greater understanding and cooperation between peers and clinicians and decrease stigma.

The stigma and discrimination associated with mental disorders needs to be targeted both within the mental health care community and in the society at large. Meeting with people with lived experience can play a significant role in challenging stereotypes and dispelling myths about mental illness. By sharing their stories and offering hope, they can contribute to the creation of a more accepting and compassionate society. Technology and innovation also hold promise for the future of peer support. Online platforms can provide accessible avenues for people to connect with peer support specialists regardless of their location. As technology continues to advance, there are opportunities to develop more tailored and effective digital interventions that complement traditional face-to-face support.

Additionally, research and evaluation are essential to demonstrate the effectiveness of peer-supported interventions. Gathering data on outcomes, such as improvements of mental health, reduced hospitalization cases, or increased quality of life can help secure funding and bolster support for these programs. It's crucial to build an evidence basis that highlights the value of peer support in achieving positive mental health outcomes.

The prospects for peer support in mental health care look promising, with the potential to transform how we approach and deliver mental health services. This transformation hinges on the integration of peer support into the system, education and training, stigma reduction, technological innovations, and robust research.

CONCLUSION

Hungary possesses good practices in community-based psychiatry, but the structure and funding of health and social services remain institution-based. There is continuous development of community services. Their quality varies, as quality insurance is missing. By working in cooperation and embracing the unique contributions of peer support specialists, we wish to create a mental health care system that is more holistic, person-centered, and effective in achieving recovery and well-being.

Article history
Submitted: 06.12.2023
Accepted: 21.03.2024
Published Online: 26.03.2024

[4] Harangozó J, Rupp Á, Kéri P et al. Peer support involvement: Practice models and costs. Presentation at the 23th World Congress of Psychiatry; Sept 28 – Oct 1 2023; Vienna.

Authors' contribution: All the authors made a significant contribution to the article.

Funding: The research was carried out without additional funding.

Conflict of interest: The authors declare no conflicts of interest.

For citation:

Bulyáki T, Wernigg R, Kéri P, Ács A, Slezák A, Bodrogi A, Harangozó J. Community-based psychiatric care provision in Hungary: trends and steps towards progress. *Consortium Psychiatricum*. 2024;5(1):CP15483. doi: 10.17816/CP15483

Information about the authors

* **Tünde Bulyáki**, PhD, Assistant professor Department of Social Work, Eötvös Lóránt University Faculty of Social Sciences
E-mail: tunde.bulyaki@gmail.com
Robert Wernigg, MD, Head of the Department for Primary Care Planning and Development National Directorate-General for Hospitals
Péter Kéri, peer support worker, PR expert, President, GAMIAN-Europe; Member of the Board, European Psyciatric Association; Member of the Board, European Brain Council; Manager of Peer Innovations, Awakenings Foundation
Andrea Ács, PhD, Assistant professor, Semmelweis University Faculty of Health Sciences, Nursing Department
Adrienn Slezák, MD, Head of Institute Community Outpatient Psychiatric Service for 13th District
Andrea Bodrogi, MD, Chief physician, Awakenings Foundation Community Psychiatry Centre, Semmelweis University
Judit Harangozó, MD, Head of Community Psychiatry Centre, Semmelweis University

