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2009

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ATHENS

Editorial Άρθρο Σύνταξης

Medicine, Psychiatry and Professionalism

The International Labour Organisation Standard Classification of Occupations (2008) defines doctors as those that “diagnose and treat human physical and mental illnesses, disorders and injuries, and recommend preventive action, based on the scientific principles of modern medicine. They may specialise in certain disease categories or methods of treatment, or assume responsibility for the provision of continuing and comprehensive medical care to individuals, families and communities”.

Psychiatry as a medical specialty was first defined in 1808 by J.C. Reil. H. Miller, a neurologist and friend of psychiatrists, wrote in 1997 that the psychiatrist “...must be first and foremost and all the time a physician. In fact, psychiatry is neurology without physical signs and calls for diagnostic virtuosity of the highest order.

Recently, in “Good Psychiatric Practice”, The Royal College of Psychiatrists (2009) notes: “Patients, their carers, their families and the public need good psychiatrists. Good psychiatrists make the care of their patients their first concern: they are competent; keep their knowledge up to date; are able and willing to use new research evidence to inform practice; establish and maintain good relationships with patients, carers, families and colleagues; are honest and trustworthy and act with integrity. Good psychiatrists have good communication skills, respect for others and are sensitive to the views of their patients, carers and families. A good psychiatrist must be able to consider the ethical implications of treatment and clinical management regimes. The principles of fairness, respect, equality, dignity and autonomy are considered fundamental to good ethical psychiatric practice. A good psychiatrist will take these issues into account when making decisions and will need to pay particular attention to issues concerning boundaries and the vulnerability of individual patients. A good psychiatrist will not enter into a relationship with a patient or with someone who has been a patient.”

Professionalism implies a contract between the medical profession and society. Public trust is the cornerstone of professionalism in medicine. This is particularly so in psychiatry where concerns about patient welfare are complimented by concerns about public safety. The contract is underpinned by private ethics and public morality and is arrived at through public discourse and legitimation. It is supported by legislation, professional standards, material and human resources and enforced through professional governance, professional regulation and the courts. Politicians have an important role in negotiating and supporting professionalism.

In recent years the contract between medicine and society seemed to be under threat. Several European and American Medical Associations have proposed professional principles and responsibilities. The professional principles of medicine were defined as giving primacy to patients’ welfare, patients’ autonomy and social justice. The professional responsibilities in medicine were defined as commitments which include professional competence, patients’ confidentiality, maintaining appropriate relationships with patients and maintaining trust by managing conflicts of interest: integrity, compassion and excellence, wider team partnership, improving quality of care, improving access to care, just distribution of finite resources, scientific knowledge and training the next generation, leadership, facilitating multidisciplinary work and taking ultimate responsibility for patient care.

Professionalism in psychiatry does not stand in isolation from other mental health professions such as psychologists, social workers etc, but is enhanced by effective collaboration. All mental health professions have a moral obligation to collaborate effectively to ensure efficient and just use of resources in the service of patient welfare.

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Άρθρο Σύνταξης Editorial

Ιατρική, Ψυχιατρική και Επαγγελματισμός

Η Επίσημη Ταξινόμηση των Επαγγελματιών του Διεθνούς Οργανισμού Εργασίας ορίζει τους ιατρούς ως εκείνους που «διαγιγνώσκουν και θεραπεύουν τις σωματικές και ψυχικές νόσους, διαταραχές και κακώσεις και συνιστούν προγνωστικές παρεμβάσεις που βασίζονται στις επιστημονικές αρχές της σύγχρονης ιατρικής. Μπορεί να εξειδικεύονται σε κάποιες κατηγορίες παθήσεων ή μεθόδους θεραπείας ή να αναλαμβάνουν πρωτοβουλίες για την παροχή συνεχιζόμενης και συνολικής ιατρικής φροντίδας για τα άτομα, τις οικογένειες και τις κοινωνίες».

Η ψυχιατρική ως ιατρική ειδικότητα καθιερώθηκε για πρώτη φορά το 1808. Το γεγονός οφείλεται στο Γερμανό Καθηγητή J.C. Reil. Στα 1997 ο νευρολόγος H. Miller, φιλικά προσκείμενος προς τους ψυχιάτρους, γράφει: «Ο ψυχίατρος πρέπει πρωτίστως και πάντα να είναι ιατρός» και επισημαίνει ότι η «ψυχιατρική είναι η νευρολογία χωρίς φυσικά σημεία, που απαιτεί διαγνωστική δεξιοτεχνία υψηλότατου επιπέδου».

Πρόσφατα (2009) το Βασιλικό Σώμα Ψυχιάτρων στη Μεγάλη Βρετανία στο τεύχος «Έγκυρη Ψυχιατρική Πρακτική» σημειώνει: «Οι ασθενείς, οι φροντιστές τους, οι οικογένειές τους και η κοινωνία χρειάζονται έγκυρους και ικανούς ψυχιάτρους. Οι έγκυροι ψυχίατροι πρέπει να έχουν ως πρώτιστο καθήκον τη φροντίδα των ασθενών τους, να έχουν επάρκεια γνώσεων, να ενημερώνονται πάνω στις σύγχρονες γνώσεις, να είναι ικανοί και πρόθυμοι να χρησιμοποιήσουν την τεκμηριωμένη νέα γνώση από την έρευνα στην καθημερινή πρακτική, να εγκαθιστούν και να διατηρούν καλές σχέσεις με τους ασθενείς, τους φροντιστές, τις οικογένειες και τους συνεργάτες τους, να είναι ειλικρινείς και άξιοι εμπιστοσύνης, και να ενεργούν με εντιμότητα. Οι έγκυροι ψυχίατροι πρέπει να έχουν καλές επικοινωνιακές δεξιότητες, να δείχνουν σεβασμό προς τους άλλους και να είναι ευαίσθητοι σε σχέση με τις απόψεις των ασθενών τους, των φροντιστών και των οικογενειών. Ο έγκυρος ψυχίατρος πρέπει να είναι σε θέση να εξετάσει τις πιθανές ηθικές συνέπειες της θεραπείας των κλινικών χειριστικών παρεμβάσεων. Οι αρχές της τιμότητας, του σεβασμού, της ισότητας, της αξιοπρέπειας και της αυτονομίας θεωρούνται κεφαλαιώδους σημασίας σε σχέση με την έγκυρη ηθική ψυχιατρική πρακτική. Ένας έγκυρος ψυχίατρος πρέπει να λαμβάνει υπόψιν του τα παραπάνω θέματα όταν παίρνει αποφάσεις ενώ χρειάζεται να έχει ιδιαίτερη προσοχή σε θέματα που αφορούν τα όρια και την ευαλωτότητα του κάθε ασθενούς. Ακόμη, ένας έγκυρος ψυχίατρος δεν θα πρέπει να συνάπτει στενή σχέση με ένα (μία) ασθενή ή κάποιον(α) που υπήρξε ασθενής».

Ο επαγγελματισμός υποδηλώνει μια στενή σχέση συμμαχίας ανάμεσα στο ιατρικό επάγγελμα και την κοινωνία. Η εμπιστοσύνη του κοινού είναι ο ακρογωνιαίος λίθος του επαγγελματισμού στην ιατρική. Αυτό ισχύει ειδικότερα στην ψυχιατρική, όπου η φροντίδα για την ευημερία του ασθενούς επικροτείται και ενισχύεται από τη φροντίδα για τη δημόσια ζωή και ασφάλεια. Αυτή η στενή σχέση ενισχύεται από τους προσωπικούς ηθικούς κώδικες και τα δημόσια ήθη που προκύπτουν μέσα από δημόσιες συζητήσεις και νομιμοποιήσεις. Υποστηρίζεται ακόμα αυτή η σχέση από νομοθετικές ρυθμίσεις, επαγγελματικούς κανόνες, από υλικά και ανθρώπινα μέσα και ενισχύεται από επιστημονικές οργανώσεις, επιστημονικές ρυθμίσεις και δικαστικές αποφάσεις. Οι πολιτικοί βέβαια έχουν ένα σημαντικό ρόλο στις διαβουλεύσεις για την υποστήριξη του επαγγελματισμού.

Τα τελευταία χρόνια αυτή η σχέση ανάμεσα στην ιατρική και την κοινωνία φαίνεται να είναι σε προοδευτική εξέλιξη. Αρκετές Ευρωπαϊκές και Αμερικανικές Ιατρικές Ενώσεις πρότειναν συγκεκριμένες επαγγελματικές αρχές και υπευθυνότητες στην άσκηση της ιατρικής. Όσον αφορά τις επαγγελματικές αρχές δίνεται προτεραιότητα στην ευημερία και την αυτονομία του ασθενούς και την κοινωνική δικαιοσύνη. Εξάλλου, οι επαγγελματικές υποχρεώσεις σχετικά με την υπευθυνότητα στην άσκηση της ιατρικής περιλαμβάνουν την επαγγελματική ικανότητα του ιατρού, την εχεμύθεια ως προς τον ασθενή, τη διατήρηση της αρμόζουσας σχέσης με τον ασθενή, τη διατήρηση της εμπιστο-

σύνης προς τον ασθενή, διευθετώντας συγκρούσεις ενδιαφερόντων, την τιμιότητα, τη συμπόνια προς τον ασθενή, την εξαιρετική επιστημονική επίδοση, την ευρύτατη συντροφικότητα προς την ομάδα εργασίας, τη βελτίωση της ποιότητας ζωής του ασθενούς, τη βελτίωση της πρόσβασης του ασθενούς στις υπηρεσίες υγείας, τη σωστή κατανομή περιορισμένων οικονομικών πόρων, την εκπαίδευση των νέων ιατρών, τις ηγετικές ικανότητες του ιατρού, τη διευθέτηση της πολυεπίπεδης επιστημονικής εργασίας, την ανάληψη της τελικής υπευθυνότητας για την φροντίδα του ασθενούς.

Βέβαια, ο επαγγελματισμός του ψυχιάτρου δεν πρέπει να είναι απομονωμένος από τους άλλους επαγγελματίες ψυχικής υγείας, όπως ψυχολόγους, κοινωνικούς λειτουργούς, κ.ά. αλλά αντίθετα, να ενισχύεται από την ενεργητική συνεργασία τους. Όλοι οι επαγγελματίες ψυχικής υγείας έχουν την ηθική υποχρέωση της αποδοτικής συνεργασίας, με απώτερο στόχο την αποτελεσματική και σωστή χρήση των υπηρεσιών για την ευημερία των ασθενών.

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Special article Ειδικό άρθρο

A novel, metaphor-based description of the structural and functional aspects of cognitions for the clinical setting

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In view of the continuous theoretical and clinical expansion of cognitive therapy, the traditional, information processing-based description of cognitions into products, processes and schemata displays certain, mainly clinical, limitations. The authors try to refine and expand this “tripartite” conceptualization by employing a new, clinically relevant metaphor to describe cognitions and offer new ideas of potential theoretical and practical utility. Indeed, the dispositional (structural) and functional (state-dependent) aspects of cognitions may be seen as reflecting an underlying theme that could be labeled “the mind as a parliament”. Conceptualized as such, the various types of cognitions may then be metaphorically described as members of a parliament, who when confronted by environmental constraints, confer, discourse and decide to give meaning to one’s experience and direction to one’s behavior. This paper provides a general overview of this metaphor-driven model and a detailed description of its various components. The potential applications of this model as a clinical and educational tool and its limitations are also discussed.

Key words: Mind-parliament, cognitions, structural aspects, functional aspects.

Introduction

“Metaphors ...should be derived from what is beautiful either in sound, or in signification, or to sight, or to some other sense”

Aristotle,
The art of Rhetoric, 3.2.12¹

“Easy learning is naturally pleasant to all, and words mean something, so that words which make us learn something are most pleasant.”

Aristotle,
The art of Rhetoric, 3.10.2

In clinical practice, one broadly adapted system of cognitive taxonomy identifies three types of interdependent cognitive constructs.² The first content-related construct, cognitive products, refers to ongoing, transient, state-dependent, cognitions such as thoughts and images. The second component, cognitive processes, refers to the style or the mode of processing that characterizes cognitive products. Finally, the last component, cognitive schemata, refers to the most enduring organized structures of prior experience that select, integrate and direct the processing of personal information.

This so called “tripartite model”,³ however, heavily relies on the information processing metaphor⁴ and has been criticized as not adequately addressing clinical needs.^{3,5,6} Furthermore, the ongoing expansion of the cognitive approach has furnished it with several newer concepts,^{7,8} that have yet to be registered into a comprehensive taxonomic system; hence clinicians may be unprepared to integrate these newly-developed concepts into their routine practice. Such a development would be unfortunate, as psychosocial approaches with multiple potential clinical applications such as cognitive therapy⁹ can be a valuable tool in the treatment of mental illness.¹⁰ Therefore, a clinically-focused rather than experimentally-driven conceptualization of the mind could be more attractive to clinicians.

In this paper, we present a new approach to conceptualized cognitions driven by a “mind as a parliament” metaphor, followed by a discussion about its possible advantages and limitations. We suggest that this approach, while preserving established knowledge reflected in the tripartite model, is nevertheless flexible enough to incorporate newly introduced concepts, especially those more suited to the clinical setting.

The Mind-Parliament metaphor

The concept of the “mind”, as collectively the sum of mental or cognitive activities (or cognitions), may be conceived as reflecting an underlying theme that could be labeled “the mind as a parliament”. We further envision this parliament in action with the assembled “cognitions-representatives” operating together, debating on issues of significance, voting upon decisions and planning action. Thus outlined, this “mind-parliament” (MP) metaphor can be described from a structural (dispositional) prospective and from a functional (state-dependent) prospective. By “structural” we mean cognitive activity so habitual in nature that it is fairly constant across situations,¹¹ while as “functional” we define changes in the ongoing cognitive activity over time and across situations.¹²

a. Structural (disposition) aspects of the MP

The structural elements of the “mind-parliament” consist of several domain-specific cognitions specialized for constructing different aspects of one’s experience.

Factual domain: Beliefs and attitudes. There is a wide range of cognitions loaded merely with factual knowledge regarding the various domains of one’s experience. Whether personal, familial, cultural, religious, gender-related, or occupational, these cognitions represent the “solid part”, “material” or the “bricks” of mental construction. Through them, people are able to construe reality with a certain degree of objectivity (evidence-based knowledge), in a less certain manner (beliefs), in a tentative manner (opinions), or in a “like-dislike manner” (attitudes).¹³ A common metaphor for attitudes compares to the view from a “color-tinted window”.

Axiological* domain: values and goals. There is a certain class of cognitions empowered with the ability to weigh things and set objectives, either immediate or distant, thus providing direction, intensity and persistence to one's action.⁷ These types of cognitions are akin to "motives", and for the sake of our metaphor may be conceived as occupying a higher level (upward position) in the MP construction. More specifically, through these mental activities, people are in a position to assess the specific weight of things (values),¹⁴ to express their desires or commitments to certain things (preferences), and to pursue or accomplish some of them through planned action (goals).⁷

"Scientific" domain: Post-dictions and pre-dictions. The discovery of the cause, effects as well as the prediction of future events lies not only in the formal agenda of science, but also, according to Frith Heider¹⁵ and George Kelly,¹⁶ in the heart of every layman. This task is undertaken by at least two classes of major cognitions that operate in a time-oriented framework, namely post-dictions and pre-dictions, respectively.

Certain cognitive activities are engaged in the reconstruction of the cause and meaning of past experiences, a task implying a retrospective view within the mental assembly. Since they influence present behavior by drawing knowledge from past experiences, they belong to the realm of post-dictions. Through post-dictions, people can categorize their experience (labeling), or determine the meaning or significance of those experiences (interpretations), including their internal, implicit, hidden or secret meaning (hermeneutics). Through post-dictions, people can also compare a particular experience against their moral standards (moral attributions), or, by drawing information from various sources (pre-attributions), determine the factors responsible for their experience (causal attributions).⁷

In contrast to post-dictions, there are certain cognitive activities preoccupied with the prediction of future events, a task implying a prospective, fu-

ture-oriented view. Since such activities influence present behavior by forecasting future events, they belong to the realm of pre-dictions. Pre-dictions occupy a central position in cognitive accounts of motivation, emotion and behavior,¹⁶⁻¹⁸ in contrast to some theories, like psychoanalysis, where this role is assigned to post-dictions.¹⁹ Through predictions, people are able to tell in advance what is going to happen (anticipations, expectations), estimate the degree of their own influence upon these future events (locus of control),¹⁷ or their ability to execute certain behaviors (self-efficacy),¹⁸ foresee the effect of these behaviors (outcome expectations),¹⁸ or express their merely intellectual (optimism/pessimism), as well as desired estimations (hope/hopelessness) regarding future events.²⁰

Constitutional domain: Assumptions, schemata and modes. Finally, there are cognitive structures that account for the more abstract, general and enduring characteristics of the mind. These structures can be conceived as the "constitution", or the "foundations" of the mind, and represent the most invisible "parts" (tacit knowledge) of the mind. These attributes imply not merely another type of cognition, but "tools" through which people organize and understand reality (super-ordinate or core cognitions).¹⁶ They share some similarities with the concept of traits (the building blocks of personality), but unlike traits it is not clear if these structures are persistently or periodically active.²¹ The content of their information is manifested in a constellation of interrelated beliefs and attitudes (propositional aspects) while their procedural aspects dominate and shape the individual's information processing style.²¹ Through them people are able to construe their experience of themselves and the world in various levels of abstraction: From an elementary level and in a conditioned-type manner (rules and assumptions), to an intermediate level presented in an unquestionable form, mainly around issues related to the definition and the experience of the "self" (schemata), and finally to an even more integrated level of representation including bio-psycho-social aspects of experience (modes).²²

* From gr. *axios*, worthy; and -logy: The branch of philosophy dealing with the nature of value and the types of value as in morals, aesthetics, religion, and metaphysics-Webster's Dictionary, 1977.

b. Functional (procedural) aspects of the MP

Having outlined the structural (disposition) perspective, the mind's faculties are ready to function within the individual's temporal and contextual frame. Several "representatives" gathered in the "main conference room" exchange views about the incoming and outgoing events, through which the "parliament" interacts with the physical world. From a clinical point of view, the most significant functional aspects of the mind are described below.

Content-related aspects: Thoughts and images. From a content-related point of view, the ongoing, transient, state dependent or situation-specific cognitions, the so-called "stream of thought", consist of thoughts and images. They are considered to be the end result of the thinking process (manipulation of symbols), corresponding roughly to cognitive products of the tripartite model. "Self statements" or "internalized verbalizations",²³ "automatic thoughts",²⁴ or "internal or private dialogue",²⁵ are but a few of the various terms used to describe certain aspects of such cognitions, that are especially important in cognitive psychotherapy. Beck²⁴ describes "automatic thoughts" as a series of idiosyncratic cognitions, differed from the commonly reported ideation, as being automatic, rapid and barely noticed during emotional encounters.

Process-related aspects: Appraisals and heuristics. Besides their content-related aspects, automatic thoughts are characterized by a specific processing style as well.¹⁹ These functional aspects, which "underly" automatic cognitions and are loaded with evaluative and coping properties, are related to the concept of appraisals, which also possess these properties.²⁵ Appraisals are a series of related cognitions, which are unfolded when a person evaluates the significance of a specific transaction and its implications for personal wellbeing.²⁶ Specifically, through appraisals, people are able to determine whether a situation is problematic (primary appraisals), assess available resources to manage the situation (secondary appraisals), and reflect on the effectiveness of these evaluations and coping resources (re-appraisals).²⁶ As evaluative mechanisms, appraisals may reveal the underlying strategies

from which they are drawn. When confronted with a stressful situation, people employ simple rules or strategies called heuristics, which reduce complex judgmental tasks to a set of simpler operations.²⁷ Although these are "fast-track defensive algorithms that are sensitive to threat", hence serving an evolutionary adaptive function, they nevertheless oftentimes lead to systematic and predictable errors, already described by cognitive therapists.²⁸ Thus, the distortions of information processing in depression described clinically by Beck, are the same events that are labeled "heuristics" by Tversky and Kahneman.²⁹

Emotion-related aspects: "Cold" and "hot" cognitions. Each appraisal is a function of two broad classes of variables, situational and dispositional.²⁶ Regarding stressful appraisals, the situational variables consist of such events as harm or loss (damage already done), threat (potential for harm/loss), and challenge (opportunity for mastery, growth or gain).³⁰ The dispositional class can be any element of the MP, such as attitudes,³¹ commitments,³⁰ values,¹⁴ beliefs and expectations³² and attributions.³³ These cognitions, as long as they remain descriptive, fact-oriented, and non-evaluative, are only indirectly implicated in the generation of emotion (cold-cognitions). It has been suggested that in the synthetic process, appraisals provide the emotional "heat" in an encounter ("hot cognitions").³³

Comments

It is the main thesis of this paper that the introduced model of conceptualizing cognitions may offer distinct advances as a framework especially for clinical and educational purposes.