*corresponding author

References

1. Stein LI, Test MA. Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. Arch Gen Psychiatry. 1980;37(4):392–7. doi: 10.1001/archpsyc.1980.01780170034003
2. Falloon IRH, Montero I, Sungur M, et al. Implementation of evidence-based treatment for schizophrenic disorders: two-year outcome of an international field trial of optimal treatment. World Psychiatry. 2004;3(2):104–9.
3. Drake RE, Bond GR. Supported employment: 1998 to 2008. Psychiatr Rehabil J. 2008 Spring;31(4):274–6. doi: 10.2975/31.4.2008.274.276
4. A közösségi pszichiátria kézikönyve [Handbook of Community Psychiatry]. In: Bulyáki T, Harangozó J, editors. Awakenings foundation; 2018. 398 p. Hungarian.
5. A közösségi addiktológia kézikönyve [Handbook of Community Addictology]. In: Bodrogi A, Harangozó J, Bulyáki T, Falloon IRH, editors. Awakenings Foundation; 2014. 152 p. Hungarian.
6. Spencer LH. Living with voices: 50 stories of recovery. In: Romme M, Escher S, Dillon J, Corstens D, Morris M, editors. PCCS Books; 2009. 346 p.
7. Clark M. Co-production in mental health care [Editorial]. Mental Health Review Journal. 2015;20(4):213–9. doi: 10.1108/MHRJ-10-2015-0030
8. Bulyáki T. Utazás a mentális zavarból a felépülés irányába. [The journey from mental disorder to recovery]. Eötvös Kiadó; 2023. 313 p. Hungarian.
9. Harangozó J, Bodrogi A, Nemessuri J, Bulyáki T. A semmelweis Egyetem Közösségi Pszichiátriai Centrum és az Ebredések Alapítvány tevékenységének bemutatása [Activities of the awakenings foundation and the community mental health centre of Semmelweis University of Medicine]. Psychiatr Hung. 2008;23(4):224–30. Hungarian.
10. Kovács ZA, Váradi E. Rehabilitációs szemlélet a pszichiátriai gondozásban: bio -behaviour módszerek és a kognitív rehabilitáció távlatai. [Rehabilitation approach in psychiatric care: bio - behavioral methods and cognitive rehabilitation perspectives]. In: Váradi Enikő: Pszichiátriai gondozási kézikönyv. [Handbook of Psychiatric Care]; Budapest, Oriold és Társai Kiadó; 2012. P. 29–68. Hungarian.
11. Endre S. Integrált közösségi ellátások szerepe a felépülésben — egy hatékonyságvizsgálat tükrében [The role of integrated community care in recovery - in the light of an effectiveness study]. Doktori (Ph.D.) értekezés, Doctoral (PhD) thesis; PTE-BTK Pszichológia Intézet; 2020. 198 p. Hungarian.
12. Ács A, Petri G. Szemléletbeli különbségek a pszichiátriai betegek megítélésében és a szektorközi együttműködések szerepe. [Attitudinal differences in the judgment of psychiatric patients and the role of intersectoral cooperation]. In: Perlusz A, editor. Kutatási beszámoló a pszichoszociális fogyatékos személyek társadalmi helyzetét feltáró országos kutatásról. [Research report on national research on the social situation of psychosocial disabled persons]; Budapest: A Gyógypedagógia Fejlesztéséért Alapítvány; 2017. P. 43–58. Hungarian.
13. Budai I. Az interprofesszionális együttműködés és a szociális munka [Interprofessional cooperation and social work]. Esély. 2009;5:83–114. Hungarian.
14. Ács A, Bányai B, Bugarszki Z, et al. A mentális problémával küzdő emberek és a magyar pszichiátriai ellátórendszer bemutatása [People with mental health problems and the Hungarian psychiatric care system]. Perlusz A, editor. A pszichoszociális fogyatékossággal élő személyek társadalmi helyzetét feltáró országos kutatásról [Research Report on National Research on the Social Situation of Psychosocial Disabled Persons]. Budapest: Gyógypedagógia Fejlesztéséért Alapítvány; 2017. P. 58–66. Hungarian.
15. Gomory T, B. Erdős M, Kelemen G. Kényszer vagy együttműködés? Vitatott kérdések a közösségi pszichiátriai
16. ellátás gyakorlatában [Coercion or cooperation? Contentious issues in community psychiatric care practice]. Esély. 2006;5:101–29. Hungarian.

Η Ψυχή.[1] Study of the Soul and Its Feminine Side

Η Ψυχή.[1] Психея или женская природа наук о душе

doi: 10.17816/CP178

Interview

Maria Dolgaleva
Mental-health clinic No. 1 named after N.A. Alexeev, Moscow, Russia

Мария Долгалева
ГБУЗ «Психиатрическая клиническая больница № 1 им. Н.А. Алексеева Департамента здравоохранения города Москвы», Москва, Россия

The progress in any field depends, first and foremost, on the people who work in it. Luckily, today the indispensable contribution of women to all areas of knowledge is widely recognized. However, it is crucial to continue advocating, challenging prejudices and promoting empowerment of women worldwide.

International and regional platforms to address gender equality issues, the UN Women initiative and the annual Women's History Month, which is celebrated in March in many countries across the globe, are intended to emphasize the role of women in world history and the development of modern society.

While mental sciences by their very name refer to Psyche, the young heroine of ancient Greek myths, women began to contribute fully to psychology and psychiatry as late as the beginning of the 20th century. Sabine Spielrein (1885) is known to be the first woman psychoanalyst. She was a student, a friend and a colleague of Freud and Jung. Karen Horney, born in the same year, was one of the key figures of neo-Freudism. At the end of the 19th century, Ivan Mikhailovich Balinsky gave lectures on psychiatry to the young women attending medical courses.

Why do women increasingly choose the path once dominated by men? What motivates bright young women to pursue this career? Why have some of them dedicated their lives to caring for others' mental health? We had an opportunity to talk to several female psychiatrists and psychologists, members of the editorial board and authors of Consortium Psychiatricum.

We asked our interviewees, explorers of human mind, a few simple questions so that this time, they could open up their own souls and share. The key features that distinguish our interviewees are the desire to follow their vocation despite stereotypes, a true passion for science, the ability to empathize and to create a safe space for themselves and others wherever they go.

We hope that their memories, reflections and guidance will inspire and support the next generation of women working in the mental health field.

[1] Ancient Greek — soul. Feminine.

Victoria Bird

Professor of Mental Health Care (Unit for Social and Community Psychiatry) Queen Mary University of London: London, London, GB

Author "Cognitive behavioural therapy in virtual reality treatments across mental health conditions: a systematic review"

DOI: https://doi.org/10.17650/2712-7672-2020-1-1-30-46

Maya Kulygina

PhD (psychological sciences), Senior Researcher, Department on International Collaboration, Scientific and Clinical Research Center of Neuropsychiatry

Editorial board member

Author "Impact of COVID-19 pandemic on anxiety, depression and distress — online survey results amid the pandemic in Russia" DOI: https://doi.org/10.17650/2712-7672-2020-1-1-8-20;

"Engagement of Russian Mental Health Professionals in the Development of WHO's ICD-11" DOI: https://doi.org/10.17816/CP79;

"Toward ICD-11 Implementation: Attitudes and Expectations of the Russian Psychiatric Community" DOI: https://doi.org/10.17816/CP80

Elena Molchanova

MD (Psychiatry), Professor, Division of Social Sciences, Department of Psychology American University of Central Asia, Bishkek, Kyrgyzstan.

Editorial Board member

Author Outpatient Services for People with Mental Disorders in the Kyrgyz Republic: What Is Next? DOI: https://doi.org/10.17816/CP133

Natalia Petrova

Doctor of Medical Sciences, Professor, Head of the Department of Psychiatry and Narcology, St. Petersburg State University.