Several authors have argued that important clinical aspects of the mind,^{5,6} whether developmental,³⁴ emotional,³⁵ or interpersonal,³⁶ are not adequately addressed in the traditional information processing metaphor. In contrast, by endorsing the systematic registration of clinically relevant concepts such as appraisals or "hot cognitions", attitudes, goals, modes that surpass the informational stand, the MP

conceptualization can be more attractive and applicable.

The information-processing paradigm has also been criticized as inefficient in guiding clinicians as to which are the most important cognitions amenable to intervention.³ In contrast, the MP approach endorses a more psychopathology-specific registration of cognitions, thus leading to interventional specification, as well. For example, the dysfunctional attributions about past-losses, displayed by “past-oriented” depressed patients, stand in sharp contrast with the dysfunctional expectations about future threats, displayed by anxious “future-oriented” patients.³⁷ Both attributions and anticipations are prominent and distinct components of the MP paradigm, thus amenable to separate evaluation and specific intervention, according to the presented clinical entity.

Furthermore, by endorsing a multi-dimensional evaluation, the MP approach allows for the possible combination of several psychopathology-specific cognitions in understanding behavior (conjunctive explanations). For example, attributions shape expectations, yet there is no one-to-one correspondence between the two in understanding and predicting behavior, necessitating the assessment and treatment of both.^{38,39}

By transcribing the various abstract components of the mind (cognitions) to the more distinct aspects of the “parliament” (representatives), the former concepts will hopefully emerge more clearly. Moreover, for mnemonic purposes, the mind’s parliament might be represented by several distinguishable components or “loci”: The factual cognitions (beliefs and attitudes) may be conceived as forming the “walls and windows”, while the scientific cognitions (pro- and pre-dictions) as being represented by the “rear and the front”. The axiological cognitions (values and goals) consist of the “top,” while the constitutional cognitions (assumptions, schemata, modes) may be linked to the “ground.” The main “conference room” of the MP defined by a “back door” (input) and “front door” (output) is occupied by several “representatives” that confer, discourse and decide (functional aspects of cognitions).

By using this method of loci, the proposed model is easily conceptualized and remembered. Hence the extenuation offered by MP does not seem to impose a burden on the unfamiliar clinician’s learning resources in accordance to Aristotle’s plea for “easy” and “pleasant” learning.¹

This metaphor-driven conceptualization of cognitions may draw criticism and raise objections on several issues.

As in the case of every metaphor, MP may be misleading if taken literally, i.e. equating the “mind” with a “parliament”, and not merely as a useful tool for transcribing meaning from one domain to another or generating new testable ideas and hypotheses. In a similar vein, the aforementioned, mainly clinical disadvantages may have their origin in the misuse of the mind-computer metaphor, a model implicitly endorsed by the information processing approach. Nevertheless, appropriate metaphors, when employed judiciously, do have a place in science,⁴⁰ in psychotherapy,⁴¹ or in cognitive therapy.⁴

By assigning some attributes to cognitions i.e. emotionality to appraisals, scientific status to time-oriented cognitions, or motivational properties to goals- it should not be assumed that the former are specifically linked to the latter. Instead, it is conceivable that these attributes are probably distributed –albeit unequally– to all cognitions.

Our preference for endorsing and elaborating on certain cognitive terms over others can be questioned, even though we tried to select the most frequently employed terms in the literature. Our intention is to illustrate the diversity of clinically relevant cognitions in a simple and didactic manner, rather than present an exhaustive catalogue of the various types of cognitions, a task unattainable at present. Besides, future renovations are possible and welcome, as this model appears to fulfill the criteria of generality, extendibility and sufficiency.⁴²

In conclusion, our effort in this article is to promote a new conceptualization of cognitions that will encompass the most important, newly introduced but unclassified, clinically relevant concepts, and define them in a clear and teachable way and perhaps pose some testable hypotheses.

Μια νέα μεταφορική προσέγγιση των δομικών και λειτουργικών πλευρών των γνωσιών για κλινικές εφαρμογές

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Υπό το πρίσμα της συνεχούς θεωρητικής και κλινικής ανάπτυξης της γνωσιακής θεραπείας, η –βασισμένη στο παράδειγμα της επεξεργασίας των πληροφοριών– παραδοσιακή περιγραφή των γνωσιών (cognitions) σε παράγωγα, διεργασίες και σχήματα, εμφανίζει ορισμένους, κλινικούς κυρίως, περιορισμούς. Οι συγγραφείς προσπαθούν να εκλεπτύνουν και να επεκτείνουν αυτή την «τριμερή» διαίρεση, με τη χρήση μιας νέας κλινικά σημαντικής, μεταφορικής προσέγγισης για να περιγράψουν τις γνωσίες και να προσφέρουν νέες ιδέες δυναμικά θεωρητικής και πρακτικής χρησιμότητας. Πράγματι, οι δομικές και λειτουργικές πλευρές των γνωσιών είναι δυνατόν, να θεωρηθούν ότι απηχούν ένα βαθύτερο θέμα, που θα μπορούσε να αποκληθεί «ο νους ως κοινοβούλιο». Κάτω από την θεώρηση αυτή, οι διάφορες πλευρές των γνωσιών θα μπορούσαν μεταφορικά να περιγραφούν ως μέλη του κοινοβουλίου, που ερχόμενα αντιμέτωπα με τις περιβαλλοντικές προκλήσεις, συνέρχονται, συζητούν και αποφασίζουν, δίνοντας νόημα στην εμπειρία του ατόμου και κατεύθυνση στις πράξεις του. Το άρθρο αυτό δίνει μια γενική άποψη του μεταφορικού αυτού μοντέλου και μια λεπτομερή περιγραφή των διαφόρων συστατικών του. Επίσης συζητούνται οι πιθανές εφαρμογές του μοντέλου αυτού ως κλινικού και εκπαιδευτικού εργαλείου, καθώς και οι περιορισμοί του.

Λέξεις ευρετηρίου: Νους-κοινοβούλιο, γνωσίες, δομικές πλευρές, λειτουργικές πλευρές.

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Special article Ειδικό άρθρο

Smoking in patients with psychiatric disorders: Effects on their psychopathology and quality of life

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We are living in an era of implementing complete smoking cessation in all closed areas, following the example of the USA and other countries in the European Union. We appear more tolerant in our mentally ill in-patients, especially the ones suffering from long-term schizophrenia, where smoking is accepted and even encouraged. We tried to investigate the effect of smoking in these patients. We performed an in depth literature research of medical databases and web search engines containing relevant articles, opinions and arguments. It has been shown from a lot of different studies that the proportion of persons with mental health problems who smoke is considerably higher compared to the general population. 51% of individuals with diagnosis of schizophrenia and 50% of those with bipolar affective disorder smoke more than 20 cigarettes per day against 8% of the general population who smoke the same amount. In another study from the USA, it was calculated that 45% of all cigarettes smoked in one month, were consumed by individuals with diagnosis of mental disorder or substance abuse. Smokers that suffer from schizophrenia present more positive symptoms, although clinical observation and research confirmed data show a positive effect in extrapyramidal symptoms and other side effects of medication. For other parameters such as attention, cognitive function and impulsivity, research is non conclusive and with contradictory results. Rates of premature death are higher for persons with mental illnesses compared with the general population, even if we don't include suicides. Much of these deaths are attributed to cardiovascular and respiratory problems and smoking is considered to be a major contributor to these illnesses. Substances found in cigarette's tar act as enhancers of P450 liver enzymes, increasing the metabolism of certain of antipsychotic medication, including clozapine, fluphenazine, haloperidol and olanzapine. This leads to higher required doses of medication. Smoking adds a big economical burden upon the smoker, who, as an individual with mental illness, is likely to have low income and should be directed to cover other real life necessities that could improve the overall quality of life. People who are heavy smokers find difficult to participate in certain activities or attend places where smoking is not allowed. This contributes further to their social exclusion. This habit should be treated as an addiction. Currently a lot of different treatments both pharmacological and non-pharmacological are available, which can be combined with promising results.

Key words: Smoking, nicotine, mental illness, schizophrenia, bipolar disorder, psychopathology.

Smoking and health

The incriminating association of smoking with many and various medical diseases is well known. Smoking is the greater cause of premature death in the United Kingdom. One of two smokers will die prematurely, as a consequence of smoking, half of them being in middle age. Roughly 114,000 persons in the United Kingdom die from smoking each year and constitute one fifth of all British deaths.¹ The commonest illnesses caused by smoking include coronary heart disease, lung cancer, chronic bronchitis, emphysema, pneumonia and chronic obstructive pulmonary disease. It can also cause illnesses of the mouth, nose, neck, cancer of oesophagus and larynx, decreased fertility and premature ageing. The toxic chemical substances found in cigarette smoke repress the immune system and also decrease body vitamins. A smoker could have up to 30% less vitamin C compared to a non-smoker.²

Smoking and mental health

It has been shown from a lot of different studies that the proportion of persons with mental health problems who smoke is considerably higher compared to the general population. Patients suffering from psychotic disorders have the higher percentages of smoking among people with mental health disorders.³ The association between smoking and mental illness appears exceptionally complex. We know from both official studies and informal observation, that smoking is an important part of in-patients' life in psychiatric wards. It has been calculated that between 70% to 80% of mentally ill in-patients smoke.⁴ Rates of smoking in people with mental health disorders tend to be in average up to two times higher compared to the ones in the general population. Smokers with mental health problems tend to smoke more cigarettes and are more depended compared with smokers without mental health problems. For example, 51% of individuals with diagnosis of schizophrenia and 50% of those with bipolar affective disorder smoke more than 20 cigarettes per day against 8% of the general population who smoke the same amount.⁵ In general, rates observed among people living in institutions are considerably higher than those recorded in patients

living at their own place, while even higher rates of smoking have been observed among homeless people. These data show that the environment plays a significant role in the predominance of smoking, although it is possible that patients with more severe forms of mental health disorders are either in-patients or homeless.⁶

In another study from the USA, it was calculated that of all cigarettes smoked in one month, 45% were consumed by individuals with diagnosis of mental disorder or substance abuse.⁷ In the United States 44% of cigarettes were smoked by individuals with a diagnosis of psychiatric disorder.² Similarly, other studies have reported that this population has two to three times greater possibility to be dependent on nicotine than the general population.⁸ Rate of cigarette smoking appears higher among patients with more severe mental disorders, but it also remains high in people with depression, anxiety disorder and personality disorders. Respectively high percentages of smoking are recorded in people attending programs for substance abuse. Roughly 60–95% of these patients are depended in nicotine also and almost 40–50% are heavy smokers (smoking more than 20 cigarettes per day).^{9,10}

All these research findings show that the habit of smoking is sovereign not only among in-patients in psychiatric wards, but also in people with mental health issues. This has as result marked high rates of mortality and smoking-related illnesses for people with mental with disorders. Nevertheless, more than half of those suffering from major mental disorders wish the cessation of this deliberating habit for their general health.

Schizophrenia and smoking

For people that live in long stay psychiatric institutions, OPCS study shows that 74% of people with schizophrenia were smokers.¹ The degree of nicotine dependence is greatly associated with the total consumption of cigarettes, the difficulty of smoking cessation and the time of having the first cigarette of the day. In all these indicators, smokers with schizophrenia have the higher scores. In this study above half of the sample (51%) were heavy smokers (smoking more than 20 cigarettes daily), from which

55% were men and 45% women. The corresponding percentage in the general population is 8%. 80% of smokers with mental health issues considered difficult to avoid smoking for one entire day, against 57% of smokers in the general population. 70% smoked their first cigarette in the first 30 minutes from the morning awakening, compared with 41% in the general population. Despite this high dependence, more than half (52%) said that they would wish to stop smoking, when 69% in the general population expressed the same wish. The high rates of smoking between people with schizophrenia have been also observed in other countries. Rates of smoking can vary depending on the schizophrenia type. A Greek study found that the rates of smoking were different between the different types of schizophrenia.¹¹ Furthermore, smoking rates could differentiate according to the smoker's sex. At OPCS study, 62% of women with schizophrenia were smokers, against 78% of men with similar diagnosis. A study in American hospitals showed that men suffering from schizophrenia had the higher frequency of smoking, followed by non schizophrenic men, and followed by women with schizophrenia.⁶

Taking all these elements into consideration, it isn't curious that lethal illnesses and mortality related with smoking are more frequent among people with schizophrenia compared to the general population.¹² In this study a team of 370 patients with schizophrenia were followed in the community, from 1981 and for 12 years. Within this period, 79 died, 73% from natural causes (this includes illnesses associated with smoking) and 24% by not natural causes, such as suicides or accidents and this should be taken into consideration given the fact that suicidal ideation appears to be frequent among patients with acute schizophrenia as it was verified by a Greek study.¹³ The standardised rates of mortality (SMRs) were considerably increased only for smokers and for the illnesses associated with smoking. The SMR for lung cancer was two times higher than expected.

Bipolar disturbance and smoking

Regarding people living in psychiatric institutions and suffering of bipolar affective disorder, the OPCS

study showed that 70% of people with affective psychotic disorder (with manic episode and bipolar disorder included) were smokers. Once again, in this population of smokers, high levels of nicotine dependence were evident. Almost half of this population (49%) were heavy smokers and the big majority of smokers (82%) considered difficult to avoid smoking for one entire day and 61% smoked their first cigarette in less than 30 minutes after awakening in the morning. Nevertheless, more than half (58%) would wish to quit smoking. High rates of smoking between patients with bipolar disorders are also prevalent in other studies.¹⁴

Why people with the mental health issues smoke?

In our effort to comprehend the reasons that lead mentally ill patients to smoke more than the general population, we owe to clarify the role and the action of nicotine, the basic component of cigarette smoke. Nicotine is a compound with double action. It paradoxically acts as a stimulant and also as a relaxing agent. The mental and physical condition of smokers, as well as the circumstance in which a cigarette is smoked, could influence the psychological consequences of smoking.¹⁵ The addictive effect of nicotine is connected with its ability to cause dopamine release – a neurotransmitter in the brain connected with the affect of pleasure. Nevertheless, the opposite opinion supports that, in the long term, nicotine decreases the possibility of the brain to feel pleasure.¹⁶ Accordingly, smokers need bigger sums of nicotine in order to achieve the same levels of satisfaction. Smoking is consequently a form of self cure. Therefore, smoking eases the symptoms of deprivation of nicotine.

The purpose of the present study is not just to enumerate the biochemical effects of nicotine in the brain, but to clarify the advantages and disadvantages of smoking in mentally ill people. What are the likely biological, psychological, and social factors that have led to high rates of smoking prevalence among the mentally ill? This is a complex question having a not so forthwarded explanation. The likely biological factors include an increasing genetic liability. The psychological factors are relat-

ed with a progressive dependence, because of the subjective experience of compensation or pleasure or reduction of certain symptoms. The social factors are related with an effort to treat depressive symptoms, concern, boredom, loneliness, and other feelings prevalent in this population.¹⁷

In a study where smokers from the public were asked for the reasons for which they smoke, they have given reasons like enjoyment, alleviation from boredom and alleviation from the symptoms of lack of nicotine. When persons with schizophrenia were asked the same question, the more frequent answers were viewing as a habit, helping relaxation, improving social interaction, feelings of pleasure and being an addiction.¹⁸

It appears therefore that it is not absolutely explicit why people with mental health issues smoke more than the public. Various factors can account for that:

Nicotine, via the inhalation of smoke, is used as form of self cure. It is considered that a nicotine does help to alleviate certain positive psychiatric symptoms, as auditory hallucinations and delusional ideas.¹⁹⁻²¹ It can also, via the excretion of dopamine, help in the negative symptoms of schizophrenia, such as lack of motivation, lack of energy and flat affect.^{22,23} Nicotine causes relaxation and can decrease the intensity of negative feelings such as anxiety, volatility, anger, contributing in the improved management of high anxiety situations.²⁴ Smoking alleviates specific symptoms which are side effects of antipsychotic medication, such as extrapyramidal tremor, dystonia, drowsiness²⁵ and akathisia.²⁶ Smoking can also improve disabilities of cognitive function presented in mental disorders, such as schizophrenia or Attention Deficit Hyperactivity Disorder.²⁷ In the same research has been reported that smoking appears to improve the attention and the functional memory of 25 smokers with schizophrenia, but did not have corresponding effect in 25 not schizophrenic smokers. When smokers tried to cease smoking, the functional memory was negatively influenced in smokers suffering of schizophrenia, compared to the control smokers. Another study found that the thousands of chemical substances inhaled with cigarette smoking do appear to change the expression of genes in all individuals, and on top of that could really contribute to regression towards the norm of certain genes'

expression of mentally ill from schizophrenia. The researchers came to this conclusion after examining post mortem brain tissue from hippocampus of smokers with schizophrenia, non-smokers with schizophrenia and smokers and non-smokers without mental disorder.²⁷ Smoking can be used as a means for the patient to overcome the social isolation created by the mental disorder. McNeill reports the explicit connection between smoking rates and social isolation, as well as the relation between mental disorders and social isolation.⁷

Socially excluded groups tend to smoke more and their members are more dependent from nicotine. Individuals with chronic mental health problems are usually socially declined either because of unemployment or as a result of their illness. Thus, smoking can decrease boredom, provide a framework for everyday life of the patient and improve his social interaction, something that can be particularly beneficial in people with negative symptoms. Observed high percentages of smoking in psychiatric hospitals can also portray poor policies of smoking cessation. The offer of cigarettes is often used as means of negotiation between the mental health personnel and the mentally ill or as remuneration for the patient's good behavior.²⁸

What is the harm of smoking in mentally ill patients?

Smoking constitutes an important cause of illness and mortality in these populations. Mentally ill people consume almost half of all the cigarettes produced, therefore we could assume that roughly 200,000 smokers with mental illness will die each year, because of smoking.^{12,29} Rates of cancer, cardiovascular and respiratory diseases among smokers with schizophrenia have been presented to be twice the ones of the control population.^{30,31} Individuals with schizophrenia present roughly almost ten times higher danger of respiratory illness compared to other ill patients.²⁸ It has been proved that smoking cessation in an acute phase worsens the stress of the patient, while anxiety levels are decreased considerably after one week of recommencing smoking.³² Smoking can influence up to 40%, the necessary therapeutic dose and the levels of medication in the blood, with the challenge

of P450 CYP1A2. A lot of psychiatric medication are metabolized via this route, including antipsychotic medication (clozapine, olanzapine, haloperidol, and fluphenazine), antidepressant medication (amitriptyline, nortriptyline, imipramine, clomipramine, fluvoxamine and trazodone), and various other medicines.³³ Smoking also increases the levels of CYP1A2 enzyme which is responsible for the enhancement of medication metabolism. Thus smoking increases the metabolism of medication, so that bigger therapeutic doses are required.⁵ Increased medication doses lead usually to increased economic expenses, for both the patients and the mental health system. Other studies also show that smokers with schizophrenia present increase of their psychiatric symptomatology, their number of hospital admissions, and they need higher doses of medication.^{20,21,34,35} Smokers with mental disorders spend the bigger part of their low income for the purchase of cigarettes. In an American study was calculated that a smoker with schizophrenia spends more than one third of his weekly income for cigarettes.³⁶ So this money is consequently not available for the coverage of important needs, such as food, heating or other activities of social interaction and hobbies that could improve their quality of life. Accordingly, their physical and mental health is in greater danger.⁷ Since smoking is prohibited in the majority of public places, such as public services, mass transport media, places of amusement etc, the continuation of non prohibition at the psychiatric hospitals maintains the habit of smoking and enhances the social isolation of mentally ill people who are heavy smokers when they are discharged from hospital, because of their inability to attend social activities and places where smoking is not allowed.