Author "Long-Acting Injectable Drugs in the Maintenance Therapy of Patients with Schizophrenia" DOI: https://doi.org/10.17650/2712-7672-2020-1-2-53-62

Mariana Pinto da Costa

MD, MSc, PhD, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust; Senior Lecturer, Institute of Psychiatry, Psychology & Neuroscience, King's College London; Professor Auxiliar, Institute of Biomedical Sciences Abel Salazar, University of Porto, Porto, Portugal; Chair of the Early Career Psychiatrists Section of the World Psychiatric Association

Author "Community psychiatry in Portugal: a critical review"

DOI: https://doi.org/10.17650/2712-7672-2020-1-1-49-59

Denise Razzouk

MD., PhD, Affiliated Professor, Department of Psychiatry, Universidade Federal de São Paulo Coordenadora do Centro de Economia em Saúde Mental (CESM)

Author "Community-based mental health services in Brazil"

DOI: https://doi.org/10.17650/2712-7672-2020-1-1-60-70

Anita Riecher-Rössler

MD, Professor em. of Psychiatry and former Head of the Center for Gender Research and Early Detection at the Psychiatric University Clinics in Basel, Switzerland

Editorial Board member

Natalia Semenova

Associate Professor, PhD (psychological sciences), Senior Researcher, Moscow Research Institute of Psychiatry, a branch of V. Serbsky Federal Medical Research Centre of Psychiatry and Narcology of the Ministry of Health of the Russian Federation

Editorial board member

Why did you choose the mental health career?

Victoria Bird: I have always been interested in people, and in particular social interactions. I have a drive to understand and am always wanting to know more. I wanted to have a career that followed my interests and would be fast paced and energetic. With mental health, everything is unique and about the person, no two days are the same. I work in mental health research, where I get to interact with really interesting people. One thing that drives me is the stories of the people who use our services.

Maya Kulygina: For me it was somehow predestined. As a friend of mine used to say, I was lucky to be born in a room with a bookcase. So, in our bookcase between Lermontov and Chekhov there were works by P. Gannushkin, G. Sukhareva, B. Zeigarnik, S. Rubinstein: my mom was a psychiatrist. I remember coming to her hospital, her conversations with colleagues, reading those books, all that created an environment in which poor mental health and a mentally sick person were perceived as something natural and deserving sympathy. While I was still a child I wondered what people thought about, why they acted the way the acted, what helped them to overcome difficulties and achieve success. In school I had a passion for biology, mathematics and literature which led me to the Faculty of Psychology of Moscow State University named after M. Lomonosov. And there the choice was clear — the Department of Neuro- and Pathopsychology. And so it went.

Elena Molchanova: Ever since school I've been interested in mental health. Initially I wanted to become a psychologist, but after attending lectures at several universities in Frunze (that's how Bishkek was called at the time) I was disappointed. Once I happened to be at a seminar taught by V. Solozhenkin after which I immediately made my choice. So I found a Master rather than a profession.

Natalia Petrova: For me there were no alternatives. Back in school I got fascinated by higher nervous activity, since the 1st year I had been a member of a student scientific society for psychiatry. If I tried to rationally look back at my choice I'd say psychiatry is really intriguing, it challenges an inquiring mind.

Mariana Pinto da Costa: When I was studying medicine, I soon realised that many specialities are very specific (and too narrow) in their focus and in their care towards patients, as if one could become the expert of the little finger of a patient, not being concerned with the rest.

Being interested in supporting 'the person as a whole', beyond any specific organ or body part, I decided in my medical studies that I wanted to train in psychiatry, and pursue a career in mental health.

Denise Razzouk: Before starting my course in Medicine I was in doubt between Psychiatry and Psychology because I was very interested in human behavior and all human dimensions, including anthropological, historical and philosophical issues. In summary, I was interested in human beings.

Anita Riecher-Rössler: When I was 16 years old I read Sigmund Freud and was very impressed by his thoughts on the unconscious and all these psychological processes driving human beings. Later, after having finished my psychoanalytic training, I stayed in psychiatry, as I got more interested in scientific evidence. For example I got very interested in sex and gender differences of mental disorders or in the development of psychosis.

Natalia Semenova: I studied at the Faculty of Psychology at Lomonosov Moscow State University and my choice to become a "psychologist working in psychiatry, in collaboration and close contact with psychiatrists" was influenced by two professors, namely Bluma Wolfovna Zeigarnik and Yuri Fedorovich Polyakov.

B. Zeigarnik was teaching a course on pathopsychology, and I always tried to sit as close to the podium as possible so as not to miss anything. I even bought a very cute notebook specifically for my notes on pathopsychology. And among them were some very important notes — on psychic pathologies in mental diseases, on the key role of social environment and the cultural space for the patient, on the importance of the patient's own activity, on psychological correction and rehabilitation as necessary conditions for the return of an ill person to normal social life.

Y. Polyakov (who was my Ph.D. thesis supervisor later on) gave a course of lectures on the pathology of cognitive activity in schizophrenia (covering, in particular, various types of motivational and personality dis-

orders). In terms of career choice, as it turned out, I was not the only one who was influenced by him. The well-known German psychiatrist Manfred Spitzer once admitted in our personal conversation that if he hadn't come across a little book "Schizophrenie und Erkenntnistatigkeit" (a work of J. Polyakov translated into German and published in Stuttgart in 1972) at the time, he probably would not have chosen this field of medicine for himself.

What is most important to you in your job?

Victoria Bird: Having supportive colleagues and a stimulating work environment is essential for mental health research. You cannot do research on your own, rather you need others. Having a supportive environment allows ideas to flourish and grow, it also promotes creativity. Within this, it is important to ensure a range of perspectives are heard, importantly including people with lived experience in the discourse.

Maya Kulygina: I could say that it is important to feel needed, to be able to see the result of your work, whether it is research or clinical practice. But there is always more: craving for knowledge, the opportunity to explore on your own, feeling of commitment to an important common cause, and of course that basic interest to human beings.

Elena Molchanova: To understand what I'm doing, what the purpose is, and what my patient will receive as a result. To retain the ability to empathize at least at the level that I have so far. It's important to remain empathetic, at least as much as I already am so far.

Natalia Petrova: Helping people who are suffering.

Mariana Pinto da Costa: I am driven to make a positive and meaningful change in people's lives. This can be on a one-to-one individual level, or more globally at organisations level. It is extremely rewarding every time I receive a message of a patient or a colleague and knowing that I was able to help that person.

Denise Razzouk: Mental health is about how human beings feel and react while facing life challenges, individual limitation and expectations. Ultimately, suffering is a consequence of our ability failure of dealing with the imbalance between how society supports/threaten us and how our biological and psychological skills are appropriate to survive and to pursue happiness and well-being. Then, poor mental health represents a lack of individual freedom to decide and to choose his/her best possible trajectory in life. A psychiatrist should be able to keep in mind that a mentally ill person is someone that needs support to restore his/her life in all dimensions and not only receive "interventions" focused exclusively on symptoms and claims. Therefore, a psychiatrist should be interested in all human beings aspects and have empathy regarding human suffering.

Anita Riecher-Rössler: For me psychiatry is the most interesting discipline, because it deals with the most important subject, the human being, and in all its aspects from biology to psychology, sociology, etc.

Natalia Semenova: There are probably two things that are worth mentioning. The first one can be described by the expression "need-induced immunity". It's when you as a professional are really needed. My work mostly involves psychosocial support for the sick. In terms of the experimental component, I have always been more into experiments that help with personal growth and development rather than just detect certain disorders in the patient. "Need-induced immunity " goes hand in hand with increased resilience to life's challenges (and diseases!). This is due to the specialist's experience of being needed by others to successfully carry out an activity that is significant both to them and to the society.

The latter consideration also concerns psychosocial help for the mentally ill. Personally, I call it "protecting" or "saving". One way or another, from different theoretical perspectives and using different conceptual languages, many have mentioned this common idea which is important for our work. I mean the connection between such phenomena and statements as, for example, once proposed by Solzhenitsyn expression of the national idea, namely "saving the people" and my teacher and doctorate thesis supervisor Isaak Yakovlevich Gurovich's concept of psychosocial rehabilitation in psychiatry.

The pandemic-related crisis is still tough for the whole world. What would you recommend to strengthen one's mental health?