Discussion

We should wonder why patients with mental illness should aim to quit smoking. There are a lot of reasons and few of them particularly important. The negative results of smoking for people with mental illnesses could be summarized in the following:

Rates of premature death are higher for persons with mental illnesses compared to the general population, even if we don't include suicides. Many of

these deaths are attributed to cardiovascular and respiratory problems and smoking is considered a major contributor to these illnesses.^{30,31} Substances found in cigarette's tar act as enhancers of P450 liver enzymes, increasing the metabolism of certain antipsychotic medication, including clozapine, fluphenazine, haloperidol and olanzapine. This leads to higher required doses of medication.⁵ Smoking adds a big economical burden upon the smoker, who, as an individual with mental illness, is likely to have low income and could be directed to cover other real life necessities that could improve the overall quality of life.^{4,37} Heavy smokers find it difficult to participate in certain activities or attend places where smoking is not allowed. This contributes further to their social exclusion. Smoking or nicotine addiction of individuals with mental disorders cannot any longer be ignored. It is our debt as health professionals to aim an an effective public health policy to smoking cessation. In this way we could confront one of the main causes of sickness and mortality in the mentally ill population. We should not be part of the shared misbeliefs that smoking constitutes an integral part of mental illness or that mentally ill people are not interested or lack the will to quit smoking. This habit should be treated as an addiction and currently a lot of different treatments both pharmacological and non-pharmacological are available, and can be combined with promising results.³⁸ The individual economic expense for the maintenance of smoking dependence is enormous, while the patients often miscalculate or overestimate the benefits of it. We are aware that smoking is addictive and kills more mentally ill people than suicide, homicide, AIDS, and most other known illnesses. We owe to inform our patients and their families for the benefits of smoking cessation and the particular dangers from the maintenance of smoking. All patients deserve free access in effective treatments of smoking that are carefully planned to address specific patient's needs. Planning for these interventions is subject for further bibliographic research and study, but in combination with the prohibition of smoking at psychiatric wards will ensure the offer of a different choice and prospect of quality of life in mentally ill patients, certainly healthier than the current.

Το κάπνισμα σε άτομα με ψυχικές διαταραχές: Επίδραση στην ψυχοπαθολογία και στην ποιότητα ζωής τους

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Μελέτες έχουν δείξει ότι ο αριθμός των ανθρώπων με προβλήματα ψυχικής υγείας που καπνίζουν είναι σημαντικά μεγαλύτερος από αυτόν του γενικού πληθυσμού. Υπολογίζεται ότι 70–80% των ψυχιατρικών ασθενών που νοσηλεύονται καπνίζουν. Καπνιστές με πρόβλημα ψυχικής υγείας τείνουν επίσης να καπνίζουν περισσότερα τσιγάρα και να είναι πιο εξαρτημένοι από τους καπνιστές χωρίς προβλήματα ψυχικής υγείας. 51% των ατόμων με διάγνωση σχιζοφρένειας και 50% εκείνων με διπολική συναισθηματική διαταραχή καπνίζουν πάνω από 20 τσιγάρα ημερησίως έναντι 8% του γενικού πληθυσμού. Η νικοτίνη, μέσω του καπνίσματος, βοηθά να υφεθούν μερικά από τα θετικά ψυχιατρικά συμπτώματα, όπως ψευδαισθήσεις και παραληρητικές ιδέες, βοηθά στα αρνητικά συμπτώματα της σχιζοφρένειας, όπως έλλειψη κινήτρου, έλλειψη ενέργειας και επίπεδη διάθεση, μειώνει την ένταση αρνητικών συναισθημάτων όπως ανησυχία, ένταση και θυμός, και ανακουφίζει μερικές από τις παρενέργειες των αντιψυχωτικών, όπως τον παρκινσονισμό. Παράλληλα αυξάνει τα καρδιαγγειακά και αναπνευστικά προβλήματα, απότοκα του καπνίσματος, το κίνδυνο για πρόωρο θάνατο, αυξάνει το μεταβολισμό μερικών αντιψυχωτικών φαρμάκων, προσθέτει ένα μεγάλο οικονομικό βάρος στον καπνιστή και αυξάνει το κοινωνικό αποκλεισμό του. Πρόσφατες μελέτες δείχνουν ότι η διακοπή είναι δυνατή για αυτόν τον πληθυσμό με συνδυαστικές θεραπείες που περιλαμβάνουν τεχνικές κινητοποίησης, χρήση φαρμάκων και συμπεριφορική θεραπεία

Λέξεις ευρετηρίου: Κάπνισμα, νικοτίνη, ψυχική νόσος, σχιζοφρένεια, διπολική διαταραχή, ψυχοπαθολογία.

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Special article
Ειδικό άρθρο

**Male depression:
Discrete differences between
the two sexes**

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Recent research indicates that subtle differences may exist in the symptom profile of male and female depression. The aim of this review is to examine male/female differences in depressive psychopathology in light of the latest research findings and discuss whether these differences might suggest the need for gender specific treatments. Multiple searches using Medline (1985–2008) were carried out. Additional searches were made using the reference lists of published papers and chapters from books. Differences exist in the clinical profile and comorbidity of male and female individuals with depression. Subtle genetic differences, the role of hormones, the role of preexisting anxiety, and personality differences are some of the factors responsible for these findings. These differences imply that different treatment options should be available for males and females suffering from depression. The available data suggest that clinically relevant differences in depressive symptom profile and the underlying pathophysiology between genders in depression do exist. The identification of distinct endophenotypes for major depression, will not only improve our understanding of the disease, but will also contribute to more specific treatment strategies.

Key words: Depression, gender phenotype, psychopathology.

Introduction

Although it is widely held that there are no significant differences between men and women in terms of the symptoms they experience during depressive episodes, recent research suggests that subtle differences in symptom profile may indeed exist. These differences may suggest fundamental gender differences in the pathophysiology of depressive states.

Men are about half as likely as women to suffer from major depressive disorder (MDD) during their lifetime¹ and a number of studies have found that depressed females tend to exhibit more "atypical" depressive symptoms (excessive fatigue, overeating and oversleeping, more anxiety and somatisation) than men.² However men commit suicide, an act associated closely with severe depression, more often than women.³

Apart from the scientific research on this matter which is not widespread, the general public seems to assume the matter is settled. A quick search on the web reveals thousands of sites referring to male depression. The majority of them seem to take for granted that male depression is different from female depression. These sites aim to advertise and offer information on therapists and therapies, private or public related enterprises, that claim to be gender sensitive and gender specific. The majority of these sites are based in the US. The prevailing assumption is that homosexual orientation is somehow related with greater vulnerability to depression. This however is not supported by the the scientific literature. It seems that in the general public there are issues of information and education.

This article reviews the literature on gender differences in depression and whether the roles of genetic and environmental risk factors for MDD differ in men and women, whether the genetic risk factors for MDD operative in men and women are the same.

Method

Multiple literature searches using Medline (1985–2008) were carried out, using the search terms: male, female, major depression, depressive symptoms,

treatment, sex differences, gender differences, atypical depression, and combinations.

Additional searches were made using the reference lists of published papers and chapters. All abstracts found were studied. When there was indication that a paper might contain relevant information it was obtained. All papers studied were in English.

Findings

Findings can be organised under two separate headings. First the ones associated with the differences in phenomenology and secondly findings associated with the aetiology of these differences. A third heading could be added regarding the different response to treatment between the genders.

Phenomenological differences in male and female depression

General characteristics

Compared to males, females reported earlier age-at-onset of depression (defined as age at first onset of functional impairment due to depression, median 24 years versus 30 years), a higher median number of depressive episodes (mean 4 versus 3), and a higher mean number of atypical depressive symptoms during their worst ever depressive episode (10,4 versus 9,6).¹ Additionally, the lifetime prevalence of MDD is nearly twofold higher in females than in males.^{4–6} Compared to men, women also have a much higher rate of 12-month depression, this seems to be largely due to women having a higher risk of first onset compared to males.⁵

Symptom profile

In both genders, common signs of depression include depressed mood, poor sleep, feelings of guilty and worthless. However, there seems to be significant differences between the sexes for five symptoms. Males reported "initial insomnia", more frequently and females more frequently reported "diminished libido", "excessive sleep", "diurnal variation of mood" and excessive self-reproach.¹ According to other researchers, men more commonly report anger and frustration, violent behaviour, risk taking, such as reckless driving, loss of concentration and isolation from family and friends. Fatigue and loss of interest in work, hobbies and sex are also common as well

as alcohol and substance abuse. Men, in addition, are more often than women unaware that physical symptoms, such as headaches, digestive disorders and chronic pain, can be symptoms of depression.⁷

When compared to women, men report statistically less depressive symptoms.⁸ According to the same study, depressed women were more likely to report "increased appetite" (15.5% vs 10.7%), being "often in tears" (82.6% vs 44.0%), have "loss of interest" (86.9% vs 81.1%), and "thoughts of death" (70.3% vs 63.4%). The remaining depressive symptoms tested yielded no significant differences. However, other researchers found no evidence that symptoms of depression tend to be differentially reported between the sexes.⁹

There are reports¹⁰ that male depression has a later onset than female (25.5 years, SD=12.56 versus 23 years, SD=10.6). The same researcher also found that men had less frequently some clinical symptoms of depression. These symptoms have also been described as "atypical" ie proneness to fatigue, increased appetite, weight gain and hypersomnia).

The diagnosis of atypical depression requires at least two out of the three symptoms: excessive physical fatigue, hypersomnia and hyperphagia. These need to be present during a major depressive episode.¹¹ It was also reported¹ that the prevalence of atypical depression during the worst-ever episode was clearly superior in females, compared to males (31.6% vs 21.1%).

These findings are similar to the findings of Silverstein¹² who defined somatic depression as sleep disturbance, fatigue and appetite disturbance for at least 2 weeks and pure depression as "high levels of depression not associated with these other symptoms". Kessler, data from the National Comorbidity Survey, found that men had half the prevalence of somatic depression (as defined) when both 6-month and lifetime depressive criteria were taken into account, as assessed by the Composite International Diagnostic Interview.¹³ As a result, he raised the possibility that somatic depression might be a diagnostic category separated from major depression. In the same vein, a study by Wenzel et al,⁷ provides partial support for gender differences in somatic depression as assessed by items on the Beck Depression Inventory (BDI-II). In particular

change in appetite was sensitive in detecting gender differences even in milder cases of somatic depression. On the other hand, tiredness or fatigue were useful symptoms in detecting gender differences only in moderate to severe cases of somatic depression. The finding that change in appetite was the most consistent symptom to differentiate the genders, raises the possibility that biological factors underlie gender differences in depression.⁹

The scientific literature has up to date, focused on females from a "male perspective". This can only be done in a "negative way", i.e. what men do not have (in contrast to women). It was reported⁶ that the sex differences in the rate of earlier anxiety disorder play a considerable part in the observed sex difference in MDD. The lower male risk for MDD might be explained in part by the higher rate of anxiety disorders in females than males beginning early in life. In other words, anxiety disorders may be particularly important as a precursor to MDD, but only in women. The same researchers note that any sex differences that might originate in late onset MDD might have little to do with pre-existing anxiety. Apart from the implications of sex differences in MDD, the results emphasize the strong connection between anxiety disorders and subsequent MDD, and they suggest that future research on the nosology of MDD might benefit from distinguishing cases according to previous history of anxiety.

In men, on the contrary, disorders such as alcoholism and drug abuse, which are also genetically influenced may increase the risk of developing MDD.¹⁴⁻¹⁶ These hypotheses point to the theory that the developmental pathways toward MDD differ substantially in men and women.

Suicide

Males commit suicide more often than females. In the United States, 80% of all suicides have men as victims (WHO).¹⁷ Male suicides by violent means have also more pronounced seasonal variation¹⁸ (Christodoulou et al 2008), while male suicide rate at midlife is three times higher than women's.¹⁷ However the issue is not resolved. It is well known that one of the greater predictors of eventual suicide is "parasuicide", which broadly defined, includes both suicide attempts and deliberate self-harm inflicted

with no intent to die.¹⁹ A review²⁰ indicated that 30 to 47 per cent of suicide completers had a prior history of parasuicide. All but one studies reviewed by Welch,¹⁹ show consistently lower rates of parasuicide for males. The authors are not aware of any research paper showing whether the suicide attempters that consequently went to commit suicide were or were not mostly male. As mentioned most studies show the highest rates for suicide attempts among women in their teens to early twenties and men in their twenties.

Findings associated with the etiology

Hormonal studies

It has been hypothesized that the lower levels of atypical symptoms in males could reflect a pathophysiological difference between male and female depression. It has been suggested that atypical depression is associated with hypersuppression of the hypothalamic-pituitary-adrenal (HPA) axis, while melancholic depression is associated with HPA overactivity. In particular corticotropin-releasing hormone (CRH), a hypothalamic hormone, seems to be of fundamental importance in depressive illness. Melancholic depressed patients with a syndrome of hyperarousal (anxiety, insomnia, diminished appetite, etc), have increased activity of CRH-producing neurons, while patients with atypical depression, a syndrome of under-arousal much more common in women, have decreased activity of CRH-producing neurons. Besides HPA axis functional changes, distinct alterations of the serotonergic system may also play a critical role for the melancholic and atypical subtypes, namely a reduced restraint via 5-HT-1A autoreceptors in the former and primarily serotonin synthesis in the latter.²¹ Gold & Chrousos²² have also presented data indicating that symptoms of atypical depression are associated with concomitant hypofunctioning of the locus coeruleus-norepinephrine (LC-NE) system.

Female hormones-estrogens in particular exert potent effects on the expression of various forms of psychopathology. Additionally, they have a neuroprotective role regarding neuronal degeneration, growth and susceptibility to toxins. The literature on depression holds female hormones indirectly responsible for the greater prevalence

of depression in women. It is not that estrogens directly dampen mood, although progestins may do so,²³ but that the off-and-on binding to intra-nuclear estrogen receptors in the brain, starting in the early teens, somehow renders women vulnerable to stress, probably through glucocorticoid-induced neuronal toxicity.²⁴ The cyclic nature of estrogen secretion from puberty to menopause and, subsequently its almost total withdrawal may account for the special vulnerability of young women to depression. Recurrent estrogen withdrawal may interfere with estrogen's ability to neutralize the effects of glucocorticoids released during stress.²⁴ According to the same author, this explanation, speculative as it is, fits the epidemiologic evidence that the high prevalence of depression in women is evident only after puberty.

Further support to the hormonal hypothesis is added by.²⁵ They suggested that increased risk of depression is related to high organizational testosterone. Additionally Manning²⁶ suggested that finger length ratio (2D:4D) index to ring finger is associated with a trait depression subscale in males and Bailey²⁷ found that depression in men is associated with more feminine length ratios.

Twin studies

A slightly greater correlation in liability to MDD in the female+/- female (FF) versus the male+/- male (MM) pairs has been reported. However, the best fitting model suggested equal heritability for MDD in the two sexes.^{16,28}

It has been argued, that using broader but not narrower definitions of illness, genetic factors play a smaller role in the aetiology of MDD in men than in women. The genes that influence risk for MDD in the two sexes are correlated but might not be entirely the same. This raises the possibility that, in linkage and association studies, the impact of some loci on risk for MDD will differ in men and women.²⁹

Given that the most sensible interpretation of all available data is that men and women share some but not all the genes for MDD, two hypotheses have been advanced. The first, suggests that such a pattern might be due to susceptibility genes for MDD located on the X chromosome. The pattern of correlations in liability observed for sibling and

parent-offspring pairs does not fit that predicted for an X-linked trait.¹⁶ The second hypothesis suggests that some proportion of the genetic risk factors for MDD in women might reflect the sensitivity to the “depressogenic” effects of menstrual and/or pregnancy-related hormonal changes²⁴ that do not appear in men. Thus, males and females may react differently to similar life experiences, but there may also be different genetic and molecular mechanisms behind female and male psychopathology. Many studies on the neurotransmitter systems like the ones on polymorphisms of the promoter serotonin transporter gene, or in HPA – axis or in the *CREB1* gene which has synergistic interactions with the female sex hormones (estrogens and progesterone) have confirmed this hypothesis.^{30–32} These findings may provide the mechanisms on how sex-specific patterns of gene expression could be facilitated. These can manifest themselves in the sex-specificity of the susceptibility locus for Mood Disorders. Concordant with this hypotheses, is the finding by Kendler²⁸ who establishes that genetic risk factors for premenstrual symptoms accounted for nearly 17% of the genetic risk factors for lifetime MDD in female twins.

Personality differences

We are now increasingly aware that both biological and psychological sex variables shape personality. Investigators have looked for personality factors associated with the sex role that are capable of explaining women’s special vulnerability to depression. Women, to a greater degree than men, invest their emotions in interpersonal relationships, consequently they suffer from the impact of life events that take place not only in their own lives but also in the lives of their network of friends and relatives. However this hypothesis is not supported by the evidence which suggests, to the contrary, that strong social networks more prevalent among women, protect against depression.³³

Another reported personality difference, widely accepted though difficult to prove empirically, is that women internalize their feelings to a greater degree than men and blame themselves for incompetence or failure which leads to depression, while men blame others which leads to anger.²⁴

Conflicting and changing social expectations of women and the higher rates of sexual abuse of girls during childhood and adolescence have also been considered as possible explanations for high rates of depression in women.^{34,35}

What is the practical significance of these findings?

Treatment implications: It has been reported that female patients respond better to selective serotonin reuptake inhibitors (SSRIs) than tricyclic antidepressants (TCAs). This might be associated with the side effects profile of the SSRIs. Male depressed patients have on the other side been reported to respond better to TCAs.³⁶ Interestingly the female predominance among patients seem to be restricted to the atypical subtype.²¹ Other studies also mention that TCAs are not particularly effective in the treatment of atypical depression. Atypical depression is related to a decrease of CRH secretion and TCAs also decrease CRH production.³⁷ Kier,³⁸ reported that treatment with the monoamine oxidase inhibitor (MAO-I) phenelzine, in mice, could reverse the psychiatric symptoms of glucocorticoid deficiency in atypical depression, results that confirm those of Stewart³⁷ seems that chronic phenelzine treatment induces sustained increases in glucocorticoids by impairing glucocorticoid feedback, increasing adrenocortical responsiveness to ACTH, and increasing glucocorticoid independent stimulation of hypothalamic-pituitary activity.³⁸ The reported hypofunctioning of the HPA and LC-NE system indicate the need for research on a different therapeutic strategy for this subtype of MDD³⁹ & Chrousos, 2002.

Conclusion

Overall, the clinical presentation of MDD in males and females is not the same. There are differences in presenting depressive psychopathology and comorbidity. Sex modifies clinical features of depression and an earlier onset of depression and atypical symptoms seems to occur more frequently in women while more aggressive symptoms (against themselves or others) occur more frequently in men. The genetic risk factors for MDD, also appear to have minor differences. There also seem to be different

hormonal dynamics, different influences on the preexisting anxiety and various personality traits between the sexes. These differences though are not pronounced.

We have now reached a stage where we should probably talk about endophenotypes of depression. This suggests that studies of depression should examine each endophenotype separately. Future studies on gender differences in genetic risk factors for depression will determine the way men and women respond to environmental risk factors and will affect the profile of depressive symptoms resulting from these interactions.

Furthermore, regarding the effects of antidepressants in MDD, psychiatrists may need to pay close attention to gender differences and the profile of depressive symptoms before and after antidepressant therapy. The literature reviewed indicates the need for research on a different therapeutic strategy than the one currently used for the treatment of depression. Findings suggest that each subtype of major depression may be associated with its own unique repertoire of presenting symptoms and long-term medical consequences. Gender might be an important parameter that needs to be taken into account.

Ανδρική κατάθλιψη: Διακριτές διαφορές ανάμεσα στα δύο φύλα

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Πρόσφατες ερευνητικές εργασίες προσφέρουν ενδείξεις ότι είναι πιθανόν να υπάρχουν λεπτές διαφορές στα συμπτώματα που χαρακτηρίζουν την ανδρική και τη γυναικεία κατάθλιψη. Σκοπός της ανασκόπησης αυτής είναι η διερεύνηση των διαφορών ανδρών/γυναικών στην καταθλιπτική ψυχοπαθολογία υπό το φως της πρόσφατης βιβλιογραφίας και να συζητήσει αν αυτές οι διαφορές οδηγούν στην ανάγκη αναζήτησης θεραπευτικών παρεμβάσεων που είναι ειδικές για το κάθε φύλο. Πολλαπλές αναζητήσεις στο Medline για την περίοδο 1985–2008 με τη χρήση λέξεων κλειδιών: κατάθλιψη, ανδρική κατάθλιψη, γυναικεία κατάθλιψη, διαφορές, φύλο και συνδυασμών τους.

Λέξεις ευρητηρίου: Κατάθλιψη, άρρεν φύλο, ψυχοπαθολογία.

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Special article Ειδικό άρθρο

Deinstitutionalization in Greece: Ethical problems

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The following paper is based on a Concerted Action which focused on the "Ethical aspects of deinstitutionalisation in mental health care" in 2001. It investigates the development and the ethical dilemmas posed by deinstitutionalization in Greece. This movement has recently undergone a very active phase but the transition from the traditional model of psychiatric care to the community based system unavoidably creates many ethical problems related to the professionals' attitude towards individual liberties, dignity and other fundamental rights of mentally ill persons. These problems exist not only in the level of the therapist-patient relationship but in the level of policy making as well as its implementation. Moreover, the paper deals with specific ethical problems such as stigmatisation and isolation in the community context, as well as the role of the family.

Key words: Deinstitutionalization, mental illness, ethical aspects.

Introduction

Mental health has always been an area triggering numerous conflicts and tensions, many of which are of a moral nature. Although for more than a hundred years psychiatrists have been practising their profession without being concerned with ethical and moral issues, following a long existing,

paternalistic tradition of how to serve the patient best, in the last few decades this has profoundly changed. Various developments in the societal context have played an important role in the shaping of new attitudes towards the patients as well as towards the notion of mental health and its social ramifications per se. During the last three decades, following the expansion of biomedical

ethics, which started in the 70's, the ethical dimensions of psychiatric care, have gradually received adequate attention and changes are beginning to be undertaken, even though psychiatric ethics still remains a bioethical "ugly duckling".¹ The increasing interest on ethical concerns has led to extensive writings, to Psychiatry training programs and texts such as the Principles of Medical Ethics in 1973 with annotations especially applicable to Psychiatry, as well as to the Declaration of Hawaii by the World Psychiatric Association in 1977.^{2,3} This shift in awareness has led to the corroboration of a view which had once been hard fought against but is today widely accepted: the view that science and ethics are closely interwoven and that modern Psychiatry cannot exist without reference to its ethical background and the inherent values, without the recognition of rights and duties or without the application of norms and rules which dictate respect to the legal and moral entity of the individuals concerned. This framework, which has been reinforced by the increased emphasis on human rights, including the rights of people with mental disability or incapacity⁴ does not refer only to the traditional hospital/asylum context but also to the modern movements of deinstitutionalization and rehabilitation: in the community environment the fundamental values which lay the foundation of ethical reflection in Psychiatry, i.e. trust, autonomy, privacy, care and justice⁵ acquire a new significance as they function in a different milieu. The above mentioned moral considerations which also include the inhuman character of long-term hospitalization, as well as the right of individuals with mental health problems to be integrated into society, along with financial and legal concerns, have not only been some of the major incentives for deinstitutionalization but have also led to serious ethical ramifications of this process in most of the countries in which it was implemented.

The historical background of deinstitutionalization in Greece

Since 1980, the term "deinstitutionalization" has been used in Greece to describe the integration of mentally ill people to the community. Similarly with

other countries, the transition was motivated by the need to face the distressing conditions of large psychiatric institutions, especially the violations concerning dignity, autonomy and privacy of the individuals. It was also driven by the need to decrease the high financial maintenance cost of such institutions.

When this movement started twenty five years ago, it had as its main target not to close down these institutions but rather to downsize them and to restrict their role in the care of mentally ill people. This process did not of course develop in a cultural and conceptual vacuum but emerged slowly as the product of various fermentations which took place in the field of Psychiatry in many countries and subsequently in Greece.

A brief overview of the history of Psychiatry in Greece would focus on three different phases of development:

- a. The practice of popular beliefs, which pre-existed to psychiatric services and later survived in parallel: these had been always related to religion as some churches and monasteries, following the Byzantine tradition of hospitality, used to admit a small number of insane people.⁶ We can also mention beliefs on the "evil eye".⁷
- b. The introduction of modern psychiatric practices and the training of mental health professionals: these followed the dominant model of European medical and University practices. Education of medical doctors who were interested in psychiatry, was widely dependent on studies and educational journeys mainly to European countries. These influences were reflected in legislation and in transfer of practices in Greece.⁸ The first law regarding mental health, Law Ψ MB of 1862, was heavily influenced by the French law on mental health of 1838. Decree 104 of 11.8.1973, another important piece of legislation, abolished Law Ψ MB, maintained hospitalization as the centre of mental health care system, focused on dangerousness but on the other hand introduced, for the first time, the possibility of voluntary hospitalization for mental patients.⁹ Finally, Law 2071 of 1992 harmonized Greek legislation concerning psychiatric care with European guidelines.

c. The foundation of psychiatric services: the first psychiatric hospital was founded in 1838 in the island of Corfu which was then under British control and the second one, "Dromokaition", was founded in Athens in 1887. These were the first examples of a development which took place in the first decade of the twentieth century along with urbanization, economic progress and industrialization of the country. A network of 9 hospitals was completed after the 2nd World War. Nevertheless, albeit the picture of the mental health institutions in Greece was not very different from that of the other European countries, the most important developments in the field of mental health took place much later than in the rest of Europe.

The psychiatric hospital of Leros (in the well-known Aegean island), the psy. hospital for children, of Daou-Pendeli's (near Athens) and the psy. hospital of Petra (at the mountain of Olympus), in their beginnings used to admit chronic patients referred to them mainly from the psychiatric hospitals of Athens and Thessaloniki. These heavily institutionalized patients constituted one of the main target groups of deinstitutionalization programs. The population of chronic patients in the totality of Greek psy. hospitals has greatly diminished, through a widespread network of community-based housing units, which has to achieve now its integration in community based psychiatric units of care and its financial survival. Since 2004 the psy. hospital of Petra-Olympus, and since 2006 the psy. hospitals of Corfou and Chanea (Crete) do not admit patients any more.

The landmarks

In the 70s and the 80s the experiences of Italian deinstitutionalization and French sectorization had an important impact to Greek Psychiatry but the major obstacle at that time was the lack of outdoor and outpatient services, the establishment of which being the main target in the late 70s for the deinstitutionalization of patients of major psychiatric hospitals.^{10,11} In the early 80s, despite the existence of some pilot programs, psychiatric in-patient care was mainly provided in public and

private mental hospitals. Apart from these pilot studies, neither community based mental health services nor psychiatric beds existed in general hospitals.^{12,13} Social and vocational rehabilitation, part of the deinstitutionalization movement, appeared in Greece in the middle of the 80s, although some earlier efforts had been done in the 50s, focusing on chronic patients of public psychiatric hospitals.¹⁴

The landmarks of the recent development of psychiatric care in Greece were the introduction of the National Health Service in 1983, the Regulation 815^{15a} (1984–1994) (EEC 1984) and the application of the "Psychargos" I and II^{15b} program of the European Union, which provided very important financial support to changes and progress realized in the years to follow. One of their main objectives was deinstitutionalization of long stay patients in mental hospitals, but in a short period, Greece also managed to make a considerable progress in community based mental health services and increase of psychiatric beds in General Hospitals.

The most recent law, enacted in 1999 (L.2716/99) provides extensively, among others things, for the development of halfway houses, nursing homes, hostels, supervised apartments, family foster care and other residential options that represent steps towards the goal of independent living as part of the deinstitutionalization and rehabilitation process. According to Section 1 of Law 2716/99: "Mental health care services are structured, organized, developed and functioning according to the present law on the basis of the principles of sectorization, community psychiatry, priority of primary care, extramural care, deinstitutionalization, psychosocial rehabilitation and social reintegration, continuity of psychiatric care as well as information and voluntary contribution of the community in the promotion of mental health". Emphasis has been given on development and improvement of the users skills with the application of social and professional rehabilitation programs. Thus, a replacement of institutional forms of care by a network of alternative preventive and therapeutic structures outside the hospital, could be gradually achieved.

The existing network of services of care and rehabilitation is functioning within Public Hospitals, University Hospitals and non-profit private organizations. Private clinics (estimated to reach a number of 30 on a national level in 2007), provide only indoor care and their beds are in majority occupied by chronic patients.

Although remarkable efforts have been made, the total number of outdoor services still remains insufficient. The programs of public hospitals deinstitutionalization in Greece, including the deinstitutionalization of Leros from 1989 to 1994 (Leros I and II, through the program "Psychargos" I and II, have led to the development of an important network of half-way houses and supervised apartments – 269 units, with 2695 residents and 3061 staff members.¹⁶

The primacy of outdoor care and prevention, recognized by Law 2716 of 1999 could be achieved through an effective application of sectorisation of mental health services (sectors of 250–300,000 inhabitants). To this day, outdoor services of care, psychiatric hospitals, psychiatric units in general hospitals and housing units in the community have not been coordinated through sectorisation, while financial problems heavily burden the progress of the reform.

The ethical dimensions of deinstitutionalization

The experience of deinstitutionalization in different countries and the transition from traditional to community based psychiatry which has promoted the "public health model", has yielded a number of problems and has created a variety of ethical ramifications as the psychiatrist acquires a more active role in the social network.¹⁷ Moreover, the principle of least restriction, one of the central ideas behind the process of deinstitutionalization which concerns the management of incapacitated persons provides a new prism through which their whole physical and psychological existence is being viewed. In the most recent Code of Medical Ethics in Greece, it is mentioned that psychiatrists have the duty to proceed to therapeutic interventions which restrict as little as possible the freedom of the person concerned.

Also, additional discoveries regarding the biological foundations of behaviour, have had considerable influence on the conception of mental health and consequently its ethical framework. It is well accepted that the therapeutic goals of psychiatry are best fulfilled only if considerations regarding the individual's dignity and autonomy are taken into account and under the condition that the patient's consent is being sought; it has been considered an abuse of one's own right of liberty and dignity to involuntarily place him to an institution, even for him own benefit unless the exact requirements of the existing legislation are being followed. However, the question arises whether it is ethically appropriate to enforce a patient to live in the community if he is not fit for this and to refuse him a sheltered environment. It should be pointed out here that in Greece, the network of halfway houses permits the existence of a gradual transition from hospital to the community and that the problem of homeless people is not yet as serious as in other countries, although, at least in the capital, the situation is rapidly changing for the worse.

Currently, in Greece, deinstitutionalization is undergoing a very active phase with many ethical ramifications which can be found in two different levels: firstly in the level of inter-personal relationship between the therapist and the patient (the term client is not broadly used in Greece) as well as in the level of mental health care provided in the community context.

The role of the therapist and the environment in which the patient and the therapist co-exist, have been described as two of the most important factors in the formulation of ethical questions.¹⁸ The success of deinstitutionalization depends a lot on the human factor and especially on how mental health professionals grasp the notions of autonomy and beneficence. Moreover, the way in which professionals view demented patients has many ethical implications regarding the notions of personhood and personal identity.¹⁹ In the Greek medical context, where the interpretation of the Hippocratic tradition has led to the emphasis of the notion of duty in a way which has nurtured deeply paternalistic attitudes, a provision of care which takes seri-

ously into consideration the notion of individual autonomy is not self-evident. Paternalism in Greece has prevailed for a long time as an extreme form of the notion of beneficence and despite the fact that the Greek Constitution safeguards respect and protection of individual value as well as each citizen's right to develop freely their personality, for a very long time relationships in the medical setting have followed a more austere and traditional pattern based on "medical authority". According to the American bioethicist, Robert Veatch, the development of autonomy presupposes abundance of financial resources, technological scepticism and liberal individualism emphasizing the importance of autonomy in relation to the Hippocratic tradition.²⁰ The fact that Greece did not fulfil these conditions could indeed be a reason why paternalistic attitudes survived not only in the psychiatric but in the general medical context. Until the 70's these attitudes were reinforced by the fact, uncontested by the social environment, that medical doctors negotiated with the family rather than with the patient himself.²¹

Although similar attitudes have been gradually changing and the existing Patients' Rights legislation safeguards autonomy, provision of information and consent, these issues continue to constitute in practice some of the main ethical problems in the process of deinstitutionalization.

Results of concept mapping in Greece

In 2001, UMHRI (University Mental Health Research Institute) participated in a BIO-MED program of the EU on "Ethical aspects of deinstitutionalisation in mental health".²² A limited sample of patients, family members and professionals was interviewed according to the "concept mapping" method²³ where the opinion of various stakeholders regarding their perception of "good care" were asked. These stakeholders were people with mental health problems, family members, professionals, policy makers and the local community. In each participating country 86 statements of what "good" mental health care is, were proposed to representatives of the five stakeholder groups, who first prioritized the statements on a scale of

importance and organized them into clusters. The data collected were statistically processed by the Trimboos-Instituut which was the central coordinator of the project.²⁴ The results concerning Greece could be summarized as follows: Patients and professionals working in the deinstitutionalization field believe that priority should be given to treating the patients with respect, to cooperation, to the accessibility of mental health services and to the avoidance of coercive treatments. Other priorities were believed to concern adequacy of a crisis response, involvement of carers, accessibility of rehabilitation services, involvement in the evaluation of mental health services and support for the neighbourhood. Thus, good care was in general considered synonymous to a respectful attitude of professionals, trust and confidence, individually tailored care, encouragement of responsibilities and active participation in decision-making. The respectful relationship between patients and care providers especially, was considered by all as the most important aspect of good care. Nevertheless there were some interesting differences between the participating countries: in the Netherlands, for example, respondents placed more emphasis on the role of good care in rehabilitation, whereas in Greece and Belgium more importance was ascribed to the effectiveness of care. Good care, however, is also supposed to mobilize community support mechanisms in parallel with medical treatment. For example, treatment of relapses of patients in halfway houses has been trying to avoid reproduction of the "revolving door" phenomenon.^{24,25}

Stigmatization

Schizophrenia has always been associated with a significant amount of stigma all over the world: studies suggest that the majority of citizens in the United States²⁶ and many Western European nations have stigmatizing attitudes about mental illness.²⁷ In Greece there are many folk beliefs, stereotyped ideas and scornful expressions about schizophrenia generated by strong religious and cultural values. These notions are mostly empirically noticeable in

some aspects of interpersonal relationships in everyday life, the mass media and the civil laws.^{28,29}

Despite the Greek origin of the words "stigma" and "schizophrenia", stigma attached to this severe mental illness has not been adequately studied in Greek society. Up to 1980, there were very few studies on people's perception of mental illness, mainly among relatives of the mentally ill conducted in 1964 and 1977.^{30,31} In the general population, two studies^{32,33} showed some changes in public attitudes and beliefs about the various causes of mental illness. The majority of the respondents in the 1964 study believed that the main cause of mental illness was "poverty" and "bad socioeconomic conditions", whereas the 1977 study revealed that "everyday life stress" was the main cause and only older individuals expressed the view that mental illness is inherited. In the second study, in terms of seeking help, it was found that only young respondents raised and living in Athens would seek help from a psychiatrist in the case of a major psychological problem, while the rest of the population preferred other traditional means of seeking help such as priest, folk healers, relatives, etc.

In 1980, public attitudes towards mental illness were explored and the majority of lay respondents were found to be rejecting and afraid of people with mental illness, with only younger and better educated people expressing humanitarian views and tolerance of any deviant behaviour.³⁴ A decade later, respondents from the same cohort were found to be more positive towards social integration of people with mental illness and against social discrimination and restriction of mental patients.¹³ Madianos et al attributed this improvement to social changes that took place in Greece at the time and to the crucial role played by community mental health prevention programmes.

In 2001, the University Mental Health Research Institute (UMHRI) joined the World Psychiatric Association's international programme "Against stigma and discrimination because of schizophrenia" and has undertaken a number of research and training initiatives since then. Congruent with this, it conducted a national survey on the general population's knowledge about schizophrenia and its at-

titudes towards the people who suffer from it.^{35,36} The results demonstrated that lay people aged over 65, of a lower educational level and social class, living in semi-urban/rural areas, endorsed the most stigmatising attitudes towards people with schizophrenia (PWS). Furthermore, the degree of desired social distance from a person with schizophrenia was found to increase, as the intimacy necessitated in the interaction increased as well. In addition, and quite surprisingly, the Greek public was shown to be more reluctant to have someone with schizophrenia as a colleague rather than as a friend. Concerning comparisons of public attitudes towards people with mental illness and other groups vulnerable to stigmatisation (e.g. immigrants, HIV patients, etc) it was revealed that Greeks tended to stigmatise people with schizophrenia the most, even more than serious law offenders. The implications of these findings can be better grasped, if one considers the responses given to questions addressing attitudes towards the operation of small group homes in the community accommodating PWS. In particular, while 51% of the sample was in favour of such a prospect, 20% objected to it, while 57% of the opposers claimed that they would actively resist such a development. In terms of their knowledge about schizophrenia, the Greek public was found to be either poorly informed or misinformed. The vast majority of respondents regarded PWS as dangerous (75%), with split personalities (81%) and being incapable of employment (83%). Furthermore, they tended to be oblivious of the genetic factors in the etiology of the disorder, as 1/3 of them attributed it solely to environmental and psychosocial agents. Interestingly, 66% of the respondents reported that television was their primary source of knowledge about schizophrenia.

Building upon the aforementioned survey findings and existing literature,³⁷ a subsequent investigation of the role of media on promoting the stigma attached to mental illness was carried out.³⁸ The study examined the ways whereby mental illness and people suffering from it are represented in Greek newspapers and magazines. Specifically, the stigmatising articles were found to have significantly larger sizes and more memorable layout than the neutral or the

anti-stigmatising ones. Moreover, only a minority of the mental health articles were written by mental health experts; most of them did not entail any scientific research; and while half of them had incorporated comments made by experts, PWS could not share their experiences and raise their concerns in these articles. In fact, in the majority of them, they were portrayed as being violent and dangerous. It is, therefore, safe to claim that schizophrenia is highly stigmatised in print media, where stereotypes of violence, danger and unpredictability are prevalent.

Furthermore, stigma has been proposed to be a multidimensional concept entailing faulty beliefs (stereotypes), unfavourable attitudes (prejudice) and negative behaviours (discrimination).^{39,40} It has also been shown to affect the lives of both the people who suffer from mental illness as well as their families; in areas such as interpersonal relationships, daily activities, media, legislation, and interactions with health professionals.⁴¹⁻⁴³

In several European studies, mainly in Greece and Portugal, it is shown that families are very important for psychological as well as financial support of patients living in the community. Indeed, a significant number of mentally ill patients, with diagnoses of schizophrenia and other severe psychiatric illnesses, are living with their families, usually with their parents. Although during the past decades there has been a great shift in the attitudes of families towards mental illness and the ways families respond to their mentally ill member, from being highly isolated from the rest of the community and embarrassed and ashamed about it to being more open and integrated, psychological and financial burden still remains high.

In an effort to reduce the family burden and stigma associated to mental illness, SOPSI (Family Association for Mental Health) was founded in 1993 by relatives of people with mental illness. Its main objectives are to promote support for the mentally ill and their carers, improve care and welfare, provide information about mental illness and the availability of mental health services, improve public awareness about mental illness and reduce the stigma, and the discrimination against the mentally ill and their families. In the beginning, mainly due to stigma it was

difficult for family members to join SOPSI. However, after time and effort from families and mental health professionals, SOPSI has become a highly active families association with more than a thousand members in Athens. Today, a well-cooperated and organized network of family associations has been established across Greece forming a federation under the name of POSOPSI (Panhellenic Federation of Family Associations for Mental Health).

The precise effectiveness of interventions and efforts undertaken against stigma remains to be investigated; however, it is encouraging that there is a universal endeavour to combat psychiatric stigma and Greece actively participates in this effort.