Victoria Bird: I think we need to focus on our youth people, their mental health and wellbeing. Young people have really had a tough time over the last year, with the closure of schools and the loss of normal social interaction. However, I do not think it is about diagnosing and putting people in treatment, rather we need to focus on giving young people the skills and resources to overcome mental distress. In particular, we need to strengthen community resources, such as those provided by sports and arts groups to enable young people to interact and express their feelings.

Maya Kulygina: The advice would be quite common and even simple actually, but it should be followed: keep in contact with people, and not only with the loved ones, but also on other social levels; take care of your body, in terms of a healthy diet or regular physical exercise, learn something new. What is particularly important in the context of the restrictions and distancing, fill your daily schedule with activities in order to avoid routine, monotony and lack of will. Finally, I guess, it is imperative to create your own meanings and stick to them, i.e. find something that inspires you, brings satisfaction and answers the questions: why am I doing this? For what purpose?

Elena Molchanova: My profession is not about offering advice. Evidence-based medicine believes that regular physical exercise boosts neuronogenesis and lowers cortisol levels. So I would say any type of sport that feels good will do. There's a lovely book by Robert Sapolsky that is called "Why zebras do not have ulcers". There's nothing to add to this.

Natalia Petrova: Work hard.

Mariana Pinto da Costa: The current COVID-19 pandemic has led to social isolation blocking people from their usual face-to-face interactions with their family and friends. This led to many feeling helpless, anxious and depressed.

Therefore, there should be an increased capacity to support individuals in their local communities, including through the use of technology. This should be at the services level, facilitating access to mental health services when required to provide treatment, but equally through initiatives that provide volunteering support in the community, and promote social cohesion and support, focusing on (new symptoms or their relapse) prevention.

Technology has been fundamental to provide care and support to patients during the ongoing pandemic. On several occasions it allowed to address social isolation and overcome distances, but also to contribute to patients' recovery and their social integration. It has not only been an alternative available or a preference for some but for many and on many occasions the only choice available.

In my PhD research I developed a new intervention called 'Phone Pal' to overcome social isolation in people with mental illness, connecting community volunteers with patients with psychosis remotely through smart-phones (Pinto da Costa M, 2020), with encouraging findings.

To strengthen mental health I would recommend self-care interventions, the utilisation of resources in the community that provide support, particularly to socially isolated individuals, and that the access to mental health services to those who require it is facilitated through the use of technology.

Denise Razzouk: There are potential actions according to two levels: national level (public health policy) and individual level.

I think that public health policies must address mental health issues together with COVID-19 control strategies. Mental health cannot be apart from it. Mental health is everybody's business and all sectors of society should be involved to strengthen mental health. Regarding public health policies, it is important to address the main triggering factors of poor mental health: financial insecurity, poverty, unemployment, grief, social isolation, anxiety, depression, burnout, suicide risk, lack of social support and alcohol use. It is important to deliver public psychoeducation about signs of poor mental health and to promote a healthier lifestyle. Of course, primary care should be prepared to assist and identify not only the first signs of COVID-19 but also mental health needs. Other actors such as teachers and entrepreneurs should be trained and involved to identify signs of men-

tal health needs as well as to guarantee a supportive environment for students and workers.

Regarding the individual level, it is very important to avoid alcohol and to acquire healthier habits and lifestyle, including exercises as well as keeping in contact with friends and family members. Also, it is important to avoid being several hours on the Internet or using mobile apps. It is important to schedule daily activities, and balance self-care, rest, leisure and work activities. It is good to learn something new or to do something that promotes motivation such as an old or new hobby. Don´t answer emails/WhatsApp 24 hours per day! If all measures are not enough and anxiety and depressive symptoms became dysfunctional, then, is better to have a consultation with psychiatrists.