Conclusions

At present, apart from the essential problem of maintenance of a sufficient material infrastructure, what is mostly needed is a change of mentality and the attitudes of health professionals, especially of those who, in the past, had been working in large institutions and who are now facing the challenge of working in a completely different environment. The task of enabling mentally ill chronic patients to realize their potential, to use it and to wish to live outside the mental hospital is very difficult and complicated.

In psychosocial rehabilitation and reintegration, however, considerations arise in an additional level: in the level of community and society, of strategies and policies. Most often, policy makers do not pay the attention needed to the ethical dilemmas raised and deinstitutionalization is not an exception to this rule. Nevertheless, decisions made in this level aim at the wellbeing and at the good quality of life of the individual. The exact content of these notions as well as the criteria according to which this content is measured, are determined according to a series of value judgements which are materialized through the setting of priorities. Decision makers in Greece have to realize that ethical problems exist not only in the level of the therapeutic relationship between the patient and the person who provides care, but in the level where today the genesis and the rapid development of new relationships between medicine, public health, ethics and human rights are taking place.⁴⁴ The responsibility of those who formulate policies

to be followed is an ethical responsibility of a dual character: to protect and promote mental health but also to protect and promote human rights of a most vulnerable group of the population, to evaluate their quality of life, to ensure access to health care services and to offer job opportunities. This is well reflected in modern legislation regarding protection of human rights: for example, General Comment 14 of the Commission of the International Covenant on Economic, Social and Cultural Rights. The right of health should be approached through 4 parameters, i.e. availability of services, accessibility, acceptability and quality of care. Mental health which, compared to other forms of care, is being neglected, is mentioned as an example of dysfunction of all efforts to materialize the right to health.^{45,46}

Deinstitutionalization in Greece has been a long and painful, but quite successful so far and still continuing journey, whose most difficult part for the pa-

tient is not getting out of a psychiatric hospital but being re-integrated into community. Nevertheless, the very nature of deinstitutionalization which is based on a different perception of mental illness makes plausible the fact that the road is full of ethical pitfalls, the most dangerous of which is to focus on the idea and to forget the persons and what all this means to them. During the deinstitutionalization process it is important to make the underlying values sufficiently explicit, to increase awareness and to integrate ethical principles in regulatory measures. Moreover, education of professionals in bioethical issues should be enhanced towards the above mentioned directions.

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Αποϊδρυματισμός στην Ελλάδα: Ηθικά προβλήματα

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Η εργασία αυτή βασίστηκε στην ανταλλαγή απόψεων και στα αποτελέσματα του Ευρωπαϊκού Προγράμματος "Ethical aspects of deinstitutionalisation in mental health care". Εξετάζει την ανάπτυξη της αποκατάστασης στην Ελλάδα και τα ηθικά προβλήματα που θέτει. Παρά το γεγονός ότι η αποκατάσταση αναπτύχθηκε σημαντικά τα τελευταία χρόνια, η μετάβαση από το παλιό σύστημα ψυχιατρικής φροντίδας στο εξωνοσοκομειακό δημιουργεί πολλά προβλήματα, ιδιαίτερα σε ό,τι αφορά τη στάση των επαγγελματιών ψυχικής υγείας απέναντι στις ατομικές ελευθερίες, την αξιοπρέπεια και άλλα θεμελιώδη δικαιώματα των ψυχικά ασθενών. Αυτά τα προβλήματα δεν υπάρχουν μόνο στο επίπεδο θεραπειών-ασθενών αλλά και στο επίπεδο λήψης πολιτικών αποφάσεων. Το κείμενο πραγματεύεται επίσης ειδικά ηθικά προβλήματα όπως το στίγμα και η απομόνωση στο πλαίσιο της κοινότητας ή τον ρόλο της οικογένειας.

Λέξεις ευρητηρίου: Αποϊδρυματισμός, ψυχική ασθένεια, ηθικές πλευρές.

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Special article Ειδικό άρθρο

The notion of “Sisyphus task” in medicine A reconstruction

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In medicine, along with the other domains of our life, the myth of Sisyphus is frequently evoked upon confronting a task conceived as laborious, endless and for some futile or even purposeless and meaningless. In this paper, we explore the origin of the myth of Sisyphus so that its connotations and symbolizations will hopefully emerge clearer. It is suggested that the natural background of the myth might be related to the seismologic history of Greece, and Corinth in particular, a city ruined and rebuilt several times. The natural component might symbolically echo in the personified myth of Sisyphus, Corinth's founder and might explain the peculiar labor he was condemned to execute eternally, as well as the meanings the myth carries. Like his own city, Sisyphus also suffered the same “ups and downs” of fate, either as a public figure –patron of several big achievements– or as a punished hero condemned to roll a stone in the underworld. His persistent efforts led to temporary successes, even though he could not find permanent solutions to the labors he undertook alive or dead. Thus, the myth of Sisyphus is related to human efforts and its limitations, the feasible and infeasible the two main poles between which the myth functions. Conceptualizing with Sisyphian terms their function, physicians can celebrate their transient victories, and by realizing their limitations, reconstruct their aspirations without decreasing their efforts.

Key words: Myth of Sisyphus, Sisyphian task, medicine.

Introduction

«Aye, and I saw Sisyphus in violent torment, seeking to raise a monstrous stone with both his hands. Verily he would brace himself with hands and feet, and thrust the stone towards the crest of a hill, but as often as he about to heave it over the top, the weight would turn it back, and then down again to the plain would come rolling the ruthless stone. But he would strain again and thrust it back, and the sweat flowed down from his limbs and dust rose up from his head»

HOMER, *Odyssey*¹

It has been suggested² that articles with "catchy" titles –that is titles "catching" the eye of the reader–work best in medicine, although they may occasionally introduce a systematic, so-called "catchy title bias".³ This may be the case with the word "Sisyphus" and its derivatives such as "Sisyphian task" or "Sisyphian labor". By using Pub Med and searching for published articles containing the words "Sisyphus" or "Sisyphian", we found 62 publications between 1965 and 2006, 53 of which used this catchy title. In scholar google, the response to "sisyphian" were 2270 citations in fields, including medicine, like education, philosophy, ecology, economy, computer sciences, or physics. The meaning, however, of a medical task called "Sisyphian" is far from clear: In the majority of cases it bears vaguely negative connotations, variously described as laborious, endless, frustrated or even futile, purposeless and meaningless. It is, therefore, interesting to trace its origins and the symbolic meanings that this unusual myth resonates, so that their semantics may be better elaborated. Our main emphasis is the working connotations of the myth, the constructions, physical and mental, since their building blocks, "the stones", stand prominently on the "Sisyphian" labor.

The myth

Sisyphus, a Greek mythical hero, was condemned to eternally roll a huge stone up the top of a hill. He never succeeded, because as soon as the "shameless"¹ stone almost reached the summit, it bounced to the very bottom. This myth, authored by Homer,¹

was broadly disseminated, particularly by the Nobel prize winner in literature, Albert Camus in a semi-essay titled "The myth of Sisyphus".⁴ The task Sisyphus was condemned to perform was laborious, as it required great physical effort, since the rock was huge and heavy. Furthermore, it was an endless task, as he had to repeat it eternally. Finally it was incomplete as the ultimate goal was to keep the rock permanently on the top of the hill. Due to its universality, and its relevance to everyday life, a task is oftentimes called «a labor of Sisyphus» or the efforts as «Sisyphian» if it possesses the above attributes.

Sisyphus was a creator: The founder and king of Ephyra (later Corinth), and of the biennial Isthmian Games; he was also credited as promoting Corinthian commerce and navigation,⁵ considered to be wise: Homer calls Sisyphus the "craftiest" («κέρδιστος») of men,⁶ Hesiod as "very clever" («αιολόμυτης»)⁷ and Pindar describes him "like a very god, was most wise in his counsels" («πυπνότατον παλάμαις ως θεόν»)⁸. His cleverness could only be compared to Ulysses' who was allegedly his son.⁵ Moreover, etymologically, although not all authors unanimously agree, the name Sisyphus means "wise man".⁵ But the strongest evidence of Sisyphus' ingenuity comes from his innumerable endeavors and tricks played on men and gods.⁵

Bringing to mind contemporary detective stories, Sisyphus trapped Autolycus, a thief of cattle (his name and his character borrowed by Shakespeare in his "Winter's Tale"), by engraving the inside of all his cattle's hooves with the monogram SS, or according to another version with the words "stolen by Autolycus". By this action, the stolen beasts could be later recognized in Autolycus' stable. In another story, however, reminiscent that of Autolycus, a woman, named Mistra, defeated Sisyphus. Sisyphus bought her from her father hoping to take advantage of her exceptional abilities and become wealthier, but she deceived him and returned to her father.

He attracted the wrath of the Gods, though, by revealing Zeus' whereabouts with Aegina, the daughter of the river-god Asopos, to her searching father. In exchange, Asopos undertook to supply the town of Corinth with a perennial fresh-water spring, Peirine, on the summit of Acrocorinthus, its

acropolis. Not forgiving Sisyphus, Zeus asked his brother Hades to fetch the informer down to the underworld. Sisyphus, however, chained Hades by persuading him to demonstrate the use of handcuffs and he quickly locked them. As long as Hades was kept prisoner in Sisyphus house "nobody could die, even men who had been beheaded or cut in pieces; until at last Ares, whose interests were threatened, came hurrying up, set him free, and delivered Sisyphus into his clutches".⁵

Anticipating his descent to Hades, Sisyphus plotted another ingenious escape: He instructed his wife Merope not to bury him. (She herself suffered Gods' resentment for marrying a mortal- and a criminal too! – and as a punishment she became the only pale star among her star-sisters, the Pleiades). On Hades, Sisyphus requested to return for a while to the upper world to arrange the neglected duty of his burial. The deceived Persephone granted the request, but he abandoned his promise to return to the underworld. It was left to Hermes to perform his duty, fetch him to Hades permanently and pay the labor ordered by the Gods.⁵

Thus, it seems that the Gods condemned him for trying to service his fellow citizens by giving them water, just as Prometheus was condemned for giving mortals fire. Sisyphus, however, never enjoyed the epic status and the happy end of Prometheus,⁹ apparently because some questioned the true reason for his punishment, as well as the morality of his character. According to Hyginus,¹⁰ the reason for his punishment was that Sisyphus seduced his brother's daughter, Tyro, to revenge his brother, as the two brothers hated each other. When Tyro learned that Sisyphus' motive was not love but hatred of her father, she killed the two sons she had borne to Sisyphus. Sisyphus has been also described as a villain or a street bandit, allegedly killed by Theseus (generally not mentioned among this hero's feats) who was credited as founder of the Isthmian games.⁵

At the end, no matter how creative or ingenious, Sisyphus was eventually defeated. This may imply that any constructions will be found some day inadequate and be reconstructed or replaced by new ones.

Tracing the origins: the ups and downs of Corinth

It is of interest to look upon some more or less salient physical features inherited to the myth, for most myths usually derive from popular efforts to explain natural phenomena.¹¹

By reflecting upon the marvelous Homeric description of Sisyphus pushing the rock (see above), we are impressed by the picture of Sisyphus himself: It is a human figure, perhaps that of a stone worker who tries hard, muscle-tensed, dusted and sweating. Camus himself makes the association: "The workman of today works everyday in his life at the same tasks..."⁴

In contrast to other condemned heroes such as Ixion (crucified, in a rotating fire wheel), Tantalus (imprisoned, chained and unable to drink or eat) and Prometheus (chained to a cliff and having his liver eaten by a vulture) who were all restrained, almost incapable of doing anything, Sisyphus remained active and movable.

Moreover, knowing Sisyphus' origin, it is rather easy to associate the stone, the rock and the hill with Corinth's Acropolis, Acrocorinthos. Some vessel paintings show the top of the hill bearing resemblance to that of Acrocorinthos.¹² This huge, monolithic rock easily appeals to the stone and stone up-rolling hill task of Sisyphus. Acrocorinthos, indeed, symbolizes the triumph and the fall of Sisyphus.

Lastly, the city "Corinth" offers important clues. Corinth is Sisyphus's country and Poseidon, god of the sea and earthquakes, the chief god of the city. Often referred by the epithets Enosichthon, Seisichthon, and Ennosigaios -all meaning "earth-shaker", with "seismos" the Greek word for "earthquake"- Poseidon visits the area quite often. He is depicted as riding a chariot with horses, near the sea, possibly symbolizing the tsunamis after the earthquakes. Indeed, Corinth is one of the most seismically active areas in Greece, just as Greece is in Europe.¹³ There is evidence that the city of Corinth was destroyed around 2000 BC, but the reason for this event is not mentioned.¹⁴ Although it is not conclusive, some scientific data point towards an "earthquake storm" that may have occurred in the

Late Bronze Age Aegean and Eastern Mediterranean between 1225–1175 BC.¹⁵ The National Geophysical Data Center (NGDC)¹³ based on its own scientific criteria of significance, reports an earthquake in this area in 373 BC which has been described by several authors, such as the Greek writer Pausanias.¹⁶ In 1858, the old city was totally destroyed by an earthquake and the new city was founded 3 km NE, on the coast of the Gulf of Corinth. The most recent major earthquake (6,8 Richter) shocked and damaged the whole area, including Athens, in 1981. The connection between the water spring Peirine on the summit of Acrocorinthus and Poseidon's earthquake associations are evident. Poseidon, in his contest with Athena for the possession of Attica, thrust his trident into the Acropolis of Athens, and a seawater spring immediately gashed out.⁵

By combining these elements together, it can be suggested that the origin of the myth might be connected with the perpetual destruction and rebuilding of the city, due to the habitual in this region earthquakes. "The strong earthquakes (in Greece) have affected the history, tradition, religion, arts, building habits, political, social and economic status for a very long time".¹⁷ Such an explanation seems plausible and fits the peculiarity of this myth and the unique form of Sisyphus' punishment; otherwise a punishment compatible with other prominent attributes to his character would be more comprehensive. For example, since he was accused to be a street bandit, he might have been more "restricted" and assigned to a "Tantalian-like" punishment, such as desiring everything but achieving nothing. Instead, a task involving the burden of bearing a huge stone on his shoulder in an endless repetition and not accomplishing the ultimate goal fits rather better as a punishment, knowing the adventurous, crafty, creative, novelty seeking nature of Sisyphus.

Comments

Assuming that the main theme of the myth of Sisyphus is that of work and that our hypotheses regarding its physical origins has some merit, then the peculiar labor of Sisyphus seems more sensible. The real "ups and downs" phenomena of Corinth consist

of the physical framework, the "bones" for the myth, around which the fate of Sisyphus is folded and unfolded: An eternal physical and mental up and down, built and rebuilt, construct and reconstruct, stitched in an apparently monotonous rolling stone labor of Sisyphus or the rolling life labor of mortals.

At first glance and from an "external" point of view, any human physical and mental constructions seem to have the same rather pessimistic fate. No matter how marvelous they are, eventually, under the passing of time and/or the light of new knowledge, they yield to revision, reconstruction or replacement. A closer look, however, reveals that such an attitude does not necessarily need to be adopted. Although the task seems laborious and endless it need not be completely futile, unless the ultimate and unique goal is permanency, for the hero at least temporarily succeeds in bringing the rock to the peak, in spite its hugeness. Furthermore, even if we accept that the labor is actually futile, it need not be meaningless or purposeless, for the former is not synonymous or equal to the latter.^{18,19} For, according to Joske,¹⁹ besides futility (no achievement of the required end), to be meaningless an activity should be worthless (lacking intrinsic merit), pointless (not directed towards the fulfillment of an end) and trivial (lacking sufficient worth) as well. Thus, between fully meaningful (if it suffers from none of the four defects) and valueless (if it suffers from all of the four defects) an activity could be still valuable: that which is worth performing even though it falls short of the fully meaningful and suffers from at least one of the above mentioned defects.¹⁹

From an "inside" or empathic point of view, it is true that the myth and Homer in particular, says nothing about the psychological condition of Sisyphus and the way he looks upon the situation. Because if we adopt the dictum of Epictitus –as the cognitive approach in psychotherapy does– that "people are disturbed not by the things but by the way they view things", Sisyphus is not necessarily unhappy unless he mentally constructs his condition as such. Having portrayed Sisyphus as a person not easily bound from external restraints, it is rather impossible to envision him helpless and hopeless, in line with Camus' optimistic concluding remark "We must imagine that

Sisyphus is happy".⁴ Hope and faith are both beyond the realm of proven facts,²⁰ but Sisyphus shows no signs of demoralization. Indeed, if we believe Ovid's testimony, Sisyphus "climbed on his rock to listen" to the divine music played by Orpheus in Hades in his search for Eurydice.²¹

How does this myth apply to medicine? The fact that Sisyphus was able to defeat Death, albeit only for a short period of time and in an unconventional way, would be enough to put him into the Pantheon of medical heroes. Again, this glory was not for Sisyphus but saved for Asklepios, the medical hero who, by reviving a dead man, was blasted to Hades by Zeus' thunderbolt, perhaps as a warning to physicians' attempts to be god-like in overcoming death.²² Today, medicine is reminded of Sisyphus to express the vague notion of a medical task as "Sisyphian", denoting that medical efforts and new discoveries fall apart and disappear oftentimes without a trace. Furthermore, the myth of Sisyphus is becoming more relevant nowadays in medicine due to the current notion of "medical futility". A futile medical action is characterized as one that "cannot achieve the goals of the action, no matter how often repeated".²³ Hence, the danger of identifying

"Sisyphus" and "Sisyphian" with "medical futility" which is apparently inappropriate, as we argued earlier, is visible.¹⁸ Instead, the association of medical futility with the myth of the Danaids (they were condemned in Hades for murdering their cousins to having to carry water continuously in containers that had holes) seems better fit.^{23,24} On the other hand, the myth of Sisyphus seems to be more in concordance with the "Sisyphus syndrome":²⁵ Although medical expenditures increase with the increase in life expectancy, this seems a success for medicine rather than a desperate endeavor.²⁶

In conclusion, the Sisyphus labor reminds us of our capabilities as well as our limitations. If the ultimate goal of medicine is to negate death, a task that exceeds our capabilities it seems that all physicians are condemned to perform a futile task, such as the one illustrated by the myth of the Danaids. But if the physicians' task is "to cure sometimes, relieve often, comfort always",²⁷ physicians need not be frustrated. Instead, as Huntley²⁸ put it commenting on the myth of Sisyphus, no matter how small our medical victories are, we must always pursue and enjoy them and at the same time reconsider our goals without decreasing our efforts.

Η έννοια του «Σισύφειου έργου» στην ιατρική: Μια ανακατασκευή

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Στην ιατρική, όπως και σε άλλες επιστημονικές περιοχές, συχνά γίνεται επίκληση του μύθου του Σίσυφου όταν έρχεται κανείς αντιμέτωπος κάποιου έργου που θεωρείται κοπιώδες, ατελείωτο και για ορισμένους άγονο και ενδεχομένως χωρίς σκοπό ή νόημα. Στο άρθρο αυτό διερευνούμε τις πηγές του μύθου του Σίσυφου, ευελπιστώντας οι συνεκδοχές και οι συμβολισμοί του να γίνουν πιο

εξάκαθοι. Υποστηρίζεται ότι το φυσικό πλαίσιο του μύθου είναι δυνατόν να σχετίζεται με τη σεισμολογική ιστορία της Ελλάδος και της Κορίνθου ειδικότερα, μιας πόλης που καταστράφηκε και ξαναχτίστηκε πολλές φορές. Το φυσικό στοιχείο μπορεί συμβολικά να αντανακλάται στον προσωποποιημένο μύθο του ήρωα, ιδρυτή της Κορίνθου και ίσως να εξηγεί τον παράξενο έργο που καταδικάστηκε να επιτελεί αιώνια, καθώς και τα νοήματα που ο μύθος μεταφέρει. Ο Σίσυφος, παρόμοια όπως και η πόλη του, υπέφερε τα «πάνω» και «κάτω» της μοίρας, είτε ως ένα δημόσιο πρόσωπο και δημιουργός διάφορων μεγάλων επιτευγμάτων – είτε ως τιμωρημένος ήρωας καταδικασμένος, στον κάτω κόσμο να κουβαλάει την πέτρα. Οι επίμονες προσπάθειές του οδηγούσαν σε πρόσκαιρες επιτυχίες, αν και δεν μπορούσε να βρει οριστικές λύσεις στα έργα που αναλάμβανε, ζωντανός ή πεθαμένος. Κάτω από το πρίσμα αυτό ο μύθος του Σίσυφου έχει να κάνει με τις ανθρώπινες προσπάθειες, και τους περιορισμούς τους, το κατορθωτό και το ακατόρθωτο, τους δύο κύριους πόλους μεταξύ των οποίων λειτουργεί ο μύθος. Κατανοώντας με Σισύφειους όρους την λειτουργία τους, οι ιατροί μπορούν να επιχαιρόνται για τις εφήμερες επιτυχίες τους και με το να αναγνωρίζουν τους περιορισμούς τους να επαναπροσδιορίσουν τις φιλοδοξίες τους χωρίς να χαλαρώνουν τις προσπάθειές τους.

Λέξεις ευρετηρίου: Μύθος του Σίσυφου, Σισύφειο έργο, ιατρική.

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Research article Ερευνητική εργασία

Public opinions about mental illness in a Greek area: The influence of socio-demographic factors

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The importance of certain socio-demographic factors, which influence the attitudes and ideas regarding the mentally ill, were investigated in a resident population of a Greek region. An urban and a rural sample of 1,975 inhabitants were selected with an age range between 18 and 65 years. The Greek version of the Opinions about Mental Illness Questionnaire (OMIQ) was used for measuring the attitudes of social discrimination, social restriction, social care, social integration towards the mentally ill and the beliefs for the aetiology of the mental illness. The collected data were statistically analysed with stepwise multiple regression analysis and for the coding of the variables the method of dummy or indicator variables was followed. Educational level, age and place of residence are the main socio-demographic variables on which the OMIQ score depend. The results of this study could lead to the identification of target groups for the organisation of prevention programs aiming at changing public beliefs towards the mentally ill.

Key words: Community, mental health, public's attitudes, mental illness, OMIQ.

Introduction

Public attitudes towards mental illness were always an important issue of discussion, but in the last 3–4 decades it became the subject of systematic investigation. A number of scales, measuring opinions of people towards mental illness and the mentally ill, have been used for this purpose. In a first phase, investiga-

tors tried to evaluate and understand the general public's attitude towards mental illness.^{1–3} Subsequently, the research was focused on attitude and perceptions of mental health professionals towards their patients.^{4–6} The last tendency was considered to be more important in order to change inappropriate attitude. The development of new community-based psychiatric services and the practice of community

oriented treatment of mental illness produced a new problem: The research focused again to the attitude and conceptions of the general public towards mental illness, in order to organise psychiatric services in an effective way.

The investigation of public attitudes towards mental illness is an important prerequisite for a reform of Psychiatric Services. Reform of mental health care in Greece is, at the time being, under development. Legislative changes, the increasing number of psychiatric units in General Hospitals, the integration of psychiatry into the primary health care in rural areas and the development of Mental Health Centres, have been some of the reforms assumed.^{7,8} It is clear that these reforms could not take place easily if the attitude and behaviour of the general public towards the mentally ill is characterised by fear, stigmatisation, rejection and misinformation.^{9,10}

There is considerable evidence in the literature that socio-demographic factors such as gender, age and education affect the public's conceptions and attitudes towards the mentally ill.^{8,10-20}

In Greece, only a few investigators have been engaged in this field. Some of them²¹⁻²³ have evaluated the attitudes of relatives of the mentally ill towards their patients, while others investigated the general public's belief concerning mental illness, using either open-ended questionnaires in personal interviews,^{24,25} either more structured questionnaires.^{8,17,20,26,27}

The survey reported here is based on a sample of both urban and rural Greek population, related to the services of a Community Mental Health Centre (CMHC) in the area of Ioannina. The aims of this study were: (a) to estimate the public attitudes and ideas concerning mental illness in order to assist in the planning and organisation of mental health care and prevention programs in this area, and (b) to establish a baseline measure of such attitudes against which to evaluate the impact of community-based prevention programs. The present study investigates the relationship between socio-demographic factors and these attitudes and ideas within this local population.

Material and method

Sample

The area of Ioannina is a mountainous territory in Northwest Greece with a population, according to the census of 2001, of 170,244 inhabitants. The area's main city is Ioannina with a population of about 70,000 inhabitants, surrounded by 312 communities.

The data were collected in the context of a broader epidemiological survey concerning mental disorders in the population of this area. A random sample of 2010 households was selected with a systematic cluster sampling method. Then, from each household an adult aged between 18 and 65 years old was selected at random for the interview, using the Kish selection grid.²⁸ The final sample of this study included 1,975 subjects who answered to the Greek version of the Opinions about Mental Illness Questionnaire (OMIQ).^{4,8} Twenty-six individuals (1.3%) refused to participate and 9 questionnaires were discarded as uncompleted. The mean age of the participants was 44.6 (sd 14.7) years. Table 1 shows the profile of the final sample.

Interviewing methods and questionnaires

Data were collected using a personal interview including:

1. Questions on socio-demographic data.
2. The 22-items scale of Langner.²⁹
3. The Center for Epidemiological Studies Depression Scale (CES-D).³⁰
4. The Social Readjustment Rating Scale modified for Greek population.³¹
5. Questions on personal experience of seeking help
6. The OMIQ.^{4,8}

Table 1. Profile of the sample of the survey.

Population of the area	170,244	habitants
Total sample	1,975	persons
Residents of the city	616	persons
Residents of the communities	1359	persons
Mean age of the sample	44.6 (14.7)	years (sd)
Men	692	persons
Men in the city	211	persons
Men in the communities	481	persons
Women	1283	persons
Women in the city	405	persons
Women in the communities	878	persons

This article focuses on the public's attitudes towards mental illness according to the results of the OMIQ, which is the most widely used instrument for the measurement of attitudes towards mental illness. It comprises of 51 items with Likert's type answers. The OMIQ^{4,5,32} is a sensitive, comprehensive, reliable and valid instrument that serves to evaluate many components of the attitudes towards mental illness, although it has been criticised as being too complex³³ or incomplete.³⁴ We used the OMIQ as was modified and standardised for the Greek population.⁸ The Greek version, after factor analysis, yields five factors, defined as:

1. Social discrimination (16 items). It includes an authoritarian attitude towards the mentally ill, who are considered inferior requiring coercive handling
2. Social restriction (13 items). The central idea is that the social and/or family activity of the mentally ill should be restricted both during and after hospitalisation.
3. Social care (8 items). A positive view towards treatment ideology suggesting improvement of quality of care and social support.
4. Social integration (8 items). The central belief is a favourable attitude towards the social participation and incorporation of mentally ill in community life.
5. Aetiology of mental illness (6 items). The last factor concerns conceptions about the aetiology of mental illness. High score reflects conceptions about the importance of interpersonal relationships and the cohesive or destabilising influence of the family.

The structure of these factors is not very different from the original five ones developed by Cohen and Struening: authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal aetiology.

The gradation of each factor is given by a mathematical equation. High score in each factor means a positive attitude towards this factor. It has become a main instrument used by Greek investigators, both to study the general public's beliefs regarding mental illness,^{8,20} and to evaluate the ideas that the mental

health professionals have about it.^{7,17,27} Koutrelakos et al²⁶ were the first who used the OMIQ in a Greek population sample.

Statistical analysis

For the statistical analysis of data, multiple regression analysis was used in order to find out the variables affecting the scores at the OMIQ. The 5 factors of the OMIQ were used as dependent variables and the socio-demographic variables such as: gender, age, place of residence, change of place of residence after the age of 15, marital status, educational status, professional level, and the number of family members, as independent. The variable of socio-economic status is not used, as in Greece there isn't a unified categorisation for it. However, several investigators suggest different categorisations for the above variable based on educational level in combination with professional status.⁸ Then, at a second stage, stepwise multiple regression analysis is used with emphasis on the effects of the first order interactions of the socio-demographic variables. For the coding of the variables the method of dummy or indicator variables was followed.³⁵ By this method of coding, an independent variable is substituted by a number of independent sub-variables depending on the number of the values of the initial variable. So, the independent variable "age" is substituted by five sub-variables "age 1", "age 2", "age 3", "age 4" and "age 5". This coding not only allows to detect the effect of a socio-demographic variable on the attitudes towards mental illness, but also to find out which group of the population has either more important impact or a different attitude. The statistical analysis was carried out using the Statistical Package for the Social Sciences (SPSS).³⁶

Results

In table 2 the mean values and standard deviations on the total population by place of residence (urban or rural), concerning all five factors are shown. We observe that inhabitants of rural areas show higher mean values in factor A (social discrimination) and factor B (social restriction), which means that they are more in favour of social discrimination and social exclusion. They also show a higher mean as far

Table 2. Means and Standard deviation of OMI factors by place of residence.

<i>OMI Factors\Residence</i>	<i>Urban</i>	<i>Rural</i>	<i>Total</i>
Social Discrimination	37.8 (8.3)	42.5 (6.3)	41.1 (7.3)
Social Restriction	22.5 (7.9)	27.8 (8.1)	26.1 (8.4)
Social Care	22.9 (2.9)	22.9 (3.1)	22.9 (3.1)
Social Integration	15.7 (4.6)	14.8 (4.6)	15.1 (4.6)
Aetiology	14.4 (4.3)	16.1 (3.5)	15.6 (3.9)

as the aetiology factor (D) is concerned, that is, they support less the opinion that intra-familial relationships play an important role as causes of mental illness. Inhabitants of rural settings favour less social integration of the mentally ill in comparison to residents of urban areas, while opinions on social care are consistent between residents of both urban and rural areas.

Multiple regression by factor

1. Factor A: Social discrimination and autarchy

a. When we examine the effect of demographic variables, considered independently, educational level affects Factor A negatively, while place of residence and population age affect Factor A positively (table 3). Consequently, elderly people show a more positive attitude to social discrimination and a more authoritarian view towards mentally ill than younger persons. The same applies to the population of rural areas against the population of urban areas, and between people with low educational level and people with higher educational level.

b. The picture of Factor A is altered when first order interactions enter into regression analysis, i.e. when demographical variables are not examined independently, but a potential relation between them is considered. Demographical variables and variables created by correlation of demographical variables one-to-one –the value of which equals the result of multiplication of the respective values of demographical variables– participate as independent variables.

In that case (table 4), as far as demographical variables are concerned, Factor A is negatively affected by the educational level and by divorce. Factor A is, at the same time, negatively affected by the variable age-students and positively affected by the variables gender-students, place of residence-educational level, age-small business owners, age-educational level.

Therefore, although educational level contributes negatively in the favourable attitude towards social discrimination, when it is combined with age and place of residence it affects positively the opinion in favour of social discrimination. In particular:

Table 3. Socio-demographic variables which affect the OMI factors (Stepwise Multiple Regression Analysis).

	<i>Education</i>		<i>Age</i>		<i>Residence</i>		<i>Family members</i>		<i>R²</i>
	<i>B</i>	<i>Sig T</i>	<i>B</i>	<i>Sig T</i>	<i>B</i>	<i>Sig T</i>	<i>B</i>	<i>Sig T</i>	
Social Discrimination	-1.1656	0.000	0.9996	0.000	1.8469	0.000	-	-	0.1978
Social Restriction	-1.2890	0.000	1.1567	0.000	2.1391	0.000	0.3870	0.019	0.1904
Social Care	-	-	-	-	-	-	-	-	-
Social Integration	0.4186	0.000	-0.3087	0.000	-	-	-0.2948	0.003	0.0401
Aetiology	-0.4525	0.000	0.2586	0.000	0.7365	0.001	-	-	0.0843

-: The variable is not in the equation

No variables entry in the equation of Social Care

Table 4. Socio-demographic variables which affect the OMI factor of Social Discrimination (Stepwise Multiple Regression Analysis).

<i>Variable</i>	<i>B</i>	<i>SE B</i>	<i>Beta</i>	<i>T</i>	<i>Sig T</i>
Education	-3.17939	0.18235	-0.61636	-17.436	0.000
Divorce	-3.70064	1.61593	-0.04540	-2.290	0.022
Age * Education	0.36423	0.03980	0.24711	9.362	0.000
Residence * Education	0.56987	0.10846	0.14770	5.254	0.000
Age * Students	-4.39748	0.91328	-0.24693	-4.815	0.000
Sex * Students	3.38705	0.93421	0.18904	3.626	0.000
Age * Small business man	0.43492	0.14389	0.06010	3.022	0.002
Constant	43.75340	0.40921		106.922	0.000

R Square: 0.22906

- Individuals of high educational level, who are of older age or reside in rural areas, show a more favourable attitude towards social discrimination in comparison to individuals of the same educational level, younger or residing in urban areas
- Individuals of a given age and high educational level show a more positive attitude in favour of social discrimination than individuals of the same age but lower educational level
- Individuals who live in a place of residence and have a high educational level show a more positive attitude in favour of social discrimination than individuals living in a similar place of residence but with lower educational level.

There were also population groups with a distinct behaviour towards factor A:

- Female students have a more positive attitude towards social discrimination compared to male students
- Small business owners of older age have a more positive attitude towards social discrimination compared to younger small business owners
- Divorced persons have a more negative attitude towards social discrimination
- Older students have a more negative attitude towards social discrimination compared to younger students.

2. Factor B: Social restriction

a. Examining the effect of demographic variables, considered independently, educational level affects Factor B negatively while place of residence and population age affect Factor B positively (table 3). Consequently, elderly people show a more positive attitude in favour of social exclusion towards mentally ill, compared to younger persons. The same applies to the population of rural areas against the population of urban areas, and between persons with low educational level and persons with higher educational level.

b. When first order interactions enter into regression analysis, the picture of Factor B is altered. In that case (table 5), Factor B is negatively affected by educational level and divorce. Factor B is, at the same time, negatively affected by the variables age-small business owners, age-students and positively affected by the variables gender-farmers, age-small business owners, age-educational level, and place of residence-educational level.

Therefore, although educational level contributes negatively in the favourable attitude towards social exclusion, combined with age and place of residence it affects positively opinion in favour of exclusion. Namely:

- Men of high educational level show a more favourable attitude towards social exclusion in comparison to men of lower educational level,

Table 5. Socio-demographic variables which affect the OMI factor of Social Restriction (Stepwise Multiple Regression Analysis).

<i>Variable</i>	<i>B</i>	<i>SE B</i>	<i>Beta</i>	<i>T</i>	<i>Sig T</i>
Education	-2.30329	0.34030	-0.39028	-6.768	0.000
Divorce	-5.34125	1.88364	-0.05727	-2.836	0.005
Residence * Age	0.38646	0.08588	0.16326	4.500	0.000
Sex * Farmers	1.52555	0.37969	0.08508	4.018	0.000
Age * Students	-1.15811	0.47242	-0.05684	-2.451	0.015
Age * Small business man	1.21458	0.33942	0.14670	3.578	0.000
Sex * Education	0.39749	0.11544	0.12927	3.443	0.000
Sex * Small business man	-2.07403	0.96131	-0.08777	-2.158	0.031
Age * Education	0.12954	0.06152	0.07682	2.106	0.035
Constant	26.47831	0.89481		29.591	0.000

R Square: 0.20507

- Women of high educational level show a more favourable attitude towards social exclusion in comparison to women of lower educational level
- Women of high educational level show a more favourable attitude towards social exclusion in comparison to men of similar educational level
- Elderly people of high educational level show a more positive attitude in favour of social exclusion than individuals of similar educational level but of a younger age
- Individuals of a given age and high educational level show a more positive attitude in favour of social exclusion than individuals of the same age but lower educational level.

It is worth mentioning that age and place of residence do not present as independent factors, although they affect positively Factor B as an interaction variable. Consequently:

- Elderly people living in a certain place of residence show a more positive attitude in favour of social exclusion compared to younger persons living in the same place of residence
- Individuals of the same age living in rural areas show a more positive attitude in favour of social exclusion compared to individuals of the same age living in an urban area.

There were population groups with a distinct behaviour towards factor B:

- Divorced people have a more negative attitude towards social exclusion
- Older students have a more negative attitude towards social exclusion compared to younger students
- Female owners of small business have a more negative attitude towards social exclusion compared to male small business owners
- Female farmers have a more positive attitude towards social exclusion compared to male farmers
- Older small business owners have a more positive attitude towards social exclusion compared to younger small business owners.

3. Factor C: Social care

a. Examining the effect of demographic variables, considered independently, factor B is not affected by any variable (table 3)

b. However, when first order interactions are involved in the regression analysis, the profile of factor C is slightly differentiated.

In this case (table 6), with reference to demographic variables, factor C is negatively influenced by the profession of farmer and positively by the place of residence-age variable.

Consequently:

- People working as farmers have a more negative attitude towards social care

Table 6. Socio-demographic variables which affect the OMI factor of Social Care (Stepwise Multiple Regression Analysis).

<i>Variable</i>	<i>B</i>	<i>SE B</i>	<i>Beta</i>	<i>T</i>	<i>Sig T</i>
Farmers	-1.00679	0.22208	-0.10556	-4.533	0.000
Residence * Age	0.04132	0.02017	0.04770	2.049	0.041
Constant	22.74096	0.15329		148.355	0.000

R Square: 0.01067

- Older people of a given place of residence have a more positive attitude towards social care than younger people living in the same place of residence
- People living in communities express a more positive attitude in favour of social care than people of the same age living in urban centers.

4. Factor D: Social integration

a. When the impact of demographic variables, considered as independent variables, is examined, then factor B is positively influenced by the level of education and negatively influenced by the age and the number of family members (table 3). So, young people show a more positive attitude towards social integration for mentally ill patients than older people. The same stands for people coming from families with a few members, as opposed to people with families of many members, as well as for people with high education level as opposed to people with lower education level.

b. However, when first order interactions are involved in the regression analysis, the profile of factor D is barely differentiated (table 7). In this case, with reference to demographic variables, factor B is negatively influenced by age and positively influenced by education level and divorce variables.

Therefore

- People with high education level have a more positive attitude towards social integration than people with lower education level
- Younger people have a more positive attitude towards social integration than older people.

A population group presenting a particular attitude towards factor D has also emerged:

- Divorced people have a more positive attitude towards social integration.

5. Factor E: Aetiology in favour of interfamilial relations

a. When the effect of demographic variables, considered as independent variables, is examined, then factor E is negatively influenced by education level and positively influenced by the place of residence and the age of the population (table 3). So, older people have a more positive attitude towards interfamilial relations being the aetiology of mental illness than younger people. The same stands for people living in communities as opposed to people living in urban centers, as well as for people with low education level as opposed to people with higher education level.

Table 7. Socio-demographic variables which affect the OMI factor of Social Integration (Stepwise Multiple Regression Analysis).

<i>Variable</i>	<i>B</i>	<i>SE B</i>	<i>Beta</i>	<i>T</i>	<i>Sig T</i>
Education	0.41653	0.08438	0.12738	4.936	0.000
Age	-0.28445	0.07955	-0.09229	-3.576	0.000
Divorce	2.45907	1.14157	0.04758	2.154	0.031
Constant	15.06919	0.49832		30.240	0.000

R Square: 0.03897

b. However, when first order interactions are involved in the regression analysis, the profile of factor E is differentiated. In this case (table 8), with reference to demographic variables, factor E is negatively influenced by educational level and divorce. Moreover, it is negatively influenced by the variable gender-high professional level and positively influenced by the place of residence-high professional level and place of residence-age variables.

So, although high educational level continues to contribute negatively to the attitude towards interfamilial relations being the aetiology of mental illness, age and place of residence contribute positively to factor E but only as a unique interaction variable. Therefore:

- Older people of a given place of residence have a more positive attitude towards interfamilial relations being an aetiology of mental illness than younger people living in the same place of residence

- People living in communities have a more positive attitude towards interfamilial relations being an aetiology of mental illness than people of the same age living in urban centers.

Population groups presenting a different attitude towards factor E have also emerged:

- Divorced people have a more negative attitude towards intrafamilial relations being an aetiology of mental illness

- Women with a high professional level have a more negative attitude towards interfamilial relations being an aetiology of mental illness, than men with a high professional level and

- People with a high professional level living in communities have a more positive attitude towards interfamilial relations being aetiology of mental illness than people with a high professional level living in urban centers.