Anita Riecher-Rössler: Strengthen body and soul. For example by doing lots of sports and outdoor activities, cultivate all the creative work and hobbies you always wanted to, but never found the time for. And most importantly: keep in contact with people using all possibilities like telephone, online or outdoor meetings or social media.

Natalia Semenova: Leading experts in domestic and foreign psychiatry and clinical psychology have already given valuable advice on preservation and promotion of mental health in the context of COVID-19. I can only add a few things. It is about the willingness to act in a situation of anxiety and uncertainty, about the important role of action in general (Fais ce que dois, advienne, que pourra — Do what you must, come what may) and "search activity", as understood by our physiologists V. Arshavsky and V. Rotenberg. The common ground here is continue searching in conditions, when one cannot be sure of the consequences of one's behavior, when there is no certain prediction of the outcome of the whole COVID-19 situation and despite of that the person continues to act consciously and meaningfully, which helps to restore the peace of mind.

What advice would you give to young women who have chosen the mental health career?

Victoria Bird: You can do this — you are strong, confident and have an opinion to be heard. There is nothing you cannot do. Empowered women, empower women.

Maya Kulygina: If we are talking about the profession of a psychologist or psychiatrist, about someone who combines science and practice, my first advice will be gender neutral and rather standard for those who are just beginning their journey to carreer: read, think, write, learn, grow. And for women specifically, it might be useful not to forget to maintain a balance between professional and personal life, which includes relationships, family, hobbies, without going to any of poles, since both these domains can be mutually enriched if you distribute your attention, time, mental and physical energy equally and create harmony.

Elena Molchanova: Think twice. And then think for the third time. Make a checklist of occupation burnout symptoms and as soon as the diagnosis becomes obvious, take a break. Otherwise you will not be able to guarantee individual approach anymore, which can be harmful for the patients. And then again, think carefully.

Natalia Petrova: To remember that there's more to life than your profession.

Mariana Pinto da Costa: Follow your dreams. Challenge and improve the "status quo" and do it in a way that you will feel proud of, and that inspires others. Be a good listener and show empathy. Speak your mind, and advocate for what you believe. Never tolerate any kind of abuse. Demand respect and to have your voice heard. Say 'Thank You' and show your appreciation. After a while you will see that you were able to build and nurture long-term professional relationships and a successful mental health career.

Denise Razzouk: A high level of professionalism and competence are always desirable and essential, but being women requires much more than that. One important issue is about having good self-esteem and self-confidence because the path for success is much harder and longer for women than for men. Hostility, lack of opportunity, unfair critical and judgemental comments addressed to women´s behaviour and ideas are very common. Being persistent and catching all opportunities (even the small ones) to show the excellence of your work is important too. Don´t expect recognition, instead use actively the media to enhance the visibility of work because this opens new opportunities and it gives you

a voice to show your ideas. Developing good professional and public network are worthwhile strategies. Also, it is important to balance work and personal life, especially pursuing positive experience because psychiatry practice is hard in terms of dealing with suffering and high emotional demand. It is important to take care of your mental health.

Anita Riecher-Rössler: Set your own goals and work on them. Question gender stereotypes in others and in yourself. If you don't dare to do something/to claim something, do it/claim it nevertheless! Make your dreams come true. Be self-confident! Self confidence in my experience is the key for women — they often do not dare to...

Natalia Semenova: I would advise women who have chosen this profession to «be seen». I first heard this expression at an international psychiatric forum from Sophia Frangou, who was teaching a course there. To understand what "to be seen" means for a female professional, I recommend the book edited by Frangou “Women in Academic Psychiatry” [Frangou, S. (Ed.). (2016). Women in Academic Psychiatry: A Mind to Succeed. Springer. — the book is the public domain]. In particular, it includes first-person accounts from some of the most influential women in psychiatry about why they chose the field, what challenges they faced and how they managed to succeed. Among these stories there is that of Danuta Wasserman, who will head the World Psychiatric Association in the foreseeable future.

Consortium
PSYCHIATRICUM

www.consortium-psy.com