Discussion

The attitude of the general population in the area of Ioannina (Greece) –an area including both urban center and rural population– was investigated through the OMI questionnaire, modified for the Greek population.

The mean values for factors A, B, C, D, and E in the total sample are similar with those of the respective factors of similar studies conducted for the general population of Greece^{8,20} and fairly higher than the mean values of the respective factors in special population groups involved in health.¹⁷ Given the fact, though, that the above mentioned studies in the general population concern mainly the urban population, it is noted that some of the corresponding mean values for the urban population of the sample are lower than those reported in studies conducted in the general population⁸ and closer to those of special population groups.¹⁷ For example, for the factors A and B the mean values in Madianos' studies are 41.8 & 27.07⁸ and 35.07 & 23.77²⁰ respectively, while in Mantas' study they are 30.51 and 19.03.¹⁷

We believe that this finding is quite interesting and gives us indications for the possibilities of interpretation and the significance of quantitative measures resulting from the OMIQ. First of all, the large variety of mean values seen in the literature concern-

Table 8. Socio-demographic variables which affect the OMI factor of Aetiologie (Stepwise Multiple Regression Analysis).

<i>Variable</i>	<i>B</i>	<i>SE B</i>	<i>Beta</i>	<i>T</i>	<i>Sig T</i>
Education	-0.58906	0.08440	-0.21685	-6.979	0.000
Divorce	-0.69614	0.29006	-0.05505	-2.400	0.017
Residence * Age	0.10268	0.03185	0.09424	3.224	0.001
Residence * High Profession	2.42753	0.76414	0.17234	3.177	0.002
Sex * High Profession	-1.46373	0.62472	-0.12754	-2.343	0.019
Constant	16.52216	0.42051		39.291	0.000

R Square: 0.08861

ing both the initial OMIQ and the modified OMIQ by Madianos for the Greek population, indicate clearly that it is not the absolute values of the results which is important, but rather their tendency as well as the relations between them. Secondly, the evolution of values within time and their differentiation depending on population groups clarifies the relation between these values, considered as indications of the attitude of the population towards mental illness, and its socio-cultural features. More specifically, if we restrict to the Greek population where results can be directly compared, we see that not only studies concern different parts of the Greek population, but also have a big temporal difference between them. All studies compare the relation of attitude towards mental illness with social and demographic variables. Demographic, and mainly social variables change through time, and the same happens to the population's views. Madianos²⁰ explains for example the evolution of values, based on the population's familiarization in community mental health programmes. Another interpretation of our findings, where mean values especially for factors A and B are clearly lower (37.8 versus 41.8 and 22.5 versus 27.07), is related to specific features of the urban area, which we investigated. Ioannina is one of the most isolated and inaccessible areas of Greece. Difficulty in communication is one of the basic characteristics of the area and isolation is one of the population's "negative" experiences. Possibly, this fact makes the population of this area more negative against social isolation and social discrimination and, consequently, more tolerant towards the mentally ill. No matter how this differentiation and progress through time is interpreted, it is a fact confirming on the one hand the significance and complexity of the impact of demographic and social variables and on the other the necessity to perform repeated studies.

The study of demographic and social variables impact on attitude and opinion about mental health leads to the following basic conclusions and raises the following issues:

It is confirmed that the factors depending mostly on the demographic and social variables are Social Discrimination and Social Restriction.^{8,10,17,37-39}

These factors are influenced by educational level, age, and place of residence,^{8,17,37-39} while they do not seem to be influenced by profession, gender, family status and number of family members. The same attitude is observed for factor Aetiology, something that comes in contrast to Madianos'^{8,20} findings where profession and gender exert great influence on factor E. These results are similar to those of other investigators.^{8,10,37-39} Several observers of Greek customs describe interpersonal relationships as strongly oriented towards traditional authority.^{26,40-42} The strong priority given to family life^{40,43,44} might be the reason why older people, residents of rural communities, consider that mental disorders appear as a consequence of disturbed family relationships. Furthermore, the traditional belief in authoritarianism seems to change with education. The fact that the aspect of disturbed relationships is expressed by people with high professional level and consequently high socio-economic status, living in rural communities, could lead to the conclusion that the place of residence is, probably, a more important variable in the aetiology of mental disorders than socio-economic status. Educational level and age influence the factor of Social Integration, compatible to Mantas,¹⁷ but in contrast to Madianos.^{8,20} Finally, the factor of Social Care does not seem to be influenced by any social or demographic variables, thus being compatible with the findings of the aforementioned studies.

Any differences observed as to the impact of social and demographic variables, as reported in literature, can eventually be explained based on the special cultural characteristics of every place and population group. At the same time, they show that the influence and relation of the social and demographic variables to the opinion and attitude towards mental health is not that simple. The study of this relation with the use of multiple regression and first-order interactions (discussed below) supports this point of view.

The demographic variables that have an effect on all factors, except for C, are educational level and age, whereas A, B, E are also influenced by the place of residence. This effect, although consistent with most Greek and international studies, is not that simple as

shown by the study of the relationship between factors and socio-demographic variables with the use of multiple linear regression and first-order interactions. More specifically:

1. *Educational level.* Education continues to have a negative impact on factors A, B, E and positive on factor D. The main role of educational level in all attitudes towards the mentally ill could lead to the conclusion that education can change at least some components within the range of attitudes towards mental illness.³ This influence remains clear for factors D and E. However in combination with age for factors A and B, with the place of residence for factor A and with gender for factor B, this has opposite results. So, high educational level in older people has a positive influence on the factors of social discrimination and social restriction. In other words, older age reverses the influence of education on the attitude for social discrimination and social exclusion. Respectively, residents of rural areas with high-level education and women with higher education have a positive attitude towards social discrimination and social exclusion. The differentiation of these groups may eventually be explained based on the cultural features of these groups: we could argue that older people of high educational level come from more conservative population groups. However, in our point of view, the interpretation is not a simple case. We believe that these findings show the complexity of the relationship between factors and attitude towards mental illness and further investigation is needed in order to find out the causes of these differences by studying the social context in which these opinions are expressed.⁴⁵ In this context, we note that young students appear to have the most liberal attitudes towards the mentally ill. On the other hand, the liberal attitudes of the divorced may be the effect of their own experience. Greek family still insists that solutions must be found in the context of the family. So, divorced people may feel empathic to the discriminated against and rejected mentally ill.

2. *Age – Place of residence.* When first-order interactions between socio-demographic variables enter into multiple regression analysis, age influences only the factor of social integration (D). In the rest factors,

age does not seem to have an effect on its own, as reported in literature,^{8,10-20} but only in interaction with other variables. Besides interaction with educational level discussed in the previous paragraph, we observe, in interaction with the place of residence, an impact on factors B, C and E in the same way, positively, as on other variables. In other words, individuals of the same age who live in communities have a more positive attitude towards these three factors than those living in urban centers; this enhances the explanation that a more liberal social environment has a negative effect on the “negative factors”,^{8,17,20,45} and so there is access and familiarization to institutions of provision of mental health services or, to say it differently, that the above social context helps the formation of a more positive attitude for the proper management of mental illness.

Conclusions

The results of data analysis and their study in relation to the results recorded in literature show the significance and limits of epidemiological studies regarding the population's opinion and attitude towards mental illness.

The questionnaire measures the opinion and attitude towards mental illness. Yet, the value of the results of this measurement is not absolute, but it must be interpreted as tendency of the population groups.

The impact of demographic, social and cultural factors on the opinion and attitude towards mental illness is given. However, as was shown by the study of first-order interactions of demographic and social variables, the influence is a rather complex phenomenon and for a more thorough explanation of the influence, complementary investigation with qualitative analysis of the context and cultural characteristics is needed.

The use of first-order interactions also identified other population groups with supportive attitude towards the mentally ill or with negative attitude towards mental illness. The identification of these groups remains significant in the planning of intervention and organization programs for community mental health services.

Απόψεις περί των ψυχικών νόσων σε περιοχή της Ελλάδας: Η επίπτωση κοινωνικών και δημογραφικών παραγόντων

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Το άρθρο αυτό διαπραγματεύεται τη διερεύνηση των δημογραφικών και κοινωνικών παραγόντων που επιδρούν στη διαμόρφωση στάσεων και αντιλήψεων του γενικού πληθυσμού και αποτελεί μέρος μιας ευρύτερης επιδημιολογικής έρευνας που έγινε στο νομό Ιωαννίνων. Το δείγμα της έρευνας αποτέλεσαν 1975 κάτοικοι, ηλικίας 18 έως 65 ετών (μέσος όρος 44,6 έτη με τυπική απόκλιση 14,7), των αστικών και αγροτικών περιοχών του νομού Ιωαννίνων. Η μέθοδος επιλογής του δείγματος ήταν η επιτόπια διατμηματική έρευνα των δυο σταδίων (επιλογή οικοδομικού τετραγώνου –επιλογή νοικοκυριού). Το τελικό δείγμα αποτελείται από 616 (31,3%) κατοίκους της πόλης των Ιωαννίνων και 1359 (68,7%) κατοίκους των κοινοτήτων. Οι 692 ήταν άνδρες και οι 1283 ήταν γυναίκες. Η ελληνική εκδοχή του ερωτηματολογίου για τη Γνώμη για την Ψυχική Ασθένεια (Opinions about Mental Illness Questionnaire, OMIQ) χρησιμοποιήθηκε ως εργαλείο συλλογής των δεδομένων. Το ερωτηματολόγιο OMIQ αναδεικνύει πέντε παράγοντες σχετικούς με τις αντιλήψεις και τη στάση απέναντι στη ψυχική ασθένεια: την κοινωνική διάκριση, τον κοινωνικό περιορισμό, την κοινωνική φροντίδα, την κοινωνική ενσωμάτωση και την αιτιολογία ψυχικής νόσου. Ως στατιστική μέθοδος για την επεξεργασία των δεδομένων χρησιμοποιήθηκε η multiple logistic regression analysis. Τα αποτελέσματα έδειξαν ότι οι παράγοντες της κοινωνικής διάκρισης, του κοινωνικού περιορισμού και της αιτιολογίας επηρεάζονται αρνητικά από τη μεταβλητή της εκπαίδευσης και θετικά από τις μεταβλητές του τόπου διαμονής και της ηλικίας. Ο παράγοντας της κοινωνικής ενσωμάτωσης επηρεάζεται αρνητικά από τη μεταβλητή της εκπαίδευσης και θετικά από τις μεταβλητές του τόπου διαμονής και του αριθμού των μελών της οικογένειας, ενώ ο παράγοντας της κοινωνικής φροντίδας δεν επηρεάζεται από καμία κοινωνικό-δημογραφική μεταβλητή. Η μελέτη των αλληλεπιδράσεων πρώτης τάξης των μεταβλητών επέτρεψε την ανάδειξη των ομάδων του πληθυσμού αφενός με θετική και υποστηρικτή στάση απέναντι στους ψυχικά ασθενείς και αφετέρου εκείνες που έχουν αρνητική στάση απέναντί τους. Τα αποτελέσματα αυτά αναδεικνύουν καταρχήν την πολυπλοκότητα του φαινομένου της συσχέτισης των κοινωνικών και δημογραφικών χαρακτηριστικών με τα ζητήματα των αντιλήψεων και των στάσεων απέναντι στην ψυχική ασθένεια. Επιπλέον επιτρέπουν τον προσδιορισμό των ομάδων του πληθυσμού που είναι σημαντικές για την οργάνωση προγραμμάτων παρέμβασης και οργάνωσης των υπηρεσιών ψυχικής υγείας.

Λέξεις ευρετηρίου: Κοινότητα, ψυχική υγεία, αντιλήψεις, ψυχική νόσος, OMIQ.

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General article Γενικό άρθρο

Mental and Physical Health - A holistic approach

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The promotion and the protection of physical and, recently, mental health is a globally recognized priority. This is not true though with regard for their interrelationship which has received little attention from both medical branches. It is well known that physical health problems or disabilities are accompanied by or combined with mental health symptoms or disorders and vice versa. The advantages of a holistic, individualized approach, which covers not only the subjective complains of the patient but also the interaction between physical and mental health are well established based upon credible scientific data.

Key words: Mental health, physical health, holistic approach, individualized approach.

One of the most ancient and most revered axioms in Medicine, since the Age of Asclepius and Hippocrates, states that “a healthy mind resides in a healthy body”.

This axiom retains its validity nowadays more than ever, especially in the case of mental illness. The impact of mental disorders on the overall burden of disease was likely to be underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions, due to various economic, social and scientific factors. Therefore the trend has been to neglect or at least marginalise the fact that poor physical health

linked particularly with chronic or terminal conditions can make patients susceptible to poor mental health. Persons with an enduring mental illness are at much greater risk of developing certain physical health problems, most notably cardiovascular disease and diabetes and consequently of increasing the already substantial economic cost of the health care treatment, with a direct negative impact on national economies.¹

This is, for instance, the case of most low and middle-income countries where mental health remains a low priority and of developing countries which tend to prioritise the control and eradication of infectious

diseases. This also applies in developed countries which prioritise non-communicable diseases that cause early death (such as cancer and heart diseases) above those that cause years lived-with-disability (such as mental disorders). Consequently, although the importance of promoting and protecting both physical and mental health is well recognised, the complex interaction between the two has received comparatively little attention until recently. Of course the impact of poor mental health on physical health has been documented for many decades: yet this has only emerged as a major issue in the last ten years, as evidence on this relationship grows rapidly and the results of relevant studies have shown that unless the issue is duly taken into consideration, its social and economic impact shall seriously damage (personal, familial, national, European and global) economy at all levels.² For instance, the fact remains that in the WHO European region, mental and neurological problems account for 22% and 17% of the total burden of disease respectively, second only to cardiovascular disease.³ Also about 14% of the global burden of disease is attributed to neuropsychiatric disorders which increase the risk for communicable or non-communicable diseases, while conversely many health conditions increase the risk for mental disorders.⁴

These facts have led the WHO European Ministerial Conference Mental Health Plan for Europe of 2005, in Copenhagen, to the conclusion that there can be “no health without mental health”, which in essence is nothing more than just a variant verbal formulation of the above ancient Greek medical axiom.

The substance of this slogan, also endorsed, among others, by the EU Council of Ministers and the World Federation of Mental Health, is that mental disorders make an important contribution to the burden of disease worldwide as shown by the WHO Global Burden of Disease Report. This has revealed the degree of contribution of mental disorders by use of an integrated measure of disease burden, named the disability-adjusted life year, (i.e. the sum of years lived with disability and years of life lost). It should be added that of all the non-communicable diseases, neuropsychiatric conditions contribute the most to the overall burden, more than cardiovascular diseases or cancer.

In this context, neuropsychiatric conditions account for up to 25% of all disability-adjusted life-years and up to 33% of those attributed to non-communicable diseases, varying on the income level between countries. Mental disorders are the neuropsychiatric conditions that contribute the most disability-adjusted life-years, especially unipolar and bipolar affective disorders, substance and alcohol-use disorders, schizophrenia and dementia. Neurological disorders such as migraine, epilepsy, Parkinson's disease and multiple sclerosis make a smaller but still significant contribution. More specifically, according to the 2005 WHO's report, 31.7% of all years lived-with-disability are attributed to mental disorders with the unipolar depression occupying the first place among five major contributors (11.8%) followed by alcohol-use disorders, schizophrenia, bipolar depression and dementia. Conversely, the proportion of cases of disability that would not have occurred in the absence of mental disorders could be as high as 0.69%, which suggests that failing health and consequent disability could be the most important contributory cause for late-life depression.⁴

As far as mortality is concerned, the same WHO estimates refer to neuropsychiatric disorders accounting for 1.2 million deaths every year and 1.4% of all years-of-life lost, most of these caused by dementia, Parkinson's disease and epilepsy; only 40,000 deaths were attributed to depression, schizophrenia and post-traumatic stress disorder and 182,000 to use of drugs and alcohol. It should be noted that these numbers are almost certainly underestimated since the report attributes the yearly 800,000 deaths by suicide to intentional injury. However a systematic review of relevant studies identified mental disorders as important proximal risk factors for suicide with a rate of 91% in suicide completers and of 47–74% in a population-attributable fraction.⁴

Schizophrenia is generally acknowledged as a life shortening illness with patients dying on average ten years earlier than the general population (one third due to suicide and increased risk of accidents and two thirds due to poor physical health). Individuals with depression have a 24% increased risk of dying in the next six years compared with the general population.⁵

In parallel, evidence consistently indicates that the mortality rate or many physical illnesses, most notably cardiovascular disease and diabetes (with the exception of most cancers), are significantly higher for people living with enduring mental problems than rates found in the general population, regardless of the type of the mental problem (it was found in England, for example, that the risk of coronary heart disease related mortality was 188% greater than the general population for those aged between 18 and 49 and 76% for those between 50 and 75).⁶

Similar estimates were reached for risk of death from stroke with more than 139% for those aged under 50 and 83% for those over 50.

Beyond the particular issue of mortality and early death, mental health carries an equally strong association with non-communicable diseases such as cardiovascular risk exposures. It was found in that sense that psychoses of people living in London were associated with a 80% increase in the ten year risk of cardiovascular disease and that people with clinically severe depression were at greater risk by 150% of having stroke and heart attack, while those suffering from mild depression were at greater risk by 39%.

Conversely, poor physical health can be a cause of mental health problems. One US based study reported that cardiovascular disease was a significant trigger for depression and anxiety in people over 45 compared to the same age group of the general population (15% versus 7.1%) The same with stroke, chronic obstructive pulmonary disease, cancer, diabetes and arthritis.

Mental disorders also affect other health conditions such as obesity, smoking and medical conditions. One US study reported that 50% of women and 41% of men receiving psychiatric care were obese compared with 27% and 20% of the general population respectively. Further people with mental problems are twice as likely to be smokers. In the case of medical conditions, such as hypertension, arthritis, peptic ulcer and diabetes, the rate is almost three times greater than that of the general population and the evidence for comorbidity between mental disorder and the disease is much stronger. The prevalence of diabetes in people with schizophrenia being consistently shown to be about 15% compared with a typical community prevalence of 2–3%.⁷

Finally mental disorders also interact with some particular health conditions such as the medically unexplained somatic symptoms and syndromes which are strongly associated with common mental disorders. It should be noted that at least a third of those with somatisation have no comorbid mental disorder.

With regard to communicable diseases- mainly AIDS- which continue to cause substantial death and disability in low and middle-income countries, some indirect evidence shows that people with mental disorder are at heightened risk of contracting HIV/AIDS and that for patients with schizophrenia, mental illness generally precedes HIV infection. Moreover, apart from the psychological trauma the infection itself has direct effects on the central nervous system, and causes neuropsychiatric complications, depression, mania, cognitive disorder and frank dementia, often in combination.

Generally speaking, the interactions between mental disorders and other health conditions are widespread and complex. Mental disorders are risk factors for the development of non-communicable and communicable diseases, and contribute to accidental and non-accidental injuries. For some infectious diseases, mental disorders in infected persons increase the risk for transmission. Many health conditions increase the risk for mental disorder, or lengthen episodes of mental illness. The resulting comorbidity complicates help-seeking, diagnosis, quality of care provided, treatment, and adherence, and affects the outcomes of treatment for physical conditions, including disease-related mortality.⁸ For many health conditions, mental illness makes an independent contribution to disability and quality of life.

In a nutshell, mental disorders affect the rate of other health conditions, some health conditions affect the risk of mental disorders either by affecting directly the brain though infection, diabetes etc, or by creating a heavy psychological burden and, finally, some comorbid mental disorders affect treatment and outcome for other health conditions though delaying help seeking and reducing the likelihood of detection and diagnosis. Thus, it is evident that there are inextricable links between good physical and mental health. People living with a range of mental

problems and those coping with chronic or terminal illness as well as permanent disability appear to be at greater risk than the general population for developing co-morbid physical or mental health problems respectively.^{9,10} Hence action has to be taken not only by the individual States but also by the European Commission which can play a vital role by endorsing as a starting point for all European development of strategies to promote health holistically. Also the concept of liaison psychiatry might be expanded to include greater collaboration of psychiatrists with other specialities with the primary care sector. Finally, one potential way might be through community based multi-disciplinary primary care teams which would include not only primary care doctors and mental health professionals but also other disciplines such as community nursing and social work. This would aim to take a holistic approach to health promotion, including monitoring physical health needs, providing and monitoring medication and providing advice on healthy living to people experiencing psychoses for the first time aged between 16 and 30. This would be an extremely efficient way to avert, for instance up to 20% of infant stunting in Pakistan if maternal depression was treated more effectively as a relevant study

has shown, or to avert up to 15% of suicides in China by interventions to treat major depression as another similar study concluded.

A new European Commission study (HELPS) aims to identify best practice for physical health promotion in mental health and social care. Work is also underway in Europe to bring psychiatrists, dialectologists and cardiologists together to develop a joint statement on how people with severe mental health problems should be monitored for risk of hyperglycemia and cardiovascular disease.¹⁴

By the same token, mental health professionals should routinely assess their patients to identify and monitor physical health problems, should encourage them to attend regular tests, and should generally place a greater emphasis on lifestyle review and management, since there is a strong link between mental health, poverty and social exclusion and it is well known that those with depression are less inclined to engage in physical activity.

Finally, greater attention should be, given to the use of pharmacological treatment in order to avoid the so called metabolic syndrome and its severe side effects and risks for diabetes and heart diseases.

Ψυχική και Σωματική Υγεία- Ολιστική προσέγγιση

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Ψυχιατρική 2008, 19:350-354

Η διεθνής κοινότητα έχει αναγνωρίσει ως προτεραιότητα την προαγωγή και προάσπιση της σωματικής υγείας και πρόσφατα παρόμοια αναγνώρισης έτυχε και η ψυχική υγεία. Δεν συμβαίνει όμως το ίδιο και για την αλληλεπίδραση μεταξύ τους, η οποία δυστυχώς τυγχάνει μικρής προσοχής και από τους δύο επιστημονικούς κλάδους. Είναι πολύ καλά γνωστό ότι η σωματική αρρώστια ή αναπηρία συνοδεύεται ή συνυπάρχει με ψυχιατρικά συμπτώματα ή διαταραχές και το αντίθετο. Τα πλεονεκτήματα μιας ολιστικής, εξατομικευμένης προσέγγισης, που καλύπτει όχι μόνο τα υποκειμενικά ενοχλήματα του ασθενούς αλλά και τη διάδραση μεταξύ σωματικής και ψυχικής υγείας είναι αποδεδειγμένα και βασίζονται σε αξιόπιστα επιστημονικά δεδομένα.

Λέξεις ευρετηρίου: Ψυχική υγεία, σωματική υγεία, ολιστική προσέγγιση, εξατομικευμένη προσέγγιση.

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Case report Ενδιαφέρουσα περίπτωση

Quetiapine monotherapy in bipolar disorder: Two years maintenance treatment in an elderly woman

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Psychiatriki 2008, 19:355–358

Quetiapine has been used in bipolar mania and most recently in bipolar depression with good results. However its use in maintenance treatment has not been established yet. A case of an elderly woman suffering from bipolar disorder and diabetes mellitus (type II) is presented. The use of quetiapine as a monotherapy (300 mg/day) was efficient and safe and proved to be a good treatment in mood stabilization for two years.

Key words: Bipolar disorder, elderly, quetiapine, stabilization.

Introduction

Long term stabilization in bipolar disorder is a therapeutic goal which has not yet been achieved. Lithium and anticonvulsants often appear with serious side effects, especially for elderly patients. Atypical antipsychotics are useful in acute mania, but they could prove to be beneficial in maintenance treatment as well.

Quetiapine is an atypical antipsychotic which has been used in acute mania with good results.^{1–4} It has also proved to be effective as a monotherapy in bipolar depression.^{5,6} In long term treatment of bipolar disorder, quetiapine has been used as an adjunctive

therapy to lithium or anticonvulsants.^{7–11} The use of quetiapine as a monotherapy in bipolar disorder is limited to some case reports and one open-label study.^{3,12–14}

A case of an elderly woman with bipolar disorder and diabetes mellitus in which quetiapine proved to be efficient as monotherapy for two years maintenance treatment is reported.

Case report

Mrs Y, a 77 years old woman, widow, mother of three children, housewife, suffering from bipolar disorder. She is also under treatment for blood hyper-

tension and diabetes mellitus (type II). She had three major depressive episodes (MDE); at the age of 40, 58 and 69 years. The first two episodes had remitted fully under amitriptyline (150 mg/day). For the third MDE, she needed hospitalization. She had not remitted fully after six months under nortriptyline (75 mg/day) and paroxetine (40 mg/day). Lithium was tried as an adjunctive treatment, but it was stopped due to side effects: hypothyroidism and somnolence. At the age of 72, she had the fourth MDE, for which she was again hospitalized. Six months after discharge her remission was poor and she was examined in our Outpatients'. On assessment she was receiving sertraline (200 mg/day), mirtazapine (45 mg/day) and risperidone (2 mg/day). She remained rather depressive for the next two years: psychomotor slowness, somatic complaints, fatigue, dysphoric mood, preoccupation with health, overvalued ideas for constipation and bowel disease. She reported amelioration during summer and deterioration during winter. She was fully remitted on July 2005 (age 74), receiving amitriptyline 100 mg, sertraline 200 mg and quetiapine 25 mg. She was normothymic for the next 2 months when she expressed a manic episode. All antidepressants were stopped, quetiapine was raised to 600 mg and haloperidol 5 mg was added. Two months later she was normothymic and she was receiving 100 mg of quetiapine from her own for the next 3 months. She was in good mental state and mood until the next summer (2006) when she had her second manic episode. Quetiapine was raised to 500 mg and lorazepam 2 mg was added. In two months' time she was normothymic again and quetiapine was gradually lowered to 300 mg, a dose stable for the next two years until October 2008 (age 77). The patient had stable mood for these two years and did not appear any problems with her somatic health: no QTc prolongation, no need to adjust hypertension or diabetes treatment (GHbA1=6.3 g/dL). Though she had not insight of the manic phase, she kept on receiving 300 mg of quetiapine, since she had no adverse events and felt that her medication "protected her from depression".

Discussion

In this case report quetiapine was used as monotherapy for maintenance treatment in an elderly pa-

tient with bipolar disorder and diabetes mellitus. The age of the patient and the previous failure with lithium were the main reasons for choosing quetiapine in the beginning, since it is generally well tolerated. In the beginning of treatment, when the patient was still manic after initiating quetiapine, it was preferred not to raise the dose to 800 or 1,000 mg/day, in order to avoid orthostatic hypotension and severe somnolence and thus low doses of haloperidol were chosen, for two months. Haloperidol was helpful when quick suppression was necessary but was not preferable by the patient. On the other hand, quetiapine showed its antimanic effects in a mild but continuous way and finally proved to be very effective in stabilizing the patient's mood for two years. It is also worth noting that the patient's health problems were not affected; stable blood pressure, no weight gain, blood glucose regulation.

Quetiapine's use in bipolar disorder started from the management of mania; sedation and lack of extrapyramidal side effects proved to be advantageous.¹⁵ In acute mania it has been effective in combination to mood stabilizers^{3,7} or alone,¹ especially in the elderly.¹⁶ On the other hand quetiapine's good results in bipolar depression seem to be confirmed in large double-blind studies.^{5,6} The fact that quetiapine appears to be efficacious and safe both in mania and bipolar depression, increases the possibility to be beneficial as a mood stabilizer in long term treatment of bipolar disorder.⁹ Quetiapine has been tried in maintenance treatment of bipolar disorder, mainly as an adjunctive agent to resistant cases.^{3,8,10,13} Altamura et al have conducted a 12-month open-label study with quetiapine monotherapy in the maintenance treatment of bipolar disorder using 150–300 mg/day, similar doses with our case.¹² In a previous case of ours 400 mg/day were efficacious in a younger patient.¹⁴

In our patient the use of quetiapine helped managing bipolar disorder in an elderly woman without affecting her somatic problems. Mood stabilizing properties, along with good toleration and compliance made quetiapine efficacious as a monotherapy in our case. Mood stabilizing properties of quetiapine deserve further investigation with long term double-blind studies.

Η χρήση της κουετιαπίνης στη διπολική διαταραχή: Δύο χρόνια μονοθεραπεία σε μια ηλικιωμένη γυναίκα

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Ψυχιατρική 2008, 19:355–358

Η κουετιαπίνη έχει χρησιμοποιηθεί στη διπολική διαταραχή με καλά αποτελέσματα. Αρχικά στη θεραπεία του μανιακού επεισοδίου και προσφάτως στη θεραπεία του καταθλιπτικού επεισοδίου. Οι σταθεροποιητικές της ιδιότητες δεν έχουν εξετασθεί επαρκώς. Παρουσιάζεται η περίπτωση μιας γυναίκας 77 ετών, που πάσχει από διπολική διαταραχή τύπου I. Η ασθενής λαμβάνει επίσης, φαρμακευτική θεραπεία για αρτηριακή υπέρταση και σακχαρώδη διαβήτη τύπου II. Από την ηλικία των 40 εμφάνισε 4 καταθλιπτικά επεισόδια, για τα οποία είχε λάβει διάφορα αντικαταθλιπτικά σκευάσματα σε επαρκή δοσολογία. Για τα δύο τελευταία, μάλιστα, χρειάστηκε να νοσηλευτεί. Και τις δύο φορές, ακόμα και μετά την εξοδό της, παρουσίασε επίμονα συμπτώματα και καθυστερημένη ύφεση. Μέσα σε δύο χρόνια μετά το τελευταίο καταθλιπτικό επεισόδιο εμφάνισε δύο μανιακά επεισόδια. Και τα δύο υφέθηκαν σύντομα με τη χρήση κουετιαπίνης και μικρών δόσεων συμπληρωματικής θεραπείας (αλοπεριδόλης στο πρώτο και λοραζεπάμης στο δεύτερο). Η μονοθεραπεία με ημερήσια δόση 300 mg κουετιαπίνης μετά το τελευταίο μανιακό επεισόδιο ήταν αρκετή να κρατήσει την ασθενή ελεύθερη συμπτωμάτων σε νορμοθυμία για τα επόμενα 2 χρόνια. Ιδιαίτερες ανεπιθύμητες ενέργειες δεν εμφανίστηκαν καθόλη την πορεία της θεραπείας.

Λέξεις ευρετηρίου: Διπολική διαταραχή, ηλικιωμένη ασθενής, κουετιαπίνη, σταθεροποίηση.

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Future scientific meetings

Προσεχείς επιστημονικές εκδηλώσεις

- **WPA International Congress “Treatments in Psychiatry: A New Update”, Florence, Italy**
April 1–4, 2009
Organizer: Italian Psychiatric Association
Contact: Dr Mario Maj
E-mail: majmario@tin.it
Website: www.psichiatria.it
- **“10th ECNP Regional Meeting, Tallinn, Estonia**
April 23–25, 2009
Organizer: European College of Neuropsychopharmacology
E-mail: tallinn2009@ecup.eu
Website: www.ecnp.eu
- **CINP Thematic Meeting on Major Psychoses and Substance Abuse, Edinburg**
April 25–27, 2009
Organizer: Collegium Internationale Neuro-Psychopharmacologicum
Website: www.cinp.org
- **3rd World Congress of the APPAC, Athens, Greece**
May 5–8, 2009
Organizer: Association of Psychology & Psychiatry for Adults & Children
E-mail: appachellas@yahoo.gr
Website: www.epsep.org.gr
- **35ο Ετήσιο Πανελλήνιο Ιατρικό Συνέδριο, Αθήνα, Ελλάς**
Μάιος 5–9, 2009
Οργάνωση: Ιατρική Εταιρεία Αθηνών
E-mail: iea@mednet.gr
Website: www.mednet.gr
- **6ο Πανελλήνιο Παιδοψυχιατρικό Συνέδριο: Ψυχική υγεία παιδιού και εφήβου στη σύγχρονη Ελλάδα Αίγλη Ζαππείου, Αθήνα, Ελλάδα**
Μάιος 15–17, 2009,
Οργάνωση: Παιδοψυχιατρική Εταιρεία Ελλάδος
Website: www.hscapsongress 2009.gr
- **“II Thematic Conference on Legal and Forensic Psychiatry”, Madrid, Spain**
June 16–20, 2009
Organizer: Spanish Society of Legal Psychiatry
Contact: Dr Alfredo Calcedo Barba
E-mail: forensicpsychiatry2009@gmail.com
- **12th Annual Scientific Meeting of the European Association for Consultation-Liaison Psychiatry and Psychosomatics (EACLPP-Evidence Based Medicine in CL Psychiatry and Psychosomatics), Noordwijkerhout, The Netherlands**
June 25–27, 2009
Organizer: Nederlandse Vereniging voor Psychiatrie
Contact: A. Leentjens, EACLPP President
E-mail: i.sonderen@nwp.net
Website: www.eaclpp.org
- **8th International Conference on Bipolar Disorders, Pittsburg, Pennsylvania, USA**
June 25–27, 2009
Organizer: Western Psychiatric Institute & Clinic/ University of Pittsburg School of Medicine
Website: www.8thbipolar.org
- **Διεθνές θεματικό Συνέδριο: Από την ψυχική αναστολή στην υπερκινητικότητα-ψυχοπαθολογική προσέγγιση, Αθήνα, Ελλάς**
Ιούλιος 3–5, 2009
Οργάνωση: Ελληνική Εταιρεία για την Προαγωγή της Ψυχιατρικής και Συναφών Επιστημών
Συνεργασία: Α' & Β' Ψυχιατρική Κλινική Πανεπιστημίου Αθηνών, Παιδοψυχιατρική Κλινική Πανεπιστημίου Αθηνών
E-mail: easytravel@hol.gr
- **World Congress of the World Federation for Mental Health, Athens, Greece**
September 2–6, 2009
Organizer: World Federation for Mental Health,
Cooperation: Hellenic Psychiatric Association, Society of Preventive Psychiatry
Contact: Prof. George Christodoulou
Tel.: 0030-210-7291 389
Congress Secretariat: ERA Ltd, 17 Asklipiou Str., 106 80 Athens

E-mail: Info@era.gr

Website: www.wmhc2009.com

- **22nd ECNP Congress, Istanbul, Turkey**

September 12–16, 2009

Organizer: European College of
Neuropsychopharmacology

E-mail: organisingsecretariat@ecup2009.eu

Website: www.colloquium-group.com

- **"Second European Conference on Schizophrenia Research (ECSR)", Duesseldorf, Germany**

September 23–25, 2009

Organizer: German Research Network on
Schizophrenia

Contact: Dr Wolfgang Gaebel

E-mail: wolfgang.gaebel@uni-dusseldorf.de

Website: www.kompetenznetz-schizophrenia.de

- **20th World Congress on Psychosomatic Medicine, Torino, Italy**

September 23–26, 2009

Organizer: Department of Neuroscience, Università
degli Studi di Torino

E-mail: info@icpm2009.com

Website: www.icpm2009.com

- **"Annual Meeting of the International Society of Addiction Medicine (ISAM)", Calgary, Canada**

September 23–27, 2009

Organizer: International Society of Addiction Medicine
(ISAM), Calgary, Canada

Contact: Nady el-Guebly, MD

E-mail: office@isamweb.com

Website: www.isamweb.org

- **"WPA Regional Meeting", Abuja, Nigeria**

September 24–26, 2009

Organizer: African Association of Psychiatrists and
Allied Professions

Collaboration: Association of Psychiatrists in Nigeria

Contact: Dr Oye Gureje

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- **"VII World Congress of Depressive Disorders and International Symposium on Posttraumatic Stress Disorder", Mendoza, Argentina**

September 24–26, 2009

Contact: Dr Jorge Nazar

Organizer: University of Cuyo

E-mail: Jorge_Nazar@hotmail.com

- **2nd Eastern European Psychiatric Congress, Moscow, Russian Federation**

October 27–30, 2009

Contact: Prof G.N. Christodoulou

Congress President

Tel.: 210-72 14 148, Fax: 210-72 42 032

E-mail: psych@psych.gr

Website: www.paeeb2009moscow.ru

- **"56th Annual Meeting of the Academy of Psychosomatic Medicine (APM). Quality of Care: Implications for Psychosomatic Medicine", Las Vegas, USA**

November 11–14, 2009

Organizer: Academy of Psychosomatic Medicine: The
Organization for Consultation-Liaison Psychiatry

Contact: Executive Director APM

E-mail: apm@apm.org

Website: www.apm.org

- **10th World Congress of the World Association of Psychosocial Rehabilitation, Bangalore, India**

November 12–15, 2009

Organizer: World Association for Psychosocial
Rehabilitation

Contact: Dr Afzal Javed, T. Murali, Prof. M. Madianos

E-mail: afzal@afzalaved.co.uk/muralitryloth@gmail.com

- **1st International Congress on Neurology and Clinical Pharmacology & European Psychiatric Association Conference on Treatment Guidance, Thessaloniki, Greece**

November 19–22, 2009

Organization: International Society of Neurobiology
and Psychopharmacology

Collaboration: WPA Section on Private Practice
Psychiatry, European Psychiatric Association

E-mail: info@globalevents.gr

Website: www.globalevents.gr

- **DGPPN Congress, Berlin, Germany**

November 25–28, 2009

Organization: German Psychiatry & Psychotherapy
Association

Website: www.dgppn-congress.de

- **4th International Congress on Brain & Behaviour & 17th Thessaloniki Conference-Dual Congress Thessaloniki, Greece December 3–6, 2009**

Organizer: International Society on Brain and
Behaviour

Collaboration: Hellenic Psychiatric Association,
Psychiatric Association for Eastern Europe and the
Balkans, Hellenic College of Academic Psychiatry

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Website: www.triaenatours.gr

- **"WPA Regional Meeting", Dhaka, Bangladesh**

January 21–23, 2010

Organizer: Bangladesh Association of Psychiatry

Contact: Prof A.H. Mohammad Firoz

E-mail: bap@agni.com

- **18th European Congress of Psychiatry Munich, Germany**
 February 27–March 2, 2010
 Organization: European Psychiatric Association
 Website: www.Kenes.com/epa
- **CINP World Congress, Hong Kong**
 June 6–10, 2010
 Organizer: Collegium Internationale Neuro-Pharmacologicum
 Website: www.cinp2010.com
- **20th IFP World Congress of Psychotherapy, Lucerne, Switzerland**
 June 16–19, 2010
 Organizer: International Federation for psychotherapy
 Website: www.IFP-FMPP2010.com
- **“WPA Regional Meeting”, St. Petersburg, Russia**
 June 17–19, 2010
 Organizer: Russian Society of Psychiatrists
 Contact: Dr Valery Krasnov
 E-mail: krasnov@mtu-net.ru
- **“XIII Annual Scientific Meeting of the European Association for Consultation-Liaison Psychiatry and Psychosomatics (EACLPP) and XXVIII European Conference on Psychosomatic Research (ECPR)”, Innsbruck, Austria**
 June 30–July 3, 2010
 Contact: Prof. Gerhard Schüßler, MD
 E-mail: info@eaclpp-ecpr2010.org
 Website: www.eaclpp-ecpr2010.org
- **13th European Symposium on Suicide and Suicidal Behaviour, Rome, Italy**
 September 1–4, 2010
 Organization: University of Molise, Campobasso & University of Chieti-Pescara, Italy
- **“WPA Regional Meeting”, Beijing, China**
 September 1–5, 2010
 Organizer: Chinese Society of Psychiatry
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- **“WPA Regional Meeting”, Cairo, Egypt**
 January 26–28, 2011
 Organizer: Egyptian Psychiatric Association
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- **“WPA Regional Meeting”, Yerevan, Armenia**
 April 14–17, 2011
 Organizer: Armenian Association of Psychiatrists
 Contact: Dr Armen Sophoyan
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- **“XV World Congress of Psychiatry”, Buenos Aires, Argentina**
 October 11–15, 2011
 Organizers: (a) Argentina Association of Psychiatrist (AAP), (b) Association of Argentinean Psychiatrists (APSA), (c) Foundation for Interdisciplinary Investigation of Communication (FINTECO)
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- **“WPA Regional Meeting”, Taipei, Taiwan**
 November 12–13, 2011
 Organizer: Taiwanese Society of Psychiatry
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